The Committee will meet at 10.00 am in Committee Room 1 to consider the following agenda items:

1. **Item in Private:** The Committee will consider whether to take item 5 in private.

2. **Primary Medical Services (Scotland) Bill:** The Committee will take evidence on the Financial Memorandum of the Bill from—

   - Dr David Love, Joint Chairman; Dr Robin Balfour, Vice Chairman; and Dr Barbara West, member of Executive Committee, Scottish General Practitioners Committee;
   - Ian Reid, Chief Executive; Douglas Griffin, Director of Finance; and Terry Findlay, General Manager with responsibility for Primary Care services, Greater Glasgow Primary Care NHS Trust.

   *No later than 11.15 a.m.*

3. **Primary Medical Services (Scotland) Bill:** The Committee will take further evidence on the Financial Memorandum of the Bill from—

   - Lorna Clark, Bill Team Manager, Scottish Executive;
   - Dr Hugh Whyte, Senior Medical Officer, Scottish Executive;
   - David Notman, Economic Adviser, Scottish Executive.

4. **Children in Poverty:** The Committee will consider the Scottish Executive’s response to the previous Finance Committee’s report entitled “Cross-Cutting Expenditure in relation to Children in Poverty” (SP Paper 4).

5. **Primary Medical Service (Scotland) Bill:** The Committee will consider the evidence on the Financial Memorandum of the Bill in advance of its report to the Health Committee.
The papers for this meeting are:

**Agenda items 2 and 3**

Primary Medical Services (Scotland) Bill and Explanatory Notes

*Paper by the Clerk – Written Evidence*  
PRIVATE PAPER  
F1/S2/03/4/1

**Agenda item 4**

PRIVATE PAPER

**Agenda item 4**

*Scottish Executive response dated 26 August 2003*  
F1/S2/03/4/2
Finance Committee  
Primary Medical Services (Scotland) Bill  
Financial Memorandum  

Written Submissions

1. In order to assist the Committee in its consideration of the Financial Memorandum of the Primary Medical Services (Scotland) Bill, written submissions have been received from the following organisations:

   Appendix A – British Medical Association Scotland  
   Appendix B – Ayrshire and Arran NHS Health Board  
   Appendix C – Greater Glasgow Primary Care NHS Trust  
   Appendix D – Forth Valley Primary Care NHS Trust

2. **The Committee is invited to consider these submissions.**

David McGill  
September 2003
Introduction

The Primary Medical Services (Scotland) is a unique piece of legislation for the Scottish Parliament. As an enabling piece of primary legislation, its sole purpose is to put in place the legislation required in order to implement a new GMS contract for GPs in Scotland.

The new GMS contract was jointly negotiated between the British Medical Association and the NHS Confederation on behalf of the four UK governments, with Scottish representation on both sides and Scottish Departmental Observers. The new contract aims to address low morale within the profession, allowing doctors to regain control over their workloads and receive funding to enable them to deliver a wider range of high quality services. It is hoped that, over time, this will improve recruitment and retention into general practice, improve services to patients and ensure the future of general practice.

Background

The BMA welcomes the principle outlined in Our National Health\(^1\) that “if it can be done in primary care, it should be done in primary care.” However, more and more work has transferred from the secondary care sector into primary care without the appropriate transfer of resources. Currently over 90 per cent of patient contacts begin and end in primary care, but it receives disproportionately lower levels of funding.

Family doctors are very much part of local communities and are valued and trusted by the public. However, GP morale is at an all time low. A recent job satisfaction survey conducted on behalf of the Scottish Executive\(^2\) echoed results of previous surveys conducted by the BMA\(^3,4\). These surveys found that job satisfaction was low and job stress high among GPs, particularly middle-aged GPs (aged between 40-45). Sources of stress included excessive bureaucracy and paperwork, increasing workload, lack of time and increased demand from patients. Twenty one per cent of GPs said that they

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\(^1\) Scottish Executive Health Department. Our National Health – A plan for action, a plan for change. Scotland; 2000
\(^2\) Simoens S, Scott A. General Practitioner Job Satisfaction: Health Economics Research Unit, University of Aberdeen; 2001.
\(^3\) Scottish General Practitioners Committee. The Reality Behind the Rhetoric: A survey of the views of GPs in Scotland on morale, service provision and priorities for improving primary care. BMA; 2001 March
\(^4\) Royal College of General Practitioners (Scotland) and Scottish General Practitioners Committee. Valuing Scottish General Practice; 2000 October.
would leave general practice within the next five years. (This figure rises sharply among GPs aged 55 and over.)

This comes at a time when general practice is facing a recruitment crisis with vacancies running at the highest level in years. Since 1995, the number of whole time equivalent GP principals has increased by only 4%; consultant numbers have increased by 17%\(^5\). Worrying trends have developed in general practice in recent years. Many GPs are retiring early, too few medical graduates are choosing general practice as a career and an increasing number are choosing to work part time. The number of GP registrars (doctors in training) was 284 in 2002/03 and will fall to 260 in 2003/04. There has been a drop of 21% in the number of doctors in training for general practice compared with 1990 when there were 330 GP registrars in training. It is estimated that 150 new entrants are needed to replace every 100 GPs who retire\(^6\) because of the changing demographics and career intentions of the profession.

The new contract

The new contract comes with the promise of unprecedented levels of funding for general practice. Spending on primary care in the UK will increase from £6.1 billion to £8 billion per annum by April 2006, an increase of £1.9 billion which represents an uplift of 33 per cent over three years. This new investment is protected by a Gross Investment Guarantee.

Under their current contract, GPs are paid through a system of fees and allowances which are set out in the Statement of Fees or Allowances commonly known as the Red Book. The new GMS contract will completely rewrite the arrangements for general practitioners, replacing all payments in the Red Book.

The new contract should see a substantial increase in resources for practices. This increase will depend on both the range of services provided and the achievement of quality markers covering both clinical and organisational quality. The practice will have the option of using this additional resource to recruit more staff, to invest in facilities in order to enhance the range and quality of services offered and to improve access for patients. GPs will also have the opportunity to bring their own rewards back in line with comparable highly skilled professions, having fallen significantly behind in recent years.

Practices will have the flexibility to decide how high quality care should be delivered to meet local needs, making better use of the skills of the wider primary care team. Practices should have the resources required to meet the needs of their practice population and will for example, no longer have to seek the approval of their NHS Board for funding for an extra nurse.

\(^5\) ISD Workforce Statistics. October 2002

\(^6\) Royal College of General Practitioners. The Primary Care Workforce (second edition) (London); 2000
With the ability to manage workload, better resources, increased income, improved seniority payments, improved pensions, and the ability to opt out of out-of-hours service provision, this new contract should make general practice a much more attractive career option and should improve recruitment into the profession. The ability to control workloads could act as an incentive for GPs to remain in practice longer than at present.

The BMA therefore supports the principles of this Bill.

**Scottish Allocation Formula (SAF)**

Under the old Red Book contract, patients were registered on an individual GP’s list. A significant proportion of a practice’s resources followed the GP, not the patient. If a GP left the practice, and could not be replaced, the payments relating to that doctor were lost, with the result that not only did the remaining GPs have to bear the increased workload but the practice also lost income.

The new contract changes this. Money will flow into practices according to the weighted needs of their patients. The old system, which was based, to an extent, on the number of doctors, will disappear. Instead, patients will register with a practice and funding will be based on the health needs of the patients.

A formula (Scottish Allocation Formula) has been developed to work out the weighted needs of a practice's patients. The intention is to allocate more funding to those practices whose patient populations have greatest need as determined by such factors as age, deprivation, rurality etc. This formula will need to be refined and improved as better data becomes available from practices. Total reliance on the formula as a means of allocating resources to practices is not possible at this stage because of the excessive redistribution of resources between practices caused by the formula. An early review of the allocation formula is planned to ensure that resources are being distributed fairly and appropriately.

For this reason, the Minimum Practice Income Guarantee (MPIG) was introduced to protect practices that would otherwise be destabilised because of the redistributive effect of the funding allocation formula.

We would strongly disagree with the comments on the MPIG in paragraph 87 of the Financial Memorandum to the Bill which states “The principle of the MPIG is permanent but the policy intention is that the vast majority of practices will quickly discover that, when they take account of all of the funding streams, the new contract will leave them, even without the MPIG in a better financial position than the current Statement of Fees and Allowances at which point they will cease to be losers and will no longer require the MPIG.” Entitlement to the MPIG is based on a comparison of a practice’s Red Book global sum equivalent with its global sum under the formula, not with its receipts from the totality of funding streams.

The object of the new contract was to deliver substantial new resources to practices related to the provision of enhanced services and the delivery of high quality. Without the MPIG, many practices found that because of their reduced global sum allocation, they would have had to carry out substantial additional work simply to maintain their current funding. This was unacceptable to the profession.
It is essential that practices which provide new services and higher quality attract the appropriate additional funding. It is misleading to suggest that practices which equal or exceed their historical funding through substantial additional work and improved quality will no longer need their MPIG. The rewards for those efforts should be additional to current funding, not a substitute for it. The MPIG must be available in perpetuity until a practice’s global sum allocation exceeds its uprated historical funding. The global sum does not include new funding for Enhanced Services and quality achievement.

**Categorisation of services**

The new contract clearly defines what general medical services are and splits them into three categories: essential, additional and enhanced. Funding for essential and additional services will be financed by the global sum. It should be noted that all practices already provide essential services and most also provide the full range of additional services to their patients. It is anticipated that only those practices struggling to cope with workload or having difficulties with recruitment will opt out of providing additional services. This will have a cost implication in that the practices will have to pay a fixed, nationally agreed, percentage of their global sum to the Health Board for the services that they cannot provide to enable the Board to contract for that service to ensure patient services are guaranteed.

Many practices will also wish to provide a range of enhanced services to patients. Directed and National Enhanced Services are nationally priced and funding, managed by Boards, will be allocated to practices providing those services.

However, the Policy Memorandum to the Bill indicates that “Practices will be able to opt into ‘enhanced services’, which will be commissioned by the Health Board and delivered by selected practices within a Board area.” The BMA believes that patients are entitled to choice. If the practice with which the patient is registered is willing to provide a particular enhanced service and can comply with the required standards, that service should be available from the patient’s own practice. The BMA believes that, wherever possible, most patients would prefer to receive services from their own practice, rather than being forced to attend another practice or alternative provider.

The Policy Memorandum to the Bill suggests that contracts between practices and Boards will be negotiated at a local level with a “degree of uniformity to reflect the fact that the principles of the new contract have been agreed at a UK level”. The BMA would seek clarification on this point. This is a nationally negotiated contract and we would question the justification for local negotiation. We would suggest that rather than local negotiation being general, it must be limited to discussions on such matters as the provision of Enhanced Services, particularly Local Enhanced Services where pricing for the service is to be negotiated and agreed locally, not on the wider detail of the contract.
There is a minimum floor of funding available to Health Boards to ensure that funding is available for Enhanced Services. However, it is essential that current funding streams to practices are preserved to maintain existing service developments within general practices, and that the new funding is not used to substitute for existing funding.

Health Board administered funds

The Financial Memorandum to the Bill states “Health Boards have discretion on how the enhanced services and Board administered lines are spent. Boards can exceed these minimum levels, but must not go below it”. We would point out that in terms of the new contract, these decisions should be taken in consultation with Local Medical Committees (LMCs)/GP Sub-committees.

We note that GPs’ seniority payments are included in this funding stream and as they are part of a GPs’ guaranteed income they should not be discretionary. Seniority payments bear no relationship to the needs of the population, and are one of the few remaining doctor-specific payments. We would question the logic of applying the SAF to the funding for seniority payments to Boards.

Quality and Outcomes Framework

The BMA welcomes the emphasis on quality in the new GMS contract. Significant levels of new investment will flow into general practice from achievement against the Quality and Outcomes Framework. This is optional for practices, but with resources of £8m in this current year (2002/03) rising to £64m and £100m in years 2004/05 and 2005/06 respectively, it represents a large proportion of the increased resources available to practices.

The quality markers are evidence based and ensure that high quality care for patients is rewarded and resourced. The principle of informed dissent ensures that GPs are protected from financial penalties if patients exercise their right to decline treatment or any other intervention. However, the BMA is disappointed that this principle has not been applied to the childhood immunisation programme, where the current target system remains, particularly given the current lack of public confidence in the MMR triple vaccine. GPs will therefore continue to be penalised for patients taking decisions on the principle of informed dissent.

The Financial Memorandum to the Bill provides estimated expenditure on the quality framework. It has predicted that 90% of practices will achieve 90% of the available points each year. This is likely to be an overestimation of achievement. There must be some mechanism to ensure that any underspend is made available to practices in order to preserve the Gross Investment Guarantee.
Remote and rural

The SAF is weighted to allocate additional resources to remote and rural practices in their global sum. Where this is less than their historic Red Book income they will receive income protection through the MPIG. For inducement practices with small list sizes and fewer opportunities to increase income through the Quality and Outcomes Framework the introduction of the new GMS salaried contract may prove an attractive option. Inducement practitioners have been becoming increasingly dissatisfied in recent years with the inequities and excessive bureaucracy of the current inducement scheme. The salaried option may also prove attractive to young doctors who do not want to commit themselves to a lifetime in a remote and rural area.

Consideration is still being given to how the MPIG arrangements under the new contract will apply to practitioners in remote areas who are currently part of the inducement scheme. It is essential that dependable, high quality services are maintained in remote and rural areas. The degree to which this is achieved under the new GMS contract will be determined by the willingness of the Health Boards to offer attractive packages to their existing GPs to retain them and to recruit new applicants for unfilled vacancies.

University practices

The small number of university practices in Scotland have distinct practice populations largely comprising younger people. The needs-based Scottish Allocation Formula will deliver relatively fewer resources to such practices as it is recognised that younger people generally have fewer health problems and needs than older people and people living in areas of high deprivation.

Nevertheless, university practices have a transient population which creates an additional administrative and patient care burden as a result of high list turnover. The allocation formula recognises this through weightings for new registrations.

In view of the relatively low rates of chronic disease amongst younger people and hence a lower workload associated with caring for this group of patients, university practices will have fewer opportunities than most other practices to increase their income through some of the domains in the Quality and Outcomes Framework. However, there will be scope for such practices to attract additional income through funding for National and Local Enhanced Services designed to provide much more specialised services to their young population e.g. counselling, sexual health, alcohol and drug misuse.

University practices will also have their historic Red Book equivalent income, and hence their stability protected through the Minimum Practice Income Guarantee (MPIG).
Deprivation

It is generally recognised that people from deprived backgrounds typically have poorer health outcomes, higher morbidity and greater health needs. Such needs are associated with additional workload. The Scottish Allocation Formula recognises this through the inclusion of an additional need weighting which uses indicators such as unemployment rates and standardised mortality rates to deliver additional resources to practices in deprived areas. Practices receiving less than their historic income through their global sum allocations will have their income protected in perpetuity through the MPIG.

The contract proposes Enhanced Services that could make a material difference to the provision of health care in deprived communities. These include services relating to sexual health, depression, alcohol and drug misuse and homelessness.

Conclusion

The move to practice based payments using the Scottish Allocation Formula for the global sum will only be possible with the implementation of this legislation. It is vital that this legislation passes through the parliamentary process in time for implementation on 1 April 2004. If this deadline is missed, all funding made available for this financial year will be lost and the additional investment of 33% over the next three years will not be guaranteed for general practice.

In the latter stages of the negotiations between the BMA and the NHS Confederation, on behalf of the four UK governments, the Minimum Practice Income Guarantee was introduced to protect those practices that would lose funding because of the effects of the allocation formulae. It is essential that this guarantee be available in perpetuity to ensure the long term financial stability of practices in Scotland, and to ensure that practices receive the appropriate increase in resources as intended. It is essential to bear in mind that almost 80% of practices in Scotland will need the MPIG to ensure they do not start from a losing position and have to make up losses through increased work and better quality. It was never the intention of the contract that practices should lose resources this way.

In the examples above for remote and rural, university and deprived community practices, this protection will prove essential for those practices which need assistance to maintain their current levels of income.

However, it must not be forgotten that the provision of Enhanced Services brings additional resources into practices. This unlocks additional income potential for all practices based on the skills and experience of the entire practice staff. As the proposed Bill stands, it allows Boards to decide which practices can provide enhanced services. However, the BMA believes that if a practice has the capacity and the desire to provide an enhanced service, it should be funded to do so to ensure that patients can receive care in the
practice with which they are registered. It must also be emphasised that current local innovation and service developments must be maintained through the continuation of existing funding from Health Boards.

Traditionally GPs north of the Border have earned on average £10,000 less per annum than their colleagues south of the Border. The emphasis on rewarding quality may help to reduce that gap.

This legislation, and subsequent secondary legislation, provides the mechanisms by which a new contract for general practice can be introduced in Scotland. A historical lack of funding and the expectation that the capacity within primary care to cope with increasing demand is finite have led to a crisis in general practice. This legislation offers a sound foundation by which to turn this around and represents a unique opportunity that must not be lost.
Dear Mr McNulty

Primary Medical Services (Scotland) Bill

Thank you for your invitation addressed to Wai-yin Hatton to express views to the Finance Committee of the Scottish Parliament on the above Bill.

Ayrshire & Arran NHS Board is supportive of the general policy direction contained within the Bill, however your interest is specifically concerned with the financial costs associated with the Bill and I will therefore limit comments to this.

The Financial Memorandum is very detailed for this Bill and the Board supports the concept of distribution of resources based on patient need instead of through the current system of payment per GP. You will be aware that the Arbuthnott formula is used for the majority of NHS spend and the Arbuthnott group also reviewed spend in General Medical Services and suggested a formula. We understand however that this is not going to be implemented and instead a new “Scottish Allocation Formula” is to be used for distribution of the General Medical Services funding. We have not been able to examine in detail the Scottish Allocation Formula, but would hope that this is very close to the Arbuthnott Formula which has been widely consulted upon.

During negotiations of the new GMS contract, the issue of certain practices losing funding resulted in the new “Minimum Practice Income Guarantee” (MPIG) which has been allocated around 4% of the available funding. This skews the funding basis away from purely based on patient need which is unfortunate, but was necessary to secure GP endorsement of the new contract.

Paragraph 58 of the Financial Memorandum notes that spend will increase by 33% over a three-year period and therefore this equates to around 11% per annum. This requires to be considered alongside primary care prescribing costs which have also increased on average over the last 10 years by almost 10% per annum and in 2002/03 increased by around 12%. Since the total Health and Community Care budget is not increasing at the same rate, these two elements are taking up a bigger proportion of the total spend within the NHS. We are not in a position to comment on whether the 33% increase is adequate to address the increased cost likely to arise.

Cont’d/…
The Financial Memorandum is fairly explicit about certain risks in the assumed funding. In paragraph 89 it refers to cost estimates for the MPIG and in paragraph 95 the risk around the budget for quality payments being understated (potentially by £16 million in 2004/05 and up to £29 million in 2005/06). The assumptions around this though are fairly clear and this seems a reasonable approach.

One concern with the Financial Memorandum is on paragraph 8 where the last sentence says “The Scottish Ministers intend to use powers of direction to ensure that monies allocated to Health Boards for GMS contracts and section 17C arrangements are not used to fund contracts with private providers”. Given that Boards may require to provide out of hours services if GPs choose not to do so, this could leave Boards with a problem in that they would not be able to use the money for GMS to pay an external party for this out of hours service. Alternatively it could allow GPs to “hold the Board to ransom” for the rates that they wish to charge for out of hours services. We would therefore not wish this further restriction placed, but rather that all money issued for General Medical Services is used for that purpose.

With regard to the two specific questions, my views would be as follows:

a) Whether implementing the new contracts will have any additional financial impact on Health Boards

The Health Boards will suffer additional financial pressure during the lead up to the implementation of the contract on 1 April 2004. This pressure will be caused by the burden placed on Administration/Finance/Medical Directorate staff to understand, negotiate and cost the new contract.

Once negotiated the monitoring of each individual contract will be a pressure on Health Boards. Also, the contract itself may well give rise to increased prescribing costs and increased laboratory costs as the practices try to ensure that they are meeting all the quality indicators.

b) Whether the new funding mechanism is felt to be adequate to aid in recruiting and retaining both GPs and other medical personnel in remote, rural and deprived areas

The “Scottish Annex” to the new GMS Contract has specific sections linked to remote, rural and deprived areas, most notably Paras 32, 33 and Para 41 through to 49. It is hoped that by maximising these, it should help recruitment and retention in these areas.

I trust these comments are helpful.

Yours sincerely

Derek Lindsay
Director of Finance
Primary Medical Services (Scotland) Bill- Financial Memorandum.

Comments are provided on each sub-heading of the Memorandum, beginning with “New Arrangements” on page 9 at paragraph 56 and finishing with “Costs on other bodies, individuals and businesses” on page 17 at paragraph 102.

New Arrangements

Para 56. We welcome the move from individual GP remuneration to practice remuneration. This recognises that services are now provided by a range of health care professionals and involve a range of interventions which do not always require the direct involvement of General Practitioners. This is something we have encouraged and the new payment arrangements will further re-enforce this.

Para 57. This is a fundamental change moving from a non-cash limit to a cash limited allocation. This will have the effect of requiring services to be planned more effectively, however it fundamentally shifts the management of risk from national to local systems.

Para 58. This level of additional investment in Primary Care is very much welcomed and will allow the further development in Primary Care which will help to lessen the burden on specialist, acute hospital care. The key question is will the investment in primary care spending be sufficient to meet all the requirements promoted in the new GMS contract.

Para 59, 60 and 61. The division of GMS into 5 funding streams supports work in Primary Care to enhance services and to drive service quality improvement. The creation of the Minimum Practice Income Guarantee (MPIG) is critical in ensuring a smoother transition from existing remuneration arrangements to the new Contract.

Para 63. The replacement of the existing method of distributing reimbursements, as set-out in the current Statement of Fees and Allowances, by the Scottish Allocation formula (SAF) will change the focus from administering payments to securing improvements in the quality of care provided. This is to be welcomed.

For a shift to a global sum approach to work effectively a high trust relationship between the primary care organisation and its GP practices will require to be achieved.

Scottish Allocation Formula (SAF) and global sum

Paras 64 to 70 inclusive. The use of a resource allocation formula to allocate resources to practices on the basis of the relative needs of their patients and the associated workload for GPs is welcomed. This will help to address present inequalities in the funding of primary medical services. Future
enhancement and refinement of the formula will further improve this approach.

Out of Hours

Provision for out of hours care is included in the calculation of the global sum payment. The new contract gives GPs the ability to opt out of the provision of out of hours primary medical services. Where practices opt out obligation to provide out of hours care will transfer to the Health Board/Primary Care Organisation.

There are a number of key issues regarding the provision of an out of hours service by the Health Board/Primary Care Organisation. They are:

- The question on whether GPs will continue to support a Glasgow Emergency Medical Service (GEMS) type service which they are no longer responsible for managing on their own behalf. Some 30% of Glasgow doctors work for GEMS at present. Factors which influence GPs to work in the service are an interest in the provision of out of hours care and the opportunity to enhance their income.
- It is unlikely that Greater Glasgow NHS Board will be able to provide an equivalent service to that currently provided by GEMS, from funding streams available under the new GMS Contract. Indeed the cost of providing an equivalent service is likely to exceed the current cost of service provision.
- Another factor which could affect the cost of providing/commissioning an out of hours service is the probability of an increase in the cost of the sessional payments to GPs resulting from the increase in GP earnings brought about the introduction of the new contract.

Quality Payments

Paras 71 to 75 inclusive. Resourcing practices on the basis of the quality of care delivered to their patients rather than simply the numbers of patients they treat is a welcome development to the provision of primary medical services. This builds on existing clinical and organisational standards and puts quality improvement at the forefront of the service delivery.

With the new contract funded on a cash limited basis, the assumption that only 90% of practices will achieve 90% of the available quality points each year is key. If this level is exceeded a cost pressure will be created. However, the risk of the cost estimates being exceeded in the first three years of the contract is considered minimal, albeit the availability of contingency funding to cover the slight risk of an increased level of achievement would be reassuring.

Enhanced Services

Paras 76 to 80 inclusive. Giving NHS Boards the flexibility to commission enhanced services to meet patient need is most welcome. The ability to
secure directed enhanced services for all patients in Greater Glasgow practices and national and local enhanced services to meet local needs provides the framework to ensure more patients have more choice and access to a range of enhanced primary medical services.

Funding calculations indicate that the funding available for enhanced services in Greater Glasgow will fund, with some HCHS input, the directly enhanced services and a limited number of national/local enhanced services.

**Health Board administered funds**

Paras 81 to 84 inclusive. The release of additional IT and premises funding by the NHS Board will facilitate a more strategic approach to modernising practice premises and providing IM&T services.

**IT**

The new contract affords the NHS Board more opportunities to achieve a consistent approach to the development and management of IM&T within primary care.

In Glasgow, there is an immediate need to upgrade some hardware, complete branch surgery links and provide clinical software by December 2003. It is estimated that this may cost considerably more than the £0.55M allocated for 2003/04. A clear estimate of the cost will be established once the recently started baseline audit of practices’ equipment and software is complete and the quality indicators software requirements established.

The contract does give GP practices the option to change operating systems every 3 years which could potentially be counter-productive to ensuring a consistent approach to systems development and use.

**Premises**

The new contract opens up the possibility of NHS Boards requiring to take over property leases which have been entered into by general practices. This creates the potential for financial risk. There is a risk to the NHS Board around taking over property leases entered into by practices as there will be a significant financial impact in granting mortgages to buy out existing leases.

If premises funding is ring fenced the NHS Board will potentially have less flexibility than before regarding the funding of primary care medical services provision.

**Minimum practice income guarantee**

Paras 85 to 89 inclusive. Having the minimum practice income guarantee (MPIG) as a permanent guarantee that will be available as long as any practice needs it is a key factor in ensuring the smooth implementation of the new contract. It permits all practices to start delivering the new contract from
at least a neutral position and go on to earn additional income from the quality and outcomes framework, enhanced services, IT, premises and seniority pay.

Summary of Costs

Paras 90 to 97 inclusive. Comments on areas of expenditure relating to Greater Glasgow are addressed under the appropriate section above.

COSTS ON LOCAL AUTHORITIES

Para 98. Not applicable for comment.

COSTS ON OTHER BODIES, INDIVIDUALS AND BUSINESSES

Paras 99 to 102 inclusive. The provision of funding to meet NHS Board and central support implementation costs is very helpful.

However, an area which has still to be addressed is how Primary Care Family Health Services administration staff and the Practitioners Services Division of the Common Services Agency work to support the overall administration of the new contract, e.g. financial implications for the retraining of staff have still to be assessed.
Dear Mr McGill

PRIMARY MEDICAL SERVICES (SCOTLAND) BILL

Ms Fiona Mackenzie, Chief Executive Forth Valley Health Board has passed me a copy of your letter dated 22 July 2003 in order that I may make a response from the Primary Care perspective within NHS Forth Valley. The Bill is very welcome but there are some areas of uncertainty in relation to the financial implications. The first of course is the cost of implementation itself and the degree of administrative and organisational change that will need to take place over the next two years in order to accommodate the new way of working.

The areas where there is most uncertainty in respect of the financial implications include:

1. The new Out of Hours service which will clearly be a new model and as such is untested and uncosted.

2. The information technology infrastructure can be fairly reasonably costed but it does make the primary care organisation a provider of such technology and general practices are also given a choice of which systems they may use. Should a large number of Practices wish to move away from the most commonly used system then this would have a significant financial impact, and because this is at present a matter of preference it is difficult to estimate.

3. Certain payments to General Practices for quality and enhanced services will be made of right from what it essentially a cash limited budget. It is difficult to put a figure on what will be a top sliced fund thus creating uncertainty about the level at which other Primary Care services can be resourced.

The/
The above seem to be the most obvious first areas of concern but potentially much greater value in monetary terms is the impact on the prescribing budget which is again essentially cash limited. There will be an element of cashing up as hopefully patient services improve and given that most of the quality points relate to chronic disease management, this will almost certainly have a sizable impact on the prescribing budget which already has double digit inflation across Scotland.

I hope these comments are helpful.

Yours sincerely

Dr G Davies
Medical Director

c.c. Anne Hawkins
Fiona Mackenzie

I attach the Executive’s response to the Committee’s report at Annex A.

If you have any questions about this response, or require any additional information, then please do not hesitate to contact me.

ANDY KERR
Executive’s Response to the Recommendations in the Finance Committee’s Report on its Cross-Cutting Expenditure Review of Child Poverty

Recommendations

1. The poverty indicators used by the Executive are influenced by both UK policy and economic performance. As the data in the Social Justice Annual Report shows, since 1997 poverty has consistently fallen in absolute terms, but grew again in 2000-01 in relative terms. This may reflect the fact that after the initial social security reforms, the previous patterns of wages and salaries growing faster than benefit levels has reasserted itself. We therefore recommend that the Executive raises this concern with colleagues in the UK government and stresses its adverse impact on the child poverty strategy. (Paras 122 & 123)

The suggestion that the figures for relative child poverty grew in 2000-01 is not statistically robust. The estimate of the proportion of children in relative poverty is based on data from a very small sample size in Scotland and therefore the estimates are subject to considerable sampling variability. Statistics show that there has been a decrease in relative poverty since the baseline measurement in 1996-97, with the Executive meeting its Programme for Government pledge to raise 60,000 children out of relative poverty by 2002, an achievement we are proud of. 210,000 children have been lifted out of absolute poverty.

We believe that we are making clear progress on tackling child poverty in Scotland. Work is the best route out of poverty and the Executive is delivering this through training and skills development, supporting growth in the economy through Smart, Successful Scotland and building sustainable communities across Scotland. We work in partnership with the UK Government to deliver New Deal in Scotland. Already over 20,500 lone parents have entered work through the New Deal for Lone Parents, and there are falling numbers of children in workless households.

We work in partnership with the UK Government developing a joint child poverty strategy which includes contributing to the Joint Ministerial Committee on Poverty chaired by the Chancellor of the Exchequer. We also feed into ongoing reviews and consultations on child poverty, including the recently announced cross-cutting review of child poverty by HM Treasury which will consider the role of public services provided nationally and locally to combat poverty and social exclusion, and the risk factors affecting vulnerable groups.

2. We ask the Executive to explain why spending on core services which help tackle poverty and disadvantage – such as local government and housing – are growing below average, and why the housing budget was frozen in the Spending Review. (Para 126)
The perception that local government and housing expenditure is growing below the average Scottish budget is based on a comparison of the 1999-00 and 2002-03 budgets as presented in the 2000 and 2001 Annual Expenditure Reports and that is not a valid comparison for a number of reasons. Firstly, the 2002-03 budgets contain some large figures for cost of capital and depreciation which were not included in the 1999-00 budgets. That was the result of a change in accounting practice, which did not have a uniform impact on all departments, and these figures cannot be included in any like-for-like comparison. Secondly, both the 1999-00 and 2002-03 total budgets contained centrally-held budgets – New Deal, Modernising Government, DEL and AME reserves – which would later be assigned to individual departments, including Local Government and Housing, but which could not be attributed at the time. Again, these figures need to be removed before any like-for-like comparison can be made. Finally, the figures quoted for Housing spending in each of the years was £530m and £650m, whereas the sums of Housing-related budget lines actually come to £524m and £661m.

Taking all these adjustments into account, and also including capital spending in the comparative figures, the growth in the Local Government and Housing budgets was 18.5% and 26.2% respectively compared with a total budget growth of 20.6%. Thus the growth in Housing spending proposals was considerably higher than average whilst the growth in Local Government spending was not so far below average, in percentage terms, as the Committee indicated. In absolute terms, the increase in Local Government spending of almost £1 billion is second only to the increase in Health.

Also, the figures for Local Government do not reflect the amounts of funding for local authorities provided from other departmental budgets (for example, from the wider Communities/Social Justice budget which has risen by almost 40% over the same period). Nor are they necessarily indicative of the actual amounts spent on addressing specific issues such as deprivation or child poverty.

The average annual increase in the Housing budget of 6% in real terms between 1999 and 2006 will enable increases in a number of programmes which have a significant impact on child poverty issues. Increases in the Communities Scotland Development Programme will provide increased numbers of new and improved affordable houses, extra resources will be put into tackling homelessness and increased resources will be provided for the community ownership programme to improve the quality of housing stock through transfers to not-for-profit community landlords.

Such investment by the Executive also attracts substantial private investment:

- £360m over the next 3 years through the Communities Scotland Development Programme.
- £2,000m over the next 10 years in the 3 areas (Glasgow, Scottish Borders and Dumfries and Galloway) where the councils have transferred all their houses to community ownership.

In addition, the introduction of Supporting People is providing substantial increases in funding for the most vulnerable groups to live independently in their own homes.

It is unfortunate that the anomalies in the budget comparisons were not spotted and resolved in earlier dialogues with the Committee. Nevertheless, we would hope that the
more appropriate comparisons, and other comments, provided in this response will reassure the Committee that the rate of spending increase on local government support is only marginally less than average, but still substantial in absolute terms, and that housing, which is targeted on poor households, has, in practice, been a spending priority.

3. **We recommend that the Executive gives high priority to anti-poverty programmes through end-year flexibility or any in-year allocations which flow from UK decisions on spending.** (Para 129)

   Our allocation of end-year flexibility takes into account the Executive’s priorities. In 2002-03, using end-year flexibility, we allocated £95 million to local authorities to fund Quality of Life initiatives under the broad themes of “children and young people” and “improving our local environment”. A further £180 million from core funding has been allocated to local authorities for Quality of Life initiatives over the period 2003-06.

   There will be a parliamentary announcement in September 2003 about the Executive’s use of end-year flexibility money in 2003-04.

4. **We recommend that the Executive reviews the workings of block allocations systems for health and local government to ensure that adequate reporting systems exist to audit expenditure on cross-cutting priorities such as child poverty.** This may require new review mechanisms, as the audit process is concerned with probity and best value, not priority setting and implementation. Under the current arrangements we cannot effectively scrutinise spending relative to child poverty in those programmes. (Para 132)

   Supporting vulnerable children, young people and their families is central to the Executive’s current and future policy agenda and considerable funding has been made available to local authorities in this area in recent years. For example, the Changing Children's Services Fund (CCSF), available to local authorities and their partners in health and the voluntary sector, has a total cross-Departmental budget of £175 million (2003-06) and aims to support change and improvement in children’s service delivery at local level for children and their families, and in particular Scotland’s most vulnerable children, including those living in poverty. Other targeted support for families and children includes Sure Start Scotland where funds provide targeted support for families of very young children (0-3) in areas of greatest need. Sure Start funding will increase from £23 million this year to £50 million in 2005-06. Sure Start Scotland funding is earmarked within local government Grant Aided Expenditure (GAE). The Executive has recently consulted widely on its Integrated Strategy for the Early Years and is currently undertaking research to evaluate the effectiveness of early years policies and spending.

   The Executive supports the principle of providing as much information as possible in the accounts of publicly funded bodies, to promote scrutiny and comparison as far as possible. However a comprehensive analysis of expenditure amounts and trends within GAE and Health funding is complex and, in practice, very difficult to achieve because of definitional difficulties including the allocation of fixed costs and the costs of programmes with multiple objectives. The approach of the Executive is to encourage and promote systematic audit and assessment of policies to ensure that clear aims and objectives have been set and that satisfactory progress is being made towards achieving
these. We believe that the emphasis in Executive funding should be on outcomes rather than more detailed measurement of spending input.

There is a strong and explicit Ministerial commitment to supporting the NHS to help tackle child poverty and its consequences. With reference to some programmes, for example in health improvement and dentistry, specific targets have been set for improving child health, particularly in disadvantaged or excluded groups and communities. Significant investment is directed to cross-Departmental initiatives to support inter-agency working at local level, including the integrated funding stream CCSF. £60 million has been committed directly from the Health budget to CCSF in 2001-2006. Feedback from NHS Boards on Health Improvement Fund (HIF) expenditure indicates a significant proportion of HIF monies were and are targeted on children in vulnerable families or deprived areas, and funding to support preventive dentistry is targeted on children.

The Health Department is working closely with colleagues in other Departments to develop and agree frameworks for measuring and monitoring the impact of central policies and expenditure on child health and welfare, most notably in the early years. There are also local pilots underway in Highland, Stirling and Perth & Kinross developing joint local authority and health outcome indicators for children in terms of improved health, educational attainment and social welfare objectives. In the longer term central and core funding should be based on delivery of these outcomes for which local inter-agency partnerships will be accountable. These developments should ensure that tackling health and social inequalities should be visible as a core objective in child health services and programmes in NHS Scotland. We will continue to develop objectives and targets for health and community care services that promote a focus on tackling health inequalities including those specific to children.

5. We reviewed the weightings for poverty and disadvantage in both the local government GAE, and the Arbuthnott formula in the NHS. Our main concern is that the method used to measure relative need utilises only met need, as reflected in past expenditure or past utilisation of these services. It is well recognised by specialists in this field that the techniques of needs assessment are imperfect, and cannot take account of unmet need. We were pleased to note the ongoing work within the health department to address this and its impact on health inequality, and we recommend that the Executive gives urgent consideration to the impact of this problem on expenditure needs assessment, and the inclusion of an appropriate weighting to reflect it for local government and the NHS. (Para 133)

In the calculation of local government expenditure, the GAEs used in the distribution of the revenue support grant are distributing factors which have been agreed with local authorities in order to enable a single allocation figure to be calculated for each authority. Individual GAEs do not represent a spending limit or target in that service area. Historically, local authorities may spend more or less than a particular GAE allocation to reflect the local needs and circumstances of that authority. There have been a number of long and technical reviews of allocation methodology in past years, leading to marginal changes in relative allocations between local authorities. The emphasis is now on outcome focused analysis of what resources buy, given that GAEs represent only a notional allocation of resources which local authorities are not tied to in terms of overall spending.
The formulae distributes a pre-determined amount of resources through an objective methodology, which enables authorities to provide universal services (for example, refuse collection) upon which deprivation may not have a direct impact. Instead, the approach being taken is to not measure individual inputs, but to provide local delivery agents with the freedom to deliver (and measure) outcomes through the allocation of unhypothecated funding, coupled with further development of appropriate Local Outcome Agreements. Ultimately all authorities have received above inflation increases for this Spending Review, as well as in the last Spending Review, of which the Scottish average increase in 2003-04 over the prior year was 8.54%. However it is up to each authority how it then allocates these resources, through its normal budgeting process, to address local priorities and needs.

The Scottish Executive and COSLA believe that the existing core distribution methodology of local government resources should remain essentially as it is. However, we will review certain aspects of the system as part of the next spending review and will be discussing the exact nature of this exercise over the coming months.

The Executive recognises that the relationship between poverty and healthcare is an explicit one and that the Arbuthnott formula used in calculating the distribution of funds among Health Boards currently treats relative use of health services as a proxy for relative need, and that this may not fully reflect relative needs for healthcare. The Health Department is currently considering the implications of research that has been undertaken in this area by the Standing Committee on Resource Allocation (SCRA).

6. There is a need to monitor the extent to which additional resources are being used to benefit poor households in local authority and health board budgets, whether through Local Outcome Agreements, the Performance Framework or other appropriate mechanisms, and we recommend that the Executive gives consideration as to how best to achieve this. (Para 133)

We are working with COSLA to look at the wider potential of Local Outcome Agreements to ensure the delivery of national initiatives and commitments, whilst allowing flexibility to respond to local priorities. Outcome agreements are already in place for a number of initiatives, for which funding might otherwise have been ring-fenced, including adult literacy, homelessness and the Better Neighbourhoods Services Fund for deprived communities.

The Performance Framework (PAF) for NHS Scotland is based on a mix of quantitative indicators and qualitative information from NHS Boards and partner agencies. Qualitative aspects of the PAF on health improvement and services for children and young people have a strong focus on NHS Board's investment and work to tackle inequalities in child health. For example the PAF includes a self-assessment return on health services for children and young people which asks NHS Boards for information about arrangements to ensure that the health needs of vulnerable or excluded groups are identified and met, with particular reference to services for looked after children; children living in homeless families; children living in travelling families; children in ethnic minority communities and, where appropriate, refugees; children affected by substance misuse; and support for lone parent families, young parents, and families living in areas
of multiple disadvantage. We will continue to refine the PAF to capture how well the NHS supports vulnerable groups of people, including children in poverty, noting the difficulty in identifying NHS expenditure on specific groups as set out in the response to recommendation 4.

7. **We recommend that ‘Closing the Opportunity Gap’ should be organised around the key client groups in the Social Justice Annual Report in future rather than by ministerial portfolios with all new spending proposals fully costed (para 136).**

   During the 2002 Spending Review, Closing the Opportunity Gap was one of the Executive’s cross-cutting themes. All portfolios were required to demonstrate how they would contribute towards ensuring that Scotland is a society founded on fairness, equality and opportunity. The document “Closing the Opportunity Gap” was therefore set out in a way which reflected the 2002 Spending Review process, and the layout of “Building a Better Scotland”.

   The arrangements for the 2004 Spending Review have not yet been finalised. We will carefully consider the Committee’s recommendation during the course of the next Spending Review.

   The Cabinet has recently established the Closing the Opportunity Gap Delivery Group to drive action across all relevant portfolios, and make sure objectives and targets are met. The Group will bear the Committee’s recommendation in mind in its future work.

8. **We looked at the key performance indicators for child poverty, (Social Justice Milestones One and Two) and felt that whilst the poverty measures were useful, the four measures of disadvantage (Social Justice Milestones Three to Six) were not particularly helpful for measuring progress in reducing inequality, as they referred to national data rather than disaggregated data relating to access for different groups, households or areas.**

   **We therefore recommend that the Executive reviews these indicators as a matter of urgency with a view to replacing them with indicators which more meaningfully measure the opportunity gap, as discussed earlier in this report. In addition, we recommend that 1999 should be used as a baseline in future, so that we can monitor progress since the establishment of the Scottish Parliament. (Paras 137 & 138).**

   The Executive will consider these recommendations during any future review of the social justice indicators. In the case of Milestone 5, the four indicators are disaggregated by deprivation quintile and this is reported in the technical annex to the Social Justice Annual Report.

   The baseline for those indicators which are concerned with devolved matters are already measured against the position in 1999. However, where the issue is reserved, the baseline is 1997. It is considered that this more fully reflects the change in responsibilities. Where data are not available for 1999 (or 1997 for reserved milestones), the baseline is taken to be the closest year (to 1999 or 1997) for which information is available.

9. **Pichaud and Sutherland (2002) have modelled the changes in tax and benefits and argue that these are insufficient to reach the child poverty targets. The problem is**
that the increases in cash benefits and tax benefits for families with children, although greater than the increase in median earnings, have not been sufficient to lift enough children above the 60% of median-income threshold. This suggests that the prescription for change is right, but the dose is too weak (Judge 2002). We therefore conclude that the Executive’s strategy needs a step change to make further progress, to deal with the problem of persistent poverty. Such a step change will need to take into account the imminent changes in UK benefits.

This is why we favour an Executive review of anti-poverty programmes which are targeted directly on poor households, such as free school meals or concessionary fares, as these are more direct mechanisms for alleviating poverty. The review could consider both eligibility for current programmes, and the scope for further development, for example over exemption from charges for public services. (Paras 140 & 141).

The Executive’s Partnership Agreement includes a commitment to review prescription charges for people with chronic health conditions and young people in full time education and training. The Agreement also commits to extending concessionary fare schemes, including a national free off-peak bus scheme for older people and people with disabilities as well as progressively introducing a scheme of national bus, rail and ferry concessionary travel for young people, initially for all in full time education or training.

Other Issues Raised by the Committee

10. Our review shows clearly that the interdependence between Westminster and Holyrood is such that decisions taken at a UK level on benefits often have implications for Scottish programmes. Given the priority placed on tackling poverty, it would be helpful if data on spending on cash benefits and tax benefits by client groups were published annually. This could, in our view, be dealt with by the Scotland Office. (Para 35)

Responsibility for tax credits and benefits rests with the Inland Revenue (IR) and Department for Work and Pensions (DWP) respectively.

The IR already produces statistics, including data published quarterly on awards of tax credits by client group, broken down for Scotland.

The DWP publishes quarterly statistics on the numbers of people claiming benefits. Information on individual benefits is available from the departmental web site (http://www.dwp.gov.uk/asd/). In addition, information on the three key client groups (working age, children and families, pensioners) is available, removing the overlaps caused by people receiving more than one benefit at once. These are also available from the departmental web site, or on paper from DWP Information and Analysis Directorate. Many of these publications include government office region as a key breakdown, therefore providing figures for Scotland.

11. We have doubts over the efficiency of deprivation payments to doctors and dentists, as these influence remuneration levels rather than health care, and we recommend that the Executive considers targeting funding to improve staffing levels in poorer
areas rather than simply providing additional payments to existing practices. (Para 72)

Payments to Dentists

The enhanced capitation and caries prevention schemes provide additional payments to dentists based on the deprivation category of the practice postcode. These payments were designed to improve dental health.

The enhanced capitation scheme is aimed at children aged 0 - 2 years (in all deprivation categories) and 3 - 5 years (in deprivation categories 6 and 7) registered with a dentist under NHS arrangements. Dentists receiving the enhanced capitation payment are required to ensure that the patient/parent/carer has access to appropriate preventive advice.

In August 2002, a package of recruitment and retention measures was introduced. This package included payments to newly qualified dentists taking up vocational training in designated areas (mainly remote) and payments to dentists who enter substantive general dental practice within 3 months of completion of training, with payments doubling where the dentist enters substantive practice in a designated area. Areas of deprivation are included in designated areas.

The Executive has undertaken to review all of the initiatives introduced in Scotland. As part of this review we will look at whether the initiatives are delivering the desired outcomes.

Payment to Doctors

A new UK contract for General Medical Services (GMS) has been agreed and will be fully implemented during 2004-05, subject to primary and secondary legislation.

Under the new contract GPs will no longer receive separate payments for deprivation, or any other individual fee and allowance currently listed in the Statement of Fees and Allowances. Instead, resources will be allocated to practices using a formula for GMS, which reflects the relative health needs of the patient population. These depend significantly on the age, sex-structure and socio-economic status of the GP practice population. The population groups that are relatively intensive users of GP services are children, young women and older patients. People from deprived backgrounds typically have poorer health outcomes, higher morbidity and greater health needs. The formula allocates a greater share of resources to practices with greater proportions of these high user patient groups than the Scottish average.

There will also be separate funding streams to be administered at NHS Board / Primary Care Trust level. Practices and NHS Boards / Primary Care Trusts can decide where local priorities for such additional funds and enhanced services lie and support for deprived areas will be an important factor in such considerations.

Finally, the new contract focuses on service quality and healthcare outcomes through a system of performance-related payments to practices, made against a framework of
clinical, practice management and patient experience indicators which has been designed on a strong evidence base.

12. **It is recommended that SIPs should be given an explicit goal of targeting child poverty in order to make a clearer, more co-ordinated and focused contribution to defeating the problem.** (Para 75)

The integration of SIPs with Community Planning Partnerships (CPPs) from 2004 aims to ensure that local regeneration takes place within the wider strategic context of community planning so that core services and core budgets of public bodies are working together to close the opportunity gap for disadvantaged communities. As part of the integration process CPPs will need to develop and implement a Regeneration Outcome Agreement which sets out the specific and measurable outcomes they expect to achieve through SIP expenditure.

13. **Communities Scotland is encouraged to assess the extent to which its allocation formula for housing needs is sensitive to the prevalence of poor children.** (Para 89)

Communities Scotland’s resource allocation system for the distribution of programme resources is based upon a standard approach whereby resource planning assumptions are derived based on a series of social exclusion indicators. These indicators were developed and designed to quantify the incidence of housing stress experienced by individual households that could put them at risk of social exclusion and the volume of households living in potentially excluded neighbourhoods/communities in urban and rural areas. The indicators selected relate to households with insufficient income levels to meet their own housing requirements in the private housing market and are therefore sensitive to the prevalence of poor children within these households.
WHY DO WE HAVE A DIFFERENT ALLOCATION FORMULA IN SCOTLAND?

Background

1. The purpose of this short note is to explain the reasons behind the move to a different allocation formula in Scotland for General Medical Services. This note should be read after the note entitled “The Scottish Allocation Formula (SAF) for General Medical Services.”

2. In Scotland, we have a separate allocation formula, the Scottish Allocation Formula or SAF. For the remainder of the UK, the UK or Carr-Hill¹ allocation formula will be used. Both formulae are very similar; they both use registered lists as the basis for the population of the GP practice. Likewise, both formulae have adjustments for:

   - Demography (the age and sex structure of the population)
   - Additional need (morbidity and socio-economic circumstances of the population)
   - Additional cost of providing an adequate GP service in remote and rural areas
   - Additional cost of recruiting staff (the staff market forces factor)
   - Patients in care homes
   - New patients (new registrations)

3. There are however a number of variations between the UK Formula and the Scottish Allocation Formula. These variations are justified on the following basis:

   - Where better data is available in Scotland it should be used to inform relative patient need for Scotland. This applies to the age-sex and additional need adjustments.

   - Where Scottish circumstances are particularly exceptional the UK formula in Scotland should be modified to reflect these circumstances. This applies to the remote and rural adjustment.

The remaining adjustments are identical between the Scottish Allocation Formula and the UK or Carr-Hill Formula.

Demography

5. The data that informs the demographic or age-sex weighting for the Scottish Allocation Formula is based on consultation information split by age and sex taken from Continuous Morbidity Recording (CMR) practices in Scotland. There are approximately 70 practices that participate in the CMR exercise, a dataset which is representative of all practices in Scotland.

6. The UK Formula uses the General Practice Recording Database (GPRD), which unfortunately records information from only 12 Scottish GP practices. This information is not statistically representative of the patterns of GP workload by the age and sex of the patient in Scotland.

¹ Professor Carr-Hill, York University – contracted by Department of Health.
Additional Need

7. The additional need adjustment in Scotland is based on an index of the following four measures of deprivation and morbidity:

- The unemployment rate.
- The proportion of elderly people claiming income support.
- The standardised mortality rate amongst people under the age of 65.
- Households with two or more indicators of deprivation.

The adjustment in the UK Formula for additional need is based on the standardised mortality rate and self-reported limiting long-term illness. More extensive data is available for Scotland and this has allowed for a wider range of deprivation and morbidity indicators than is currently the case with the UK Formula.

Remoteness and Rurality

8. The adjustment for remote and rural areas in Scotland is based on the following factors (and how they affect GP expenses):

- The population density of the GP practice.
- The population sparsity of the GP practice.
- Rural practice payments.

The remoteness and rurality adjustment in the UK Formula retains only the first two elements, the population density and sparsity of the GP practice population. On the basis of detailed modelling work, it was agreed between the SEHD and SGPC that an additional element would have to be added to remoteness and rurality adjustment to preserve and support rural GP services. The Scottish Allocation Formula therefore allocates additional resources to remote and rural areas than the UK Formula.
THE SCOTTISH ALLOCATION FORMULA (SAF) FOR GENERAL MEDICAL SERVICES

Introduction

1. The following note is an explanation of the Scottish Allocation Formula (SAF) for General Medical Services (GMS) as part of the new contract. Under the terms of the new contract, the SAF will replace the current ‘Red Book of Fees and Allowances’ as an important element of determining remuneration for GMS in Scotland.

2. The SAF is a resource allocation formula that will allocate resources to GP practices on the basis of the relative needs and workload of their patients. The SAF will be responsible for the allocation of a global sum to each practice. The global sum will account (on average) for 50-55 per cent of a practices’ current fees and allowances in Scotland. The remainder of the resources available to GMS will flow through NHS boards (including premises, IT and seniority), the quality-outcomes framework and enhanced services.

The Scottish Allocation Formula

3. The Scottish Allocation Formula (SAF) determines how the global sum in Scotland is distributed between GP practices; it does not inform the total size of the Scottish budget for the global sum. The SAF is a population based formula at GP practice level with a series of ‘weightings’ to reflect the relative needs of GMS patients and the additional costs of providing an adequate service in remote and rural areas of Scotland. The components of the SAF are:

- The GP practice population (total practice list size).

Adjusted for ‘weightings’ to reflect:

- The age and sex structure of the practice population (demography).
- The additional need of the practice population (morbidity and deprivation).
- The rurality and remoteness of the practice population.

There are other weights - set at a UK level - to reflect nursing and residential home patients, new registrations and staff costs, but these combined have for most practices a relatively minor effect compared with the above set of ‘weightings’.
GP Practice Population

4. The SAF uses the registered list of each practice as the basis for the GP practice population.

Demography

5. The relative need for GMS will to a significant extent depend on the age and sex structure of the GP practice population. The population groups that are relatively intensive users of GP services are children, young women and older patients. The SAF includes a series of age and sex ‘weightings’ to allocate a greater share of resources to practices with greater proportions of high user patient groups than the Scottish average. The SAF age-sex consultation weights are based on data from the Continuous Morbidity Recording (CMR) practices1.

Additional Need

6. The relative need for GMS will also depend on the socio-economic status of the GP practice population. People from deprived backgrounds typically have poorer health outcomes, higher morbidity and greater health needs. The SAF includes an index of deprivation and mortality to ‘weight’ the GP practice population on the basis of the following indicators:

- The unemployment rate.
- The proportion of elderly people claiming income support.
- The standardised mortality rate amongst people under the age of 65.
- Households with two or more indicators of deprivation.

A GP practice population with a higher proportion of high user patient groups - as defined by the above set of indicators - will receive a greater additional need ‘weighting’ under the SAF. The adjustment is based on evidence about the extent to which deprivation leads to increased needs for GMS.

Remote and Rural Areas

7. The costs of providing GMS in remote and rural locations are generally greater (per patient) than in urban population centres. The SAF therefore attempts to reflect this by ‘weighting’ practices for their remoteness and rurality. The three indicators that are used to reflect remoteness and rurality in the SAF are:

- The population density (hectares per resident) of the GP practice population.
- The population sparsity (the percentage of the population living in settlements of less than 500 residents) of the GP practice population.
- The percentage of patients in the GP practice population attracting road mileage payments.

This adjustment recognises the extra costs incurred in providing GMS services in remote and rural areas.

1 Approximately 70 practices in Scotland provide monthly consultation returns to the CMR database.
The Weighted Practice Population

8. The ‘weighted’ practice population or list is the registered GP practice population adjusted to reflect the Scottish ‘weights’ for age-sex, additional need and remoteness and rurality. The following illustrative example shows how the adjustments for age-sex, additional need and remoteness and rurality impact on the GP practices’ final allocation.

9. Suppose we have two practices A and B:

- Practice A is a small practice with 2,000 registered patients.
- Practice B is larger with 8,000 registered patients.

Practice A is in a poorer rural area, which is serving an ageing population. Practice B is located in an affluent urban area, serving a relatively young population. If a budget of £10,000 was divided between practices A and B on the basis of their registered lists, then practice A would receive £2,000 and practice B £8,000.

10. However, the basis for the allocation is not the registered but the ‘weighted’ lists of the two practices, A and B. Possible adjustments for practices A and B are shown in the following table:

<table>
<thead>
<tr>
<th>Table - Illustrated Example</th>
<th>Practice A</th>
<th>Practice B</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered List</td>
<td>2,000</td>
<td>8,000</td>
<td>10,000</td>
</tr>
<tr>
<td>Age-Sex Adjustment</td>
<td>1.10</td>
<td>0.98</td>
<td>-</td>
</tr>
<tr>
<td>Deprivation Adjustment</td>
<td>1.15</td>
<td>0.95</td>
<td>-</td>
</tr>
<tr>
<td>Remote/Rural Adjustment</td>
<td>1.15</td>
<td>0.95</td>
<td>-</td>
</tr>
<tr>
<td>Weighted List</td>
<td>2,910</td>
<td>7,090</td>
<td>10,000</td>
</tr>
</tbody>
</table>

The ‘weighted’ list for practice A is equal to (2,000 x 1.10 x 1.15 x 1.15 = 2,910 ‘weighted’ patients) and for practice B the relevant calculation is (8,000 x 0.98 x 0.95 x 0.95 = 7,090 ‘weighted’ patients). Practice A with 2,910 ‘weighted’ patients receives an increase in its allocation of £910. Practice B’s final allocation falls to £7,090.
11. The effect on the allocations for practices A and B is that £910 has been redistributed from practice B to practice A compared with what they would have received on the basis of their registered lists. **Therefore, it is on the basis of the ‘weighted’ list that a practice’s indicative allocation for its share of the Scotland-wide global sum has been calculated.**

**Minimum Practice Income Guarantee (MPIG)**

12. The minimum practice income guarantee (MPIG) will apply to all Scottish GP practices that qualify for this form of relief. The method of calculation of MPIG in Scotland is identical to the rest of the UK, the only difference is that Scottish practices’ indicative allocations are based on the Scottish Allocation Formula. Any practice in Scotland with an indicative allocation, which is less than their equivalent ‘global sum’ fees and allowances would receive a MPIG.

**Summary**

13. In summary the main points are:

- The Scottish Allocation Formula (SAF) is a **population-based formula** that allocates resources according to **relative patient need** for GMS. The SAF will allocate a **global sum** for each practice in Scotland. There is **no** direct read across between the indicative global sum and current fees and allowances.
- The SAF uses **registered** practice population data, ‘**weighted**’ for variations in **demography, deprivation** and **remoteness and rurality** between GP practice populations. The ‘weighted’ list is used to calculate the share of global sum resources that are allocated to the GP practice.