

London loses out in new approach to allocating NHS resources

The recent announcement of Primary Care Trust (PCT) resource allocations was not kind to London. Although NHS spending overall continues to rise, with no PCT receiving less than an extra 10% spread over 2009/10 and 2010/11, many PCTs in the capital will be worried that their own share of the pot is set to shrink.

This was the first round of allocations using the Department of Health's new funding formula, which predicts the demand for healthcare in a given population. While London has traditionally received a higher than average allocation – there are many areas in the city with high levels of deprivation and relatively poor outcomes – the latest round heralds a shift elsewhere.

The capital has lost out largely because increased priority has been given to PCTs serving higher numbers of older people - age, like deprivation, is closely related to health need. With two-thirds of its population under 45, London has a much younger age profile than other areas.

This has left PCTs in London facing a more difficult financial future. The deemed target allocation for a PCT does not immediately translate into the money it receives, but where a trust is above or below its target the difference will be rectified gradually over a period of years. With their target allocations now relatively smaller, all London PCTs apart from Redbridge find themselves receiving more money than the government deems 'fair': Richmond & Twickenham (23% above target), Islington (12%), Lambeth (15%) and Westminster (21%) are among those trusts threatened with lower funding.

It would be wrong to assume this is solely the result of the new formula. Of course, there are ways in which the formula being used may be lacking. For instance, PCTs in London face difficulties because they are serving very mobile population with high levels of migration into London and between boroughs. This makes service provision difficult, and more expensive.

Ultimately, however, ministers decide who gets what and this involves making judgements on complex issues going to the very core of the NHS's founding principles.

The key principle underlying the resource allocation process has always been 'equal access to healthcare for equal need'. This is the basis of the new determination which has given increased resources for provision of healthcare in areas with more older people, because age is related to health need. But there is another fundamental principle: to contribute to the reduction of avoidable health inequalities.

This means that part of the NHS's resources should be put specifically into the effort to reduce inequalities in health outcomes. The current government accepts this principle and has put it into practice to some extent. The Advisory Committee on Resource Allocation (ACRA), the body which makes

recommendations on allocations to ministers, devised a separate formula for health inequalities so that deprived areas could be given a 'boost' in funding.

Ministers made the final decision on how much weight to give the inequalities formula in the overall allocation. Giving it greater weight would have been to the benefit of parts of London which have higher levels of deprivation and fewer older people – there is usually a correlation between these two. It appears, however, that ministers have decided against doing so.

There are those who argue that the roots of inequalities in health lie outside the NHS, and it is therefore inappropriate to try to address them through healthcare spending. But there are a number of ways in which the NHS can reduce inequalities – for instance, by funding preventative services such as smoking cessation, and addressing unmet need by actively finding people who do not seek NHS help. Although issues such as income or housing may be the underlying causes of inequality, the NHS has a significant part to play in countering it.

The needs of an ageing population will continue to put a strain on health spending. Although there may be a hint of electioneering in the latest allocations, supporting older people is a key priority, and those wanting the NHS to counter inequality will have to fight hard for more funding. Part of the answer, must be to develop a new settlement with social care, which many older people are also dependent on. A renewed commitment to partnership working and prevention is the most likely way to manage the costs of an ageing population, leaving more money in London's pot for health inequality.

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