BODY POLITIC  Nigel Hawkes

Resource allocation—it’s a jungle out there

Who wins and who loses under the NHS’s new scheme for awarding cash to primary care trusts?

Only the brave or the foolhardy venture into some areas of NHS management. Among these wild places, none strikes more terror than the one labelled “resource allocation.” Here be man-eating statisticians, steeped in the lore of the jungle and ready to pounce at the sound of a breaking twig. Wizards uttering incantations dance around a cooking pot stocked with tasty data, brewing up heaven knows what. The light is dim, and understanding is even dimmer. But duty calls. Just before Christmas the NHS published the long awaited report of its Advisory Committee on Resource Allocation (ACRA), and those of us who have developed a taste for danger were drawn irresistibly towards it. These arcane calculations determine the way in which the NHS cake is sliced and served to the 152 primary care trusts in England that now consume 80% of it. And nobody, it is fair to say, is ever happy with the way it is done.

Healthcare needs vary from place to place, so simply dividing the cash on a per capita basis would be unfair. Some way has to be found to allocate money so as to ensure equal opportunity of access to health care for people of equal risk and to help reduce avoidable health inequalities—or so the objectives of ACRA are defined.

Since 2003 this has been done by a formula that takes into account three elements: population, needs, and costs. The needs element is supposed to account for differences in age and health status across primary care trust areas, while the cost factor recognises that delivering health care is more expensive in some trusts than in others. Even counting population is complex: do we simply count patients registered with GPs, or do we take Office for National Statistics population projections for each trust area? They differ, and not in a predictable way.

But the population issue is child’s play in comparison with incorporating measures of need and reducing health inequalities. The complex formula that has been informing NHS allocations in recent years was devised by experts at Glasgow University. But mutterings about its supposed failings grew to a clamour; and despite assurances from ministers that it was the best available instrument, the Department of Health set up a review in 2006. The result is ACRA’s new report, available on the health department website, though the research underpinning it is not, in spite of ACRA’s assurances that it is.

The most interesting conclusion reached, on the basis of work by a team from Brunel University, is that it is impossible to combine need and inequality in the same model. So a separate formula for health inequalities has been developed, one that uses “disability free life expectancy” to measure the level of health inequality between trusts. It is left to ministers to decide how much weight this component should have in the final allocations.

More controversially, ACRA has decided that the formula is not unfair to rural areas, one of the complaints often made. It says that other factors in the formula account satisfactorily for rurality and that there is no need to introduce any new element, a disappointment to rural MPs, mostly Tories, who have long claimed that the allocations disadvantage their constituents.

What counts in the end is the bottom line. A formula that was incomprehensible to most—and that was, in the opinion of some experts, little better than econometric juggling—has been replaced by another, equally opaque. A cynic might say that this is all witchcraft. An elaborate model designed to take the guesswork out of allocations requires two interventions from ministers—how much weight to give to inequality, and how quickly to reduce “distance from target”—which between them account for more than all the other factors put together. We might have guessed in advance that no new system would disadvantage northern Labour constituencies to the benefit of the south, and so it has proved. Maybe that’s just the way the numbers fell; maybe not. Stumbling about in this particular jungle, it is impossible to tell.

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What should the US surgeon general do?

As I write this, it is being widely reported that the neurosurgeon Sanjay Gupta, who is also a medical correspondent for the US television networks CNN and CBS, is the leading candidate to be appointed surgeon general by the president elect, Barack Obama. I have nothing against Dr Gupta, who I’m sure is a fine neurosurgeon, specialising (according to his biography) in “complicated spine, trauma and 3-D image-guided operations.” And he is a skilful television medical correspondent. But his potential appointment raises two important issues about the role of what everyone calls the “surgeon general of the United States.”

The first is that the surgeon general is actually statutorily only the surgeon general of the Commissioned Corps of the US Public Health Service. The corps comprises more than 6000 uniformed officers who work in public health positions throughout the federal government and on assignment in public health agencies around the nation and the world. It is not clear what qualifies a neurosurgeon with no public health background to lead this uniformed service.

Secondly, and more importantly, I am concerned about reports that Dr Gupta has been offered a major role in the White House Office of Health Reform, working with the health and human services secretary designate, Tom Daschle, to create and pass healthcare reform legislation. If the Obama administration does this, it will undoubtedly be a contentious, highly political struggle. If Dr Gupta, with his background in the Clinton administration and his communication skills, wants to work on changing the US healthcare system, that’s great. The president should appoint him to the White House staff or make him the assistant secretary for health and let him go at it. But not surgeon general.

The most important traditional role for the surgeon general, the one that the nation knows about, is not the statutory one. It is to provide impartial, independent, evidence based advice to the president and the country about health and disease. This is the reason that everyone thinks of him or her as the “nation’s chief doctor.” If the surgeon general is seen as just another adviser to the president or as an administration spokesperson on health, the result is a huge loss of credibility and effectiveness.

There are many recent examples of surgeons general successfully taking on this role. The most notable was Luther Terry, who issued a landmark report in 1964 that unequivocally linked smoking and cancer. This came at a time when almost half of American adults smoked. Dr Terry later recalled that he chose a Saturday for the press release of his report, to minimise the effect on the stock market and to maximise coverage in the Sunday papers. The report “hit the country like a bombshell” and was “front page news and a lead story on every radio and television station in the United States and many abroad” [http://profiles.nlm.nih.gov/NN/Views/Exhibit/narrative/smoking.html].

Another example was C Everett Koop’s courageous insistence in 1986 on reporting the facts about how HIV infection is spread. Despite concerns both from conservatives in the Reagan administration and gay rights activists on the left, Dr Koop graphically described what was known about risky sexual behaviour to all Americans. He sent a mailing on AIDS to every household in the country.

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And, in 1999, David Satcher issued an important report on mental illness in America that documented the disparities in health care and coverage for people with mental disorders. Only last year were these issues finally addressed, with Congressional passage of the Mental Health Parity Act of 2008, mandating equal insurance coverage for treatment of mental disorders.

These and other crucial public health achievements could never have been accomplished if the surgeon general had been just another member of the president’s political team, trying to get his programmes passed. This is why the surgeon general’s appointment is for a fixed term of four years, which does not necessarily coincide with the term of the president and his other appointees. The surgeon general must be independent and not identified with any of the president’s personal agenda. The easiest way to do this would be for Mr Obama to appoint a current senior career officer in the Public Health Service to be surgeon general, just as career officers are appointed to be the surgeons general of the US army, navy, and air force.

The argument for Dr Gupta’s appointment is, of course, that he already has a national following that would allow him to stand up to political attempts to silence him. But if the Obama administration does wish to appoint Dr Gupta it should first decide whether it wants him to be their front man for healthcare reform—which I’m sure he could do very capably—or whether it wants him to do something else entirely: to be the surgeon general of the United States.

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