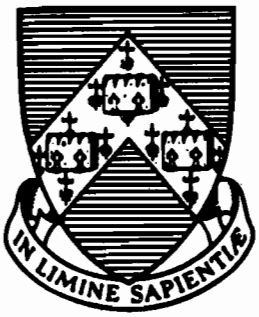

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by
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by

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and
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Abstract

The provision of health and social care for people with HIV infection or AIDS and for initiatives aimed at the prevention of the spread of HIV infection has since 1988-89 relied heavily on ring fenced Central Government funding. In 1990/91 the total earmarked central funds made available for English and Welsh Health Authorities, Local Authority Social Service Departments, and Scottish Health Boards, totalled £152.5 million. This substantial additional funding is guaranteed only on a short term basis and has to be moulded into general NHS and LASS funding to provide cost-effective health and social care for people with HIV infection or AIDS.

The responsibility for the allocation of HIV-AIDS funding has been the separate responsibility of the Department of Health in England, the Welsh Office in Wales and the Scottish Home and Health Department in Scotland. The separation of decision making has led to the adoption of different distribution mechanisms.

The consequences of the separate national systems of HIV-AIDS funding is examined in this paper. In England and Wales, Central Government allocations for health care have been based on numbers of AIDS cases alive, whilst prevention funding has been based on the regional population aged 15-34 years (in Wales a flat rate amount has been provided for prevention measures). In Scotland, overall HIV-AIDS funding made available to the Health Boards has involved a general grant distributed using a modified SHARE budget allocation formula with additional funding for three special AIDS Units providing treatment and care for people with HIV infection or AIDS

In England and Wales funds for statutory sector social care have been allocated following bids submitted by Social Service Departments to the Department of Health or the Welsh Office. In Scotland there has been no specific HIV-AIDS grant provided by the Scottish Office to Social Work Departments. In addition, no Central Government funding for HIV-AIDS services has been made available to local authority departments of Environmental Health, Education and Housing in either England, Scotland or Wales.

After a discussion of some major issues concerning the feasibility of a standard system of national funding, the use of the joint planning and joint finance mechanism for HIV-AIDS funding and the monitoring of HIV-AIDS related expenditures, the authors conclude that there is a need to manage and evaluate the use of funds carefully. Have the substantial additional resources provided for people with HIV infection or AIDS been allocated equitably to provide cost effective care? The extent of monitoring of the use of funds and the evaluation of the cost effectiveness of alternative care packages appears to be modest and of uneven quality.

GOVERNMENT FUNDING OF HIV-AIDS MEDICAL AND SOCIAL CARE

1. Introduction

The Governments funding of medical and social care in England, Wales and Scotland for people with HIV infection or AIDS, and initiatives aimed at preventing the spread of HIV infection, has been developed in an ad hoc and largely unco-ordinated manner. Systems of funding the HIV/AIDS related services of English and Welsh Regional/District Health Authorities and Social Service Departments, and Scottish Health Boards and Social Work Departments have been developed completely separately in each country.

There are two important features of the central funding provided so far which has affected the pattern of service development in England, Wales and Scotland:

(i) The short-term nature of the Health and Social Service funding, guaranteed on a one to three year basis, which makes long term planning difficult.

(ii) The differing methods used in England, Wales and Scotland for allocating funds amongst the health and local authorities for HIV/AIDS related services.

These issues are discussed below in the context of the funding of statutory HIV/AIDS medical care/prevention and social care provision in England, Wales and Scotland.

2. Funding for medical care and the prevention of HIV infection

2.1 Funding English Regional Health Authorities and Welsh District Health Authorities

The Department of Health have provided Hospital and Community Health Service (HCHS) funding to Regional Health Authorities for HIV/AIDS related services of £25.1 million in 1987/88, £59 million in 1988/89 and an additional £52 million (of £122 million in total) in 1989/90. For 1990/91 the DH have announced HCHS funding for HIV-AIDS of £126 million representing a 5 per cent increase on the amount received by each authority in the previous year (to account for inflation and a reduction in the cost of zidovudine, the drug used in the treatment of people with AIDS). Allocations to the Welsh District Health Authorities have been the separate responsibility of Welsh Office officials. The Welsh DHAs received a total HIV-AIDS grant of £738 thousand for 1988/89 which was increased by over £300 thousand for each of the two subsequent financial years, to £1.04 million for 1989/90 and £1.4 million for 1990/91.

2.2 Distribution of funds amongst the RHA's/DHA's

The spread of AIDS cases was the primary basis for the DH allocation of funds amongst the English regions in 1987/88 and 1988/89, which meant that the three Thames regions with the largest numbers of reported AIDS cases (N.W. Thames, N.E. Thames and S.E. Thames) received the largest share. This was a total of £22.5 million in 1987/88 and over £42 million in 1988/89.

£50 million of the additional Hospital and Community Health Service allocations in 1988/89 was distributed according to the number of reported live AIDS patients in each region as at the end of November 1987 (DHSS Letter to Regional General Managers, 25 February 1988). This method was ineffectual in spreading resources evenly amongst people with AIDS throughout the country. Table 1 demonstrates that at August 1988 each person with AIDS in the South Western Region received an average of only £16,000 of this special money compared to £70,000 for each person with AIDS in N.E. Thames. This uneven distribution of resources was promoted because the allocative procedure made no allowance for the expected rate of growth in the number of people living with AIDS within and outside of the London regions.

In addition, during 1988/89 the DH provided a total of £5 million to the Regional Health Authorities (ranging from £187 thousand received by East Anglia RHA to £553 thousand received by West Midlands RHA) for specific HIV/AIDS treatment, prevention, diagnosis and related initiatives.

Although Regional General Managers held responsibility for allocating the central funds amongst the District Health Authorities, the final decisions on its use lay with District General Managers. Up to 1988/89 DH funds were largely spent on treatment and care with very little having been used for prevention or health education initiatives. In an attempt to be more proactive towards the AIDS threat, the DH issued guidance that at least £14 million of the additional £52 million provided to the Health Authorities for 1989-90 was to be spent on "community based initiatives aimed at helping individuals change behaviour which puts them at risk of HIV infection" (DH Circular EL (89) P/36, February 1989). This meant a change in the way they distributed money between the authorities, so that for 1989/90 additional

Table 1 Allocation of Department of Health HCHS funding for HIV-AIDS in England

Regional Health Authority	(1) HCHS (1988/89) Allocation per person alive with AIDS as at August 1988 (£'000s)	(2) HCHS (1989/90) additional allocation for treatment and care per person alive with AIDS as at August 1989 (£'000s)	(3) HCHS (1989/90) total allocation for HIV prevention initiatives and other expenditures (£'000s)
Northern	59	20	2.8
Yorkshire	53	26	3.3
Trent	58	28	4.3
East Anglia	75	11	1.9
N.W. Thames	75	10	3.3
N.E. Thames	80	12	3.5
S.E. Thames	60	21	3.4
S.W. Thames	53	21	2.8
Wessex	62	19	2.7
Oxford	73	17	2.4
South Western	16	43	3.0
West Midlands	42	16	4.8
Mersey	40	43	2.2
North Western	50	38	3.7

resource funding of £8 million only (combined with the £59 million allocate in 1988/89) was allocated on the basis of live AIDS cases (as of October 1988). As is demonstrated in column 2 of Table 1, this has produced a distribution per live AIDS case for treatment and care which is not significantly more equitable than was the case in the previous year.

A total of £44 million in 1989/90 was originally allocated for non-treatment purposes distributed according to the population of each region. The amount allocated to each RHA varied from £1.9 million received by E. Anglia RHA to £4.8 million received by the more heavily populated West Midlands RHA (column 3, Table 1). DH officials offered very general guidance on the actual use of these funds, stating that it could be directed at the discretion of District and Regional Health Authorities managers to such areas as the treatment of AIDS patients, genito-urinary services, HIV prevention measures, blood heat treatment and the improvement of infection control (DH Circular E1 (89) P/36). As there was no strict requirement for health authority managers to ensure these funds were actually spent on community prevention and health education initiatives, the appropriateness of using the Regions' population as a basis for allocating such resources is questionable.

Overall, the flat-rate additional HIV-AIDS funding of 5 per cent for each RHA in 1990/91 suggests no immediate change in the allocative methods used by the DH is likely.

Welsh Office HCHS funding for HIV-AIDS has been based on a similar distinction between prevention measures and treatment and care. Each Welsh DHA received a flat rate allocation for preventive measures, with additional

funds for medical care dependent on the number of HIV/AIDS cases in each district.

2.3 Funding Scottish Health Boards

In Scotland, funding for HIV/AIDS medical care services and prevention initiatives has been the responsibility of officials at the Scottish Home and Health Department (SHHD) of the Scottish Office. The first major provision to the Health Boards for AIDS related services was £4.98 million for 1988/89, with a further £12.63 million allocated for 1989/90. On 1st December 1989 a sum of just under £15 million for 1990/91 was announced by the Scottish Health Minister.

2.4 Distribution of funds amongst the Scottish Health Boards

In Scotland there has been a more consistent allocative basis for HIV/AIDS funding since 1988/89 than has been the case in England, although the guidance on its use has been equally imprecise. The Scottish funding has been divided into two different allocations:

(1) A General Allocation

In March 1988 Scottish Health Boards were allocated £1.64 million in recognition of the burden HIV/AIDS placed on their hospital and community health services. This general allocation was increased to £6.71 million for 1989/90, and £7.84 million for 1990/91 (Table 2, columns 1-3). In each financial year this has been distributed according to the SHARE budget allocation formula (with unspecified local

HIV/AIDS needs adjustments) to be spent on the same types of initiatives as identified for English Health Authorities (NHS Circular 1989 (GEN) 17, May 1989). This method of distributing funds takes some account of the community implications of HIV infection. However, it has also produced an anomalous situation of Lothian Health Board receiving only 15 per cent (£1.22 million) of the general HIV/AIDS allocation in 1990/91 despite having 60 per cent of known cases of HIV infection in Scotland living within its boundaries.

(ii) Special AIDS Units Funding

The SHHD have gone one step further than in England and implemented specific recommendations arising from an expert working party on HIV/AIDS service needs in Scotland (The Taylor Committee Report, 1987). This has resulted in the provision of capital and revenue funding in 1988/89, 1989/90 and 1990/91 for the development of three special AIDS Units in Edinburgh, Glasgow and Dundee (providing a total of 40 in-patient beds and out-patient/outreach facilities). The AIDS unit allocations made to the three host health boards, totalling £3.34 million for 1988/89, £5.92 million for 1989/90, and £7.06 million for 1990/91, are outlined in Table 2 (columns 4-6). This initiative has meant that those Health Boards with the majority of people with AIDS needing treatment, and the largest number HIV positive, have received over half of the available central funding but have had little choice in how the funds for treatment and care are to be spent. It is too early to say whether the specialist AIDS units are a more cost-effective option than using existing treatment services such as Infectious Diseases facilities and out-patient services, or the development of out-

Table 2 Scottish Home and Health Department HIV-AIDS Funding to Health Boards and GAE Calculations for SWDs services

Health Board/SWD	General allocations to Health Boards for HIV-AIDS treatment/ care and prevention			Funding for 3 special AIDS Units			HIV-AIDS Grant-aided expenditure (GAE) assessments for Social Work Departments	
	(1) 88-89 (£ m)	(2) 89-90 (£ m)	(3) 90-91 (£ m)	(4) 88-89 (£ m)	(5) 89-90 (£ m)	(6) 90-91 (£ m)	(7) 89-90 (£ m)	(8) 90-91 (£ m)
Lothian HB/SWD	0.261	1.053	1.226	1.520	2.830	3.869	1.166	1.574
Greater Glasgow HB Strathclyde SWD	0.456	1.691	1.947	0.651	1.770	1.808	0.708	0.835
Tayside HB/SWD	0.149	0.617	0.721	1.170	1.320	1.380	0.450	0.605
Rest of Scotland HB/SWD	0.774	3.349	3.948	-	-	-	0.179	0.406
TOTAL	1.640	6.710	7.842	3.341	5.920	7.057	2.480	3.420

of-hospital community units. No doubt SHHD is evaluating the cost-effectiveness of these treatment options.

2.5 Drug misuse funding

Drug misuse (in particular the sharing of needles) has become increasingly associated with the spread of HIV infection. As at June 1989, 15 per cent of UK HIV positive cases reported to the PHLS Communicable Diseases Surveillance Centre were classified as intravenous drug users. A total of £11 million between 1987/88 and 1989/90 has been made available for drug misuse services in England (£9 million) and Scotland (£2 million), although none has been specifically earmarked for HIV infection prevention initiatives. A more explicit recognition of the HIV-AIDS element of the drug misuse funding may assist efficient and focused HIV prevention planning by Health Boards and District Health Authorities.

3. Funding for Social Care

3.1 Funding Social Service Departments in England and Wales

The DH have set up separate mechanisms of funding social care services for people with HIV infection or AIDS. Specific HIV/AIDS related funding has been allocated to Social Service Departments (SSDs) in two broad packages

(i) One and three year joint finance: The Governments first major financial response to HIV/AIDS community care was the provision for 1988/89 of a £2 million joint finance grant, for which the 12 inner London SSDs had to bid (DHSS Press Release 88/134, April 1988). The two London Boroughs

of Hammersmith and Fulham and Kensington and Chelsea, who were estimated to have highest numbers of residents with AIDS, received just under half of this total.

Most of the joint finance grant covered general social service expenditures on HIV/AIDS in the 1988/89 financial year only, but approximately one-third was allocated as the first part of a three year package of joint finance for specific SSD initiatives. In many cases this included plans for specialist HIV/AIDS hospital social work teams or posts. The hospital social worker resides on the boundary of hospital care and community care. The use of the joint finance mechanism to fund HIV specific hospital social work initiatives enabled decisions regarding responsibility for their role, costs and funding to be kept separate from all other HIV/AIDS related health and social care funding.

(ii) Nationwide AIDS Support Grant: For 1989/90 the DH introduced a more comprehensive national mechanism for HIV/AIDS social care funding. This consisted of a direct grant of £7 million for which Social Service Departments in England had to bid. SSDs were required to meet a minimum of 30 per cent of total estimated expenditures on HIV/AIDS social services from mainstream budgets (Circular LAC (1), January 1989).

Whilst there has only been a small proportionate increase in total HIV/AIDS HCHS funding for 1990/91, the amount of social service funds available for this year has had a substantial rise to nearly £10 million (again supporting 70 per cent of total HIV/AIDS expenditures).

The Welsh Office made available a small ring-fenced HIV-AIDS grant of £38,660 for 1989/90 and of £80,000 for 1990/91, for distribution amongst the eight SSDs in Wales. In contrast to English SSD eligibility criteria for DH grant, there was no requirement for Welsh SSDs to demonstrate minimum levels of expenditure from their mainstream budgets on HIV-AIDS services.

3.2 The distribution of funds amongst English SSDs

The Department of Health have used very different methods for allocating funds for HIV/AIDS related social care services compared to that for distributing funds for medical care and prevention. The DH funding for social services in 1988/89 was an 'emergency' response to the urgent need to support the inner London SSDs who were facing most demands on services by people with AIDS. For 1989/90, SSD bids were guided by the three somewhat obscure categories of funding determined by the DH. These were a maximum of £1 million for each authority with the greatest concentration of people with AIDS and people at risk of infection; a maximum of £300,000 for other authorities with a major treatment centre for people with AIDS; and a maximum of £14,000 for each other SSD making a bid.

The use of the bid system for allocating social care grant is related to a deficiency of comparable data on numbers of people with HIV/AIDS resident within each local authority boundary. Managers in the Welsh SSDs have also had to submit bids for Welsh Office HIV/AIDS grant, although the outcome has been an almost equal allocation of funds between them (approximately £10,000 per SSD for 1990/91, directed primarily at staff training).

The 'bid system' in England has resulted in a diverse range of community care initiatives for people with HIV infection or AIDS, which are partially or fully funded by the DH support grant. In general, within the funding categories, the Social Service Departments which received the highest level of support grant were those that produced the most innovative applications.

For instance, HIV service managers in the London Borough of Hammersmith and Fulham SSD have developed a central HIV/AIDS service budget for 'buying-in' care services from its own department, other departments and from the voluntary and private sector. This model is very much in line with current Government thinking regarding the implementation of its white paper reforms for community care, and has therefore received the appropriate encouragement and financial support from the DH. It is viewed by Central and Local Government as a 'test-case' for the practical application of such service packages in other more traditional areas of social services provision, such as that for elderly people.

With the 'bid system' generating diversity and innovation it is essential to monitor expenditure use and to evaluate the cost effectiveness of alternative care packages. However, the evidence on monitoring and evaluation is limited and the scope for learning from experience is not being exploited.

3.3 Funding Social Work Departments in Scotland

In Scotland there has been no specific grant for the development of AIDS related services by Social Work Departments (SWD). Instead the Scottish Office has for 1989/90 and 1990/91 identified 'HIV-AIDS' as a separate service

heading in its annual 'Grant Aided Expenditure' (GAE) calculations, which are used to determine total levels of expenditures to be supported by Government revenue support grant (Scottish Office Finance Circular 10/89, September 1989). Using an assessment method based on *HIV+/AIDS cases reported by each Health Board, the SWD's of Lothian, Strathclyde and Tayside were allocated the largest part of the total HIV-AIDS-GAE element (£2.32 million of £2.48 million in 1989/90, and £3.01 million of £3.42 million in 1990/91 - see Table 2, column 7/8). It is not possible to estimate how much, if any, of this is extra funding. According, to Scottish Office officials it is included solely as a means of allocating pre-determined levels of expenditure equitably amongst local authorities.

3.4 Funding for other local authority departments

The English, Welsh and Scottish systems for funding HIV/AIDS community care are harmonious in their lack of provision for the Housing, Education and Environmental Health Departments of local authorities. The Department of Environment, as evidenced by their lack of financial support, does not seem to have acknowledged the message from the AIDS service supply and support sector that adequate housing is a key element in the provision of effective social care for people with HIV infection or AIDS (Eddison, 1988).

In England a number of HIV/AIDS related housing and education initiatives have been funded from the AIDS Support Grant to SSDs. In Scotland

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* Weighted to ensure 50% percent of GAE is distributed according to live AIDS cases and 50% on number of HIV positive cases. The geographical coterminosity of SWDs and Health Boards in Scotland enables such a method to be used.

and Wales such funds have not been available. This situation seems far from being adequate for effective HIV/AIDS community care service planning.

4. Some Major Issues

4.1 Separate Funding Systems

Central Government has provided a substantial tranche of money to the Health Service and to Social Service Departments for HIV/AIDS related services. The costs of the medical treatment and care of AIDS patient is high, particularly the use of the drug zidovudine (£3-5 thousand per patient year). The amounts of central funding for treatment and care have reflected this.

Greater regional funding equity may be achieved through using a standardised system across Scotland, England and Wales for distributing funds for HIV/AIDS medical care, prevention and social care. However, administrative difficulties may arise because of the different structures of the Scottish, Welsh and English Health and Social Service systems, and their different pattern of HIV/AIDS service development to date.

4.2 Joint Planning

The SHHD HIV/AIDS - HCHS resource use guidance circular for 1989/90 (NHS Circular 1989 (GEN) 17, May 1989) includes a recognition of the need for the joint planning of HIV/AIDS service development involving Health Boards, local authorities and voluntary organisations. Specific objectives set by the DH for each DHA to implement by March 1991 have been the joint planning

of hospital and community care for people with HIV or AIDS and a three year programme of HIV prevention measures (Annex to DH Circular EL (90) p/30, February 1990).

Joint planning is particularly important for the efficient development of community based HIV prevention and health education initiatives, but there still seems to be a large amount of uncertainty amongst many key local authorities as to the extent of their financial commitment to such areas.

Local authorities' lack of previous experience of health education/ prevention and, in England, non-coterminosity with health authority districts have led to instances of a breakdown in communication between SSD/SWD's and DHA's/Health Boards, with a subsequent duplication of efforts. These problems could be overcome through the use of the joint finance mechanism to co-ordinate health authority and local authority expenditures on community based health education, prevention and social care initiatives over the medium to longer term. Its use in 1988/89 was purely a convenient method for the rapid distribution of emergency funds to Inner London SSDs for HIV/AIDS related services, and was not utilised as a basis for promoting joint planning with the district health authorities.

4.3 Monitoring expenditures

The pattern of health and social service funding for HIV-AIDS has lacked a consistent structure in both England and Scotland. Despite the large amount of funding provided the controls on expenditure may not guarantee efficiency, let alone equity. Part of the problem is that no reliable outcomes data exist to gauge how effectively health authorities/boards and social service

departments are spending their HIV-AIDS grant. This may be mitigated if effective use is made by the DH of information on local HIV/AIDS prevalence statistics and HIV/AIDS related expenditures on treatment and care, local prevention initiatives and GUM services. Such data are being collected annually from each District/Regional Health Authority and Health Board through the AIDS control Act (1987) requirements. Hopefully this data will be analysed and published in due course to illustrate how HIV-AIDS funds have been spent.

SSD managers are required to monitor their authorities' HIV/AIDS service expenditures, and are doing so to varying degree's of sophistication. They have not had to monitor other client groups service provision before and so are still learning how to do it.

5. Conclusion

The Government faces a challenge in Scotland, England and Wales to ensure future funding of HIV/AIDS medical and social care and prevention initiatives is well coordinated, equitably distributed and effectively spent by authorities receiving funds. Substantial funds have been allocated and earmarked to provide care and the use of these funds should be 'transparent' with decision makers being held to account to demonstrate the cost effective use of scarce resources.

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