CASE
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Funding Systems for Doctors, Schools and Social Landlords

- In the past decade there has been a minor revolution in how local services are funded. Those delivering the services now have their own budgets. How these budgets are calculated – how Whitehall pulls the purse strings – are now central issues in social policy. In a new book, CASE members analyse how these systems were devised, the incentives they embody, and how local service providers see them.
- A striking common theme is the increasing stress over the last century put on geographical needs-based equity, including – indeed significantly – under Conservative governments in the 1980s and 1990s.
- All three services moved away from directly encouraging particular activities towards more use of the 'passive' incentives given by fixed budgets, particularly those devolved to provider units. This may now be changing with growing emphasis on performance-related funding.
- Equity objectives were seen as 'obvious' by health service respondents, but were less clear in education and obscure in housing. GPs and schools tended to see funding as fair, even if they did not understand it. Social landlords were fatalistic.
- All the systems were seen as complex, increasing the power of the centre. The technical quality of the systems varied greatly, with the NHS formula based on more detailed data, more sophisticated techniques, and more academic input.
- There were few accusations of party-political favouritism. There were complaints about the inequity of differential treatment between different kinds of GPs and of schools (in capital allocations). Housing respondents were more relaxed about differences in treatment. London's position was often seen as a problem.
- Conservative reforms of the late 1980s which devolved budgetary responsibility to lower levels were welcomed and accepted – 'ring-fencing' of local authority housing revenue accounts, Local Management of Schools, and the aspects of the GP fundholding system which still apply to the new Primary Care Groups.

Further Information

Paying for Health, Education and Housing: How does the centre pull the purse strings? by Howard Glennerster, John Hills and Tony Travers, with Ross Hendry is published by the Oxford University Press (ISBN 0-19-924078-7; £40; available from booksellers or from OUP – 24-hour credit card hotline: +44 (0) 1536 454534; e-mail: book.orders@oup.co.uk; p&p for UK and Europe: £2.50 up to value of £50; free over £50; rest of the word: 10% of total value of order with minimum £2.50).

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Funding systems for health, schools and social housing

Over the last twenty years, ***NHS funding*** has moved onto an increasingly sophisticated needs-related basis, applied to smaller and smaller-sized areas. The last twenty years have reversed the position of the 1970s, when resources were more successfully equalised between areas for education than for health spending.

Funding reaches most ***schools*** through a two-tier process. Since 1990 central government funding to LEAs has been fixed amounts, depending on their Standard Spending Assessments (SSAs). Funding for schools is mostly based on fixed amounts per pupil (adjusted for items like numbers of lone parents, Income Support recipients, ethnicity, sparsity and local costs). Most of schools budgets have to be passed to schools, but LEAs can set their own distribution system between them.

The two parts of ***social housing*** – council housing and housing associations – are funded very differently. This raises equity issues, as rents paid by different kinds of tenant can vary considerably, even if in identical buildings and circumstances. It also means that there is no easy way of judging whether a landlord is doing a good job. The incentives built into their funding systems have changed in opposite directions. The pressures on local authorities now look more like those on housing associations in the 1970s and 1980s, when they had to operate within pre-set allowances. Housing associations became *less* constrained when they were allowed to set their own rents after 1989. Recent rent restrictions to control Housing Benefit costs have hardened budget constraints on both kinds of landlord, but the rent caps involved are unrelated to each other or to other parts of the funding systems.

Common and contrasting trends

A striking common theme was the increasing stress put on geographical needs-based equity, even by Conservative governments in the 1980s and 1990s. Differences include the systems used to slow – or 'damp' – changes from year-to-year (where the system for NHS funding has been much more successful than that in housing in achieving convergence while leaving the underlying principles clear).

The systems vary in how they embody *positive* incentives for particular behaviour, *passive* incentives of a fixed budget constraint, or *perverse* incentives which may encourage undesired behaviour. All three services have moved away from positive incentives towards much more use of the passive incentives given by fixed budgets, particularly those devolved to provider units. Debate over housing subsidies has been much more dominated by worries about perverse incentives than the others.

The structures of the funding formulae reflect technical constraints, such as the number of observations of spending behaviour from which relative needs can be inferred. Health systems have been more successful in generating data and more sophisticated in using them. Another important difference comes from the involvement of local government in education and housing, strengthening political pressures for local allocations, rather than acceptance of 'national' equity objectives.

Findings from interviews with providers

There was a strikingly shared view of what equity meant from top to bottom of the NHS – equal access to treatment for equal need. Lower down the system there was more scepticism and less understanding about the detail of the system, but overall trust in its aims. Differences between fundholding and non-fundholding GPs had breached equity principles, but the new Primary Care Groups were popular with both groups, combining devolved budgets, but restoring a uniform system. We saw a national service with clear common values to which everyone we interviewed was signed up, despite the deep divisions of the 1990s.

In our interviews with LEAs and schools there was virtually no questioning of the policy of devolving budgets to schools, despite the criticism when it was first introduced. However, the distribution of funding between LEAs was heavily questioned by LEA staff, who found it hard to identify a clear equity objective. Most LEAs believed they should receive a larger share of the total, although they did not suggest that allocations were skewed on party-political grounds. The system was, however, seen as complex and confusing, even 'bonkers'. In schools, there appeared far greater acceptance of the funding system.

The idea of an 'equity' objective baffled local housing respondents, who had never seen an official statement relating to equity. However, landlords did not generally see the differences in treatment of different tenants as a major issue. They were favourable to the reforms which had made social landlords more 'business-like' (ring-fencing of council Housing Revenue Accounts and increased financial autonomy and responsibility for associations). The balance of opinion was that the associations' 1989 capital funding reforms had achieved *some* efficiency gains. However, those reforms also decontrolled association rents for new tenants, which meant that associations lost the previous constraint on their recurrent spending.

Comparing these responses:

- The systems were free-standing, with little apparent official activity in drawing lessons between them.
- Equity objectives were seen as 'obvious' in health, but obscure in education and, particularly, in housing.
- Debate over allocations between LEAs was highly politicised in terms of local interests, contrasting with local health services where the possibly greater needs of other areas were accepted. GPs and schools tended to see funding as fair, even if they did not understand it. Social landlords' responses were fatalistic.
- The technical quality of the systems varied greatly, with the NHS formula based on more detailed data, more sophisticated techniques, and more academic input.
- All the systems were seen as complex, which increases the power of the centre, but this complexity is unlikely to diminish.
- There were few accusations of party-political favouritism. There were complaints about the inequity of differential treatment of fundholder GPs and of grant-maintained schools (in capital allocations) in the last Parliament. Housing respondents were more relaxed about the differences in treatment, partly reflecting the effects of Housing Benefit (which makes gross rents of little immediate importance for most tenants).
- Efficiency and incentive concerns dominated housing funding far more than the others, reflecting the way in which health and education funding rely on the 'passive incentive' effects of fixed budgets.
- The treatment of London recurred as a concern, with accusations from outside that the cost adjustments favoured London providers.
- Despite initial controversy, Conservative reforms of the late 1980s which devolved budgetary responsibility to lower levels were welcomed and accepted – ring-fencing of local

authority HRAs, Local Management of Schools, and the devolved aspects of GP fundholding continued into the new Primary Care Groups.

Where next? Directions for reform

By 1999 all these systems were under review. One result may be less needs-based formula funding, with more grants related to central assessments of performance. However, the centre does not possess the detailed information to make good judgements about what local agencies should do. Smaller units like schools, GPs, and smaller housing associations, or tenant-run estates do have the local knowledge.

The temptation to by-pass local government altogether may grow, not just in school-level education, but also in social housing, as its ownership is increasingly transferred to free-standing housing associations or companies. The pressure for the centre to involve itself in local detail will become irresistible, but potentially unmanageable and inefficient. The solution may involve a clearer role for local government as a local monitor and inspector.

Looking at particular service areas:

- In health, the clearest problems stem from the different treatment of care costs for the elderly depending on whether they count as ‘health’ or ‘social’ care. Formula funding of Primary Care Groups could include an enhanced element for the very elderly which would cover the costs of personal care as well as medical needs. An unprejudiced judgement could then be made of the best form of care.
- The evidence basis for the education element in local government funding is limited. There could be a national recommended spending level by age needed to achieve national minimum required education standards, but this would require higher quality robust evidence than is now available. The spending level would have to vary for children with special needs, for children from deprived homes, and for those with particular language difficulties. Such a formula could be used as the basis for funding each school, and would discourage them from ‘creaming-off’ the most able children, but only if it reflected differential needs.
- Housing subsidies could relate consistently to the elements of the cost of providing housing: its current capital value; provision for depreciation or major repairs; and recurrent management and maintenance. Ultimately all social housing could be provided by single-purpose landlords, while local authorities concentrate on their role of monitoring and ‘enabling’ activities.

About the research

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