London Councils' Response

Healthy Lives, Healthy People: an Update on Public Health Funding

London Councils' response to the Department of Health call for feedback – August 2012

London Councils represents all 32 London boroughs, the City of London, the Mayor's Office for Policing and Crime, and the London Fire and Emergency Planning Authority. London Councils is committed to fighting for more resources for London and getting the best possible deal for London's 33 councils. We develop policy, lobby government and others, and run a range of services designed to make life better for Londoners.

Summary of key points

- London local government has welcomed the opportunity to take responsibility for public health, however it needs reassurance that it will not be taking on new duties which are under funded. Department of Health must ensure that the funding it gives to local authorities for public health is sufficient to cover their costs of delivering this important function.
- It is important to get the overall quantum to be spent on public health right. There is a case to be made that this has historically been too low to achieve a significant and sustained positive impact on health outcomes and on health inequalities. Looking forward it will be important to ensure that the total resources available for public health are sufficient to meet needs.
- For those London boroughs in areas where public health has been historically under funded, London Councils strongly supports an immediate uplift for 2013/14.
- London, in common with many other urban and metropolitan areas, has a number of factors which make the delivery of public health services and achieving improvements in public health more costly. It is important for these factors to be recognised and taken into account when determining public health funding allocations.
- The sole use of the standardised mortality ratio (SMR) under 75 as a means of determining the allocation of resources is too crude and does not adequately reflect need to spend on public health services.
- London Councils proposes that further exploratory work should be done, in collaboration with local government, on the feasibility of a composite model which would include a component based on need to spend (on demand led and mandatory services, such as NHS Health checks), as well as a component based on SMR under 75 or an appropriate alternative outcome measure.

- More work with local government is needed on the incentive element component of the grant (to come in from 2015/16) to ensure this is helpful and does not create an additional burden for local authorities.

- There should be further discussions with local government on the pace of change. In particular, this must not be done in a way that risks destabilising the system.
- The requirements of the ring fenced grant should be as least burdensome as possible for local authorities to administer and should have processes that are in line with similar grants to local government.
- There is a need for further detail as soon as possible to assist local government with planning.
- Department of Health should commit to meeting the current in year costs to boroughs of public health transition, estimated to be around £0.2m per local authority.
- Local government is a key stakeholder and should be closely involved in discussions and at the table when decisions about public health funding are being made.

Introduction

The transition of public health to local government represents a significant opportunity to achieve a positive step change in health outcomes and a reduction in health inequalities through strengthening community leadership for health and integrating health improvement within the wider work of local government.

However, critical to the realisation of these ambitions will be the funding that local authorities receive to meet their new public health responsibilities.

This response by London Councils to the call for feedback from Department of Health on the issues raised in its update on public health funding (published 14 June 2012) sets out the key issues and concerns of London local government in relation to public health funding.

London Councils views this as just the beginning of what we consider should be an intensive engagement process with local government by Department of Health over the coming months in order to come to an optimum solution on public health funding.

Ensuring adequate funding for public health

Department of Health needs to ensure that the overall quantum of funding for public health is sufficient both to meet the needs of existing services and also to invest in prevention activities that will reduce the burden of ill health and avoidable disability in the longer term. There is a case to be made that spend on public health has historically been too low to achieve this effectively. Therefore, historic spend should not be used as the sole criterion for determining the size of the public health pot going forwards.

Within London, PCTs have chosen to invest variable amounts in public health (as evidenced in the six fold variation in spend per head for 2010/11), which has not correlated with need and may have been more associated with other factors, such as funding pressures in acute services.

For 2013/14, it will be important to ensure that those London boroughs that are furthest below where they should be, receive an uplift on their allocations to ensure they are able to meet their new responsibilities. This should not be at the expense of other local authorities and this raises the importance of ensuring the overall quantum of funding is sufficient.

An additional piece of context which needs to be factored in is the implications of changes to the NHS resource allocation formula. The weighting of the unavoidable inequalities element of the formula was reduced by the current government from 15 per cent to 10 per cent. From 2013/14 the decision on how much to allocate to Clinical Commissioning Groups has been delegated by the Secretary of State for Health to the NHS Commissioning Board. The Board will have the freedom

to allocate resources as it chooses, subject to the guidance of the mandate it received from the Secretary of State. The draft mandate does not include any mention of reducing avoidable inequalities. In areas that are disadvantaged due to this shift there could be larger additional demands made on public health services.

A thorough exercise should therefore be undertaken to establish the cost of the new public health responsibilities coming to local government to ensure that the sector is not left with under funded burdens.

Additional pressures on public health in metropolitan areas

London, in common with many other urban and metropolitan areas, both within the UK and internationally, has a number of factors which make the delivery of public health services and achieving improvements in public health more costly.

The context in which public health services are provided in London is complex and has a direct impact on levels of need:

- Of the 33 local authority areas in London, 20 rank within the top 50 most deprived areas (out of 354) on at least one measure of deprivation.
    - Deprivation has been found to be related to the costs of meeting needs, as well as having an effect on levels of need. (For example Matrix consultants for NICE estimate that the cost per quitter of smoking cessation when targeted at disadvantaged communities increased around three fold for pharmacy and nicotine replacement interventions, and higher for other interventions[1]).

- London experiences high levels of population churn (with churn in some London boroughs as much as a third in any one year). This means that public health interventions need to be repeated continuously to ensure that new populations are reached by them.

- London is also a hub for national and international migration and has two major airports.

- There are more than 300 languages spoken in London and more than 50 non indigenous communities with a population of 10,000 or more. The 2011 census showed that London was home to just under half (46 per cent) of England's BME population. A number of London boroughs have high levels of ethnic heterogeneity meaning that public health messages and interventions need to be tailored to meet the needs of different recipients in order to be effective. In addition, London may have higher costs associated with translation and interpretation services.
    - Studies in one area of public health intervention – alcohol – have shown that, compared to need, BME groups are under represented in seeking treatment advice. A concerted effort to improve London's alcohol services is therefore likely to reveal significant unmet need amongst BME groups, requiring additional funding to meet this.

- In some London boroughs, the day time population is significantly higher than that for the night time. At the most extreme end, the City of London has a resident population of 11,700 but a day time working population of 360,000. Research about commuters to the City of London[2] found that one in four smokes regularly (above the England average of 20per cent) and a high proportion (28per cent) binge drink. Those boroughs with a high day time population face the additional cost of delivering public health services for employees, students and visitors to the area. (For example, 10 per cent of activity in sexual health services is generated by individuals who live outside of London).

- London has almost a quarter of England's homeless population.

[1] Matrix Evidence (2008)

[2] PHAST, May 2012

- London has a young population with 32 per cent of the population under 25 and 60 per cent of the population under 40.

- As a result of London's younger and diverse population, demand in London for sexual health services is higher than elsewhere.

- Recent analysis undertaken for London Councils has found that 62 per cent of London's overall public health expenditure in 2010/11 was spent on sexual health and substance misuse services. These are demand led services where, by their very nature, it is difficult to predict or control spend.

London also has a number of significant public health challenges:

- 40 per cent of UK TB cases are in London.

- Half of the top 20 English boroughs with the highest levels of childhood obesity are in London.

- London has the highest rates of teenage pregnancy and of sexually transmitted infections in England.

- London has a higher prevalence of problematic drug users than England as a whole (12.2 per 1,000 vs 81 per 1,000).

Londoners are more likely to binge drink and levels of alcohol related hospital admissions are rising in London (up by 14 per cent between 2008/09 and 2009/10), even though overall levels of alcohol consumption in London are lower than in England as a whole.

It is vital that factors such as those above are recognised and taken into account when determining public health funding allocations.

Getting the area cost adjustment right will also be particularly important for London which has higher labour and associated costs.

Interim recommendations from ACRA on the proposed formula for allocating public health resources

The Advisory Committee on Resource Allocation (ACRA) has proposed the standardised mortality ratio (SMR) in those aged under 75 as means of determining the allocation of funding.

It is important first of all to re-iterate the point that it is vital that the overall national amount for public health is sufficient – if the size of the overall pot is not adequate then however robust the approach to resource allocation, there will still be an underlying problem.

Second, London Councils believes that an approach to resource allocation based purely on a formula is not appropriate when local authorities will have prescribed services that they have to deliver. For services that are mandatory or demand driven (such as the NHS health check, sexual health and substance misuse services), we consider that resource allocation should be determined by a bottom up costing of the service building blocks required to deliver the required services equitably and to the defined standards.

There is a risk that relying solely on a formula based approach risks certain areas being left without the funding they require to deliver the full range of public health services.

We therefore propose that further exploratory work should be done, in collaboration with local government, on the feasibility of a composite model that would include a component based on the costs of providing prescribed and demand driven services, as well as a formula based component.

The first element of this composite model would need to be reviewed on an annual basis to ensure that local authorities are not out of pocket or having to divert funding from non – mandatory services as a result of an increase in demand for services such as those for sexual health or substance misuse.

Third, in relation to the use of SMR under 75, London Councils recognises the difficulty involved in finding a formula that is both meaningful and available on a national basis. We also understand some of the perceived merits of this proposed measure, for example that it is available at small area level.

However, we also have a number of concerns about the use of this as measure without the use of other modifying elements:

- Much of what drives SMR under 75 is likely to reflect the long – run circumstances and needs of individuals in their pasts, rather than currently. As a result, there is potential that this as a measure could be too "backwards" looking, not currently reflecting the needs of local authorities' current populations.

- Whether it is appropriate to have under 75 as the cut off. Areas with large proportions of very elderly populations who can still benefit from public health interventions (for example falls prevention work), could potentially find themselves under funded with an under 75 cut off).

- Under the proposed formula, allocations per head of population seem to correlate better with the Index of Multiple Deprivation 2010 than the indicative spend figures based on historic spend. However, this comes as a result of a shift of relative funding shares from more deprived areas to less deprived ones. This holds true both in a London and an England wide context. As a result, London Councils is concerned about the equitability of the formula and calls on the Department of Health to commit to protecting more deprived areas from adverse shifts in funding.

London Councils suggests exploring various modifying elements that could be introduced to the formula to reduce the influence of SMR under 75. One key advantage of these alternative factors is that they are not outcome-based, and therefore do not undermine performance incentives:

- Levels of deprivation – emerging evidence shows that – controlling for individual deprivation – the deprivation levels in an area affect need separately over and above individual experience. It has also been shown that changes in deprivation have a stronger impact on limiting long term illness than on SMR. (This is significant given that an important component of the role of public health is to reduce avoidable morbidity, as well as to reduce the incidence of avoidable or premature mortality).
- Population age distribution is an important factor, as teenage pregnancy and sexual health-related costs constitute a large portion of overall public health costs.
- Population churn is an important factor as this means the public health needs become more unpredictable and increases costs with delivering services.
- Population density can also have adverse effects on public health, especially regarding risks of spreading infections across the population. This means that the general responsibility of the health of the public, now shared with the NHS, might be more costly to fulfil.
- The ethnic mix of the population. Many public health services rely on personal contact, which means that in more diverse communities, additional resources may be required for provision of services and information in multiple languages.

The performance incentive element of the health premium.

More work with local government is needed on the incentive element component of the grant (to come in not before 2015/16) to ensure this is helpful and does not create an additional burden for local authorities.

London Councils supports the principle of incentivising performance, however we have concerns about a potential conflict between the two funding elements, based on the interim ACRA formula. SMR under 75 is by its nature a more outcome-based measure: if a local authority improves public health outcomes for its population, any extra health premium funding could be cancelled out by a

reduction in the baseline as its mortality rates fall. This means that the incentive effect is undermined by the make-up of the funding formula.

London Councils therefore suggests reviewing the formula and reducing the influence of SMR under 75 by introducing more independent variables, as set out above, to ensure the incentive effect is not diminished by conflicts within the system.

Based on the update, we welcome the proposal for the makeup of performance measures affecting the health premium allocation to be flexible in response to local needs rather than being centrally imposed.

Pace of change

There should be further discussions with local government on the pace of change. In particular, this must not be done in a way that risks destabilising the system.

In the short term for 2013/14, London Councils would strongly support an uplift for those London boroughs that are furthest away from where they should be to ensure they are able to meet their new responsibilities.

In general, any move towards allocations based on a new formula should be done by uplifting those who are furthest below target, rather than by removing from those who are above it.

In order to be able to plan effectively, it will be important for Department of Health to provide as much information as possible to local government about how the pace of change will operate.

The operation of the grant conditions

The requirements of the ring fenced grant should be as least burdensome as possible for local authorities to administer and should have processes that are in line with similar grants to local government.

London Councils would like to see local authorities afforded maximum flexibility in terms of how they are able to use the ring-fenced public health grant to meet local needs, enabling them to draw on a range of interventions to improve local health outcomes.

We have several concerns regarding the grant conditions as published together with the update relating to administrative procedures. London Councils believes that addressing these issues could go a long way towards reducing the administrative burden that local authorities would take on.

The conditions specify that the statement of grant usage, or any alternative reporting arrangement, should be certified by the Chief Executive officer of a local authority. Most alternative grant claims and other important financial documents, such as end of year accounts, are signed off by the Chief Finance Officer. London Councils believes that any documents relating to public health grant should not be treated any differently from standard practice for other grants that local authorities receives from central government.

Second, the draft regulations mention the need for explicit audit of the expenditure details before a report on usage, or any other reporting arrangement, is submitted. As a standard procedure, the Chief Internal Auditor provides a Statement of Internal Control which encompasses financial affairs of a local authority among other elements of control. In light of this, London Councils believes that an explicit audit of the claim is not necessary in this case and suggests revising the regulations.

Third, paragraph 13 in the 'Eligible Expenditure' section of the regulations implies that cash accounting should be used for the grant. This conflicts with accruals-based accounting which is standard practice for local government, as well as the basis for the "Whole of Government Accounts" project. As such, London Councils strongly suggests revising this paragraph.

We urge the Department of Health to consider these points. It is imperative that there is as little additional administrative burden as possible on local authorities.

The need for further details about funding as soon as possible to assist planning by local government

London Councils is disappointed with the lack of detail provided regarding key elements of the public health funding system. There has as yet been no decision made on the total quantum of funding available for 2013/14.

This uncertainty makes it hard for local authorities to plan for this wholesale shift of responsibility. It is imperative that local authorities are provided with further information about key aspects of the new system, such as the total quantum of funding available and, most importantly the pace of change between the current allocation basis and the new formula, to allow them to plan for the responsibility transfer with confidence.

Meeting the in year costs to boroughs of public health transition

London Councils is also calling on the Department of Health to commit meeting the current in-year costs of public health transition for boroughs, currently estimated to be approximately £0.2m per local authority. These costs are being necessary incurred by boroughs in order to ensure a smooth transfer of responsibilities, staffing and existing contracts between PCTs and local government.

Concluding remarks

The transfer of public health functions to local authorities is a significant shift of responsibility which is taking place in the overall context of public sector austerity. As a result, it is important that any new burdens for local authorities are supported by a funding system that is adequate, robust, effective and predictable. While there has been progress in setting up the new public health funding system, London Councils still has a number of concerns as set out in our response above.

Looking forwards, it is important that local government as a key stakeholder and partner is even more closely involved in discussions about funding and that we are at the table when decisions about public health funding are being made.

London Councils
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