London Councils

Consultation Response

DH consultation on the Public health grant: proposed target allocation formula for 2016/17

Response by London Councils

London Councils represents London's 32 borough councils and the City of London. It is a cross party organisation that works on behalf of all its member authorities regardless of political persuasion.

Overview

1. London Councils welcomes the opportunity to comment on the proposed changes to the public health grant funding formula being consulted on by the Department of Health. This response firstly sets out some general comments about the consultation, followed by more detailed responses to the specific consultation questions.

2. In summary, London Councils:

   - welcomes the fact that services for children under 5, sexual health and substance misuse have been recognised as deserving of separate components in the updated formula, however, we have some reservations regarding the substance misuse formula;

   - is disappointed at the short length of the consultation period, given the complexity of the changes involved, and the timing of the consultation, given the need for certainty in funding allocations next year;

   - is very concerned about the overall levels of public health funding, given the proposed £200 million in-year cut in 2015-16, and the fact that public health is being treated differently to the wider NHS budget, and asks that funding is tied to increases in the NHS budget and, if not, for the ring-fence to be removed;

   - would like the unique characteristics of London's population to be recognised more in the funding formulae; particularly the impact of population churn and density on 0-5s and sexual health services;

   - asks that the Government clarify the pace of change policy as soon as possible, setting out clear plans for how quickly it will move local authorities to their target funding allocations, but in a way that ensures a degree of stability and consistency; and

   - asks that Government, in light of the wider changes to local government finance system, outlines its long term plans for public health funding, clarifying if and when this will be rolled into the business rates retention system.

Introduction

3. London Councils strongly believes that funding formulae should be based on the principles of transparency, predictability, stability and robust evidence without risking oversimplification. London has a unique set of public health pressures because of its complex demography and relatively high levels of deprivation and need.

4. The allocations that supported the original transfer of Public Health in 2013, and those for the 0-5 years transfer, have largely been based on historical prioritisation decisions by Primary Care Trusts, resulting in a wide range of per head allocations (from £36 to £195 per head across London in 2015-16). London Councils has repeatedly made the case that the allocations do not properly reflect the capital's population characteristics and health needs.

5. We, therefore, welcome the fact that services for children under 5, sexual health and substance misuse have been recognised as deserving of separate components in the updated formula. The latter two services account for 51 per cent of total public health expenditure in 2015-16 in London, compared with 44 per cent across the rest of England. However, we have some reservations about the current proposals put forward by ACRA for the substance misuse formula component, and more generally regarding the population data being used (see response to the questions 3 and 4 below).

Timing of the consultation

6. London Councils believes that, given the complexity of the changes being proposed to the formula, the time period of four weeks between the publication and the deadline for responses is wholly inadequate, especially given the need for political sign off from local authorities, which is even more complicated for representative bodies such as London Councils. The consultation proposes numerous changes to the formula and an appropriate amount of time, commensurate with the complexity of the proposals, should be given to allow adequate scrutiny of the formula.

7. It is also disappointing that the consultation has been delayed until October. The Department of Health (DH) stated in February that it expected 'to facilitate a public engagement over the summer on ACRA's interim recommendations on the whole formula for 2016-17 public health grants'[1]. The delay in the consultation, together with the delay in the department's response to the consultation on the £200 million in-year cut in 2015-16, only adds to uncertainty for councils and impacts on their ability to deliver robust financial planning, which is particularly important during a period of funding reductions. This is doubly important if the new formula results in significant changes from the previous years' allocations.

8. The consultation document states that funding allocations may not be announced until as late as January 2016. Many authorities will be setting their annual budgets and determining council tax levels by this time, and are likely to be doing so with far fewer resources London Councils urges the government to confirm the final allocations as soon as possible following the Spending Review, and at the very least by the end of 2015.

Ensuring adequate funding for public health

9. While the consultation deals with the distribution of funding, this is less meaningful until the overall quantum and pace of change policy are known. London Councils is concerned that, during a period of growing demand on health and social care, the overall level of funding for public health is being reduced. London Councils strongly urges the Government to reverse the proposal to cut funding in 2015-16 by £200 million, or at the very least to re-instate this funding into the overall quantum for 2016-17.

[1] http://www.local.gov.uk/documents/10180/49880/Public+health+formula+0-5+year+olds+-+ACRA+methodology.docx/5a356835-cef2-41a3-be45-ef38a453360e

10. The Spending Review will determine the quantum for the DH's spending for the next four years. The Government has committed to spending at least an additional £8 billion above inflation by 2020 on the NHS: we believe public health funding increases should be tied to those of the wider NHS. There has been a clear inconsistency in the Government's treatment of the wider NHS budget and the local government public health budget, despite the latter being used to commission NHS providers and services. Treating public health funding differently to wider NHS funding, simply because it has moved across to local government, is both unfair and short-sighted. A significant proportion of public health funding is spent on NHS services, estimated by the Association of Directors of Public Health to be between 40 and 80 per cent. Reducing the public health budget, therefore, risks cuts to NHS services elsewhere. For example, the majority of the annual £150 million spent on health visiting in London is through contracts with large specialised NHS Trusts, which fund 1,800 health visitors. We urge the government to increase public health funding in line with the rest of the NHS.

11. If overall funding for public health does not increase in line with the wider NHS budget, London Councils asks for the ring fence to be removed in 2016-17 so that local authorities are given maximum flexibility in terms of how they are able to use their funding to meet local needs. At the very least we believe the ring fence should be time limited to give local authorities greater control over their financing in the longer term.

London's unique population

12. London Councils also believes that ACRA should undertake further work to explore the impact of population churn on both the sexual health and the 0-5s formulae, which would be consistent with how it is used as a preferred variable for the substance misuse formula. London experiences high levels of population turnover, 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 boroughs and the resultant greater costs involved.

13. Linked to this is the fact that London is also a hub for national and international migration. 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 public health messages and interventions need to be tailored to meet the needs of different recipients in order to be effective. For example, HIV prevention can be aimed most effectively at high risk groups such as the Black African community. In addition, London may have higher costs associated with translation and interpretation services.

14. London Councils therefore urges the Government to consider these unique population factors when determining funding allocations for 2016-17.

Pace of Change policy

15. London Councils' analysis of the final overall weighted populations for target allocations compared with those for 2015-16, suggests there would be considerable volatility, with some large decreases in funding at the local level, were there no pace of change policy in 2016-17. However, it is also true that in the latest year for which figures are available, 27 per cent of local authorities received more than 20 per cent above or below their target funding allocation – the amount that would be their fair share taking account of relative needs.

16. London Councils, therefore, echoes the sentiment of the Public Accounts Committee, which recommended that DH 'should set out clear plans for how quickly it will move local authorities to their target funding allocations for public health'. We believe this should be done through dialogue with local government. 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. Most importantly, however, this must not be done in a way which risks destabilising the system.

17. In order to be able to plan effectively, we urge the Government to provide as much information as possible to local government, as soon as possible, about how the pace of change will operate.

The future of Public Health funding

18. The ring-fenced public health grant should be considered in the wider context of local government funding. The Chancellor recently announced the full devolution of business rates and the elimination of revenue support grant by 2020. The estimated surplus in business rates by then is large enough that, based on current trajectories, it could pay for all the specific revenue grants that local government currently receives from central government. This raises the question of whether the Government may be considering movement towards funding public health grant through business rates.

19. In that context, London Councils urges the Government to outline its current thinking on the future of revenue grants including public health grant as soon as possible to give local government greater certainty in its medium term financial planning. In particular for public health, we would like to know whether the formula-based grant will continue or whether it will be combined into the wider revenue support grant and, if so, what the timetable for rolling in the grant will be, and assurances it will not be subjected to the wider cuts to local government funding.

20. 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
November 2015

Consultation Questions

Q1. Do you agree that a modelled SMR<75 should be developed for use in the longer term?

21. London Councils agrees with the proposal. We welcome ACRAs attempt to use a modelled SMR<75 to address the perverse incentive whereby local authorities which successfully reduce their mortality ratio, through improved public health interventions, can see their resource allocations fall despite retaining high and complex levels of need. Standardised mortality rates have improved for more than two thirds of London boroughs since the last formula refresh in 2014-15. This is likely to be the result of a range of factors such as improved cancer, respiratory disease and other disease detection rates. In addition, as the median population of London is becoming younger SMR<75 is likely to fall. However, the complex make-up of London's population means that the underlying drivers of the actual levels of need are unlikely to have changed.

22. 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 believe the use SMR<75 as a means of determining the allocation of resources does not adequately reflect need to spend on public health services. We reiterate our previous call for further exploratory work to 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<75 or an appropriate alternative outcome measure. Various modifying elements could be introduced to the formula to reduce the influence of SMR<75 such as deprivation levels (using the health sub-domain of the 2015 IMD); population churn; population density and the ethnic mix of the population.

23. We also remain concerned as to the appropriateness of 75 as the cut off age. Given that a third of babies born today are expected to live to 100, we don't think it is acceptable to treat the death of everyone aged 75 and over as if it is unpreventable due to old age. Areas with large proportions of very elderly population, who can still benefit from public health interventions, such as falls preventions work, could potentially find themselves under funded with an under 75 cut off. We are concerned that the formula needs to reflect the fact that while people may be living longer, those extra years are frequently spent in poor health, and that this problem is likely to rise with the increase of public health issues such as diabetes and heart disease linked to increasing levels of obesity.

Q2. Do you agree that the sixteen groups outlined above provide a sensible balance between sensitivity to the most extreme mortality rates and protection against volatility of measurement?

24. London Councils does not agree with the proposal. The increase in bins from 10 to 16 has a significant redistributive effect. The level of detail in the explanation does not adequately justify this change, which creates a significant level of volatility. There is no justification of why 16 bins have been chosen, with ACRA itself saying this is an arbitrary choice based on the distribution of the data (with each bin having no fewer than 30 MSOAs). London Councils would like to see more detailed explanation and a stronger rationale before a change of this magnitude is implemented. It serves to reduce the weighted population of London boroughs substantially (by over 190,000 or 2.5 per cent), while other areas gain considerably, for example the North West gains by over 365,000 (4 per cent).

Q3. Do you agree that the proposed new substance misuse formula component should be introduced?

25. London Councils does not agree with the proposal. While we agree that a separate component is necessary for substance misuse, we have some reservations about the formula that has been chosen. The new weighted populations created by the new formula have a significant redistributive effect compared with the previous

distribution for 2014-15 and 2015-16. The result means significant volatility between funding for substance misuse between the 2015-16 and 2016-17, and we do not feel the consultation documentation sufficiently justifies the use of the replacement of the old methodology with the new one.

26. Firstly, the overall explanatory power of the newly proposed model is only around 46 per cent of the cost, i.e. it explains less than half of the variance in the dependent variable (cost per person). London Councils would question whether the strength of the model is great enough, when so many millions of pounds are at stake.

27. Secondly, the strongest explanatory variables within the model relate to previous treatment records (i.e. days of treatment, completed treatment, and received prescribing in the previous year). While these are the strongest indicators, they rely on the assumption that most drug/alcohol users are treated repeatedly. For major urban areas, with high levels of homelessness and population turnover there are more likely to be newly presenting cases each year and a higher proportion of cases that present only once in an area (and then move on to another area). While there is a population churn factor in the model, we would like to see more information about how important this is at a regional level, as we suspect this is more influential in areas of high churn like London.

28. Thirdly, Public Health England (which oversees the national drug treatment monitoring system) states that, "while these statistics provide information on the numbers of people accessing treatment for drug/alcohol dependency, they do not give an indication on the levels of need for drug/alcohol treatment or the prevalence of drug use/alcohol dependency in England"[2]. It could be argued that there is hidden untreated need amongst populations that is not being picked up. For example, in areas with large BAME populations, such as London, it is recognised that these groups are under-represented in seeking alcohol treatment advice. Any concerted effort to improve London's alcohol services will therefore likely reveal significant unmet need amongst BAME groups, requiring additional funding to meet this. It is not clear why ethnicity is not a variable in the proposed person base model.

29. Finally, if the new model is used we suggest a minor change to the way in which the overall population change between 2011 and 2016 is been applied to the weighted population from the first part of the substance misuse formula. The substance misuse formula calculates a weighted population using the relative distribution of age groups and modelled costs at postcode level, which are then aggregated up to local authority level and normalised for 2011. By multiplying by the overall change in population between 2011 and 2016, this assumes there has been no change in the relative distribution of age groups at local authority level. In reality, the populations of different age groups will have changed at different rates for each local authority. We believe it makes more sense to use the 2016 sub-national population projections (SNPP) for each age group within the first part of the formula, rather than using the 2011 figures. This would eliminate the need to use the overall population change factor in the second part of the calculation. This would also be consistent with the way the 2016 SNPP by age group are used in the proposed new sexual health formula.

Q4. Do you agree that the proposed new sexual health services formula component should be introduced?

30. London Councils agrees with this proposal. Expenditure on sexual health services in London represents 27 per cent of the total expenditure in England (RA returns 2015-16), and we have previously urged government to recognise this extra burden on public health funding in London.

31. However, London Councils questions why the age groups 25-29 and 30-34 have been omitted from the model, as these two age cohorts are the most expensive, in terms of cost to public health sexual health

[2] https://www.ndtms.net/Publications/downloads/Adult%20Alcohol/adult-alcohol-statistics-report-2013-14.pdf

services, of all age groups for men and women. Indeed, the latest figures from Public Health England show that the largest rises in London for all sexually transmitted infections (STIs), including chlamydia, gonorrhoea and syphilis, are in the 25-34 age bracket, with the second largest rise being in the 35-44 age bracket.

Q5. Do you agree that the proposed new services for children under five years formula component should be introduced?

32. London Councils welcomes the fact that services for children under five have been recognised as deserving of a separate component in the updated formula, and that this is based on MSOA level data, as recommended in our response to the consultation on the transfer of 0-5s funding. Boroughs across London welcomed the transfer of commissioning health visits for 0-5 year olds to local government from October 2015. This offers boroughs the opportunity to unlock long-term cost avoidance to the public purse by giving every child the best start in life.

33. With regard to the increased costs caused by population churn, London experiences high levels of population turnover, 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 by London boroughs to ensure that new populations are reached by them. While the consultation document states that ACRA "is not aware of quantified evidence that costs are higher for children moving into an area and the scale of such costs", London Councils believes that, since population turnover has been recommended as a variable in the substance misuse services formula, ACRA should undertake further work on the impact of population churn on the 0-5 formula.

34. London Councils would also encourage ACRA to undertake further work on the impact of population density, given that population sparsity is a key element of the 0-5 formula. In December 2014, DCLG and DEFRA published a report on the drivers of service costs in rural areas which found that, from a total of 50 models for Adult Social Care, there was little evidence linking sparsity to higher unit costs. Only one model showed a statistically significant relationship (Adults under 65 with Learning Disabilities), and this showed a negative correlation between sparsity and expenditure per client. Whilst this assessment did not carry out specific work in relation to health, London Councils' believes parallels could be drawn for 0 to 5 year olds, as adult social care relies on care visits. If population sparsity is to be used, then population density should also be given a commensurate weighting as it can have adverse effects on public health, especially regarding risks of spreading infections across the population.