ENGAGEMENT ON INTERIM PUBLIC HEALTH RECOMMENDATIONS

EXTRACTS RELEVENT TO ACRA RESPONSIBILITIES FROM RESPONSES OF ORGANISATIONS REPRESENTING MULTIPLE STAKEHOLDERS	
Organisation Response Received From	Officer Leading On Response
Royal College of Nursing	Policy Advisor

Health outcomes such as life expectancy continue to improve in the UK thanks to improved social conditions, advancing medical and scientific knowledge, a highly trained professional workforce and massive investment in the healthcare system. However, these improvements mask a widening gap between the health outcomes of the wealthiest and the most deprived communities.
The RCN welcomes the attempt at an evidence-based approach to defining the budget for public health, however, we have some concerns with the recommendations and the implementation of these proposals for consideration by ACRA .

ACRA's interim recommendation, that Standard Mortality Ratio for those aged under 75 years (SMR<75) should be used as an indicator of the whole population's health status, and hence need for public health services, has been contentious. The RCN notes that public health need is substantially different to health care need and that prevention interventions can be most usefully targeted at the young, pregnant and child populations. Age is a useful indicator, but, as outlined in *Healthy Lives, Healthy People: Update on Public Health Funding* paragraph 2.16, the allocation for sexual health services will need to be adjusted to reflect the greater need amongst the younger population.

The current health reforms in England must ensure that Local Authorities, Health and Wellbeing Boards, Clinical Commissioning Groups and Public Health England are held accountable for closing the inequality gap.

Funding for Public Health services must be strongly related to deprivation and direct need but also take into account the demands of an ageing population and the significant increase in the number of people with long term conditions.

The Index of Multiple Deprivation 2010 combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score and is produced at Lower Super Output Area level, this could then be matched against SMR<75 at Middle-Layer Super Output Area.

The RCN recognises rurality and 'population churn' (migration interarea or international) within communities as factors which impede the implementation of public health interventions. Migration also means that the impact of interventions as evidenced by population health improvement may be diluted as the population that received the benefit moves away. This would adversely affect progress against the indicators of the outcomes framework and ultimately would affect health premium incentive payments for that area. The RCN would like to see adjustments reflected in the allocation formula to reflect migration and rurality and an adjustment in the health premium payments formula to reflect migration.

Organisation Response	Officer Leading On Response

Received From	
South East England Councils	Director

Public Health Funding

Over a number of years, our members have been very concerned about low levels of public health funding in the South East. There are gross distortions in the way funding has previously been allocated and people in the South East are just as entitled to have their public health needs met as in other parts of the country. We welcome and support the ACRA independent review before transfer of public health responsibilities to local authorities in 2013. ACRA's work is critical to achieve fairer funding allocations that reflect the significant challenges faced by South East local authorities in improving public health for the UK's largest population. ACRA's 14 June interim suggestions are a very useful step in the right direction but there are other key issues that are critically important for the populations we serve and which should be reflected in their work:

- The cost implications of a large scale population
- The cost impact of the absolute number of people living in deprivation in an area
- A realistic assessment of the costs of providing similar services in different parts of the country
- Issues arising from the historic underfunding of public health across the region.

Deprivation

Any new funding system should recognise absolute levels of deprivation. Current local government funding focuses heavily on the percentage of deprivation but this disguises the actual number of people affected and therefore does not reflect the true cost of supporting them. Two current examples from the South East illustrate the problem:

- Percentage comparisons of children in income deprived households do not reflect the public health needs of this group – a key target for the Healthy Child Programme 5-19. The South East is considered to have the lowest percentage deprivation in this group at 14.8% while the North East has the second highest percentage at 25%. However actual figures show 235,521 South East children in income deprived households – more than double the 115,127 children affected in the North East. Public health funding should recognise the true cost of improving the health of such a large group of disadvantaged children and the problems this creates.
- Percentage comparisons of older people in income deprived households tell a similar story. Once again the South East has the lowest percentage at 13% and the North East the second highest at 23.3% but actual numbers show 248,901 older people in the South East living in income deprivation – some 110,000 more than the 138,442 people affected in the North East.

Despite the challenges of a very large population and high absolute numbers of children and older people living in income deprivation, in 2010-11 average public health spending in the South East was the lowest in England at just £27 per head. This compares to £65 per head in the North East.

Move away from historic funding levels

Our members strongly support the DH view that the current health reforms need to be supported by a new approach to public health funding. ACRA's interim proposals graphically illustrate the extent of historic underfunding of public health in the South East. This is particularly evident in how the application of the formula affects funding in the Shire counties. The average increase in funding for Shire counties across England is 21%, within a range in the South East of -18% to an increase of over

105%.

Public health funding in the region has been distorted by other PCT priorities that have resulted in our populations receiving inadequate resources over a long period. For example:

- Public health spending in Surrey and Buckinghamshire was seven times less than the money available in England's best funded area. Tower Hamlets in London was the best funded area, receiving £117 per head. This compares to just £17 per head in Surrey and £15 per head in Buckinghamshire. In Kent – an area with significant coastal deprivation – average spend was £24 per head, almost five times less than Tower Hamlets.
- An area-by-area comparison shows the South East's average public health funding is the joint lowest in England at £27 per head. This compares very poorly with average public health spend in other areas, including the North East (£65 per head), London (£57 per head) and the North West (£49 per head). These South East-wide figures demonstrate high level issues of underfunding, but it is also important to recognise that averages can disguise significant levels of inequality within areas that our individual member authorities would be pleased to illustrate in more detail.

The consequence of inadequate funding is that the health of our populations will be worse and local authorities will be inheriting problems far greater than should have been the case if resources had been properly applied. Any needs-based allocation should take into account the historic underfunding in order to rectify the disadvantage that has resulted.

Organisation Response Received From	Officer Leading On Response
Royal Statistical Society	Director of Professional and Public Affairs

The current proposal by ACRA is based on SMR for deaths less than 75 years at MSOA level. This is a very volatile indicator due to the small number of events on which it is based.

Even if the true 'risk' of early death is not changing, Local Authorities may be subjected to considerable and unpredictable variability in their allocation.

We suggest resource allocation is based on an indicator or indicators with smaller variability.

At a minimum the Department should carefully analyse the potential volatility of allocations.

Organisation Response Received From	Officer Leading On Response
S.I.G.O.M.A. *The Special Interest Group of Municipal Authorities (Outside London) Within the LGA*	Principal Research Officer

Future allocations - SMR

SIGOMA welcomes a move towards a future allocation that is more closely matched

to need, as represented by the Standard Mortality Rate for under 75s measure (SMR<75). Though the measure has a closer correlation with poverty as measured by the Index of Multiple Deprivation (IMD), the scaling factor does not appear adequate for higher needs areas.

Future allocations - Scaling factor
SIGOMA do not agree with the scaling factor of 3 and suggest that a factor of at least 5 should be used. Some members feel that a scaling factor of 8 should be used on the basis that this would more closely align the funding arrangements to relative needs formula used elsewhere in local government.

Future allocations – Area cost adjustments
SIGOMA members do not support the use of the area cost adjustment in this context due its distorting effect on distributions and the significant part the public sector plays in fixing salaries in the UK economy, employing on average 23% of the UK's total employees.

Developing a weighting measure
SIGOMA welcomes in principle the intention to further refine the weighting mechanism, so long as any proposed change is clear, objective, transparent and matches funding to needs. Whilst members have noted the comments in the exposition regarding the close link between measurements of mortality and morbidity we do not think this has been explained in sufficient detail in the exposition document. Individual members have questioned whether links to possible areas of increasing cost such as mental health are adequately represented in SMR<75 and would like to see evidence of this.

Some members feel that the specific areas mentioned of age, fixed costs and non resident populations are not appropriate measures for refining the weighting as they can not meet the standards mentioned in the paragraph above.

Organisation Response Received From	Officer Leading On Response
Faculty of Public Health	Policy Officer

The Faculty agrees with some of the components of the proposed formula, but is extremely concerned by the way in which the formula redistributes shares of funding from areas whose residents have the worst health to areas where residents have better health.

1. Proposed formula: accepted components

1.1 Using middle super output areas (MSOAs) is an appropriate geographical unit on which to allocate funding since it is a widely used unit and one for which data is available for a range of indicators.

1.2 Using the standardised mortality ratio for those aged under 75 years of age (SMR<75) is an appropriate measure since it is closely related to deprivation.

1.3 The need for adjustment for avoidable differences in costs resulting from

geographical location is accepted.

2. Proposed formula: some concerns

It is not clear why deciles of small areas with the highest SMRs receive a weighting that is in a ratio of three to one greater than the decile of small areas with the lowest SMRs

2.1 The range of SMRs in decile 10 (the most deprived) is 148.9-274.5 while in decile 4 it is only 81.7-88.0. As a consequence, a huge range of deprived areas is bundled into one bracket of funding allocation, covering 125 units of SMR. In contrast, deciles 3 to 6 differ on average by only 7 units, yet the increment of funding in the ACRA formula between each would be the same as that between adjacent deciles with much greater differences.

2.2 The current distribution of spend in England by Local Authority is clearly exponential with respect to SMR<75 once the London (and specifically Inner London) boroughs are set aside. It is useful also to exclude the Isles of Scilly because their population is so small.

2.3 If the proposed formula is used to redistribute the existing pot it will reward the lower spending less deprived and increase inequalities.

2.4 It is a core public health value that inequalities in health should be reduced.

3. An alternative approach

3.1 It should be recognised that existing investment in public health is exponential rather than linear.

3.2 The formula should be progressive rather than regressive and support reductions in health inequalities. This could be achieved by using an exponential allocation of weighting to MSOA in relation to SMR<75. Figure 3 shows an association between per capita spend on public health and SMR<75. It seems plausible that the historical additional investment in local areas has ameliorated the inequality gap since as figure 5 shows, the greatest fall in mortality from causes amenable to intervention occurred in the North East where there was the greatest per capita spend on public health.

3.3 The Faculty suggests that instead of using deciles, a weighting directly based upon SMR is adopted, using the formula:

$$w = e^{(0.02 \times SMR<75)}$$

Where w=weight, and 0.02 is an arbitrarily chosen constant which will differentially increase spending to the most deprived areas.

3.4 This brings about a pattern whereby the balance of change in funding shifts from one that is regressive to one that is more progressive. Spending is increased in areas with high levels of SMR<75.

3.5 The net effect of this proposed alternative at regional level is shown in table 1, which gives a comparison of the relative difference to funding allocation implied by the ACRA formula and by this alternative approach. This would move funding to the regions with the worst mortality and widening inequalities (North West, Yorkshire & Humber) with a relatively neutral effect on the South and Midlands in general. The regions that would be disadvantaged would be London and the North East.

4.6 It is suggested that the unique aspects of London's population, particular in the inner area will require special consideration. Further work would need to be undertaken to arrive at an appropriate allocation.

4.7 A benefit of this approach is that if the current allocation is increased, funding can be redistributed without removing funds from the most deprived and most needy areas.

Organisation Response Received From	Officer Leading On Response
ADPH	Chief Executive

Key concerns

Assurance that the final ACRA formula will be progressive and will continue to support those areas with the greatest needs.

Formula – ADPH welcomes the use of SMR<75 as aggregated MSAOs. However we caution that this approach has an element of self-referral given that improvements in PH bring improvements in SMR and this could lead to perverse incentives.

We are also concerned that the weighting 3x the SMR has a less steep gradient than historic spend and is therefore regressive.

We would also like to see consideration being given to adding an explicit element in the formula for SH services.

We also see the sense in there being a fixed element intended to cover the fixed costs of PH department.

Non-resident populations increase take up in some PH service and indeed require some specific services and we welcome consideration of this as an element of the formula.

Organisation Response Received From	Officer Leading On Response
London Health Inequalities Network	Director of Public Health

1) Support for the principle of an evidence-based allocation formula

- We support the intention to develop a robust, evidence-based allocation formula that reflects the level of challenge in local areas and provides local PH teams with the necessary resources to address those challenges. Achieving this aim would embed the principles of equity in all policies and 'proportionate universalism' that the Marmot Review has demonstrated are essential for effectively reducing health inequalities at local and national levels.

- It is disappointing that ACRA's research reports were not published alongside *Update on Public Health Funding,* as the document provides insufficient detail to provide assurance that ACRA's proposal is the most appropriate methodology. It is essential that these evidence and analyses upon which ACRA based their deliberations (e.g. impact on current funding, deprivation, etc.) are published for scrutiny. We look forward to publication as soon as possible.

- Analyses undertaken by this Network (and provided within this response) suggest that the proposed approach would divert resources from areas with high levels of deprivation and health challenge, thus undermining and prohibiting progress on reducing health inequalities.

3) Use of <75 SMR as central indicator within allocation formula

- The use of <75 years SMR at Middle-Layer Super Output Area level (MSOAs) as the central determinants of comparative allocation is a concern for a number of methodological reasons.

- The indirectly standardised nature of the SMR compares national (reference) rates to a local (index) population. It is valid only for the single local population. It is not valid to compared magnitudes of two SMRs for different index populations because SMRs do not allow for differences in population structures (i.e. there is no common reference population). Valid comparison requires the use of direct standardisation.

- SMR<75 is a crudely simplified metric that only measure one dimension of public health, i.e. mortality. The primary domains of health improvement are long term conditions (LTCs), sexual health, substance misuse and children (0-5 years), but only the former (i.e. LTCs) contributes significantly to mortality. Whilst children will not be the responsibility of LAs until 2015, sexual health and substance misuse services must be funded through the local grant and it is unclear if sufficient funding will be provided (i.e. LAs will be mandated to provide open access to sexual health services and these demand-led services account for 24-33% of the historic public health budget; substance misuse services account for 35-39% of local public health expenditure in many inner-city boroughs).

- As absolute numbers of premature deaths in individual MSOAs are small compared to their overall populations, confidence intervals are very wide. Even calculated using 5-year averages the typical width of a 95% confidence interval for SMR<75 for an MSOA is around 50. So, for example, an MSOA with an average SMR of 100 would actually have only a 95% probability that the true

value is between 75 and 125 (i.e. between having three-quarters of the expected number of death to having 25% more than expected). Because of the distribution of SMR values at MSOA level, the use of deciles of SMR means that while at the extremes of SMR (very high or very low) the position is fairly stable, within the range that most MSOAs lie quite small changes in value can result in movement between deciles, and therefore between population weights. Using the ACRA workbook with <75 SMR data from the APHO website, the effect on weighted populations is that year-on-year weighted population figures at LA level change by an average of 1.2% and a maximum of 7%; and this is purely down to the natural variation inherent in the data. The formula cannot allow for this uncertainty and builds a structural instability into the funding allocation.

- SMR<75 approximates to a Poisson distribution, right skewed, with quite long tails (please see chart below). The effect of this is that near the median of the distribution quite small changes in SMR<75 result in changes to deciles, and therefore to weighting and funding; while at the tails large differences in SMR<75 have no effect on deciles. Between deciles 4 and 5 the difference in SMR<75 is 6.4, but within decile 10 there is no difference in weighting between an SMR of 149 and one of 274.
- Focussing on SMR could be counter-productive for health improvement across the system. If a PH department influences a CCG to commission services that succeed in lowering premature mortality by more than the national average, under the current proposal it would be 'punished' for its achievement by losing funding in subsequent years.

- The proposed approach for PH funding diverges from that proposed by ACRA for funding for NHS health services (i.e. Disability-Free Life Expectancy)[i] and the overarching indicator in the PHOF (healthy life expectancy)[ii]. Consequently it could introduce discord between public health and health service in the reduction of health inequalities.

- The evidence base for using SMRs over other suitable indicators (e.g. HLE, DFLE, IMD, etc.) has not been presented. There are serious methodological issues regarding the use of <75 SMR. Thus the promised ACRA research papers need to be published as soon as possible so the proposal can be given proper consideration.

4) Modifying factors and relative contributions within allocation formula

- Whilst recognising acknowledged within *Update on Public Health Funding*, significant work is required on the modifying factors in respect to the relative influence of the stated factors and other factors. Health improvement requires working 'with' people (i.e. not simply doing things to / for populations), therefore service delivery costs are very sensitive to demographic factors and it is essential that allocations are appropriately modified.

- Many of the declared modifying factors particularly impact upon both areas of high deprivation and London (e.g. age, fixed costs, non-resident populations). It is imperative that sufficient adjustments are made for this (and other) factors to ensure allocations are equitable and proportionate to need.

- Other factors that are known to directly increase service demand, complexity and cost appear need to be considered; particularly where other public service

allocation formula already take them into account. For example, it is estimated that providing an equivalent smoking cessation service in multi-lingual areas costs three times the standard cost, so additional costs associated diverse populations are incorporated into NHS formulae (e.g. translation and bilingual advocacy). Other key factors for London include homelessness and population churn, which are linked to higher need, service continuity challenges, worse outcomes and higher service delivery costs.

- Given the long-term nature of health improvement interventions (particularly those to reduce health inequalities) it will be important to balance the 'pace of change' for funding to ensure service sustainability.

- As alluded to earlier, it is unclear what work has been undertaken to determine the level of funding required for key high cost areas of public health and therefore if funding allocations will be sufficient (particularly for sexual health and children's health). ACRA should publish these analyses to satisfy concerns any localities with disproportionately high needs in these areas may have.

5) Effect of current proposal on real funding

- Based on analyses (please see attached figures) it is apparent from comparing the ACRA allocations to 2012/13 baseline allocations that :

    - London will be a net 'loser' when comparing the ACRA allocations to the FY2012-13 baseline allocations, reducing from 21.2% to 17.6% (i.e. a 16.4% reduction).

    - Many London boroughs that have historically chosen to have lower investment in public health have received increases

    - Those areas that have received increases generally have lower levels of deprivation and those with 'losses' have higher deprivation

    - Most of the London boroughs with the greatest challenge in health outcomes will see the greatest reductions, while those with lower need are more likely to receive increases.

- The proposed changes in funding would make it extremely challenging to reduce health inequalities (and harder to meet the second overarching PHOF outcome), as (in general) areas with high levels of deprivation that have historically invested higher in public health to address this higher need will lose budget and therefore services. ACRA needs to consider how the allocation formula can be modified to balance this problem.

6) Registered and resident population

- Achievement of a step change in reducing health inequalities will require health services and public health (in its broad sense) to work in unison. This will be hugely hampered by the disparity between the use of registered and resident populations for the allocation formulas for the NHS and LA PH budgets respectively.

- Some services (e.g. vascular risk, immunisation, etc.) are based on registered (GP) populations not residents, which may be up to 50% different (especially in

cities like London). A solution needs to be found for 'list inflation' within registered GP populations, for example additional allowance for the costs of inflated list.

- In order to deliver the laudable aim of creating a local health and well-being system (i.e. integrated and synergistic health services, public health and social care) that works in concert to address the needs and improve the health of its population, consideration needs to be given to how the elements of the system can work together whilst serving different populations.

Organisation Response Received From	Officer Leading On Response
Central London Local Authorities	Councillors

At present the draft formula with the use of premature mortality as the key factor, and the statistical weightings used, are too simplistic to recognise these challenges when allocating funding for the future provision of public health services, and may help to widen health inequalities. For example, based upon the interim formula, the following factors would not be taken into account:

- The mandatory requirement for local authorities to provide demand-led, open access, sexual health services, which have little relationship with premature mortality, as well as the wider public health requirements of a large daytime population.

- Particular population characteristics, including age structure, levels of mental health problems and homelessness, which makes achieving population health improvements much more challenging.
- Application of a simple linear weighting to the premature mortality funding fails to recognise that high premature death rates will be caused by a multitude of complex and inter-related factors, which are likely to require a disproportionate amount of funding for health improvement. Over time, the formula is therefore likely to increase health inequalities between the richest and poorest areas.

- The impact of population churn, which accounts for up to 30% of inner London population. This in turn leads to additional demands for services including NHS Health Checks as well as other screening programmes.

Based upon the draft formula that was published for consultation, the Central London Forward area would see a reduction in public health funding of over £50m. A reduction of this scale would ultimately result in the wide-ranging closure and discontinuation of crucial public health services. We are also concerned that the speed of adjustment to new funding levels could exacerbate this problem. We would therefore urge you not to artificially speed up the adjustment of funding levels and instead commit to a more measured, phased approach.

In order to ensure the final allocation formula includes an adjustment for unavoidable differences in the cost of delivering services, as well as some of the unique characteristics of inner city areas, we would welcome the opportunity of a Central London Forward representative being invited to join the ACRA technical group who are developing the formula.

To help inform our position, identify alternative public health indicators which should be taken into account and revised options for the formula, we are also undertaking additional modelling which we would be delighted to share with the technical group

and yourself. We hope this will go some way to helping address the points at section 2.16 of the consultation document, which identifies areas needing further work, including adjustments for age, fixed costs and non-resident populations. To support us in this work, we would request that ACRA publish all the supporting evidence behind its interim recommendations.

Organisation Response Received From	Officer Leading On Response
Association of North East Councils	Policy Officer

…they are regressive in nature and have the impact of redirecting resources away from deprived areas with high health needs. We are sure that this is not what the Government intends. **To highlight the point the North East would lose 30% of its current share, while the South East, South West and East of England would gain 25%.**

The impact of an inadequate quantum and a distribution system which is inequitable is compounded by the fact that we have been high investors in public health and therefore the reduction proposed as a result of ACRA's formula would hit us particularly badly.

Amongst other things, in the spirit of the Government's commitment to enabling local government to fulfil its potential as a driver of positive change in people's health outcomes, we would urge the Government to review the split in historic public health spending between local government, Public Health England and the NHS Commissioning Board.

We consider there is a real need for an informed strategic discussion about the health and cost reduction benefits that could accrue from a substantial increase in the level of local public health prevention investment and activity.

The following response highlights in more detail the key issues for North East councils and the implications of the funding proposals for this area of the country.

KEY ISSUES FOR THE NORTH EAST

Regressive nature of ACRA funding proposal

We are deeply concerned that the interim funding formula recommended by ACRA would have a regressive impact on share of public health funding across England. In proportional terms, the interim formula represents a redistribution of funding share from poorer areas of the country which have greater health pressures to more affluent areas of the country. In this context, the North East would lose 30% of its current share, while the South East, South West and East of England would gain 25%. Such a scenario, whereby vital public health funding is redistributed away from the North East to more prosperous areas of the country, runs counter to the Government's own stated objectives and would have profound and negative impacts for this area of the country.

Although we recognise that it is not the Government's intention to re-distribute existing funds, this regressive pattern of share is a crucial issue, given that there is significant evidential and robust evidence of better health outcomes resulting from higher levels of investment.

Ways need to be found to adequately reflect in levels of funding the requirement to spend on public health services and issues of need, deprivation and health inequalities. The application of SMR<75 within a formula needs further consideration, which we would urge ACRA to explore. In addition, the proposed 3:1 ratio whereby areas with the greatest needs would only receive 3 times as much as those with the lowest needs seems, to say the least, arbitrary.

Negative impact of potential re-distribution from poorer to more prosperous areas of the country

The prospect, therefore, of deprived areas such as the North East suffering the biggest cuts in public health funding as a result of the indicative ACRA formula which shifts it to the least deprived areas of the country is a major issue of concern for ANEC member authorities.

We will continue to provide the Department of Health with evidence that strengthens our case for increased public health investment and to highlight the negative consequences of any significant loss of funding. Based on the current formula proposals, 10 out of 12 authorities will be worse off in funding terms. We would also propose that any such changes to funding allocations should undergo a rigorous equality impact assessment and careful consideration given to unintended consequences of a regressive re-distributional model that will profoundly impact on the quality and length of life of people in this area of the country. Whilst we acknowledge that Ministers have yet to make decisions on the level of funding in future years, there is concern that the scale of the reduction in the funding shares indicated by the ACRA formula could result in significant cash reductions in funding for public health interventions. This is at a time when there are significant pressures on resources available to public services and the health system as a whole in the North East, with pressures on one part of the system inevitably impacting on others.

Engagement with ACRA and the Department of Health

In this context, ANEC is offering to work with ACRA and the Department of Health to fully explore the proposals and to work with Ministers and Civil Servants to both consider their implications and explore options that will not disadvantage any area of the country. Furthermore, we would urge Ministers in the lead up to the next Spending Review to hold a strategic national debate around the benefits of increased investment in preventive public health activity to help not only deliver health benefits but to cut the more expensive medical treatment in future years. As highlighted by the National Audit Office report *on 'Tackling inequalities in life expectancy in areas with the worst health and deprivation' (2010)*, the NAO recommend that 'greater investment in prevention is necessary if the NHS is to tackle health inequalities now and in the future'. The report found that the failure to invest at greater levels in specific communities as being a factor in the slow progress being made in reducing health inequalities at a national level, which highlights the need to maintain a proportionately higher level of spend in the most deprived areas.

Positive impacts of higher levels of public health funding

As highlighted earlier, and as elucidated through the attached case studies, the North East is able to demonstrate the positive impacts of higher levels of public health funding – which we seek to maintain in the future. We would argue that, based on such evidence, that there is a need for a substantial increase in investment in public health at a national level to bring it up to a level of funding that will help achieve the health benefits currently being seen in this area of the country. On that basis, ANEC strongly advocates a target for investment that will bring national public health investment up to the level of the best in order to achieve our shared moral aims for equity and fairness in achieving healthier lives and healthier people.

The North East region as a whole has a higher level of public health spend on average at all levels of SMR<75. This reflects a history of additional investment through local choice – and where spend was comparatively lower in some areas, this was because of issues elsewhere in the system and plans were in fact in place to make greater investments.

Organisation Response Received From	Officer Leading On Response
NHS Confederation	NHS Confederation policy manager

We agree with the Secretary of State that the government should ensure the funding goes to the places most in need and where it could have the greatest impact. The formula for the allocation of the public health budget to local authorities must take into consideration an element linked to deprivation levels and be based on evidence. As shown by research conducted by Liverpool University with Darwen Council, it estimates the proposals would leave local authorities in most deprived areas 30% of areas losing an average of £8 per resident and those in the most affluent 20% of areas gaining the same amount. The formula should not result in wealthier, healthier areas benefitting over more deprived areas.

There is evidence available in routine data sets to allow evaluation of current spending choices against need, ACRA must therefore take this into consideration when making their recommendations. Due to historic rates of spend by PCTs being higher in areas with higher levels of deprivation the newly proposed allocations result in these areas losing funding, areas with higher Standarised Mortality Ratio (SMR) <75 years will lose funding shares to those with lower SMR <75.

ACRA's recommendation to weight the funding for areas with worst outcomes three times greater per head than the deciles with the best outcomes uses a linear gradient however the distribution of Standarised Mortality Ratio for those aged under 75 years across all Middle-Layer Super Output Area (MSOA) level is not linear but takes more of an exponential fit. This would mean areas with higher SMR <75 years should get proportionally more funding than other areas.

In principle CCGs should be able to access an appropriate level of public health support. The quality and quantity of the public health 'core offer' to CCGs funded through the public health ring-fenced grant to local authorities should not vary significantly but be based upon a clear needs based allocation, on a per capita basis.

The funding formula should take into account the entire care pathway (including specialised commissioning), bearing in mind that the NHS CB will be responsible for specialised commissioning. If this is not considered, there is a danger that upstream, more preventative investment may suffer in contrast to expensive down-stream investment in specialised commissioning, which in turn will not help to reduce health inequalities.

It is not clear how using the SMR <75 will help to sufficiently allocate funding for children’s public health, particularly under 5 years, when this responsibility transfers to local authorities in 2015. In some areas the rising birth rate will need to be considered. Similarly in some areas sexual health and drug and alcohol services, often direct health services, are a major single component of the future public health ring fenced budget. It is not clear again how the relationship between levels of need and spend in a population and the SMR<75 will be calculated. Clarity is needed and more work carried out regarding how the level of funding allocated for children’s public health under 5 years and 5 – 19 years, sexual health and drug and alcohol services will be calculated in relation to need.

2.2 ACRA's recommendations for further work

We agree further work is required for the formula for allocations in 2013-14 to take into consideration: adjustment for age, fixed cost adjustment, non-resident

populations and updates to the latest ONS population projections.

We agree the formula should include adjustment for unavoidable differences in the costs of delivering services across the country which are due to local circumstances alone, such as higher staff costs and not need. This will also need to take into consideration costs of services in rural areas. Our briefing Rural health economies and the health bill highlights key issues for rural areas which should be taken into consideration.

If the funding allocations are not transparent and fair according to evidence to decrease health inequalities this also has relationship risks particularly for PHE and local authorities. In order for the new system to work well, strong relationships are required to strengthen collaboration between bodies in different parts of the system.

Organisation Response Received From	Officer Leading On Response
Chartered Institute of Environmental Heath	Head of Policy

The use of standardised mortality ratio statistics may have been chosen because they are readily available to individual authorities, but are not closely related to deprivation. The over-arching objective in the Outcomes Framework is to improve the health of everyone but to improve the health of the poorest fastest. For this to be achieved, resources have to be targeted, especially to areas with the greatest deprivation.

The Department of Health has stated that no local authority funding will actually go down as a result of applying the new formula. However, this does nothing to address the historic inadequacies of funding, and, furthermore , the allocations to an area of highest levels of deprivation will stop rising in line with the need after year one if measures of deprivation are not reflected in the distribution formula.

Organisation Response Received From	Officer Leading On Response
London Councils	N/A

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.

VONNE	Health & Social Care Policy Lead

We are deeply concerned that the current formula as suggested by ACRA could result in a 30% reduction of funding for public health, equating to a loss of £53m for the North East. This significant reduction will reduce the gains we have started to make in both health and early deaths. The sector supports the view of North East Councils that there should be a movement of an additional £1-£2bn into public health nationally to bring services in line with the inward investment made across the North East.

It is true that current levels of public health funding across the North East are significantly higher than the national average. This is not the result of a well-designed government funding formula that targets resources to greatest health need. It is reflective of high performing Primary Care Trusts who have worked closely with partners in Local Government and the Voluntary & Community Sector to make difficult choices. Collectively we have made tackling health inequalities a top priority and redirected scarce resources to start to meet the future health needs of our communities.

It is clear from national financial returns that some PCTs have very low expenditure on public health, however the sector is strongly of the view that this is due to decisions that have been taken by PCT Boards, and that it would be gravely inequitable to redistribute funds from areas such as North East PCTs to increase funding in areas of lower health need. Nationally, the total public health budget needs to be increased to enable local authorities and their partners in the Community & Voluntary sector to address the rising public health challenges and reduce health inequalities.

The North East's evolving Clinical Commissioning Groups are committed to reducing health inequalities and this is reflected in their clear and credible plans, in their commitment to their respective shadow health and well-being boards and their already well developed approach to supporting public health programmes.

The North East is the only region that is reducing the inequality gap by reducing avoidable mortality. The sector believes that there is a major risk of losing the benefits of our long term investment in public health as the proposed formula flattens out the allocations towards a more central point and shifts funding from deprived to more affluent areas contrary to need.

Age weighting
Using standard mortality ratio as an indicator of need makes sense due to its collation with deprivation and its availability down to a Middle Super Output Area. However, many of the public health programmes that the community and voluntary

sector support demonstrate that the focus for much of this prevention activity is younger people and families for example:

- Children's Health & Wellbeing
- Sexual Health – two thirds of patients accessing services are under 25
- Drugs and Alcohol Treatment – vast majority are under 50 years
- Tobacco usage tends to be under 65 years
- CVD Health Checks – ranges from 40 to 75 years, but take up is concentrated in the middle age bracket.

The consultation document mentions that age may be factored in, but does not explain how, so it is difficult to comment. However there is clear evidence that the earlier the intervention and prevention rather than treatment increases life chances and reduces morbidity levels.

Local Government Association	Director of Finance and Resources

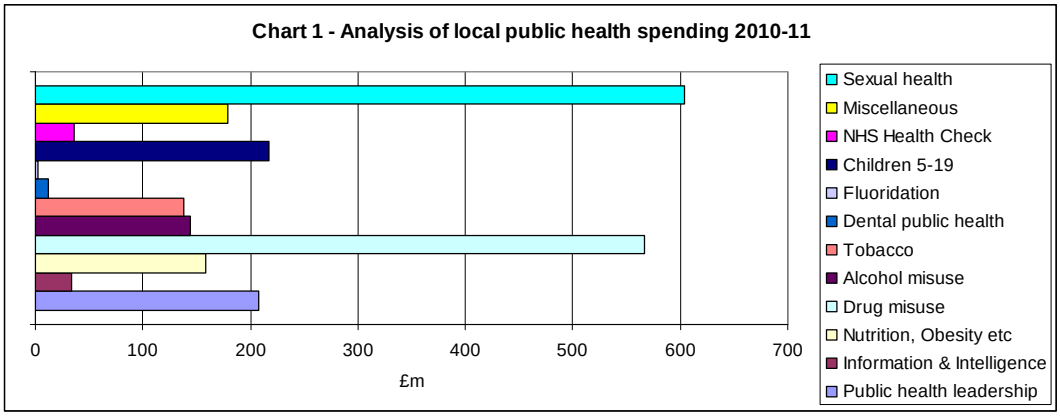
Based on the further analysis of the ACRA recommendations that we have carried out, and the views expressed to us by member authorities, we would now make the following specific comments:

1. **The formula requires further adjustment to provide an effective resourcing allocation for sexual health services**. SMR under 75 is not a measure that is well correlated with sexual health outcomes and, therefore, is of questionable value as a resource allocation measure for the substantial part of public health funding that pays for sexual health services.

2. Whilst the standardised mortality ratio (SMR) for those aged under 75 years may be a reasonable starting point for the construction of a needs based formula, **the weighting suggested by ACRA to help reduce inequalities must be reconsidered**. The suggested weighting does not appear to be based on adequate objective evidence and, as has been pointed out by the Association of Directors of Public Health, is regressive, potentially shifting future resources away from some areas where health outcomes are currently relatively poor despite relatively high levels of spending. This would clearly be an unacceptable result.

Analysis of current spend

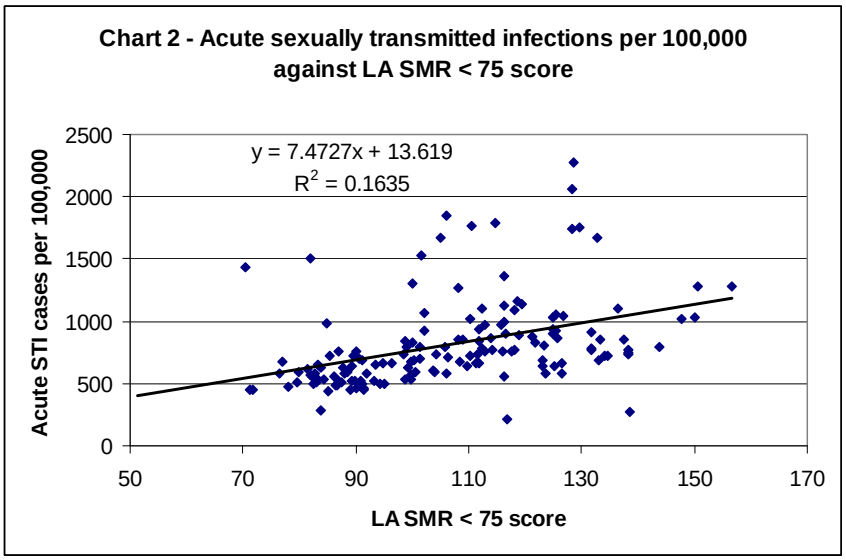
1. The Department of Health has published an analysis of the 2010-11 spending on public health functions by PCTs, analysed across the functions that are transferring to local authorities. This analysis covered total spending of £2.299 bn, broken down as shown in Chart 1 below.



2. It can be seen from the analysis that there are two dominant categories of expenditure: sexual health services and drug misuse services. In the case of the latter, the ACRA recommendation is for an adjustment to the SMR-based formula that takes into account activity based on a measure of numbers of drug users. For the former, no such adjustment is proposed.

Weakness of the proposed approach in relation to sexual health

3. In consequence, the approach proposed by ACRA can be shown to have two serious disadvantages. First, the SMR < 75 measure is poorly correlated with measures of need for sexual health services. Chart 2 below shows the lack of correlation between the SMR < 75 measure at individual local authority level and the rate of acute sexually transmitted infections per 100,000 population.



4. Second, the proposed ACRA formula has the effect of potentially reducing future relative levels of funding for London, the North East and the North West by significant amounts. London, for example, is shown as around 20% over-funded on the basis of the ACRA formula. However, London's spending on sexual health services is the highest of all regions at more than 35% of the total. It would therefore appear that the adoption of the

ACRA formula could give rise to serious difficulties around the provision of sexual health services for which there are currently high levels of demand.

Weakness of the proposed approach in relation to inequalities

5. The approach proposed by ACRA includes a weighting for inequalities. This is achieved by ranking the SMR < 75 figures at MSOA level into deciles, and then weighting populations in such a way that the ninth and tenth highest scoring deciles are treated as having a need three times as great as the lowest scoring decile, with intermediate deciles having weightings on a linear scale.

6. This weighting, though, fails to achieve its intended objective. If the ACRA recommended formula were to be applied, there would be only a 3% correlation between allocated funding across local authorities and the extent of deprivation in the authority. Indeed, as the Association of Directors of Public Health has pointed out, the impact of the formula is potentially regressive.

7. By contrast, if the estimated levels of 2010-11 public health spending at local authority level are compared with the extent of deprivation measure, a 30% correlation is observed. There is no obvious reason to suppose that current spending on local public health is any more or less efficient in different local authority areas, and there is therefore very good reason for the ACRA recommendations to be modified to give a more appropriate weighting for inequalities.

8. LGA member authorities in more deprived parts of England, in particular the North East and the North West, have expressed considerable disquiet about the approach proposed by ACRA. These concerns are clearly well founded on the basis of the above analysis.

The LGA therefore suggests that ACRA needs to consider very carefully both the level of weighting applied to the highest SMR < 75 deciles (for example, there is no obvious rationale for weighting the top two deciles equally) and the basis of weighting applied to intermediate deciles. There appears to be little or no evidence to support the use of a factor of three between highest and lowest, or the linear weighting applied to intermediate deciles. Modelling by the LGA suggests that, if weightings of intermediate deciles were increased on an exponentially based, rather than a linear scale, closer correlation between the formula and present levels of spending would be achieved.