LGA Executive
12 July 2012

Item 4

Public Health Funding to Local Government

Purpose of report

For discussion and agreement of LGA key messages regarding local authority public health funding.

Summary

This report summarises the proposals regarding funding to local authorities from April 2013 to meet their new public health responsibilities. It sets out the current LGA key positions on public health funding and seeks direction from the Executive on future lobbying positions.

Recommendation

The Executive is requested to discuss and agree the LGA key position on public health funding.

Action

LGA officers to action as necessary.

Contact officer: Alyson Morley
Position: Senior Adviser
Phone no: 020 7664 3230
E-mail: alyson.morley@local.gov.uk

Local Government Association

LGA Executive
12 July 2012

Item 4

Public health funding to local government

Background

1. The Health and Social Care Act 2012 and the wider health reforms outlined in *Healthy lives, healthy people: our strategy for public health in England* (Department of Health, 2010) introduce major new public health powers and duties for single-tier and upper-tier councils in England from April 2013. Local authorities will receive a ring-fenced public health grant to meet their new responsibilities. The Department of Health (DH) has published two documents setting out their proposals for funding health services, including public health services. The LGA has provided briefings to our member authorities on both documents and has made representations to DH on both, setting out our key messages and local authority concerns.

LGA key messages

2. The LGA current views are summarised below.

    2.1. Councils have been given a workable basis on which to plan for the transfer of public health. However, it is vitally important that the debate continues about the overall amount of funding necessary to ensure that local authorities can meet their public health responsibilities and make a lasting impact on health improvement and health inequalities.

    2.2. If the global figure is inadequate then, however accurate and equitable the distribution formula is, it will still not deliver sufficient resources. There needs to be a sustained political commitment to increasing resources to local government so that they are able to invest in early intervention and health improvement in order to reduce the rising costs of health and social care.

    2.3. We welcome the commitment that local authorities will be adequately funded (and for 2013-14 not less in real terms than the baseline estimates of PCT spend on public health in 2010-11 published on 7 February) for public health. We also welcome the commitment that any additional burdens will be met in line with the Government's New Burdens Doctrine.

    2.4. There is clearly more work to do before the final allocations for 2013-14 are decided. We have long argued that funding cannot be based solely on historic data from Primary Care Trusts (PCTs) that is no longer fit for purpose. The recommended distribution formula proposed by the Advisory Committee on Resource Allocation (ACRA) – standardised

mortality ratio for people aged under 75 – is a useful measure but this cannot be the sole basis on which distribution is calculated.

2.5. DH has suggested that final allocations to councils will be confirmed in December 2012. We are clear that councils need confirmation of their final allocations by November 2012 in order to have full financial information for their budget-setting process.

Proposals for public health funding to local government

Baseline estimates of public health spending

3. In February 2012, the Department of Health (DH) published a document with provisional estimates of funding for services that will be allocated to different commissioners in the new commissioning architecture for health, including public health, which will come into force in April 2013. The total resource for all health services from 2013-14 is £92 billion. Of this, it is proposed that £5.2 billion is allocated to public health. This will be divided between the public health grant to local authorities (2.2 billion), the NHS Commissioning Board (£2.2 billion) and the DH (£600 million).

4. Analysis of the baseline figures for public health spend by PCTs across England shows a wide degree of variation both within and between regions, ranging from £10 million to £55 million per local authority area. On a 'per head of population' basis, there is a broad trend of higher per head spending in the North and lower spend in the South (with the exception of London). Reported spending per head ranges from £15 per head in the South East to £116 per head in some London PCT areas. Much of this variation is due to intensity of public health need but some will be a result of the variable commitment to public health by PCTs.

Proposed distribution formula and further details

5. On 14 June DH published an update on public health funding, which set out ACRA's interim recommendations on public health funding, initial proposals for the health premium incentive payments and the proposed conditions of the public health grant. This report focuses on the proposed distribution formula, though the LGA also has concerns regarding the conditions of grant and health premium incentive payment.

6. ACRA's interim recommendation is that the formula will be based on the standardised mortality ratio for people under 75 in a local population (SMR>75). This measures the level of deaths of people under 75 in a local area, compared with the national average and corrected for the age profile of the local population. The LGA broadly supports the use of SMR>75 as a basis for allocation for a number of reasons:

6.1. It is updated regularly.

6.2. It is available on a Middle Layer Super Output Area level covering populations of around 7,000, which will go some way to identifying pockets of deprivation in affluent areas.

6.3. SMR>75 is closely correlated with levels of socio-economic deprivations, that are themselves are closely associated with intensity of health need.

7. The formula will also need to take account of other factors that have an impact on public health services. For example:

7.1. The level of need for open access sexual health services, which in some inner-city areas accounts for around 35 per cent of the total spend on public health.

7.2. The impact of non-resident populations on public health services, in particular the working population in cities and the impact of tourists in holiday areas.

7.3. The impact of seasonal migration in rural and seaside areas, especially where a high proportion of migrant workers do not have English as a first language.

7.4. Population churn which can be as high as 30 per cent annually in some inner-city areas and areas with high student populations. This may have a major impact on some local authority public health services, such as the annual health check.

What is not included in the DH proposals

8. We still do not have the final total allocation for public health services, nor the proportion of it to be allocated to local authorities. The LGA has consistently called for a wider debate on the level of resource necessary for councils to meet their public health responsibilities. If the global figure in inadequate then, however accurate and equitable the distribution formula is it will still not deliver sufficient resources. We recognise that the level of resources for public health is a political decision and not within the remit of ACRA. However, this needs to be urgently addressed.

9. The DH update includes a: “hope to offer greater growth to those authorities furthest below the preferred distribution”. However, it goes not give any firm commitment that there will be a clear timeline for achieving the preferred distribution. We are concerned that authorities whose allocations are furthest from target will not have sufficient resources to meet local public health needs. Pace of change is inextricably linked to the quantum available to local

government. Unless the overall total for local government is increased, movement towards target distribution will inevitably lead to reducing the grant to authorities that are above target. This is the wrong message to send to those areas that have a historic commitment to public health. Local government needs a greater share of the overall resources for health services in order to mitigate the effects of pace of change on those areas that are currently above target.

10. Final allocations to local authorities for 2013-14 are unlikely to be published until late in 2012. We have made clear to DH that this will give local authorities inadequate time to agree their budgets for public health as part of their budget-setting processes. We are working with DH to see what more can be done to provide greater certainty on funding levels for 2013-14 and 2014-15.

Conclusion and next steps

11. The DH is seeking feedback on the interim proposals by 14 August and the LGA intends to submit a formal response, as well as continuing to work with DH officials to influence the overall resource for local authorities and the distribution formula.

Financial Implications

12. The public health grant is intended to provide adequate resources for local government to deliver their new public health responsibilities from April 2013. We will seek to ensure that the allocation for local government fully reflects the costs to local government.