# ENGAGEMENT ON INTERIM PUBLIC HEALTH RECOMMENDATIONS

## Summary

Following the publication of *Healthy Lives, Healthy People: Update on Public Health Funding,* which included ACRA's interim proposals for a public health formula we received over one hundred responses.[1] Engagement events were also held in every region of England and a sub-committee of ACRA met with LGA and ADPH. This is the first attempt to engage more widely on the allocation formula and it was generally well received.

Some themes came through particularly strongly, and these included:

- Use of SMR<75 as a pragmatic solution to measuring need was supported by most, although a significant minority would prefer an additional or replacement measure of deprivation. A particular concern was around the volatility of SMR<75.

- There was significant concern that the recommendations give a significantly less steep distribution with SMR<75 than recent spending estimates. Linked to this are concerns around:
    - the linear variation in weighting across SMR<75 deciles;
    - the use of equally populous rather than equal width SMR<75 deciles; and
    - the 3:1 gearing across deciles.

- Some stakeholders were concerned that the link between need for sexual health services and SMR<75 is not sufficiently strong.

- While the retention of the NTA approach for (currently) PTB funding was welcomed there was some questioning of the rationale for moving from the York formula to favour SMR<75.

- Some areas expressed concern about the adoption of the ACA, which is not as smoothly varying as MFF.

- There was general, but not unanimous support for an age adjustment and a non-resident population adjustment. There was also some support for a fixed cost adjustment.

- This paper should be read in conjunction with ACRA(2012)16, which develops options should ACRA wish to respond to some of the issues raised.

[1] Based on correspondence to dedicated mailbox. In particular, correspondence through ministers' offices is not included in this count, but views expressed have been reflected in the summary.

## Introduction

1. ACRA's interim public health recommendations were published on 14 June 2012 in *Healthy Lives, Healthy People: Public Health Finance Update*[2]. As well as ACRA's interim recommendations this included an update on the latest thinking on the Health Premium incentive and draft grant conditions.

2. Respondents were asked for feedback by 14 August 2012, to a dedicated mailbox. Additionally, a sub-committee of ACRA was established to meet with key national stakeholders. The DH team also attended a number of regional events to brief and discuss the recommendations with both PCT and LA officials.

3. A list of respondents to the dedicated inbox is listed at the annex and ACRA(2012)14a gives the relevant sections of responses from the national stakeholders.

4. The rest of this report gives an overview of the feedback received for ACRA's interim recommendations before noon on 24 August 2012. We had requested responses by 14 August 2012. The feedback is summarised thematically. It does not attempt to estimate how frequently any particular comment was made, but focuses on the substance of each unique comment.

5. Comments made about the Health Premium Incentive, the grant conditions, pace-of-change and the quantum have not been included here as they are not matters for ACRA. They have been separately logged for policy development in those areas.

6. The summary is organised in line with the key elements of ACRA's recommendations and proposed areas for further work:
   - Building up from MSOAs
   - Use of SMR<75 as indicator
   - 3:1 gearing
   - Following NTA approach for PTB resources
   - ACA weighting for unavoidable cost differences
   - Age weighting
   - Fixed cost adjustment
   - Non-resident populations
   - 2011 census based population measures
   - Other comments and additions

7. In summary, the opportunity to comment and feedback was welcomed, and there is broad support for the general approach and use of SMR<75 as the main need estimator. There is also support for the development of an approach based more clearly on drivers of need in the medium term.

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2 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_134578

8. However, there were significant concerns about the outcomes of the formula when compared with the baseline spend:

> *I consider that the proposed formula is potentially regressive in that the areas with the best health outcomes (mainly in the south) will be the biggest beneficiaries in comparison to their current levels of public health funding and those areas with the poorest outcomes, (mainly in the north) will be the biggest losers. The formula needs to be refined to mitigate this risk.*[3]

**Building up from MSOAs**

9. This was generally welcomed, although there was one suggestion that to truly capture inequalities within LA data at LSOA level are needed (populations of around 1500).

**Use of SMR<75 as indicator**

10. There is general support for a formula driven principally by SMR<75 in the short term, although this is recognised as a compromise.

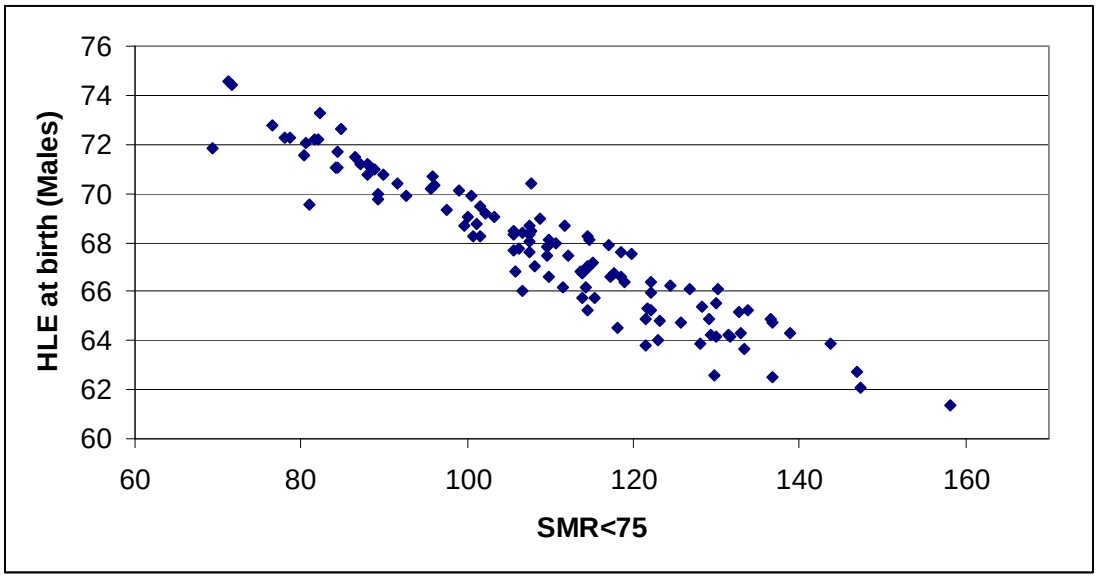
11. Some significant concerns were also noted.

12. As ACRA has previously noted, and we recorded in the engagement document there is a risk of perverse incentives that would "penalise the good work we have undertaken locally".[4] ACRA's position was that this needs to be addressed in the medium term by a formula based more clearly on the underlying drivers of need.

13. There is also concern about the relevance of SMR<75 to the needs of younger populations, especially given the Marmot Review's strong emphasis on early intervention, its link to Mental Health interventions. A counter view was that it may disadvantage areas where a health retired population migrate in. It is, however, worth noting that the engagement did not include any specific recommendations for age weighting and we have previously discussed the strong correlations between different health outcomes.

14. The divergence from both the public health outcomes framework, which uses Healthy Life Expectancy (HLE), and the previous DFLE adjustment for PCTs. The figure below shows (for a subset of LAs where we could obtain a clear match in the data sources) the strong correlation between HLE and SMR<75.

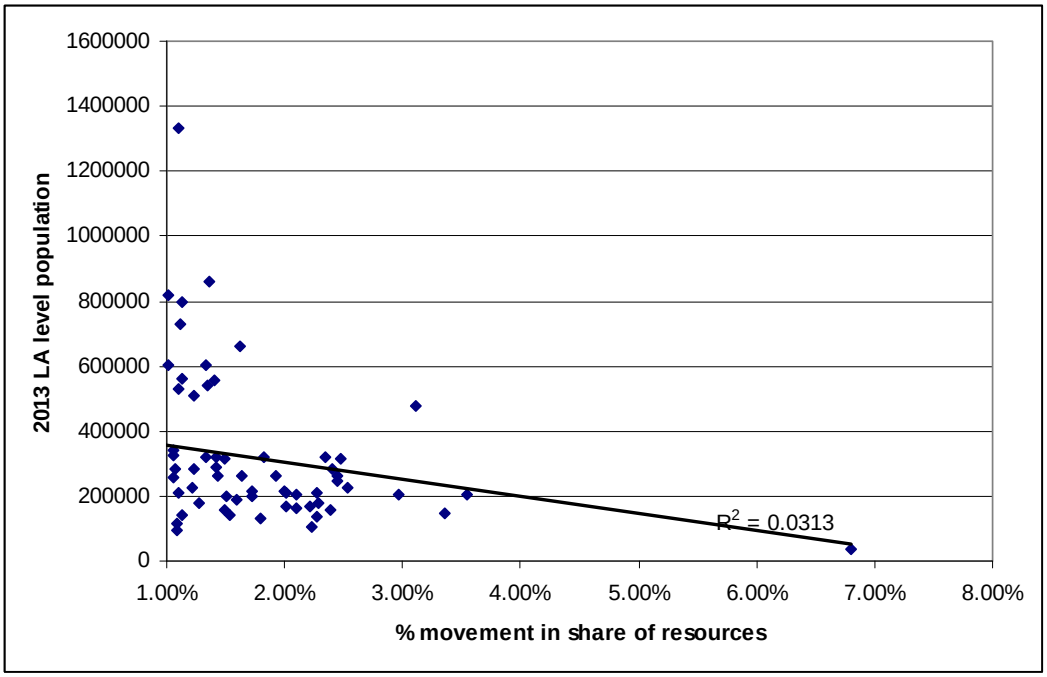
[3] North East DPH
[4] Director of Public Health, London Borough




15. Most notably this was expressed by the Royal Society of Statistics (RSS), SMR<75 is thought by some to be too volatile to use as the basis of an allocation system. The volatility of SMR<75 was part of the original logic to base the formula around a decile ranking, which was acknowledged by RSS. However, their analysis may overstate the impact as it examines the impact at MSOA level, not at LA level.

16. We have explored this concern by moving from SMR<75 2005-09 to SMR<75 2006-10. The absolute impact of this on LAs of different sizes is shown in Figure 1. Consistent with the RSS analysis, this does suggests that volatility is greater in smaller local authorities, which will have fewer MSOAs.

17. The RSS analysis also did not consider the impact of pace-of-change, which is important context here. This will have the effect of dampening volatility in the target formula.




18. A minority proposal was to use the all ages SMR, to avoid the assumption that mortality above seventy-five years is unimportant. ACRA/TAG had previously decided against this, in part, because it is believed to have significant biases (through the location of care homes for instance).

*Direct and indirect standardisation*

19. There was also concern expressed about the use of indirectly standardised mortality rates[5] (see Annex for definitions). The London Health Improvement Network in particular expressed concern that mortality rates standardised in this way should not be used to inter-compare areas – they should only be used to compare against the national average.

20. However, it is arguable that the formulas is doing just that – assessing whether need is higher or lower than the national average and assigning need on that basis. There are also concerns that direct standardisation relies on locally determined age specific mortality rate, and these may not be reliable for small areas.

21. This reflects ACRA discussions at previous rounds when TAG's clear advice to ACRA was to use indirect standardisation, and this has been followed in the development of the PCT funding formula.

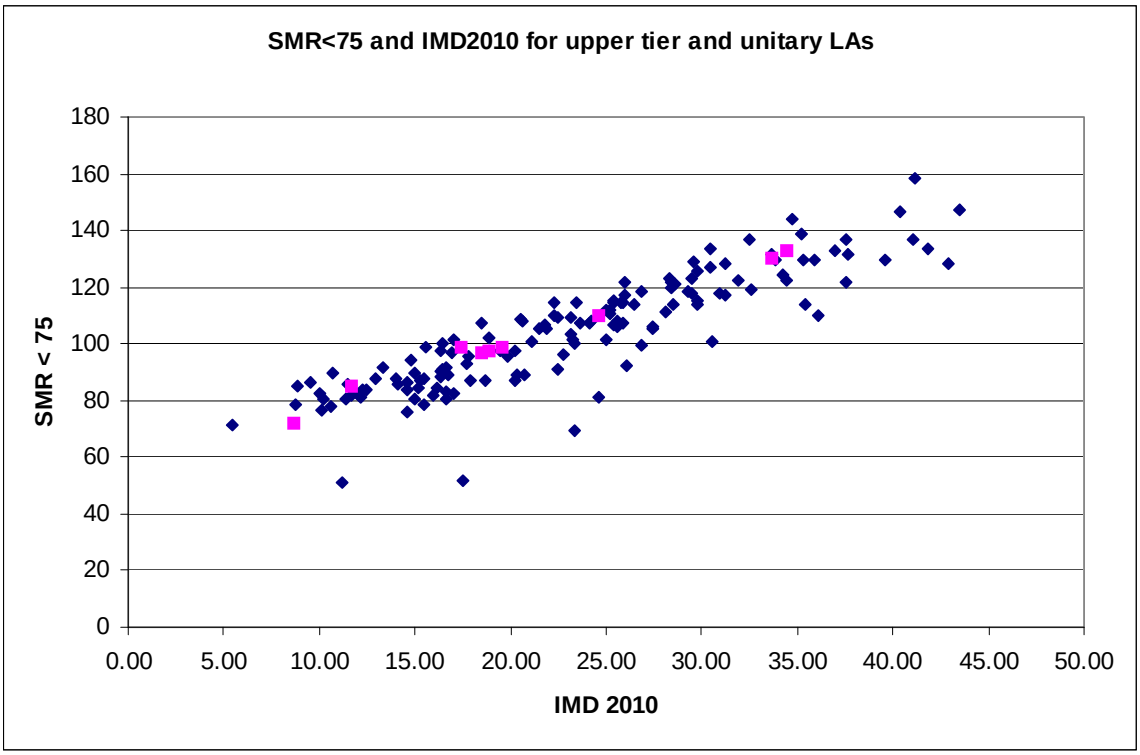
*Link to deprivation*

22. Most fundamentally, there was some concern that the formula is not based directly on a measure of deprivation. Proposals for an appropriate measure are varied or not specific, but include the index of multiple deprivation or income deprivation. Income deprivation shows considerably

[5] See www.lho.org.uk/LHO_Topics/Data/Methodology_and_Sources/AgeStandardisedRates.aspx for a useful description of the different methods.

more variation than SMR<75[6] and may have the advantage of being more responsive to changes in need than a five-year average SMR.

23. The figure below shows the strong link between SMR<75 and IMD, although it should be noted that IMD includes a health domain, and so the strength of this relationship may be misleading. Previous ACRA discussions have stressed that IMD is an average index of deprivation scores and not a measure of deprivation.

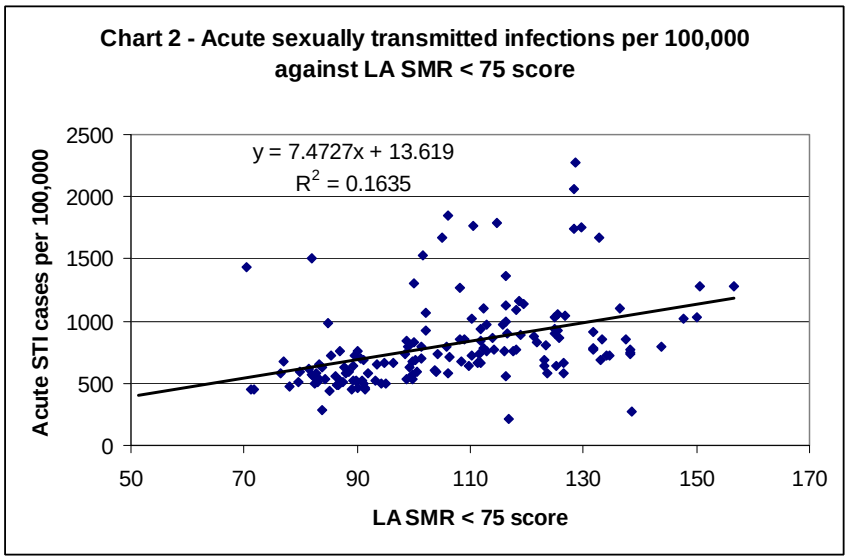



*Sexual health services*

24. There was also concern that SMR<75 may not be a good indicator of need for sexual health services. The Local Government Association noted

> *The SMR < 75 measure is poorly correlated with measures of need for sexual health services. Chart 2[7] 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.*

[6] Not verified.
[7] Taken from LGA response and reproduced below, but not verified.




25. For instance, the ADPH submission suggested that a measure based on the HPA sexual health need index (excluding some measures like chlamydia rates, that may be more susceptible to supply or screening provision).

26. These measures are not immediately available at MSOA level, but if need were to be proportionate to the index an analysis at the lower level would not be necessary. However, this may significantly weaken the overall correlation of the formula with deprivation.

27. There was also concern that SMR<75 may not reflect variation in the needs of young children and that a link to birth rate may need to considered for some services.

**3:1 gearing**

28. It is worth noting that the variation of median SMR<75 across the deciles varies linearly in a ratio of 3:1 and this caused some confusion, as some respondents did not realise that the gearing is not intended to necessarily be proportionate to the indicator.

29. The gearing was recognised as a key pivot for the model and so the lack of clear evidence to support the choice of 3:1 was disappointing and limited the level of constructive engagement, in particular as it implies a lower gradient of spend across deprivation than the latest baseline spend analysis. One correspondent suggested that this may mean the formula would not contribute to the further reduction of health inequalities. This is one of the aims of the formula, requested by the Secretary of State.

> *…it is evident that the use of the weighting factors (in particular the ratio of 1:3) has the affect of transferring funding from the poorest*

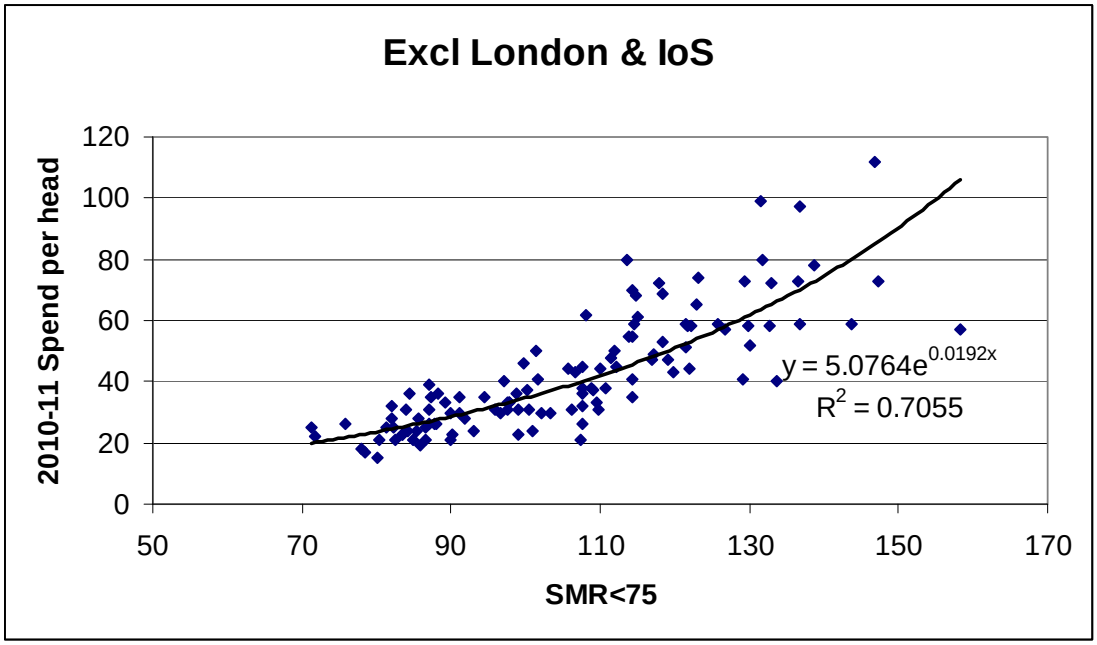
*areas to those with little deprivation… and if used, this is likely to contribute to widening health inequalities.*[8]

30. Others felt that 3:1 across deciles is about right, while remaining concerned about the degree of variation this in turn implies compared with baseline spend analysis. Specific counter views noted that IMD varied by 8:1 across similar deciles[9] and they suggested that this ratio would be worth considering, or that, linked with a shift to income deprivation need should

    *Given the expectation that these resources are used to tackle poverty related health need, it is seems fair to assume that need is directly proportional to the level of deprivation in an area. i.e as the level of deprivation doubles the need for public health resources doubles.*[10]

31. However, some clearer evidence has emerged during the course of the engagement that supports a 3:1 gearing.

32. This evidence also suggested that rather than a linear growth in gearing across deciles an exponential growth may be more appropriate. The Faculty of Public Health provided analysis of the DH's earlier spend estimates that shows the baseline spend at LA level is consistent with a weak exponential once London boroughs and the Isles of Scilly are excluded.




33. On this basis, the faculty recommends adopting a model that links directly to the SMR<75 of the individual MSOAs, giving each a weight proportional to $e^{0.02 \times SMR<75}$

[8] West Midlands DPH
[9] This has not been verified by the team, but is thought plausible.
[10] North West DPH

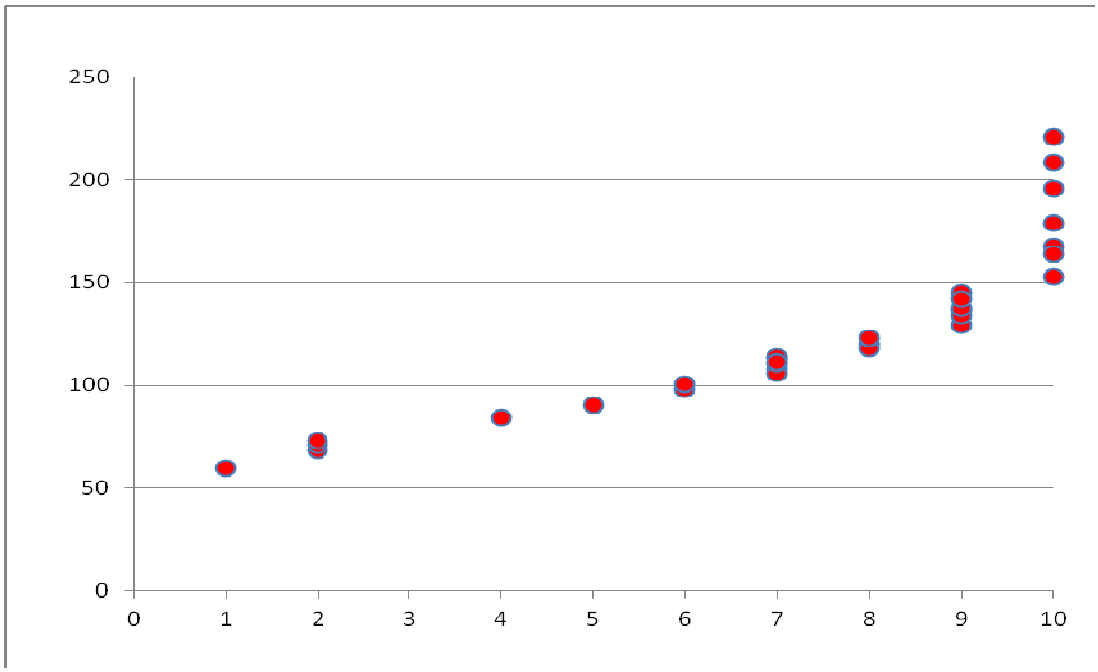
34. While the correlation between SMR<75 and baseline spend is striking, the case for an exponential fit is not as strong as this analysis at first suggests. A linear fit performs almost as well, with $R^2$= 66%.

35. The non-linear gearing option emerged early in the engagement and so we took the opportunity to test it further in discussion and there appeared to be support for this adjustment.

36. The exclusion of London illustrates a more general point that some different issues may be important in London – and potentially other city centre areas.

> *London requires particular consideration, due to the differences between London and the rest of the country in relation to turnover of population, cultural mix and concentration of specific public health issues such as STIs. More work is needed regarding the final formula to taken into consideration the different pressures that London faces.*[11]

37. The use of deciles to describe the variation in need has also been criticised, for instance by the London Health Improvement Network, pointed out that the width of each decile may be very different, as illustrated by their analysis of the distribution of MSOAs. This may mean that the discrimination of variation in need is poor at the high and low end of the distribution and is excessive through the middle of the distribution. This was strikingly illustrated by the following figure in Newcastle City Council's response, showing the variation in SMR<75 for MSOAs in their area.




**Following NTA approach for PTB resources**

[11] Social Enterprise public health service provider

38. In general there was support for this decision although there was some unspecified concern about the shift from 24% of the approach being based on the York formula [sic] to 24% based on SMR<75. Others suggested a link to homelessness and mental ill health.

**ACA weighting for unavoidable cost differences**

39. There was support for the general principle that some areas face a higher cost base and that this should be reflected in the formula. There was some suggestion that the choice of ACA should follow that used for children's services and social services (65%/ 1% for staffing/rates). ACRA should note that the ACA may not be recalculated after this year following CLG's decision to move a business rates retention model and in the longer term a reversion to MFF may be necessary.

40. There was also concern that the ACA may not be appropriate as it is based on 'blue collar labour'. It was also claimed that it retains cliff edges, which we have previously sought to smooth out in the MFF. Many areas are also set to one, reducing much of the variation the MFF shows.

41. A minority view was that no ACA should be applied as it diverts resources away from more needy areas and towards the South East. Recent work on the pupil premium did not apply an area cost adjustment for this reason.

**Age weighting**

42. ACRA did not have specific proposals that could be published at the time of the engagement. In general there is support for an age adjustment and in particular one that favours younger populations.

43. However there was also a concern that a weighting towards younger populations may unduly penalise older populations, especially in less deprived areas where a formula driven by SMR<75 does not favour them. Or that including an ageing weighting at all would imply biases towards certain age groups, or would unnecessarily complicate the formula and should be avoided entirely.

**Fixed cost adjustment**

44. There was limited comment on this and limited specific proposals, suggesting that a minimum cost might be built up from a relatively small set of services such as:

- The Director of Public Health and his/her immediate support staff
- Nationally prescribed public health functions such as:

1. dealing with health protection incidents, outbreaks and emergencies;
2. providing population healthcare advice; and

3. supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as Health Checks, immunisation and screening programmes

**Non-resident populations**

45. Agreement that this is an important issue but no specific proposals on major adjustments. There is, however, a concern that seasonal labour forces should be recognised and we should seek ways to recognise traveller populations.

46. A related issue was the impact of tourism. It has been suggested that these areas may suffer from the impact of tourist-serving businesses on their resident populations, eg, a large number of licensed premises increase the incidence of alcohol problems in the population. However, it was acknowledged that this will be difficult to quantify.

47. It was also highlighted that some public health services are accessed by tourist populations, such as Cornwall's 'Sunsafe' campaign, where about a third of the take-up was by non-residents.

**2011 census based population measures**

48. There was broad agreement that the latest population projections should be used, but it should be noted that revised SMR<75, using revised population estimates as the denominator, may not be available on the relevant timescales. Depending on the age distribution of the changes in the population estimates, there will be a compensating effect in the allocations between the latest estimates driving up the total population and driving down the SMR<75.

49. The use of GLA population estimates was also proposed, although this would clearly not be consistent with the rest of the country.

50. In addition to the total projected population, a number of respondents highlighted population churn as being a challenge in itself – perhaps particularly for public health where the impact if work with one group of individuals is not seen as they quickly move on. Population churn could perhaps be assessed from ONS statistics, but quantifying the impact on need would be more challenging.

**Other comments and additions**

51. Rurality and sparsity have also been raised as issues, although lack of data has also been acknowledged as a barrier. A related issue has also been raised that in areas with a number of CCGs provision of public health advice to support CCGs ('the core offer') may be higher. There may also be a higher number of providers, clinical networks, etc, which would increase the effort, and so resource, needed for effective partnerships.

52. The impact of ethnicity was also raised by a small number of respondents, although with no specific proposals.

53. There was also a proposal for distinct formulae to be developed for each service considered. While some areas would be unlikely to be sufficiently material to warrant this approach, this does fit with the aim of a more detailed, explicitly needs driven formula in the medium term.

54. Another more radical proposal (from a London DPH) was to avoid the perverse incentives of SMR<75 by building a formula around conditions amenable to prevention, in particular: diabetes; dementia; hyperlipidaemia and smoking rates.

55. London Councils proposed an approach with a clear separation of mandated and non-mandated services, with a bottom up ('need to spend') basis for mandated services that would be annually reviewed.

## Annex: Summary of respondents to dedicated mailbox

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|---|---|
| Association of North East Councils | Manchester City Council |
| Birmingham City Council | Middlesbrough Borough Council |
| Blackburn with Darwen Borough Council | Newcastle City Council |
| Blackpool Council | NHS Confederation |
| Bolton Council & NHS | NHS County Durham and NHS Darlington |
| Borough of Brent & Brent NHS | NHS Kirklees and Kirklees Council |
| Bradford MDC | NHS Knowsley / Knowsley MBC |
| Buckinghamshire County Council | NHS Leicester City and Leicester City Council |
| Calderdale Council | NHS Lincolnshire. |
| Central Lancashhire NHS | NHS North West |
| Cheshire East Council | NHS South of Tyne & Wear |
| Cheshire West and Chester Council | NHS Stoke on Trent |
| City of London | NHS Tees |
| Co Durham & Darlington NHS | NHS Tees Public Health |
| Cornwall Council | North SHAs |
| Council of the Isles of Scilly | North Tyne |
| Coventry CC & NHS | North Yorkshire County Council |
| Coventry Teaching PCT | Northumberland County Council |
| Darlington Bougough Council | Nottingham City Council |
| Department of Health West Midlands | Peterborough City Council |
| Devon County Council | Public Health Lewisham |
| DrugScope | Public Health Manchester |
| Dudley PCT | RBWM |
| Durham County Council | Rochdale MBC |
| Durham County Council | Royal Borough of Kingston & NHS |
| East Riding of Yorkshire Council | Royal College of Nursing |
| East Sussex Downs and Weald PCT | Royal Statistical Society |
| Essex County Council | Salford City Council |
| Faculty of Public Health | Sandwell Primary Care Trust |
| Gateshead Council | Shropsire PCT |
| Gateshead Council | SIGOMA |
| Gateshead Council | South East England Councils |
| Hampshire County Council | South Gloucestershire Council |
| Hartlepool Borough Council | South Tyneside Council |
| Hull City Council | Southwark Council |
| Inner North West London Primary Care Trusts | Staffordshire County Council & |
| Islington Public Health | Stockport MBC |
| Kent County Council | Stockton Public Health |
| Knowsley Council | Suffolk Public Health |
| Lancashire Co Council | Tameside MBC |
| Lewisham Council | Telford and Wrekin |
| Liverpool City Council & PTC | Terrence Higgins Trust |
| Local Government Association | Tower Hamlets Public Health Directorate |
| London Borough of Barking and Dagenham | Turning Point |

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| London Borough of Barnet | VONNE (Voluntary Organisations' Network North East) |
| London Borough of Newham | Waltham Forest |
| London Borough of Sutton | Wandsworth Council |
| London Borough of Tower Hamlets | Warrington Borough Council and Primary Care Trust |
| London Councils | Wolverhampton City Council |
| London Health Inequalities Network | Worcestershire County Council |
| Luton Borough Council | |