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PUBLIC HEALTH FORMULA: SUMMARY OF RECOMMENDATIONS TO DATE AND OUTSTANDING ISSUES

1. This paper sets out for the 2013-14 public health formula the recommendations agreed by ACRA and the issues outstanding following its 3 July meeting. This paper does not cover issues raised in the engagement exercise which are presented in a separate paper. Nor does it cover the work areas which are part of ACRA's longer term work programme, such as developing a more evidenced based formula.

Action for ACRA

2. This paper is primarily for information, but also provides additional context for the paper feeding back on the responses to the engagement exercise.

ACRA's interim recommendations

3. To recap, ACRA's interim recommendations last Autumn were:

   - a formula based principally on a measure of population health best meets the criteria by which resource allocation formulae are determined;
   - the standardised mortality ratio (SMR) for those aged under 75 years is used as the population health measure. This should be applied on a small area basis (MSOAs) to take account of localised health inequalities, and aggregated to local authority level;
   - the SMR is used as indicator of the whole population's need for public health services, not just for those aged under 75 years. Nor should it be taken to mean morbidity is unimportant;
   - to help reduce health inequalities, the SMR measure is incorporated into the public health formula so that the decile of MSOAs with the highest SMRs receive a weight per head three times greater than the decile of MSOAs with the lowest SMRs;
   - the adjustment used in the local government funding formula for unavoidable differences in costs due to geographical location (the Area Cost Adjustment – ACA) should be included;
   - ONS's projected resident populations are used as the population base;
   - at least in the interim, there should be a component in the formula for drugs treatment which continues to follow the approach for current Pooled Treatment Budget allocations.

Further development of the formula

4. ACRA's interim recommendations identified a number of areas that needed further work and which formed ACRA's 2011-12 work programme. Each of these is covered below.

Recommendations agreed up to and including 3 July ACRA meeting

i. **Fixed costs**. It is not possible on a technical basis to advise on whether the formula should include a fixed component to account for costs that may vary little by areas' population size and need, and that the final decision should rest on a policy view by DH on whether each area should be required to provide certain functions itself. DH's current view is that there should not be a fixed cost adjustment as it should be for local authorities themselves to determine how best to discharge their new duties, and they have the option of joint commissioning with other local authorities to gain economies of scale.

ii. **Age and gender adjustment.** There should be an age-gender adjustment using the indicators set out in Table 1. These indicators cover a high proportion of current spend on functions which will become the responsibility of local authorities from April 2013. In some cases the indicators are different for those aged under 16 years due to data availability.

Table 1: Indicators for age-gender weights

Function	Indicator for those aged 16 and over	Indicator for 5 to 15 year olds	Indicator children aged under 5 years[1]
Sexual health	Health Protection Agency (HPA) data on the rates of new episodes of diagnoses at GUMs for gonorrhoea, syphilis, herpes and warts in 2010 per 100,000 population for those aged 15 and over. HPA no longer collect comparable data for chlamydia. The rates of new episodes for these four have simply been added together, giving equal weight to each.	No weight for under 15s	Not applicable
Children 5-19	A weight of one for each	Same for those aged	Not applicable

[1] The age-gender adjustment is applied in the formula by multiplying the total population by an overall index for age-gender. This ensures where there is zero weight for some age groups, the size of this population group still contributes to the area's target allocations.

Function	Indicator for those aged 16 and over	Indicator for 5 to 15 year olds	Indicator children aged under 5 years[1]
	member of the population aged 5-19, and zero for all other population age groups.	16+	
Nutrition, obesity and physical activity	Percentage in each age-gender group who eat fewer than 5 portions of fruit and vegetables per day as recorded in the 2010 Health Survey for England (HSE).	Same for those aged 16+	Average weights for parental age groups.
Alcohol misuse	Percentage of each age-gender group binge drinking as recorded in the 2010 HSE. Defined as more than 8 units for men and more than 6 units for women in the heaviest drinking day last week.	Percentage of 14-15 year olds who reported they had an alcoholic drink or alcopop in the last 4 weeks. Used as weight for all 5-15 year olds.	Average weights for parental age groups.
Tobacco	The percentage in each age-gender group who are current smokers from the 2010 HSE.	Percentage of 14-15 year olds who reported they had smoked in the last week or that they smoked sometime or more often or are often near people who smoke at home. Used as weight for all 5-15 year olds.	Average weights for parental age groups.

For three functions, the average weights for the parental age groups were recommended for children aged under 5 years. ACRA recognised that local authorities will not be formally responsible for this age group initially, but felt in line with Marmot's recommendations account should be taken of the very early development years for their future health, influenced by their parents, and also that the precise division of responsibility by age group may be less relevant on the ground as local authorities are expected to prioritise their spend in line with the local priorities they identify.

The function not in Table 1 with high spend is drugs misuse. The public health formula has a separate component for those drugs services presently funded through the Pooled Treatment Budget (PTB). This component is partly based on activity by local area (weight of 56%) and as this provides a strong weight for age and gender, it was agreed there should be no additional adjustment for age and gender.

iii. **Age-gender adjustment by ethnicity**. The data are not sufficiently robust due to small sample sizes for different age-gender adjustments by ethnic group, though it was recognised that some aspects of life style may differ by ethnic group.

Outstanding issues

iv. **Non-resident populations**. At its last meeting ACRA asked that further work is undertaken on an adjustment for non-resident populations. This is covered in the separate paper on the public health formula for the September ACRA meeting.

v. **Weights by SMR decile**. Further consideration is given to this in the separate paper on the public health formula for the September ACRA meeting.

vi. **2011 Census**. Some additional issues have arisen in relation to the incorporation of the 2011 Census populations in the calculation of the SMR<75. This is covered in the separate paper on the public health formula for the September ACRA meeting.

Department of Health
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