Association of Directors of Public Health (UK)

Association of Directors of Public Health – Submission to the Advisory Committee on Resource Allocation (ACRA) consultation on the Public Health Grant: Proposed target allocation formula for 2016/17

The Association of Directors of Public Health (ADPH) is the representative body for Directors of Public Health (DsPH) in the UK. It seeks to improve and protect the health of the population through DPH development, sharing good practice, and policy and advocacy programmes.
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Directors of Public Health (DsPH) are the frontline leaders of public health working across health improvement, health protection, and health care service planning and commissioning.

ADPH has a strong track record of collaboration with other stakeholders in public health, including those working within the NHS, local authorities, government and other sectors.

Overview and Summary
ADPH would like to thank ACRA for its work on the allocation formula and the importance given to this area. There are many influences on the health of the population and in terms of finance the Public Health Grant itself has a small but vital influence. As well as resourcing core public health advice and specific services it can be used as a catalyst and a way of attracting other funds and ensuring financial stability that go beyond its apparent value. ADPH is concerned with the fair and efficient distribution of all resources affecting population health. Establishing the most effective and equitable funding targets is an important task, but since local authorities deal with the resources available to them at the time, which have largely been based on historic spend, it is the overall level of funding nationally and the pace of change to targets that are of primary importance in the immediate term. Therefore, although not part of this consultation, it is important to point out the concern from ADPH members that a reduction in the overall quantum of spending would be likely to cause severe disruption in services and would go counter to the desire for an enhancement of preventative work which is crucial to NHS and social care planning. One particular concern is the current in-year cut and potential future cut to resources that fund NHS services, although classed by central government as non-NHS.

ADPH is a membership organisation and its members will have different views which may be shaped by their local experience and circumstances. There is however, some widespread concern about the overall effects of the proposed formula changes. The Public Health Grant must be spent in line with guidance and to fulfil mandatory service needs, but there is no set division for how the money should be spent. Overall the Grant serves to improve health, especially in areas with the poorest health and higher levels of deprivation have been associated with higher levels of Grant. Even though Grant use for different programmes is largely up to local determination, the formula for grant allocation is still made up of areas and formulae which reflect areas of historic spend. It would be helpful for this to be reviewed so that challenges to the health of

the public, as broad as air pollution to diabetes prevention, can more easily be considered.

There is a concern that the overall effect of the new formula could result in a relatively smaller allocation to areas of high deprivation and high need, such as urban areas in the north of England, which are also facing other effects of austerity. Some deprived areas are seeing a reduction in grant share while affluent areas are seeing a rise. It is true that there is still a strong link with deprivation as shown in Figure 9 of the document. However, the association may be weaker with the new formula than with the old and it would be interesting to see the relationship quantified, for example by the use of best fit lines for the two dates in Figure 9.

Q1: Do you agree that a modelled SMR<75 should be developed for use in the longer term?
ADPH is not convinced that a modelled SMR<75 should be used and it is of particular importance to understand the difference between modelled and real values before going further. In general there may be no better measure than SMR<75, but consideration should be given to whether MSOA is too small an area. Given that funds are there to tackle whatever disease and risk factors are present in an area it could be argued that real SMR will always be better than a model and that the absolute effects of Grant spending are not likely to result in overall perverse incentives given the size of the Grant.

Q2: Do you agree that the sixteen groups outlined above provide a sensible balance between sensitivity to the most extreme mortality rates and protection against volatility of measurement?
This may be sensible, but does run the risk of enhancing outlier effects.

Q3: Do you agree that the proposed new substance misuse formula component should be introduced?
This appears to be an appropriate approach, although the use of activity data does risk a focus on historical spend rather than population need and may have a focus on opiates and away from newer drugs of addiction such as image and performance enhancing drugs.

Q4: Do you agree that the proposed new sexual health services formula component should be introduced?
This would seem to be appropriate as a way of apportioning sexual health allocations.

Q5: Do you agree that the proposed new services for children under five years formula component should be introduced?
In general this seems to be an appropriate measure. However, it does not take into account the implications of recruitment of health visitors to meet recent central government targets and areas that have met the targets and so have continuing revenue costs may be penalised by the implementation of a formula that is simply based on need. The rationale for the 4:1 deprivation weighting could have more evidence to back it up, perhaps using information from the Public Health Outcomes Framework. The sparsity adjustment is welcome, although its use could be extended to broader service provision rather than just travel; also consideration could be given to the interaction of deprivation and sparsity rather than treating them as independent

variables. Incidentally it has been pointed out that two of the columns in Figure 5 of the original consultation document appear reversed.

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