

## Chickens coming home to roost: local government public health budgets for 2017/18

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The Department for Communities and Local Government has released new data on local authorities' planned budgets for public health in 2017/18. It does not make good reading.

Since 2013, when local authorities were first given responsibility for many aspects of public health, they have received a grant for this from the Department of Health. It is easy to forget that in the first few years the growth in this grant was quite generous: 5.5 per cent in both 2013/14 (against an estimated primary care trust baseline) and 2014/15, reflecting the coalition government's commitment at that stage to investing more in public health. But in 2015/16 things changed dramatically.

First, the grant stalled in cash terms. Then in June 2015, £200 million was clawed back by the Treasury in an unexpected in-year raid.

Second, midway through that financial year local authorities took on responsibility for young children's (0–5 year olds) public health (and some other smaller responsibilities), receiving a transfer from the NHS of around £400 million, and from 2016/17 around £800 million for the full year. Although this has the appearance of boosting the public health budget, it is not growth but a transfer for the new responsibilities local authorities had taken on. So when we look at how the public health grant has changed over time we need to be careful to compare like with like.

Third, the last Spending Review announced cuts in public health funding of nearly 4 per cent a year, adding up to a reduction in spending in real terms of at least £600 million a year by 2020/21, on top of the £200 million already cut from the 2015/16 budget.

In this context, the new 2017/18 data is important because it is our first sight of what local authorities are planning to spend in the light of these settled responsibilities and on the same definition as the year before and in response to the announced timeline of the trajectory of further cuts to their grant to 2020/21. This data therefore reveals how local authorities are prioritising where to spend the budgets they have and which services are likely to be losing out, and by how much.

Figure 1 sets out what this looks like at the aggregate level in the context of the shifting grant over time. The data is based on actual outturn expenditure for 2013/14 through 2015/16, planned budgets for 2016/17 and the latest data for 2017/18. The dark blue bars show the headline numbers, the green like-for-like showing the effect of taking out the transfer of children's 0-5 services from the latter years to give a less misleading comparison. The latest data shows that 2017/18 is the first time that local authorities are planning a drop in public health expenditure in cash terms to £3.41 billion, a reduction of £85 million or 2.4 per cent since 2016/17. Once funding for children's services is stripped out, the figure is £2.52 billion, almost exactly the same in cash terms as in 2013/14 (£2.51 billion). Once inflation is factored in, this year's budget is worth around 5 per cent less in real terms than it was then. Over this time the population in England has also grown by around 3 per cent, placing further pressures on public health budgets.

***Figure 1: Local authority public health spending and plans 2013/14 to 2017/18***

**Dave blog - LA PH spending and plans 2013-14 to 2017-18.jpg**

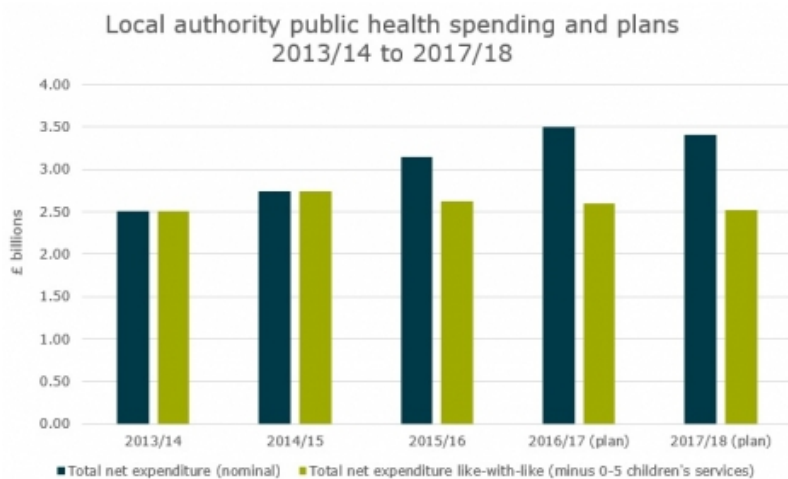


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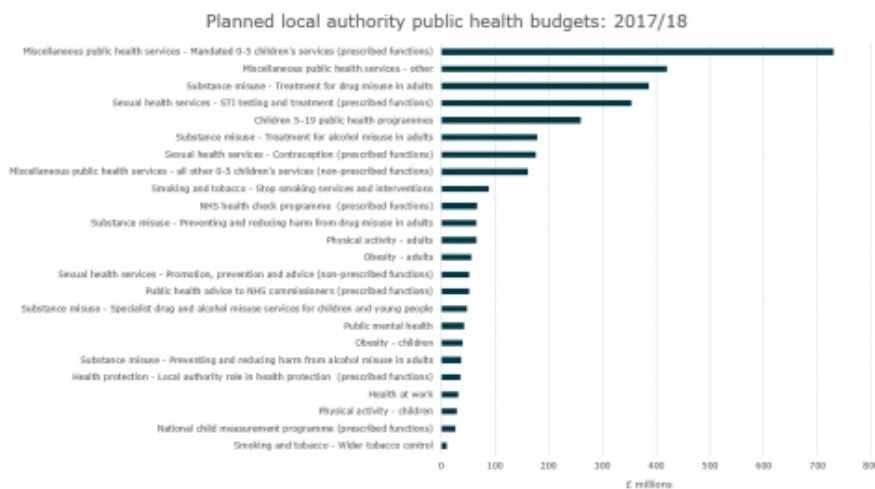


Figure 2: Planned local authority public health budgets 2017/18

and specialist drug and alcohol service for children and young people also face planned cuts of between 10 and 20 per cent. Most other services also face cuts.

### Figure 3: Percentage change in local authority planned public health budgets: 2017/18 compared to 2016/17

#### Dave blog - percentage change in LA planned PH budgets.jpg

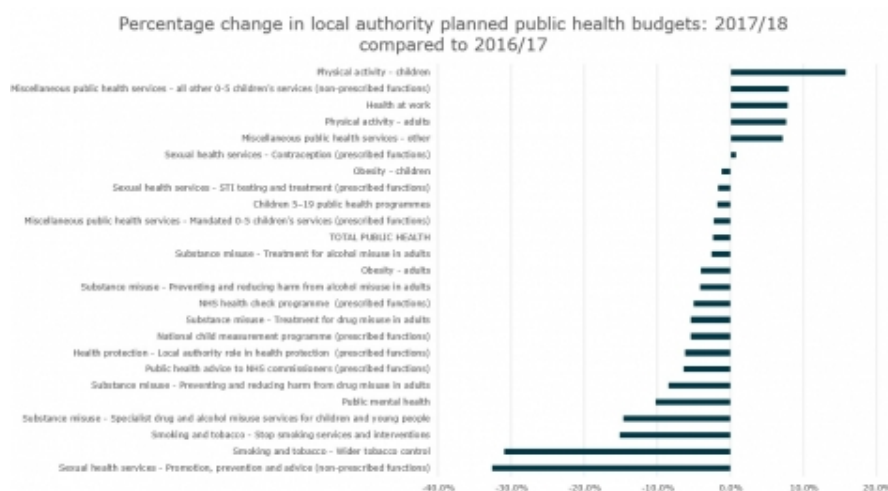


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Figure 2 shows how local authorities plan to spend the £3.41 billion. The biggest category is prescribed services for 0-5 year olds, followed by miscellaneous public health services, drug treatment for adults, sexual health testing and treatment. These categories together account for more than half of planned spending.

### Figure 2: Planned local authority public health budgets 2017/18

#### Dave blog - planned LA PH budgets 2017-18.jpg

Figure 3 shows changes in planned spending for 2017/18 compared to 2016/17. Some of these are very big in percentage terms (though the biggest changes are in those with relatively small budgets). There are some winners, notably physical activity for children (and adults) and non-prescribed services for 0-5 years olds. The biggest losers in percentage terms are sexual health promotion and prevention and wider tobacco control, both facing cuts of more than 30 per cent; stop smoking services

Some of these changes in priorities may be the result of shifts in how spending is categorised (although local authorities receive guidance on this). For example, Birmingham City Council reported planned spending on sexual health promotion and prevention of £14 million in 2016/17 and £0 in 2017/18, whereas it reported a rise in spending on sexual health testing from £1.6 million to £16 million over the same period, suggesting a change in how spending was categorised. This rise is big enough to

shift the national percentages in Figure 3. If we assume that Birmingham's plans on prevention and promotion in 2017/18 were actually the same as in 2016/17 then the national drop would be around 14 per cent (instead of 33 per cent); and if we assume in parallel that its plans on testing were the same as 2016/17, then the 1.8 per cent national drop would actually have been 6 per cent. Getting these categories right is therefore critical to our understanding of what is happening to public health, and Public Health England is rightly following up on this.

In sexual health, as in other services, some efficiencies may have been achieved through re-contracting services and changing delivery models. In London, for example, there has been [a move to online as opposed to face-to-face testing for HIV and sexual health services](#), which may explain some of the drop in expenditure on testing.

However, despite this and issues of re-categorisation, there is little doubt that the findings here are real. For us, this is most apparent in sexual health; our wider work on [the future of HIV services](#) and on [how GUM clinics are responding to financial pressures](#) has pointed to services being cut, including in the under-the-radar areas of social support, promotion and prevention, where the initial impact is least noticed but where cuts now to the 'soft underbelly' are storing up potential risks for the future.

But it's not just sexual health services that are facing challenges. As Figure 3 shows, both stop smoking services and wider tobacco control are facing big cuts in percentage terms, with stop smoking services being one of the top four services in absolute planned cuts (£16 million). Others include prescribed services for children aged 0–5 (£17 million) and treatment for adult drug misuse (£22 million). Sexual health promotion comes top of the tree at just under £25 million, but as previously mentioned the Birmingham categorisation issue accounts for a large proportion of this.

In conclusion, although some local authorities have been innovative in contracting and in seeking efficiencies in their public health budgets, there is little doubt that we are now entering the realms of real reductions in public health services. This is a direct result of the reduced priority that central government gives to public health. It should be no surprise that local authorities are having to react as they are given the pressures on their public health and wider budgets with [an estimated £5.8 billion overall funding gap by 2019/20](#). We, among many others, have consistently pointed out the folly of this course of action. Increasingly, it seems the impacts will be seen in the public health services that local residents receive.

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Great blog, as always Dave

Only one point I'd take issue with is the notion that we are only now entering into the realms of real terms cuts. Many places have been in that space for some time now.

Yes of course it's a false economy, audible sigh.

Other suggestion would be to try to compare the rate of change in reduced spend with some narrowly defined outcomes so as we can get a sense of impact

The key role of public health in reducing long term ill health is widely known. Why at a time of clearly evidenced growing pressures on health and social care budgets would anyone ever consider reducing rather than increasing these budgets?

In addition the focus on pressing social care towards managing pressures on one part of health services ie acute, to the detriment of everything else, also severely reduces their ability to carry out their often unrecognised but essential public health work eg community development. We have severe pressures on other aspects of public health such as housing, education, leisure services, employment status, infrastructure in including roads, cycle paths, street lighting....A response to reduce this dedicated budget is mind boggling!

Thanks for responses.

In full agreement Greg, there's lots of additional analysis that can be done with this data and linking it to other data and wider intelligence and information to pose all sorts of questions on effectiveness, efficiency, variation and impact over time - i've got a list as long as my arm!

And yes Geraldine, agree, local authorities are facing really tough decisions and, unlike the NHS, legally cannot spend more than they receive in grants and other income. So this is the sharp end. The positive i would take is that at least we can see the data now, before the reforms it was buried in PCTs and now it is public and transparent (if needing a lot of work) and people can analyse it and draw their conclusions. Long may this transparency continue.

[#550202](#) Dr Michael Crai...

There should be investment – not cuts.

<http://www.bmj.com/content/355/bmj.i6853/rr-1>

We believe that a major upgrade in funding is imperative to provide resources to meet the enormity of the public health challenges that the country faces.

<http://www.bmj.com/content/357/bmj.j2325/rr-0>

I've twice worked in public health departments at health authority level - first in Bristol then in Taunton (Avon as was and Somerset). I was then a senior NHS commissioner for best part of the noughties where in each role PH work shaped all commissioning plans, evidenced priorities, addressed demographic patterns and shift, enabling excellent planning, modelling and forecasting need and demand projections using strong epidemiological data illustrating incidence and prevalence indices for all aspects of health care need for respective populations. I fear in many ways those days sadly have long gone.

A very specific issue for me as, amongst several other roles, a care home owner and lead for a coalition of independent residential care providers in Devon, is a need for a refresh of an excellent health needs assessment report produced by our local PH service in April 2014. The 74 page report gives us a detailed position statement for our care home issues and a clear baseline on priorities - sadly despite numerous requests for an update 3 years on has not been seen as necessary - this despite many care homes and nursing homes now having gone out of business, massive workforce challenges, a sizable shift in placement patterns, a continuing struggle to address preventable admissions to hospital and many delayed discharges. We know that the report in April 2014 the story was that over 5,000 admissions per year came from care homes - over 100 each week - we really need to re examine what the story is now - what has changed? is it better, is it worse? what we did? what we need to do more of? - this is what I would argue to be a vital an key role for our PH experts - I will keep trying to persuade others to agree with me - I have just attempted to seek some HEE funds to assure some resource for this work to be repeated under the heading of 'enhancing a better workforce plan for H&SC' where we were asked to submit a plan as part of an STP workforce improvement initiative - we were asked to work up a bid on Tuesday with Friday as the deadline - I know we have done our best to put a plan together taking account of the restricting limiters as

to what we can and cant include - PH may be the beneficiaries of at least some dividend if successful - we really must reinstate PH as central to prevention, promotion and sustainability across H&SC NB - if you would like to see the now long out of date JSNA care home report that I still often quote from do get in touch and I will send you a copy via email or twitter.

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