Equality Analysis

Public Health Grants to Local Authorities
2013-14 and 2014-15

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Introduction

1. *Healthy Lives, Healthy People: Our strategy for public health in England* published in November 2010 set out the Government's ambitious vision to help people live longer, healthier and more fulfilling lives, and to improve the health of the poorest fastest. As part of these reforms a key change is that from April 2013 upper tier and unitary local authorities will take the lead for improving health of their local population.

2. Upper tier and unitary local authorities will receive ring-fenced public health grants for 2013-14 onwards from the Department of Health as part of these changes. This equality analysis covers how these new grants have been determined.

3. Each upper tier and unitary local authority will receive a single grant, not broken by function or policy area. It is for local authorities to determine how best to invest these resources, other than the requirement to provide a limited number of mandatory public heath functions and fulfil the grant conditions.

Equality human rights and diversity

4. Equalities, human rights and diversity are at the heart of the new health system, including public health. The Health and Social Care Act 2012 creates a legal duty on the Secretary of State to have regard to the need to reduce inequalities in health. This complements the existing Public Sector Equality Duty (2010). Local authorities are also subject to the Public Sector Equality Duty in how they fulfil their new public health duties.

5. The Public Sector Equality Duty requires public bodies to have due regard to the need to:

   - Eliminate discrimination, harassment, victimisation and any other conduct prohibited by the Equality Act 2010;
   - Advance equality of opportunity between people who share a protected characteristic and people who do not share it; and
   - Foster good relations between people who share a protected characteristic and people who do not share it.

6. The protected characteristics under the Public Sector Equality Duty are:
   - Age;
   - Disability;
   - Gender reassignment;
   - Marriage and civil partnership;
   - Pregnancy and maternity;
   - Race;
   - Religion and belief;

- Sex ;
- Sexual orientation;
- Carers 'by association' with some of the protected characteristics e.g. disability and age.

7. The Department of Health has recently published *Better Health, Better Care and Better Value for All* setting out its statutory Equality Objectives up until 2016 and its *Equality Objectives Actions Plan*[1]. This covers the Department's role as the system leader of the reformed health and social care system, as a policy maker and as an employer.

Public health grants to local authorities

8. There are three steps in determining public health grants. These are

   - determining each local authority's fair share of the total resources available for England, based on relative need for public health services;
   - establishing spend on these services in the previous year, known as baseline spend;
   - setting actual grants through pace of change policy, which balances, within the available resources, moving areas where baseline spend is less than the fair share towards their fair share and providing stability in funding for all areas.

9. The Secretary of State for Health asked the Advisory Committee on Resource Allocation (ACRA) to develop a fair shares formula for public health grants to local authorities. ACRA is an independent committee and its members are public health experts, GPs, NHS managers and academics.

10. The fair shares formula recommended by ACRA is based on relative need for public health services across the country. ACRA recognised that the data currently available are far from ideal and ACRA's recommendations therefore include a number of proxies for need. The recommended formula is comprised as follows:

    - the size of the population in each local authority area, using the sub-national population projections produced by the ONS based on the 2011 Population Census. Larger local authorities have a higher share, all else being equal;
    - a weight per head based on a measure of population health. ACRA recommended the standardised mortality ratio for those aged under 75 years of age (SMR<75). SMR<75 is used as an indicator of the whole population's health status, and hence need for public health services. It should not be interpreted as meaning that the allocation should not reflect the needs of those aged over 75 or that morbidity is not important. Analysis undertaken by ACRA showed that the SMR<75 is highly correlated with other measures of population health, such as disability free life expectancy and healthy life expectancy. It is also more regularly available for small areas than other relevant data. Local authorities with populations with poorer health will have higher fair shares, all else being equal;

[1] http://www.dh.gov.uk/health/files/2012/04/DH-Equality-Objectives-Action-Plan.pdf

- the SMR<75 is applied to small areas to take account of localised health inequalities within local authority areas as well as health inequalities between local authorities;
- the weight per head increases more quickly than the SMR<75 across small areas to into account that the costs of public health services increase more quickly than the SMR<75. ACRA recommended that the SMR<75 based weight per head is 5 time higher in the group of small areas with the poorest SMR<75 compared with the group of small areas with the best SMR<75. This targets funding towards the areas with the poorest health outcomes;
- there is an adjustment for age and gender, as different age-gender groups have different needs for public health services;
- there should be a separate component in the formula for drug treatment services funded up to 2012-13 through the pooled treatment budget. This component should broadly continue to follow the approach used to allocate that budget. This is currently based on a need component, an activity component and an outcome component. The need component should be replaced with SMR<75 as recommended for the rest of the public health formula;
- the formula includes an adjustment for unavoidable costs due to location. For example land and building costs are higher in major cities. ACRA recommended that this adjustment should be the Market Forces Factor previously used for Primary Care Trust (PCT) allocations.

11. Baseline spend is based on special collections in 2011 and 2012 from Primary Care Trusts of their expenditure on public health functions that will be the responsibility of local authorities from April 2013.

12. Overall growth in 2013-14 is 5.5%. Under pace of change policy for 2013-14, which sets actual grants, all local authorities are receiving an increase of at least 2.8% over their 2012-13 baselines and those furthest below their fair share are receiving an increase of up to 10.0%. The one exception is where there is an adjustment for recent performance for those drug services funded through the Pooled Treatment Budget up to 2012-13. This exception only affects one local authority.

13. Overall growth in 2014-15 is 5.0%. Pace of change policy in 2014-15 results in local authorities receiving an increase of at least 2.8%, and those furthest below their fair share receiving an increase of up to 10.0%.

14. Further details of the formula recommended by ACRA and the calculation of actual allocations are available on the department's website.

15. As noted above, each local authority will receive a single ring-fenced public health grant, and it is for local authorities to determine how best to invest these resources subject to the provision of a small number of mandatory functions and the grant conditions. The distribution of the national budget between local authorities cannot determine that the public health services commissioned by local authorities meet the public sector equality duty; this is appropriately and properly a matter for each local authority. The distribution of the national budget can provide the funding to support local authorities in meeting their duties.

16. In this new system for public health, the Secretary of State for Health sets the strategic direction and the Department of Health has published the public health outcomes framework, which sets out the desired outcomes for public health and how these will be measured[2]. This states "the majority of indicators in this framework have potential to impact on inequalities and we aspire to make it possible for all indicators to be disaggregated by equalities characteristics and by socioeconomic analysis wherever possible in order to support work locally to reduce in-area health inequalities where these persist."

17. The Equality Section below considers the protected characteristics in relation to public health grants.

Consultation

18. The Department of Health in December 2010 consulted on the funding and commissioning routes for public heath[3], including the broad approach to developing the fair shares formula. ACRA's interim recommendations on the fair shares formula were published in June 2012 in *Healthy Lives, Healthy People: Update on Public Health Funding*[4]. Following publication, the Department undertook a focussed engagement process and received feedback from key national and local stakeholders from both local government and the NHS. There was also the opportunity for comments to be sent by correspondence.

19. The responses to the consultation in 2010 and the engagement exercise were considered by ACRA when making their recommendations to the Secretary of State for the fair shares formula.

20. The summary of responses to the consultation is available at: http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_128838 and the overview of the responses to the engagement presented to ACRA is available on the department's website.

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[2] http://www.dh.gov.uk/health/2012/01/public-health-outcomes/

[3] *Healthy Lives, Healthy People: Consultation on the funding and commissioning routes for public health*, available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_123114.pdf

[4] *Healthy Lives, Healthy People: Update on Public Health funding*, available at: http://www.dh.gov.uk/health/2012/06/ph-funding-la/

Equality analysis

Title: Public Health Grants to Local Authorities 2013 – 14 and 2014 – 15

The intended outcomes of this work

Public health grants distribute resources to local authorities so that local authorities can help people stay healthy, avoid illness and reduce inequalities in health. Setting the distribution of the available national budget between local authorities cannot in itself 'eliminate discrimination, harassment and victimisation' or 'promote good relations' as allocations policy cannot dictate how budgets are actually spent. That is appropriately and properly a matter for each local authority. However, resource allocation can affect the equality of opportunity by ensuring resources are allocated where the need is greatest. The public health outcomes framework sets the desired outcomes for public health and how these will be measured.

Who it will affect

Local authorities will be responsible for public health services for all of their population, supported by the new public health grant. The decisions made by local authorities will potentially affect everyone, people who access public health services, public health providers, and everybody in the community. Due to the breadth and depth of public health services, every one will potentially be affected either directly or indirectly by at least one of these services.

Evidence

Evidence Considered:

In developing a fair shares formula based on relative need across the country, ACRA considered different groups within the population on account of their varying public health needs. Where need greatly varies and robust data were available, ACRA recommended 'weights' per head are applied which change the relative distribution of resources allocated between areas. The evidence discussed in this analysis draws upon ACRA's work, which is based on an array of data sets and health surveys. However, the data available were far from ideal at this point in time.

The relevant ACRA papers are available on the department's website.

Age

The need for public health services varies greatly with age, as would be expected with public functions such as alcohol and drugs misuse and sexual health services. ACRA therefore recommended that the fair shares formula included an adjustment for age.

ACRA's recommended adjustments, or weights, for age are for each public health function which historically accounted for a large share of spend on public health responsibilities to be commissioned by local authorities from April 2013, and for which there is clear evidence need varies by age. These are; drug misuse, sexual health, children 5-19, alcohol misuse, tobacco, and nutrition, obesity and physical activity. Details of the age weights are available in the

Exposition Book Public Health Allocations 2013-14; Exposition Book Public Health Allocations 2014-15; and associated guidance.

The SMR used in the fair shares formula also gives a higher weight to areas where life expectancy is lower than the national average, that is where people on average die younger and prematurely.

Sex

Both men and women benefit from most public health functions, but they have very different needs for some services, such as sexual health. ACRA recommended that adjustments, or weights, for sex are applied to the same functions as age.

Race

There is a very complex relationship between race and the need for public health services. Race may also be correlated with the SMR<75. ACRA considered a potential adjustment for ethnicity and explored the Health Survey for England data on smoking, alcohol, and fruit and vegetable consumption by ethnicity and age (data on drug use was not in the appropriate form for the analysis). Due to the low number of respondents to the survey by ethnic group, the sample numbers were too small to provide robust data by ethnicity for allocations purposes.

Disability

To advance the equality of opportunity for public health services for disabled people, resources should be allocated to account for variations in public health need. ACRA recommended that the fair sharers formula should be based on a population health measure, the SMR<75.

ACRA also considered using Disability Free Life Expectancy (DFLE), and the Healthy Life Expectancy (HLE) which more explicitly measure morbidity and disability than the SMR<75. However, ACRA found that the SMR<75, DFLE and HLE are very highly correlated so the use of the SMR<75 does capture morbidity. ACRA recommended the use of the SMR as these data are more regularly available for small areas (DFLE and HLE data for small areas depend on the 10 yearly Population Census), and ACRA felt it important to take account of health inequality within as well as between local authorities. ACRA felt the use of the SMR took account of disability, given the high correlation with DFLE and HLE.

Gender reassignment (including transgender)

Gender reassignment data within the healthcare context is complex and incomplete. When considering equity of opportunity for this protected characteristic there is a lack of data on the groups' public health needs suitable for use in an allocations formula. Due to the lack of data no adjustment can be made in the fair shares formula, though as for other groups, local authorities are subject to the Public Sector Equality Duty (Equality Act 2010) in the commissioning of public health services.

Sexual orientation

In the 2007 Citizenship Survey there was no difference in self-reported good health between heterosexual and gay/lesbian people. The Lesbian and Gay Foundation highlight that LGB&T

people are more likely than heterosexual people to smoke and drink alcohol and so could potentially have a higher need for public health services. Due to the lack of robust data available on sexual orientation within local authorities suitable for allocations purposes it is difficult to adjust for this factor. As already noted, local authorities are subject to the Public Sector Equality Duty (2010) in the commissioning of public health services.

Religion or belief

There is a lack of robust data suitable for allocations purposes on the public health needs of groups with different beliefs. No adjustment is therefore made.

Pregnancy and maternity

This characteristic is especially important to protect, as care through pregnancy and the early years impacts upon health and healthcare needs throughout life. However, local authorities will not be responsible for pregnancy and maternity services, nor for public health services for children aged under 5 in 2013-14 and 2014-15. The NHS Commissioning Board is responsible for these services.

Nevertheless, under their Public Sector Equality Duty, local authorities will need to take into account the needs of pregnant women in the commissioning of public health services for which they are responsible. ACRA recognised that a good start in life can influence future health, educational and social outcomes, and recommended an age weight for children under five years old. The weight is approximated from the behaviour of the parental age group, as an indicator of likely future public health need.

Carers

Carers play a vital role in supporting the healthcare system, however they often have poorer health outcomes. The Public Health Allocations indirectly accounts for carers through the SMR as this is correlated with for example DFLE. This is based on the assumption that carers live in the same local authority as those who they care for, which is highly likely, and indeed a majority may even live at the same property. The SMR adjusts for differences in life expectancy, where life expectancy is low we expect to see low levels of health accompanied by a higher proportion of carers and hence, a higher public health need. A more direct approach cannot be taken as data on the public health need of carers, suitable for allocation purposes is not available.

Other identified groups

The public health allocations also considered seasonal workers who may be at risk of inequity of opportunity to access public health services. ACRA considered data from the ONS on the estimates of short-term migrants which were mapped to administrative sources provided by other government departments in order to accurately allocate short-term migrants to local authorities. In the majority of local authorities the number of short-term residents is very small in comparison with the usually resident population (less than 0.5%). Those with a proportion higher than 0.5% are predominantly in London but without data on the intention of length of stay we cannot predict their pattern of public health demand. For this reason no adjustment is made.

Deprivation impacts heavily upon public health need, more affluent areas, all else being equal, are less likely to need the same level of public health services. The SMR is highly correlated with deprivation and as the SMR is applied to small areas it takes account of the relative deprivation between and within local authorities. Higher deprivation is therefore associated with higher allocations per head.

Travellers may not have access to sufficient public health services because of their non-permanent status. Public health allocations can help promote equity of access by ensuring local authorities with relatively higher populations of travellers receive a higher share of available resources. Analysis was undertaken to calculate the traveller population as a proportion of each local authorities total population. This was shown to be very low, as was the variation across local authorities. In addition, ONS undertook a special exercise to ensure that the 2011 Population Census captured all travellers, and are therefore included in the population base for public health grants. For these reasons, no adjustment was recommended by ACRA.

Engagement and involvement

This work was subject to the requirements of the cross-government Code of Practice on Consultation: http://www.bis.gov.uk/files/file47158.pdf

Gathering and testing the evidence available and testing the policy proposals

There was a formal consultation which commenced in December 2010: *Healthy Lives, Healthy People: Consultation on the funding and commissioning routes for public health*, and there was an engagement exercise following the publication of ACRA's interim recommendations in June 2012.

The independent Advisory Committee on Resource Allocation (ACRA) was asked by the Secretary of State for Health to develop the fair shares formula. ACRA's members are public health experts, GPs, NHS managers and academics. ACRA considered the responses the consultation and the engagement in developing its recommendations.

The summary of responses to the consultation is available at: http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_128838 and the overview of the responses to the engagement presented to ACRA is available on the department's website.

Summary of Analysis

The new public health grants for 2013-14 and 2014-15 distribute resources to local authorities based a needs based formula so that local authorities can help people stay healthy and avoid illness and reduce health inequalities.

Public health grants support local authorities in meeting their equality duties but it is for local authorities to determine how best to invest their resources. Local authorities are

subject to the Public Sector Equality Duty (2010)

A range of groups holding protected characteristics have been considered to be included in the public health formula. Where the evidence shows variations in need, and there exists robust, relevant data, an adjustment is made.

The protected characteristics that are not adjusted for in the public health formula will be reviewed in future work as new research and data are published.

Action planning for improvement

The public health formula has been newly developed for allocations in 2013-14 and 2014-15. It is the first time there has been a formula specifically for public health.

ACRA wishes to continue to develop the formula for future years building on that for 2013-14 and 2014-15. ACRA and the Department welcomes feedback on how to develop the formula.

For the record

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