1. Background and context

1.1 Health is about more than healthcare. Good health is much more dependent on how we live our lives (particularly our choices in relation to diet, smoking, alcohol and exercise), the opportunities and chances available to us (education, housing, decent work, supportive relationships, safe supportive communities), and the collective impact of all of this over the entire course of our lives, with getting a good start in life and successfully managing key transitions, such as into adulthood being particularly crucial to lifelong good health and wellbeing.

1.2 The evidence for this is clear. The Global Burden of Disease\(^1\) study shows that life expectancy has increased, but people are living longer with diseases. With known risk factors accounting for nearly 40% of years lived in ill health, there are real opportunities to reduce preventable disease. The leading risks are suboptimal diet, tobacco and high body mass index. Sir Michael Marmot laid out the evidence for the wider determinants of health in his report *Fair Society, Healthy Lives* making clear the importance of; getting a good start in life, decent work, healthy and sustainable places and communities.

1.3 The 2013 reforms to the public health system recognised these wider drivers of good health and wellbeing. The statutory duty to improve the health of the population was given to upper tier local authorities. Directors of public health and their teams transferred from primary care trusts (PCTs) to local government to provide the professional workforce to support local authorities, including a requirement to provide public health advice to the local clinical commissioning groups. The transition was completed in October 2015 with the transfer of responsibility for 0-5 services to local authorities.

1.4 Public Health England (PHE) was created to provide a single national expert body, bringing together a wide range of public health organisations and functions. The agency fulfils four functions:

- to protect the public's health
- to secure improvements to the public's health
- to play a key role in improving population health through sustainable health and care services
• to ensure the public health system maintains the capability and capacity to tackle today’s public health challenges and is prepared for the emerging challenges of the future

1.5 While the public health system is now led by local government, focusing on people and the places they live, the National Health Service (NHS) continues to play an important role, from commissioning and delivering immunisation and screening programmes, through the provision of healthier environments for patients, visitors and staff, to the impact of healthcare itself. The NHS has a powerful voice in the debate about health, and can have real influence over decisions of policy makers and individuals alike.

1.6 Spending in the public health system is now much more transparent than it ever was. Prior to the transfer to local government public health spend largely went unseen and without comment. There were large variations in spend on public health driven by how PCTs previously chose to prioritise it. There was at least a seven-fold variation in PCT public health spend per head of their local population.

1.7 The accounting and governance arrangements surrounding public health spend in the new system provide transparency not just in total spend, but how public health spending is broken down against a range of categories (now 20), some of which are mandated. In its value for money review of PHE’s grant to local authorities undertaken in 2014, the National Audit Office highlighted that “the new public health arrangements have increased transparency of public health spending, improving understanding of the services provided in each local authority”.

1.8 At the same time, a new Public Health Outcomes Framework was introduced, which is supported by a range of tools that PHE has developed to allow local authorities to analyse their spend against outcomes and benchmark how they are doing against other authorities. The National Audit Office reported that “the public health outcomes framework brings together public health datasets for the first time, increasing transparency and accountability”.
2. The importance of a strong and well funded NHS

2.1 Although healthcare only accounts for between 10 to 20%² of the factors that determine the public’s health, a strong, confident and appropriately resourced NHS is important in improving the public’s health. The NHS has a fundamental role to play in population level health and retains responsibility for delivery of a range of national public health functions as set out in an annual NHS Public Health Functions Agreement that is supported by specific funding (£1.8bn in 2015/16).

2.2 These functions currently include national screening and immunisation programmes, public health services for individuals in detention, child health information systems and sexual assault referral centres. Until transferred to local authorities in October 2015, this also included public health services for children aged 0-5.

2.3 PHE was a partner in the development of the NHS Five Year Forward View and as such welcomes the full funding by government of the additional £8bn requested to support transformation.

2.4 PHE believes that the additional funding will ensure that the NHS can continue to fully fund all of its public health commitments as set out above for the remainder of the Spending Review period.

2.5 Additionally, greater financial stability provides the NHS with an opportunity to demonstrate how it can expand its role in prevention. The Five Year Forward View described the “health and wellbeing gap” alongside the “care” and “efficiency” gaps – it, together with PHE’s publication From Evidence into Action published at the same time, focused on the need for a radical upgrade in prevention and with the funding provided by the Spending Review, including the additional £1.5bn invested in the Better Care Fund, there is an opportunity now to maximise system-wide efforts to prevent the preventable. PHE is fully committed to supporting this.
3. The local authority public health grant and the spending review

3.1 Prevention is better than a cure and evidence suggests it is more cost effective too. That’s why the NHS Five Year Forward View called for a radical upgrade in prevention activities across the health and care system. Prevention and early intervention help support the management of demand and consequently the pressures on the NHS and other public services.

3.2 The transition to the new public health landscape in April 2013 resulted in a ringfenced grant being provided by PHE to all 152 upper tier local authorities.

3.3 The first two years of the new system were marked by an increase in investment through the public health grant of 10% over that which had previously been invested within the NHS. Individual local authorities all received a share of this increase, however those where there was previously underinvestment against a health needs based formula received a greater share of this increase.

3.4 For the third year of the grant (2015/16) the level of the funding remained static at circa £2.8bn, although a reduction of £200m was applied in-year representing a 6.2% reduction in the value of the grant. In October 2015 an additional £430m was transferred to local government and incorporated into the grant to reflect the transfer of responsibility for commissioning 0-5 children’s public health services – this being a half year allocation.

3.5 In addition to the £200m in year reduction in 2015/16, the outcome of the spending review was a reduction in the total cash value of the public health grant totalling 9.6%. This is profiled 2.2% in 2016/17 followed by reductions of 2.5%, 2.6%, 2.6% and with ‘flat cash’ (0% reduction/increase) in 2020/21.

3.6 Over the entire period from the transition to the new public health system with the initial increased investment and including spending on 0-5’s throughout the period (which increased materially in the early years), to the end of the Spending Review period, the actual cash reduction in public health spend equates to around a 4% reduction over eight years.

3.7 The public health grant to local authorities is ring fenced and expenditure must only be on activities where the main and primary purpose of that spend is on public health. PHE has developed an assurance framework based on the HM Treasury three lines of assurance model, which seeks to ensure compliance with this requirement. The annual financial audit of PHE by the National Audit Office
scrutinises the inherent risk of irregular spend, and the National Audit Office is satisfied with PHE’s assurance framework, concluding that “Public health grant spending by local authorities is appropriately monitored by PHE, and we have obtained sufficient assurance over the regularity of these payments.” These arrangements therefore mitigate the risk of other pressures arising through the Spending Review and a tighter financial climate for local authorities, manifesting itself in the public health grant being used for purposes not intended by Parliament.

3.8 No reduction in the public health grant is ever welcome. However, at the levels of reduction highlighted above, the Spending Review did not fundamentally derail the system. Public health is about far more than the services funded through the grant. The transfer to local government provided the opportunity to join up public health with decisions on other local services such as housing and economic regeneration in the interests of improving the health of the local population. The NHS has an integral role to play too and this is reflected in the NHS Five Year Forward View commitment to prevention, with the NHS now for example funding the national diabetes prevention programme and a Five Year Forward View Prevention Board has been established, chaired by PHE, to bring to scale prevention measures within the NHS. Similarly central government has an important role to play and national action on tobacco and childhood obesity reflect this. All of these things draw upon resources over and above the funding provided in the public health grant.

3.9 Additionally, PHE considers that to focus purely on resource input and not at the value derived from that resource can be misleading. Experience from case studies in local government shows that while spending is clearly an important factor, sometimes more and better services can be commissioned and delivered for less. To this end, with a focus on the Public Health Outcomes Framework, PHE has developed a range of tools for use by local authorities that aim to benchmark spend and outcome performance.

3.10 Over the past two years many local authorities have demonstrated that they have been able to achieve efficiency gains within the local public health grant. This includes redesigning and re-tendering some services and commissioning new innovative models of care. There is scope for further efficiencies and opportunities for local authorities to learn from each other in addressing ‘unexplained’ variations across the country.
4. The impact of the Spending Review on PHE

4.1 PHE has a net operating budget in 2015/16 of £315m. For around one third of the cost of a teaching hospital the full range of at-scale national public health functions are provided as is the knowledge and intelligence, health improvement and health protection support for the local public health system. PHE also generates around £170m of external income, thereby minimising its call on the taxpayer.

4.2 PHE has been asked to make real terms savings of 30% on the administration element of its budget and around 10% on its Programme budgets. This level of saving is consistent with the requirement set for the Department of Health itself and its arms-length bodies.

4.3 PHE was formed in 2013 from around 130 former bodies and prior to the Spending Review had already delivered £100m in savings, of which £50m represented cash reductions in its operating budget.

4.4 As part of its ongoing drive to deliver its services as effectively and efficiently as possible, and in preparation for the outcome of the Spending Review, PHE has undertaken a strategic review of its functions and services, and it is through the implementation of this, coupled with its robust value for money strategy, that PHE aims to deliver the further challenging savings targets set through the Spending Review.

4.5 After implementing the organisational changes arising from the Strategic Review PHE will have removed circa 500 posts, and while the profound impact on individuals going through this process should not be underestimated, we believe that by the end of the Spending Review period we will still be in a position to deliver both taxpayer value and our mission to protect and improve the public’s health. In delivering the required savings, we will not do anything that diminishes our capacity and capability to a level where we cannot undertake the core functions of our remit.

4.6 The Spending Review also provided funding for global public health issues including the creation of a rapid response team to allow the United Kingdom (UK) to deploy on the ground anywhere in the world within 48 hours. The international experience from Ebola in West Africa suggests that had such a capability been in on the ground at the outset of the outbreak, many lives would have been saved and much of the economic damage prevented. This will be a joint endeavour between PHE and an academic partner, and a competition is currently under way to identify that partner.
5. A major investment in public health science

5.1 PHE welcomes the announcement in the Spending Review to invest over £400m capital spend in creating an integrated public health Science Hub at Harlow in Essex. This will also become the national headquarters for PHE.

5.2 The integrated Science Hub at Harlow was PHE’s preferred option in its outline business case that was submitted to government in 2014. It will create a centre of excellence for research, health improvement and protection, and bring together world-renowned scientists working to protect and improve the health of the nation. It will be fully operational by 2024 with the first facilities opening in 2019.

5.3 The importance of this investment in the country’s critical infrastructure cannot be underestimated. It will ensure we have public health science facilities capable of meeting current and future needs for decades to come. The vision is for a world-class public health science hub where academia, public health services, research and commercial activities can interact and deliver leading-edge results. The Science Hub programme is at the heart of the future development of PHE and is essential to its capacity and capability to deliver its functions. The programme creates the physical assets and resources for PHE to be a modern scientific agency working at the leading edge of technological developments.

5.4 The integrated national Science Hub will:

- provide core functions that are most effectively and efficiently delivered only once in the UK (recognising the need for resilience for key elements of the national emergency response)
- support local delivery through a network of PHE’s facilities covering the whole of England and through key partners in local government and the local NHS, in industry and academia
- deliver the UK-wide response to specific threats and the UK’s contribution to addressing global threats to health and wellbeing
6. Challenges and opportunities following the Spending Review

6.1 There are a range of challenges and opportunities facing the public health system in the post Spending Review period.

6.2 PHE is wholly and actively supportive of the devolution agenda as a means for place-based solutions to previously intractable issues that we know to be the causes of the causes of poor health. The focus of the Spending Review on extending devolution deals, coupled with the new NHS Planning Guidance that is also place based and has local government as a key partner, are both positive developments which PHE continues to rigorously support both nationally and locally. Both devolution and the greater integration of health and social care, done well, will lead to the better health outcomes from the ‘local pound’.

6.3 The additional investment in the spending review for mental health (£600m) is welcomed and presents an opportunity to invest in preventative mental health too.

6.4 Similarly, the provision of new national funds to develop approaches to help people with health problems get back to work supports the public health agenda.

6.5 The Spending Review also sustained the often overlooked investment in the country’s world leading screening and immunisation programmes. Such programmes are fundamental to population health and are a preventative investment. The introduction of new programmes, such as for meningitis B, have been funded through the Spending Review.

6.6 The Spending Review signalled a move away from the funding of local government through central government grants, including the public health grant, to a system based on the full retention of business rates by local authorities. Given the importance of employment to health outcomes (wealth begets health and vice versa), but also the unequal landscape for business growth, PHE believes that business rates retention provides both an opportunity and challenge. PHE will therefore work closely with the Department of Health, the Department for Communities and Local Government and HM Treasury to ensure that the arrangements which are put in place to facilitate the transfer and ensure appropriate redistribution between authorities, take sufficient account of health needs and the need to continue to address health inequalities.

6.7 Finally, the Spending Review process has demonstrated the need to have robust evidence on the return on investment for public health interventions across the full...
broadth of public health services, showing how, where and when savings identified can be delivered. PHE will continue to invest in its health economics function to ensure that this return on investment information is delivered and can inform investment and prioritisation decisions across the NHS, local government and the broader public service.

7. References

2. The case for more active policy attention to health promotion, Health Affairs Journal 2002.

25 January 2016