# Why greater investment in the public health grant should be a priority

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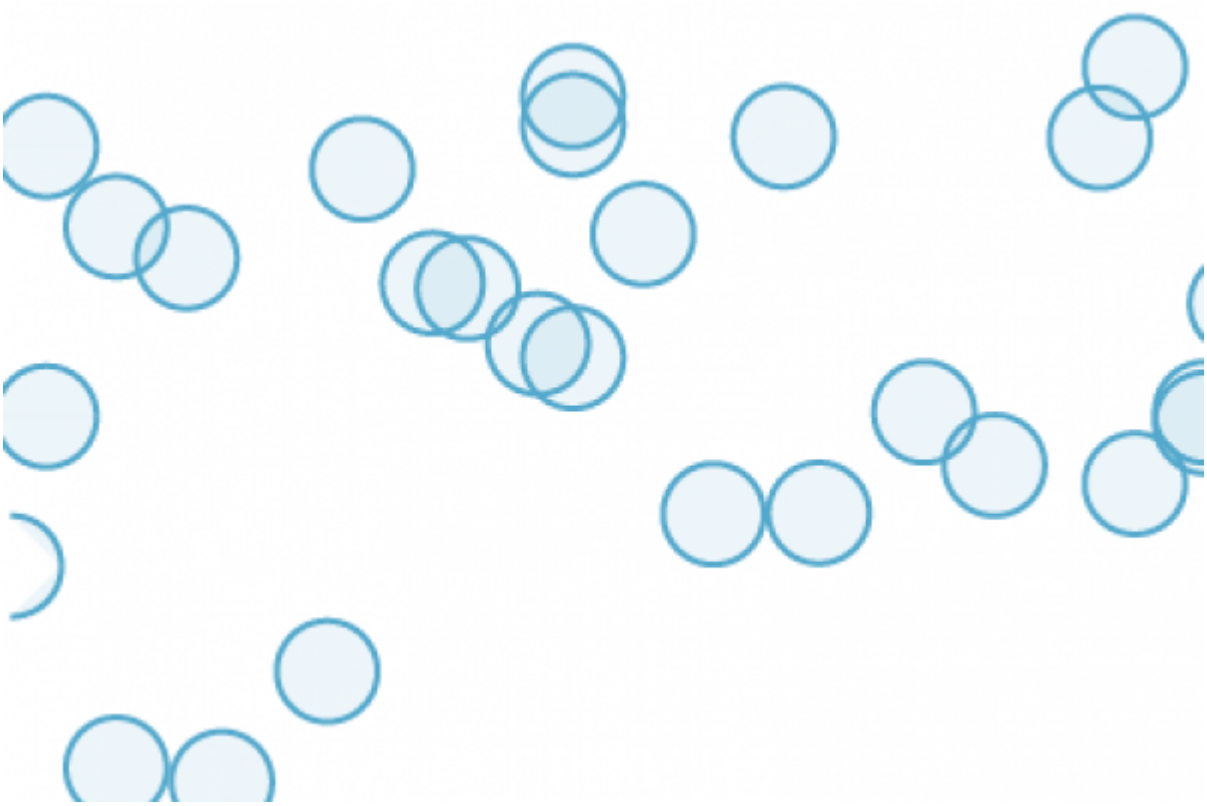

## Key points

- **Note:** Since publishing this analysis, we have published more up-to-date public health grant figures.
- The public health grant has been cut by 24% on a real-terms per capita basis since 2015/16. We estimate that restoring the public health grant to its historical real-terms per capita value – and accounting for both cost pressures and demand levels – would require an additional £1.4bn a year in 2021/22 price terms by 2024/25.
- Poor health is strongly associated with living in socioeconomically deprived areas. However, real-terms per capita cuts to the grant have tended to be greater in more deprived areas. In Blackpool, ranked as the most deprived upper tier local authority in England, the per capita cut to the grant has been one of the largest – at £43 per person per year.
- The public health grant funds things like sexual health, drug and alcohol services. Before the pandemic, the need for these services remained consistent or had increased. The full impact of the pandemic is not yet known, but there are early signs that need and inequalities have increased.
- Local authority public health interventions funded by the grant provide excellent value for money, with each additional year of good health achieved in the population by public health interventions costing £3,800. This is three to four times lower than the cost resulting from NHS interventions of £13,500. Interventions can also help reduce health inequalities.

## Introduction

The launch of the Office for Health Improvement and Disparities at the beginning of October, combined with forthcoming multi-year Spending Review, presents an opportunity to set right the past 6 years of chronic underinvestment in public health. The pandemic has highlighted stark inequalities in health and how these have widened through the period. And while government focus has been on the immediate need to provide financial support for the NHS in tackling the pandemic backlog, commitments to invest in public health have been in shorter supply.

The pandemic has resulted in a range of risks to health, both immediate and longer term – from people being unable to access services through to gaps in education and loss of work or income. Within local authorities, the public health grant has a key role to play in improving health by funding vital services. This includes smoking cessation, drug and alcohol services, children's

health services and sexual health services, as well as broader public health support across local authorities and the NHS.

The grant is paid to local authorities from the Department for Health and Social Care (DHSC) budget. For 2021/22 the allocation for the public health grant was £3.3bn. However, while DHSC spend on NHS England has increased in real terms over the past decade, a trend that is set to continue, there has been a 24% real-terms per capita cut in the value of the grant between the initial allocations for 2015/16 and 2021/22.

## A significant reduction in the public health grant

Figure 1 shows how the reduction in grant allocations fed through into spend on different elements of public health provision. It shows the change in spend between 2015/16 and 2019/20 (the latest outturn data available). The largest elements of spend were on services for children age 0–5 years – which is largely health visitors for infants and mothers (£1bn); drug and alcohol services for adults (£0.74bn) and sexual health services (£0.65bn).

*This page contains an interactive chart. You can view this chart on the Health Foundation website.*

The greatest reduction in spend over the period was for stop smoking services and tobacco control, which fell by 33% in real terms. The one area in which spend increased was in obesity services for children.

Public health grant allocations have been made just before the start of the financial year for the past 2 years, and with no clear multi-year plan. On top of the large reductions in the grant, the lack of certainty this creates can make it difficult for local authorities to effectively plan and implement services for the longer term.

## Trends in need for public health services

Prior to the pandemic, trends in many indicators of underlying need for the services provided by the public health grant have remained similar to historical levels or increased:

- Rates of obesity among adults in England increased by 2 percentage points in 5 years to reach 28% in 2019, with the largest increases in 16 to 44 year olds.
- Alcohol-specific death rates in England and Wales were 11 per 100,000 people in 2019, a slight increase from 10.6 per 100,000 people in 2014, but a 22% rise compared with 2009.
- Drug-related death rates in England and Wales increased by 29% between 2014 and 2019, following a long-term trend of increasing at around 4% a year over the past 20 years.
- Sexually transmitted infection diagnosis rates in England had remained at around 800 per 100,000 of population over the past 5 years, increasing to 830 per 100,000 in 2019 driven by an increase in Chlamydia and Gonorrhoea diagnoses.

Overall, smoking rates have improved, falling in England from 17.9% to 13.9% of people aged 18 and older between 2014 and 2019. However, across the UK as a whole they have fallen by less among people older than age 35, and the difference in smoking prevalence widened significantly between those in routine and manual occupations and those in other occupations between 2012 and 2019. People in routine and manual occupations are nearly 2.5 times as likely to smoke. So while current strategies to reduce smoking have led to a large fall at the population level, these inequalities in rates urgently need to be addressed with many still in need of support to stop smoking.

The full impact of the pandemic on these indicators is not yet known, but there are early signs that some may have worsened and inequalities increased. The Public Health England Health Profile for England 2021 reports that:

- The numbers of 'increasing and higher risk' drinkers increased in April 2020, remaining above pre-pandemic levels into summer 2021.
- Alcohol deaths have risen by 19% between 2019 and 2020. Drug-related deaths are now at the highest levels since records began with a 3.8% increase between 2019 and 2020.
- There was a reduction in physical activity levels, particularly among people from black and Asian groups, and people from more socioeconomically disadvantaged groups.
- There was an increase in the number of people trying to quit smoking, with over one in three smokers reporting attempts to quit in the 3 months to June 2021. But there are also reports of increases in smoking among young adults during the first lockdown and during 2021.
- The impact on obesity in children and adults is not yet known, although previous research links time out of school in the holidays with weight gain in children. Given the changes reported in physical activity, diet and alcohol consumption, it is possible that inequalities in

obesity will have widened.
- Measures taken during the pandemic resulted in a drop in people accessing sexual health services. It is not known to what extent this is due to reduced infection rates and/or undetected infections, with reduced contact with health services over the pandemic period.

Looking ahead, child poverty rates – used to indicate the need for children's services such as health visitors – are projected to rise with over one in three children potentially in poverty by 2024/25. This is partly due to the pending end of the £20 uplift to Universal Credit. But it is also due to the continued bite of cuts made previously to social security, including the two child limit and benefit cap.

## Local area reductions in the grant

Poor health is strongly associated with living in socioeconomic deprivation. There is a nearly 20 year gap in the years of good health that a girl born in the most deprived 10% of areas can expect to live, compared with a girl born in the least deprived 10% of local areas. These underlying health disparities contributed to the COVID-19 mortality rate for those younger than 65 in the most deprived areas being nearly four times that of those in the least deprived areas.

However, cuts to the grant have been greater in more deprived areas. Figure 2 compares the real-terms per capita cut in public health grant allocations between 2015/16 and 2020/21 to the deprivation score in each local authority. It shows that per capita reductions in the public health grant were greatest in more deprived areas. In Blackpool, ranked as the most deprived upper tier local authority in England, the per capita cut to the grant has been one of the largest – at £43 per person per year.

*This page contains an interactive chart. You can view this chart on the Health Foundation website.*

## Reinvesting to meet need

By taking into account trends in population growth, need and the cost of provision for elements of the public health grant, we are able to estimate a future path of spend that would help to ensure the grant keeps pace with demand and supports recovery from the pandemic. We

assume that the cost of service provision reflects 70% wage costs (using OBR projections of average wage growth) and 30% general price inflation (GDP deflator), in line with the approach taken in wider projections related to NHS England spend and costs set out in PSSRU unit cost estimates.

We estimate that restoring the public health grant to its historical real-terms per capita value – and accounting for both cost pressures and demand levels – would require an additional £1.4bn a year in 2021/22 price terms by 2024/25 (the final year of the Spending Review). This implies an average growth rate in the public health grant of 14% a year for the next 3 years. Figure 3 sets out the path of historical and projected spend, with scenarios phasing in additional spend to 2024/25. Beyond the Spending Review period, the public health grant should increase at least in line with NHS England spend to ensure it is prioritised relative to NHS spend.

**Figure 3**

*This page contains an interactive chart. You can view this chart on the Health Foundation website.*

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## Full data sources for Figure 3

- MHCLG, Local authority revenue expenditure data (various)
- ONS, 2018-based National Population Projections
- Department of Health and Social Care, Public Health Allocations to local authorities: 2020/21
- OBR, Economic and Fiscal Outlook, March 2021
- Department for Work and Pensions, Households Below Average Income (various)
- Public Health England, Total number of consultations at Sexual Health Services in England by gender, sexual risk & age group, 2015–2019
- NHS Digital, Health Survey for England 2019
- ONS, Quarterly alcohol-specific age-standardised death rates per 100,000 people, by sex; England and Wales, 2001 to 2019
- ONS, Number of deaths and age-standardised mortality rates for deaths related to drug poisoning, drug misuse, and selected substances by sex, England and Wales, deaths registered between 1993 and 2020
- Resolution Foundation, The Living Standards Outlook 2021

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## Using the grant to achieve effective and cost-effective public health interventions

Local authority public health interventions funded by the grant provide excellent value for money. Research shows that the cost of each additional year of good health achieved in the population by public health interventions, measured using Quality Adjusted Life Years (QALYs), costs £3,800. This is three to four times lower than the cost resulting from NHS interventions of £13,500 (per additional year of good health).

As spending from the grant tends to be more preventative – taking place before the full consequences become apparent rather than meeting acute need to treat ill health – short-term decision making has led to it being underfunded. In contrast, the NHS, where the demand is more visible, has been continually prioritised for additional spend. This is a false economy. Investing in public health now to increase healthy years of life can help to reduce future pressures on the NHS by focusing on improving health and wellbeing in later life, not just extending years of life. Postponing ill health until later in life through preventative action also has wider social and economic benefits both for individuals and society.

A review of research by the University of Cambridge, commissioned by the Health Foundation, has found a considerable evidence base demonstrating the effectiveness and cost effectiveness of public health and preventative interventions. But not all public health interventions are equally effective or cost effective . And they have different impacts on health inequalities: some may reduce the gap in health, while others may inadvertently increase inequalities. Local public health teams should use this evidence about the effectiveness and cost effectiveness of interventions, together with knowledge of their local population and understanding of local needs, in determining the combinations of services to commission and deliver. Doing so could improve health and reduce inequalities in their local areas.

## Conclusion

Investment in prevention represents excellent value for money compared with health care spend. Yet recent announcements have continued the trend of increasing spending on the NHS while disinvesting in the wider funding that helps to maintain and improve people's health.

As the country emerges from a pandemic that has highlighted and compounded inequalities, there is good evidence that specific public health interventions, such as smoking cessation services, will help to reduce health inequalities. And do so in a more cost effective way than additional NHS-based interventions.

It is clear that opportunities to prevent the early deterioration of health are being missed, while the need for such interventions is increasing. Failure to invest in vital preventive services will mean health worsening further, widening health inequalities, and the costs of dealing with this poor health will be felt across society and the economy. A coordinated cross-government strategy is now required to improve the nation's health. But, more immediately, the evidence points to funding public health properly.

https://www.health.org.uk/news-and-comment/charts-and-infographics/why-greater-investment-in-the-public-health-grant-should-be-a-priority