South East Strategic Leaders
South East England Councils

Health Premium Incentive Scheme 2014/15 and Public Health Allocations: A technical consultation

16 October 2014

1. Introduction

1.1. This is a joint response of South East Strategic Leaders (SESL) and South East England Councils (SEEC), which together represent County, Unitary and District Councils across the South East and over 8.8m residents. This submission is intended to provide strategic, principled comments on the proposed incentive scheme. We refer you to the individual responses of our member authorities for technical feedback.

1.2. **Headline messages:**

1.2.1. **Fair funding -** Public health is underfunded in the South East and does not reflect significant and rising demand for services from our large and growing population. Public Health funding formula should be reviewed and revised ahead of the 2016/17 funding allocations. In particular, there is a need to review the relevance of current deprivation factors and place greater weighting on factors of population size, sparsity and high cost base, all of which make it more expensive for councils to deliver public health services in many areas of the South East.

1.2.2. **Fit for purpose** – We feel that a larger scale pilot run over the course of a full year would provide a more effective assessment of the potential to use incentives successfully and whether the incentive scheme offers an effective, long term way of making best use of resources. Subject to the pilot results, if Government choses to proceed with a premium scheme, this should not be rolled out until after a revised funding formula is agreed which removes the risk of perverse incentives. We believe a revised formula should be in place in time for the 2016/17 allocations and that a larger scale pilot of the incentive scheme should run in 2015/16, with payments made in 2016/17.

1.2.3. **Maximum local flexibility** – The pilot positively encourages local flexibility and choice and this should be maximised in future years by giving councils freedom to develop local indicators.

1.2.4. **Minimum bureaucracy** – We welcome the Department of Health's (DH) aim to minimise bureaucracy in administering the scheme.

2. Public Health Allocations for 2014/15

2.1. There are significant discrepancies in public health funding across the country with South East councils receiving some of the lowest levels of funding per capita. Although some South East allocations appear large, once population size (the largest in England at 8.8m, projected to grow to over 10m by 2032[1]) is factored in, it becomes clear that South East councils received grant of just £34 per head on average for 2013-14 and £40 per head for 2014-15. This is lower than any other region of the UK. Wokingham (£26), Windsor and Maidenhead (£23), Bracknell Forest (£26) and Surrey (£22) received the four lowest grants (per head) of all English local authorities. Many South East authorities also have a significant shortfall between their current public health allocation and their target allocation. Buckinghamshire CC, for example, has a shortfall of £1.5m.

2.2. The South East is also home to the country's largest and fastest growing group of elderly and ageing populations. The number of people over 75 years old is expected to increase to 1.5m by 2037, nearly double 2014 levels, a rise of over 700,000 people[2]. This is placing significant demand and cost pressures on health and care services. The Association of Directors of Adult Social Services (ADASS) estimates that £3.53bn has already been taken out of adult social care budgets nationally over the past four years. Given this funding pressure, public health has a vital role to play in delaying the need for social care. Current allocations are not, however, allowing South East councils to address public health challenges as effectively as they could.

[1] Including SESL authorities Wiltshire, Swindon and Central Bedfordshire, our population is 9.8m rising to over 11m by 2032, based on 2012-based Subnational Population Projections for Local Authorities in England.

[2] Including SESL authorities Wiltshire, Swindon and Central Bedfordshire, our population aged 75+ is 847,000, rising to over 1.6m by 2037, based on 2012-based Subnational Population Projections for Local Authorities in England.

2.3. Too often the impact of the South East's very large population has been overlooked, masked by percentage comparisons nationally instead of looking at absolute numbers. For example, the number of children and older people living in income deprivation in the South East is actually 230,853 people more than the North East despite this being masked by percentage comparisons. The funding formula for public health continues to give greater weighting to measures of deprivation and not enough to absolute numbers of people. While there are links between some poor health outcomes and factors of deprivation, it is also true that many national public health priorities, for example domestic violence and abuse of alcohol, are common to all sections of the population.

2.4. **Key request: The Department of Health (DH) should commission The Advisory Committee on Resource Allocation (ACRA) to review and make recommendations for a revised public health funding formula that better balances weightings for deprivation and population size. The DH should publish a timeframe specifying when ACRA will report to the DH, when Government will issue its response and a target date for the revised formula to be in operation. We believe this should be in time for the 2016/17 allocations.**

3. The Health Premium Incentive Scheme 2014/15

3.1. Rationale and timing

3.1.1. With South East demographic change, including a growing and ageing population, placing significant and rising demand on health and social care services, investing in preventative public health is a priority. Public health spending has the potential to reduce demand and costs for acute services by early interventions. It is therefore disappointing to see the decision to freeze public health funding for an additional year to 2015/16, which means that local authority funding has essentially been cut in real terms. Distributing £5m of health premium incentives on the same basis as current public health allocations will do nothing to address imbalances in funding for South East authorities. **SESL and SEEC continue to call on Government to accelerate the pace of change to bring the South East up to a fair funding level to meet the needs of our population. With limited resource available, it is important to be sure that any scheme introduced offers best value for money over the long term and does not result in perverse incentives.**

3.1.2. **A larger scale pilot run over the course of a full year would provide a more effective assessment of the potential to use incentives successfully. For example, whether the incentive scheme offers an effective, long term way of making best use of resources** in contrast to channelling funding directly to County and Unitary councils for use creatively, in partnership with District councils, to incentivise progress against local priorities. The timing of this consultation is not ideal - 7 months into the year that the pilot scheme is due to be running. The incentive payment in 2015/16 will be based on performance this year against indicators that have not yet been agreed. Local authorities and their partners will already have plans in place as to how they intend to spend public health resource and it is likely to be too late in the year to significantly change these plans. As the pilot will use also only 2 of a potential 51 indicators and a potential pot of only £5m, **we feel it would be beneficial to commence a larger scale pilot in 2015/16 with payments made in 2016/17.**

3.1.3. **Delaying the introduction of the scheme would also allow time for Government to make sure that the incentive scheme operates alongside a revised public health formula that removes the potential for perverse incentives and acknowledges stretching but realistic gradients for improvement.** For example, some of our members have raised concerns about setting higher improvement requirements for councils performing in the upper quartile compared to those in the lower quartile. Higher performing councils will have implemented all the high impact changes that can improve performance and may be at a point of facing more challenging changes that will deliver additional improvements at a slower pace. We therefore request that levels of improvement required should be equal across all quartiles. SEEC and SESL continue to have concerns that by basing funding on improved health outcomes, the health premium scheme could lead to unintended consequences as those areas that perform well risk a reduction in their core allocation. This is a risk that has been previously recognised by the Government. In March 2013, the House of Commons Communities and Local Government Select Committee concluded, 'The Government has acknowledged that the perverse incentive in the current funding formula would be particularly marked if it were still in place when the Health Premium was introduced. This suggests that the current funding formula and possibly the Premium need to be revised. A funding system which at the same time disadvantages and rewards improvements in public health cannot be fit for purpose'.

3.1.4. The Committee recommended that the health premium be delayed until the funding formula had been redesigned[3]; however, Government has still not published a clear timetable for modifying the current formula. As stated above, **we believe that following recommendations by ACRA, Government should introduce a revised funding formula in time for the 2016/17 funding allocations.**

3.1.5. **Key request: To avoid the risk of perverse incentives, if Government choses to proceed with a premium scheme, we see benefit in delaying full rollout of the scheme until after the revised formula is in place and subject to the results of a more comprehensive pilot during 2015/16.**

3.2. **Improvement indicators**

3.2.1. **It is important that any scheme that is introduced maximises local flexibility and choice.** We, therefore, welcome the opportunity for councils to select a local indicator as part of the pilot scheme and support the notion that in future years councils should have additional flexibility to develop local indicators. We refer you to individual member responses for a view on the use of the national drugs recovery indicator.

3.3. **Data collection and measuring progress**

3.3.1. We support the approach to rewarding progress rather than arbitrary targets and welcome the DH's ambition to minimise bureaucracy in the administration of the scheme. However, for the reasons outlined above, we question whether the pilot will be sufficient to demonstrate *intentional* progress, and therefore evidence an incentive to improve. A council may have improved against an indicator during 2014/15 but only progress over the time period for which the pilot scheme is running can be used to demonstrate incentivised, intentional progress. Moreover, by making the incentive payment proportionate to each local authority's target allocation significantly reduces the incentive to South East councils which, as already highlighted, receive significantly less grant funding compared to other authorities across the country.

ABOUT US

South East Strategic Leaders (SESL) is a partnership of upper tier authorities committed to nurturing the engine room of the UK economy and promoting public service excellence. SESL supports its members to create the conditions within which individuals, communities and businesses thrive. We aim to:

- **Influence** – speaking with a stronger, united voice for South East strategic councils.
- **Inform** – producing robust evidence relevant to practice.
- **Inspire** – connecting people, sharing ideas, sparking innovation.

SESL is chaired by Cllr David Burbage MBE, Leader of Royal Borough of Windsor and Maidenhead.
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South East England Councils (SEEC) was established in 2009. It is a membership organisation representing all tiers of local authority. The SEEC area covers Berkshire, Buckinghamshire, East and West Sussex, Hampshire, Isle of Wight, Kent, Oxfordshire and Surrey. SEEC's objectives are:

- To strive for a fair funding deal for the South East
- To promote the South East's position as a leading global economy
- To act as single democratic voice for South East interests
- To monitor the pulse of the South East.

SEEC is chaired by Cllr Gordon Keymer CBE, Leader of Tandridge District Council.
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[3] House of Commons Communities and Local Government Select Committee Eighth Report, The Role of Local Authorities in Health Issues (20 March 2013)