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Funding for ill-health prevention and public health in the UK

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Summary

– With the widespread recognition of the need to shift towards a more preventative-based approach to improving health and wellbeing, this briefing explores how well this rhetoric is matched by spending commitments. It considers the data on expenditure across the UK for activities designed to reduce the instances of illnesses in a population (see note on terminology and limitations of the data analysis on page 3), and discusses the implications for the future.

What is the current level of funding and how has it changed?

– In England, public health expenditure accounts for approximately 5% of total health spending, mainly provided through the ring-fenced public health grant. Following an increase between 2013/14 and 2015/16 (reflecting the phased transition of responsibilities to local authorities), the grant has been substantially reduced (with an in-year cut of 6.2% (£200 million) in 2015/16, and real-terms cuts averaging 3.9% a year until 2020/21). This is equivalent to a real-terms reduction (in 2015/16 prices) from £3.47 billion in 2015/16 to £3.07 billion in 2020/21. This has led to significantly reduced local authority spending on the majority of public health functions between 2015/16 and 2016/17. This is compounded by a reduction in Public Health England's net operating budget between 2015/16 (£315 million) and 2016/17 (£302 million), equivalent to a 5% real-terms decrease (at 2015/16 prices).
– Although there is relatively limited information on funding in Northern Ireland, available data show an overall decrease in planned expenditure on health promotion. This declined from £110 million in 2012/13 to £103 million in 2015/16 (in cash terms); with a further decline to £93 million in 2016/17, partly because of reclassification of funding streams. Expenditure on health promotion accounts for between 2-3% of total expenditure on health and social care in Northern Ireland. A more detailed breakdown is not available. The budget for the Public Health Agency has increased over the last few years; for example from £100.5 million in 2014/15 to £105.4 million in 2015/16 (equivalent to a 5% real-terms increase at 2015/16 prices).
– In Scotland, there was an overall increase in planned expenditure (in cash terms) on improving health and better public health between 2013/14 (£231 million) and 2015/16 (£313 million); with the latter representing 2.6% of total spend on health and wellbeing. With funding for most areas – including tobacco control, alcohol misuse, and health inequality/improvement programmes – remaining broadly stable over this period, the overall increase was mainly due to additional funding (£73.5 million) for integrating health and social care services. A change to methodology in 2016/17 prevents full comparison with previous years, but between 2015/16 and 2016/17, direct Scottish Government funding for Alcohol and Drug Partnerships fell by 22% (£15.4 million) in cash terms. In 2017/18, this funding moved into territorial NHS Board baselines. Data on the money spent at a local level are not routinely collected. Funding for NHS Health Scotland stayed broadly similar between 2013/14 and 2017/18.
– In Wales, planned overall expenditure on public health and prevention remained broadly similar between 2013/14 (£158 million) and 2017/18 (£160 million) in cash terms, accounting for approximately 2.5% of total planned spend on health, wellbeing and sport. Of this overall funding, NHS expenditure (by Local Health Board and Public Health Wales) data show that £112.3 million was spent on prevention programmes in 2015/16 (1.8% of expenditure on all programmes). This is a significant decrease (in cash terms) on the £146.6 million spent on these programmes in 2011/12. Funding for this programme has also decreased as a proportion of total expenditure on all programmes (in cash terms) over the period between 2011/12 and 2015/16. A more detailed breakdown of this spending is not available.
– Data from the ONS (Office for National Statistics) – which includes a wider range of expenditure sources than the individual country data analysed in this briefing – show that overall preventative healthcare expenditure in the UK increased from £9.1 billion in 2014 to £9.6 billion in 2015 (a real-terms increase of 5.6%). The latter equated to

5.2% of total current healthcare expenditure in the UK in 2015. Nearly half (46.5%) of this preventive expenditure was on healthy condition monitoring programmes, followed by information, education and counselling programmes (32.6%), immunisation programmes (8.2%), early disease detection programmes (6.9%), and epidemiological surveillance and risk and disease control programmes (5.8%).

Discussion

The data analysed in this briefing show that the potential contribution of public health is being limited by underinvestment in prevention activities, and in some areas, funding cuts.

Rhetoric versus reality: the cost of preventing ill health

– Across the UK, commitments to prioritise ill-health prevention and public health are not matched by funding commitments. While this is demonstrated by a decline in spending on various public health activities at a national level in Northern Ireland and Wales (with relatively stable but low levels of funding in Scotland), it is most apparent with the cuts to local authority public health funding in England. The BMA believes these cuts will have a devastating effect on the health of the public, and on primary care workload and sustainability. They have been described as short-sighted, counter-productive and a false economy, resulting in disinvestment in vital public health services (such as the substantial cuts to smoking/tobacco control, public health advice to NHS commissioners, and adult obesity services in 2016/17). Beyond undermining a prevention-based approach, these cuts are likely to result in greater costs in the long term, with ill-health prevention typically more cost-effective than down-stream treatment. More immediately, the cuts are impacting on patient care, such as a poorer access to smoking cessation and GUM (genito-urinary medicine) services in some local areas. They also act as a disincentive to integration. With public health advice to NHS commissioners being one of the functions most affected by the cuts, this is likely to discourage strong working relationships between local authorities and clinical commissioning groups. It also has the potential to reduce the public health advice being used to support the development of Sustainability and Transformation Plans.

A disproportionate focus on treatment over prevention

– The proportion of health funding spent on prevention in the UK is significantly lower than that spent on treatment services. For example, in England in 2013/14, the average NHS spend per head was £1,742, compared to £49 per head for average public health spending. To reduce the demand for services, and the associated pressures on NHS resources and staff, this disparity needs to be addressed. This will support a shift towards a more preventative-based approach, away from the prioritisation of the episodic treatment of ill-health. It is also vital that action is taken to prevent the counter-intuitive use of public health funding to support greater investment in acute services, or re-balance financial deficits. In the short term, a more integrated, system approach is needed for funding decisions that reflects the interdependence between prevention activities and demand for treatment services.

A long-term aspiration for funding prevention and public health activities

– There is a need to consider future public health funding levels, moving away from short-term or annual budgets that are ill-suited for prevention activities and sustained action on reducing health inequalities. While this briefing does not attempt to set out what future funding levels should be – as this needs to be agreed and developed with input from a wide range of stakeholders – there are various key considerations. There needs to be a clearer understanding of prevention spending (taking account of activities that are not part of defined public health programmes, such as in the transport and education sector); agreement on what proportion of total spending should be allocated to support a care model of ill-health prevention and action to reduce health inequalities (and addresses the disproportionately low spending on prevention compared to treatment services); and how funding is divided between primary prevention and secondary prevention. The implications of the UK's decision to leave the EU (European Union) on access to public health funding and research funding, as well as involvement in cross-national public health initiatives, will be an increasingly important factor.

Introduction

Much has been made about the need to shift towards a more preventative-based approach to improving health and wellbeing. Yet, the way health services are organised and delivered in the UK continues to prioritise episodic treatment of individuals when they become acutely or chronically ill, over activities that prevent illness occurring in the first instance. This is reflected in the way funding is allocated between treatment services and prevention activities.

The aim of this briefing is to consider the extent to which ill-health prevention is resourced in the UK, and to consider the implications of this in relation to the current and future demand for health services.

Terminology and limitations

There are a number of terms – including health promotion, health protection, public health, ill-health prevention and health improvement – that are sometimes overlapping in their meaning but often imprecisely defined. The UK Faculty of Public Health identifies three key domains of public health practice: health improvement, improving services and health protection.[1] An alternative approach is the Tannahill model of health promotion which has three overlapping spheres of activity: health education, prevention and health protection.[2]

This briefing uses the term ill-health prevention and public health to broadly mean those activities designed to reduce the instances of an illness in a population by minimising health risk factors, providing protection against health threats, and promoting healthy behaviour.

The absence of a common definition means there are some limitations in analysing and comparing funding levels, in terms of the specific activities that are funded and how these correspond to each other. This briefing considers available data on expenditure in the UK nations, and where possible, defines the nature of the activities that are funded.

Data analysis is further complicated by the varied funding approaches in the UK. While each country funds national-level public health programmes, there are significant differences at a local level. In England, expenditure is focused on a number of discrete prescribed and non-prescribed public health functions conferred on local authorities through the public health grant, and each authority is required to demonstrate how the grant has been spent across each function. In Northern Ireland, Scotland and Wales, funding of public health activities is typically at the discretion of the local authority or NHS organisation, with an overarching requirement to support improvements in the health of the local population. There is therefore a more comprehensive picture of public health funding in England compared to other parts of the UK.

It is also worth noting that these data do not account for those activities that are not part of defined public health programmes, but that do contribute to improved health or reduced levels of health inequality. This can include health advice provided during routine clinical consultations, to action outside of the health sector (such as in the transport, education, and housing sectors).

While data are collected – by the Organisation for Economic Co-operation and Development – providing international comparisons on spend on preventive care, these are not included in this briefing due to the variation in data sources used compared to this analysis.

What is the current level of funding and how has it changed?

England

In England, funding arrangements for public health changed substantially with the introduction of the Health and Social Care Act 2012. This transferred statutory responsibility for health improvement from the NHS to local authorities, supported by a ring-fenced grant allocated by Public Health England (operating as an executive agency of the Department of Health). NHS England also commissions some public health services at a national level (such as some immunisation, screening and health visiting services).

Overall, expenditure on public health in England accounts for approximately 5% of total health spending. Figure 1 provides a breakdown of this expenditure in cash terms between 2013/14 and 2015/16, based on expenditure by local authorities on public health services (including the in-year cuts detailed below), by Public Health England on operational activities/programmes, and by NHS England on its public health functions.

Over this period, there was an increase in the ring-fenced public health grant, reflecting the phased transition of responsibilities to local authorities; and a slight increase in expenditure on those functions carried out by Public Health England and NHS England. The data for the amount spent on public health as a share of total health spending are slightly higher than other estimates – such as the estimate of 4.1% by the House of Commons Health Committee[3] – because they take account of a wider range of expenditure (eg Public Health England spend on operational activities/programmes). It is also worth noting that these data do not capture expenditure on public health functions by organisations such as Health Education England, NHS Digital (formerly the Health & Social Care Information Centre), and the National Institute for Health and Care Excellence.

Figure 1 – Expenditure on public health (£ billion, cash terms) in England, 2013/14 to 2015/16

	2013/14	2014/15	2015/16
Local authority net expenditure on public health services (public health grant expenditure)	2.508	2.737	3.152[α]
Public Health England net operating cost[π] (excluding public health grant)	0.835	0.828	0.903
NHS England net expenditure on public health functions (ring-fenced[Ω])	1.841	1.998	1.804[μ]
Total public health expenditure	5.184	5.563	5.859
Total health expenditure[β]	109.775	113.345	117.229
Total public health expenditure as a share of total health spending	4.7%	4.9%	5.0%

Source: Local authority revenue, expenditure and financing data for 2013/14, 2014/15 and 2015/16, Department for Communities and Local Government; Public Health England annual report and accounts 2013/14, 2014/15 and 2015/16; NHS England annual accountability statements for NHS public health functions (S7A) agreement 2013/14 and 2014/15; and Public expenditure – statistical analyses 2016, HM Treasury.

[α] This was the first year local authorities had additional responsibility for children aged 0-5, starting in October 2015.

[π] Expenditure primarily and substantially related to Public Health England's remit for the improvement of public health, including the oversight of expenditure on vaccines and emergency countermeasures and operational activities.

[Ω] Under the S7A public health functions agreement, NHS England is only obliged to report against the ring-fenced sum, so this figure does not include any non-ring fenced expenditure. For example, in 2014/15, £1,929 million was ring-fenced for these activities, while an additional £394 million was non-ring fenced.

[μ] This figure is based on the NHS public health functions agreement for 2015/16 as the NHS England annual accountability statements for NHS public health functions (S7A) agreement for 2015/16 had not been published at the time of writing.

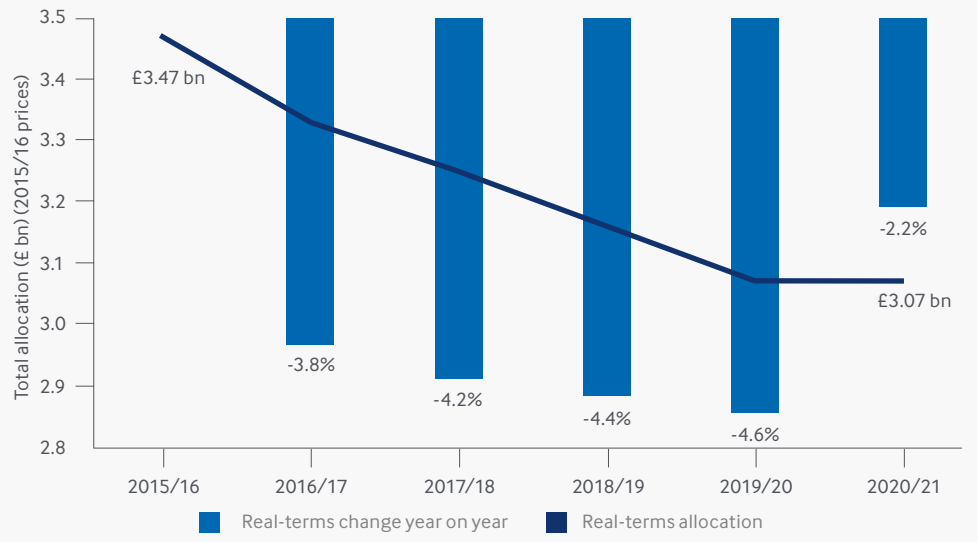
[β] Measured as a total departmental expenditure limit, excluding depreciation.

The initial increase in the public health grant since 2013/14 has been followed by some significant cuts; first, with an in-year cut of 6.2% (£200 million) to the grant for 2015/16, and then with real-terms cuts averaging 3.9% a year until 2020/21 (equating to a 9.6% reduction in cash terms over the same period).

As the Health Committee[3] and Health Foundation[4] have previously highlighted, these cuts are likely to be significantly front-loaded. This is confirmed by details of the ring-fenced grant for 2017/18 that show a real-terms reduction in the first four years from 2015/16 (-3.8%, -4.2%, -4.4%, -4.6%) offset by a lower reduction in the last year of -2.2%.[5] This is equivalent to a real-terms reduction (at 2015/16 prices) from £3.47 billion in 2015/16 to £3.07 billion (£3.13 billion in cash terms) in 2020/21 (see Figure 2).

It is likely that this funding will continue to decline in the coming years, particularly in the absence of a commitment to retain the ring-fence for the public health grant beyond 2018/19, and the plans to replace central government grants to local authorities with funding through retained business rates[a]. This will be further compounded by reduced investment elsewhere – for example, Public Health England's net operating budget has reduced from £315.2 million in 2015/16 to £302.3 million in 2016/17,[6,7] which is equivalent to a 5% real-terms decrease (at 2015/16 prices).

Figure 2 – Real-terms change in public health grant settlement for 2016/17 to 2020/21, England



	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Spending Review Settlement (£ billion)	3.46	3.38	3.30	3.22	3.13	3.13
Total allocation (£ billion)[b]	3.47	3.39	3.30	3.22	3.13	3.13
Cash growth	-	-2.2%	-2.5%	-2.6%	-2.6%	0.0%
Real-terms change (2015/16 prices)	-	-3.8%	-4.2%	-4.4%	-4.6%	-2.2%
Real-terms allocation (£ billion) (2015/16 prices)	3.47	3.33	3.25	3.16	3.07	3.07

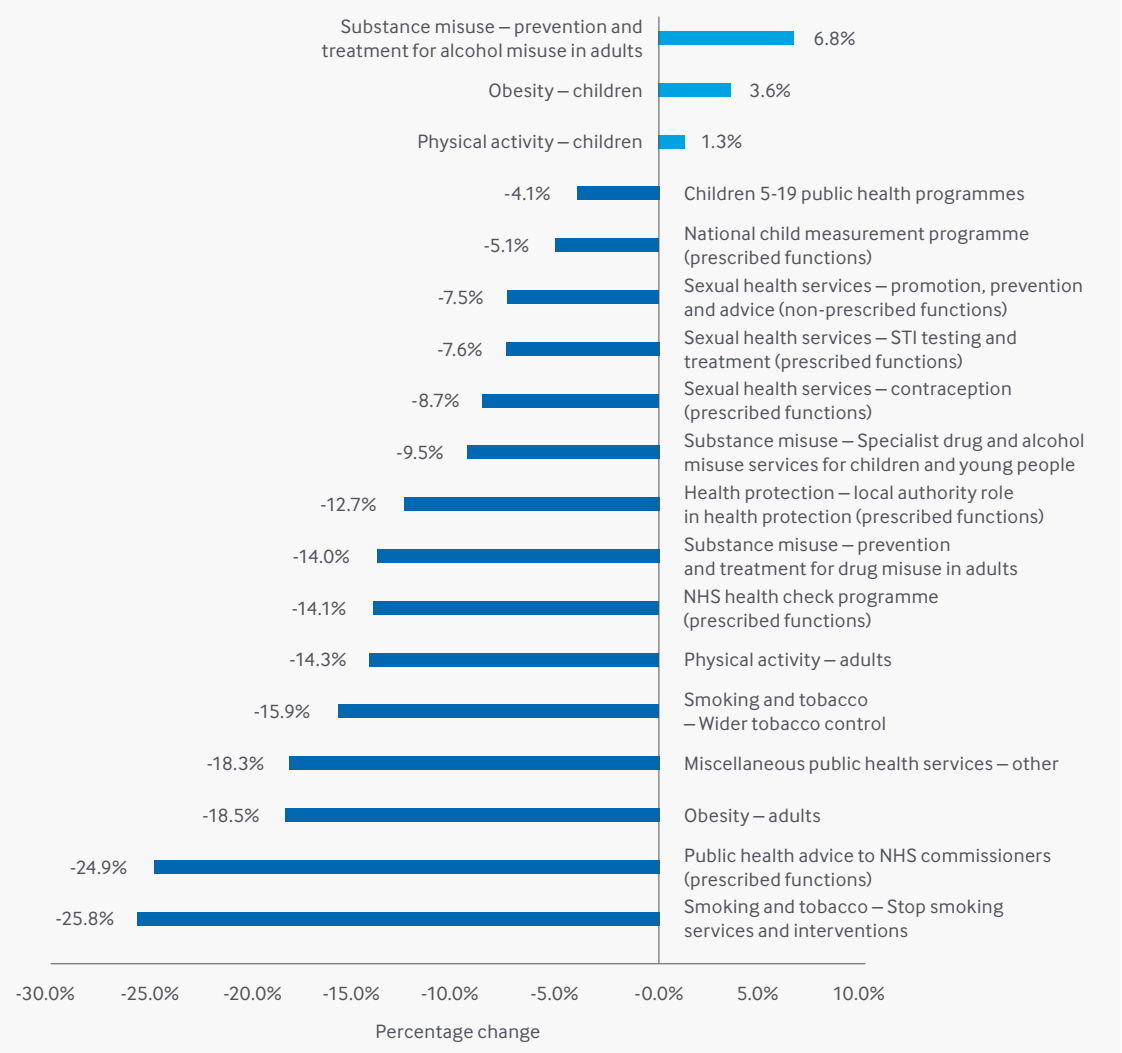
Source: Supplementary written evidence submitted by The Health Foundation (CSR0097) to the House of Commons Health Committee inquiry into impact of the Health and Social Care Act reforms; and Local authority circular. Public health ring-fenced grant 2017/18, Department of Health.

a As a part of plans to reform financing of local government, several local authorities in England are piloting 100% business rate retention and will not receive their share of the 2017/18 public health grant, and will be excluded from the grant conditions. It is anticipated that this will be rolled out across all local authorities in England from April 2019.

b The difference between the total allocation and Spending Review Settlement is due adjustments on baseline errors agreed locally.

As the King's Fund[8] have previously highlighted, analysis of data from the Department for Communities and Local Government provides an indication of the impact these cuts are having at a local level. Figure 3 shows reductions in planned spending (in cash terms) for the majority of public health functions[c] between 2015/16 and 2016/17, with the largest percentage changes for smoking and tobacco control, public health advice to NHS commissioners, and adult obesity.

Figure 3 – Percentage change in planned revenue spend (in cash terms) by local authorities in England on prescribed and non-prescribed public health functions[a] between 2015/16 and 2016/17



Source: Local authority revenue expenditure and financing England: individual local authority data for 2015/16 and 2016/17, Department for Communities and Local Government.

[a] To allow comparison on a like-for-like basis, the following public health functions are not included in this analysis: services for children aged 0-5, public mental health and health at work. Responsibility for the former was transferred from the NHS to local authorities in October 2015, and as such, there is higher funding because of this transfer, rather than a growth in funding. The latter two services are new functions for 2016/17. For 2016/17, in addition to categories of 'Substance misuse – Treatment for alcohol misuse in adults' and 'Substance misuse – Treatment for drug misuse in adults', there are two further categories for 'Substance misuse – Preventing and reducing harm from drug misuse in adults' and 'Substance misuse – Preventing and reducing harm from alcohol misuse in adults'. As these latter categories were not used in 2015/16, this analysis combines the categories for 2016/17.

c Details of what is required as a part of these public health functions is provided in 'Guidance on the ring fenced public health grant conditions and mandated functions in England' published jointly by Public Health England and the Association of Directors of Public Health.

Northern Ireland

In Northern Ireland, overall funding for health and social care is agreed by the Executive and Department of Health (formerly the Department of Health, Social Services and Public Safety), and provided jointly through the Health and Social Care Board and Public Health Agency.

Data on funding for public health activities in Northern Ireland are relatively limited. The commissioning plans developed by the Health and Social Care Board and Public Health Agency provide details of planned expenditure across various programmes of care, including on 'Health Promotion'[d]. Figure 4 provides details of the planned investment on 'Health Promotion' between 2012/13 and 2016/17. This shows an overall planned decrease (in cash terms) from £110 million in 2012/13 to £103 million in 2015/16; with a further decline to £93 million in 2016/17 (partly because of reclassification of funding for research and development activities). This expenditure accounts for approximately 2-3% of total expenditure on health and social care in Northern Ireland. A more detailed breakdown of this spending is not available.

In recent years, the overall budget for the Public Health Agency has increased – with a budget of £83.3 million in 2012/13, £94.3 million in 2013/14, £100.5 million in 2014/15, and £105.4 million in 2015/16.[9] This corresponds to real terms increases year on year of 11%, 5% and 5% respectively (at 2015/16 prices).

Figure 4 – Planned expenditure on 'Health Promotion' (£ million, cash terms) in Northern Ireland, 2012/13 to 2016/17

	2012/13	2013/14	2014/15	2015/16	2016/17
Planned expenditure on 'Health Promotion'[α]	110	114	101	103	93[π]
Total planned expenditure on 'Health and Social Care'	3,994	4,150	4,284	4,351	4,582
Proportion of total planned expenditure on 'Health and Social Care' spent on 'Health Promotion'	2.8%	2.8%	2.4%	2.4%	2.0%

Source: Commissioning plan 2012/13, 2013/14, 2014/15 and 2015/16, Health and Social Care Board & Public Health Agency. Data for 2016/17 supplied by the Public Health Agency on 7 March 2016.
α The planned figures exclude additional in-year funding allocated by the Department of Health.
π This figure is lower than in previous years as the budget for research and development (circa £10.6 million), included in the figures for 2012/13-2015/16, has been reclassified as capital in 2016/17.

d This programme of care covers all hospital, community and GP based activity relating to health promotion and disease prevention. This includes all screening services, well women/men clinics, child health surveillance, school health clinics, family planning clinics, health education and promotion clinics, vaccination and immunisation and community dental screening and prevention work.

Scotland

In Scotland, delivery of public health programmes and activities is a shared responsibility of the Scottish Government, local authorities and the NHS (including 14 territorial NHS Boards), with NHS Health Scotland as the leadership organisation.

Spending is provided through three main budgets: funding directly from the Scottish Government for public health programmes and NHS Health Scotland; direct support of the public health function and public health-related initiatives by the 14 territorial NHS Boards; and direct and indirect expenditure by local authorities (and through Integrated Joint Boards) on functions and activities which contribute to improving health and reducing inequalities. This spread of funding over different budgets makes it difficult to estimate total expenditure, in particular with local level spending hard to assess.

Analysis of funding from the Scottish Government shows an overall increase in spending (in cash terms) on 'Improving Health and Better Public Health' between 2013/14 and 2015/16, in overall amount and as a proportion of total spend on 'Health and Wellbeing' (see Figure 5).

Figure 5 – Planned expenditure (£ million, cash terms) on 'Improving Health and Better Public Health' by the Scottish Government, 2013/14 to 2015/16

Planned expenditure on 'Improving Health and Better Public Health'	2013/14	2014/15	2015/16
Health improvement and health inequalities	59.3	54.9	55.6
Immunisations	-	16.3	20.9
Pandemic flu	10.0	16.1	8.1
Health screening	3.0	2.6	2.6
Tobacco control	12.3	12.2	12.2
Alcohol misuse	42.3	41.1	40.9
Health protection	40.0	31.7	31.7
Healthy start	12.6	13.9	13.9
Mental health improvement and service delivery	22.8	22.3	23.7
Specialist children's services	21.4	21.2	21.2
Early detection of Cancer	7.7	8.5	9.3
Integration Fund	-	-	73.5
Total spend on 'Improving Health and Better Public Health'	231.4	240.8	313.6
Total spend on 'Health and Wellbeing'	11,977.8	12,199.3	12,176.8
Proportion of total spend on 'Health and Wellbeing' spent on 'Improving Health and Better Public Health'	1.9%	2.0%	2.6%

Source: Scottish draft budget 2013/14, 2014/15 and 2015/16, The Scottish Government.

Looking at some of these areas in more detail, there is relatively little change on funding for tobacco control, and a slight decrease for alcohol misuse (due to changing departmental responsibilities for these services).[10,11] Funding for programmes aimed at tackling health inequalities and promoting healthy lifestyles ('Health Improvement and Health Inequalities') decreased between 2013/14 and 2014/15 due to the transfer of some workplace health activities and programme efficiency savings; and increased again slightly in 2015/16. There was also a slight increase in funding for the benefit-based 'Healthy Start' programme (which provides qualifying women and children with support towards the cost of a balanced and nutritious diet). The main reason for the overall increase in spending on 'Improving Health and Better Public Health' during this period was the introduction of an 'Integration Fund' in 2015/16. This included £73.5 million for national initiatives to support the move in Scotland towards integrated health and social care services, designed to help drive a shift towards prevention. There is, however, a lack of clarity on how this funding specifically supports the shift towards prevention. It is also not clear why funding for this initiative is considered as investment in improving health and better public health.

In addition to the spending on alcohol misuse detailed above, further direct Scottish Government funding for Alcohol and Drug Partnerships was allocated in the community safety budget, worth £30.4 million in 2015/16.[12] In 2016/17, all Scottish Government spending on Alcohol and Drug Partnerships was brought under the health and wellbeing budget, but in the process was reduced by 22%, from £69.2 million to £53.8 million (cash terms). Territorial NHS Boards were instructed to make up this funding shortfall,[13] but there is evidence that a number of Partnerships have had their budgets cut.[14] In 2017/18, the budget for this was moved into the NHS Board baseline making tracking future spend in this area more difficult.

A change in funding allocations for 2016/17[15] and 2017/18[16] means there are no directly comparable data for spend against previous years. Figure 6 does, however, provide a detailed breakdown of planned spending on 'Health Improvement and Protection' for these years. Planned spending across the majority of activities has stayed broadly the same, with the exception of alcohol policy which has largely transferred into NHS Board baseline funds. Funding for the 'Keep Well' programme was withdrawn as this programme ended in 2016/17, although NHS Boards will continue to provide relevant services as a part of their baseline budget.

Figure 6 – Planned expenditure (£ million, cash terms) on 'Health improvement and Protection' by the Scottish Government, 2016/17 and 2017/18

Health improvement	2016/17	2017/18
Alcohol policy	55.3	1.5
Food and Health	0.7	0.7
Social Marketing for HI (Health Improvement)	0.5	0.5
Tobacco Control (Smoking)	1.3	1.3
Glasgow Centre for Population Health	0.0	1.1
Good Places, Better Health	0.1	0.1
Health Improvement General	0.6	0.6
Healthy Working Lives	0.2	0.2
Keep Well	2.0	0.0
National Demonstration Projects & Learning Networks	0.2	0.2
Obesity	0.2	0.2
Universal Health Checks	0.7	0.7

Health Protection	2016/17	2017/18
CJD (Creutzfeldt-Jakob Disease) Surveillance Unit	0.2	0.2
Contaminated Blood Programme	10.2	10.2
HPA (Health Protection Agency) radiation protection	0.3	0.3
Human Papillomavirus Vaccine	1.2	1.2
Immunisations	20.5	19.2
National Screening Programme	0.6	0.6
Death Certification	1.5	0.1
Organ Donation Taskforce	5.7	5.7
Public Health Fund	0.7	0.6
ROSPA (The Royal Society for the Prevention of Accidents)	0.1	0.1
Sexual Health and BBV (blood-borne virus) Framework	0.7	0.7
SNBTA (Scottish National Blood Transfusion Service)	0.01	0.0
Total	**103.4**	**46.1**

Source: Scottish draft budget 2017/18, The Scottish Government.

Funding for NHS Health Scotland has fluctuated over recent years, but stayed at broadly the same level (in cash terms) – with a draft budget of £18.4 million in 2017/18, compared to a budget of £18.2 million in 2016/17, £18.0 million in 2015/16, £17.7 million in 2014/15, and £18.5 million in 2013/14.[12,15,16,17,18]

While a proportion of the funding provided to territorial NHS Boards and local councils is spent on public health activities, data on the specific programmes and activities are not routinely collected. With the move towards health and social care integration, this funding is now managed by local integrated partnerships, who have been allocated an additional £300 million by the Scottish Government over 2015/16 to 2017/18, to help achieve national health and wellbeing outcomes and a move towards preventative services. As with the funding for national initiatives to promote integrated care, it is unclear how this additional funding for local partnerships specifically supports the shift towards prevention.

Wales

In Wales, the public health system is delivered through seven NHS Local Health Boards, with Public Health Wales providing each board and its Director of Public Health with specialist public health support. Public Health Wales also provides support to the 22 local authorities in Wales. Funding for public health services is allocated by the Welsh Government as part of the budget for health and social care services.

Analysis of *Welsh Government budget data* show that funding allocated to 'Public Health & Prevention'[e] has remained broadly stable (in cash terms) over the period between 2013/14 and 2017/18 (see Figure 7).

Figure 7 – Planned expenditure (£ 000s, cash terms) on public health by the Welsh Government, 2013/14 to 2017/18

	2013/14	2014/15	2015/16	2016/17	2017/18
Total spend on 'Public Health & Prevention'	158,001	158,643	160,628	158,910	162,304
Total spend on 'Health and Social Services'[a]	6,335,296	6,096,580	6,622,334	6,731,238	7,410,296
Proportion of total spend on 'Health and Social Services' spent on 'Public Health & Prevention'	2.5%	2.6%	2.4%	2.4%	2.2%

Source: Final budget 2013/14, 2014/15, 2015/16, 2016/17 and 2017/18, Welsh Government.
[a] For 2013/14, this main expenditure group was 'Health, Social Services & Children', and in 2017/18 it was 'Health, Wellbeing and Sport'.

Data on *NHS expenditure (by Local Health Board and Public Health Wales)* provides an insight of how public health funding is spent by the NHS. This includes spending on clinical programmes as well as public health activities. In 2015/16, total expenditure for all programme budget categories was £6,117.7 million (£1,974.03 per head of the population). Of this, £112.3 million was spent on the 'Healthy individuals' programme,[f] which corresponds to 1.8% of total expenditure. This is a significant decrease (in cash terms) on the £146.6 million spent on this programme in 2011/12. Figure 8 shows that funding for this programme has decreased as a proportion of total expenditure on all programmes (in cash terms) over the period between 2011/12 and 2015/16. Appendix 1 provides a breakdown of these data by Local Health Board.

Figure 8 – NHS Wales expenditure (£ million, cash terms) by selected programme budget category, 2011/12 to 2015/16

	2011/12	2012/13	2013/14	2014/15	2015/16
'Healthy individuals' programme	146.6	121.1	114.6	109.2	112.3
Total expenditure on all programme budgets (including 'Healthy individuals' programme)	5,389.5	5,427.5	5,560.1	5,802.1	6,117.7
Proportion of total expenditure on all programme budgets spent on 'Healthy individuals' programme	2.7%	2.2%	2.1%	1.9%	1.8%

Source: NHS expenditure programme budgets: 2015/16, Welsh Government. Available at: http://gov.wales/statistics-and-research/nhs-expenditure-programme-budgets/?lang=en (last accessed, 26 April 2017).

e This includes budget allocations for various areas including: sponsorship of public health bodies; Food Standards Agency; public health programmes; effective health emergency preparedness arrangements; and the development and implementation of research and development for patient and public benefit.
f The programme budget 'Healthy Individuals' captures the costs of prevention programmes.

UK preventive healthcare expenditure

Data collected by the ONS provide a broad analysis of healthcare expenditure for the UK (published for the first time in 2016), including data on preventive healthcare.[19] While the data in this briefing for the individual countries in the UK focuses mainly on government spending (by the NHS, local authorities and other government bodies involved in the provision of healthcare), the ONS analysis considers a wider range expenditure sources[g]. A breakdown of these is provided in Figure 9.

These data show that overall preventative healthcare expenditure in the UK increased from £9.1 billion in 2014 to £9.6 billion in 2015. This corresponds to a real-terms increase of 5.6%. The majority of this expenditure is government spending, which saw a real-terms increase of 3.2% over the same period. For 2015, the overall spend on preventative healthcare (£9.6 billion) equated to 5.2% of the total current healthcare expenditure in the UK (£185 billion).[19]

Figure 9 – Preventive healthcare expenditure in the UK by source of funding, 2014 and 2015

Source of healthcare funding	2014 (£ million)	2015 (£ million)	% change, current prices	2014 (£ million 2015 terms)	%, real prices (2015/16)
Government schemes (ie spending by the NHS, local authorities and other government bodies involved in the provision of healthcare)	7,196	7,428	3.2%	7,203	3.2%
Voluntary health insurance schemes (ie private medical and dental insurance, employer self-insurance schemes etc.)	201	218	8.5%	201	8.5%
Non-profit institutions serving households financing schemes (ie charity expenditure funded through voluntary donations, grants and investment income)	105	112	6.7%	105	6.7%
Enterprise financing schemes (ie healthcare activity funded by organisations outside of an insurance scheme, such as occupational healthcare)	725	756	4.3%	726	4.3%
Out-of-pocket payments (ie consumer expenditure on healthcare goods and services, outside of health insurance schemes, including client contributions for local authority and NHS provided services and prescription charges)	860	1,085	26.2%	861	26.2%
Total	9,087	9,599	5.6%	9,096	5.6%

Source: *UK health accounts: 2015* and *UK health accounts: 2014*, Office for National Statistics.

In 2015, the largest preventive care subcategory in the UK was 'healthy condition monitoring' programmes (46.5% of spending on preventive care), such as health check-ups.[19] 'Information, education and counselling' programmes accounted for 32.6% of spending, and includes advice around alcohol and substance misuse, smoking cessation, sexual health, obesity and other health promotion services. The remaining programmes were: 'immunisation programmes' (8.2%), 'early disease detection' (6.9%) such as screening services, and 'epidemiological surveillance and risk and disease control' programmes (5.8%) such as public health monitoring.

g Further details on methodology for this ONS analysis can be found at: www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/methodologies/introductiontohealthaccounts

Discussion

Providing services to prevent ill health, as well as ensuring fair and sustainable use of finite resources, are core guiding principles for a comprehensive NHS. These principles sit squarely with those of public health, in terms of its focus on improving and protecting people's health, and in light of the cost effectiveness of prevention and early intervention approaches (see complementary briefing 'Exploring the cost effectiveness of early intervention and prevention'). Yet the data analysed in this briefing show that the potential contribution of public health is being limited by underinvestment in prevention activities, and in some areas, funding cuts.

Rhetoric versus reality: the cost of preventing ill health

Despite the clear acknowledgement across the UK of the need to prioritise ill-health prevention and public health activities (see Figure 11), the data analysed in this briefing show this is not matched by funding commitments. There have been recent declines in planned expenditure on various public health activities at a national level in Northern Ireland, and at a national and local level in Wales. In Scotland, national funding commitments have remained broadly similar (when spending on transformation towards integrated health and social care services, as well as changes to funding allocations, are taken into account), but remain low. The absence of detailed data on spending at a local level in Northern Ireland, Scotland and Wales makes it difficult to provide a more comprehensive picture in these countries.

Figure 11 – Political commitment to prioritising public health

NHS England's *Five Year Forward View*

'...the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health.'

Department of Health, Social Services and Public Safety strategic framework for public health, 2013-2023, *Making life better*

'...[a commitment] to improve and protect health and wellbeing and reduce inequalities, through a focus on prevention, health promotion and earlier intervention...'

NHS Scotland's *A fairer, healthier Scotland. Our strategy, 2012-2017*

'We need to make sure that longer life means longer, healthy life – adding quality of life to years as well as years to life. We need to make sure that the benefits of investing in prevention and early intervention are understood and acted upon.'

Public Health Wales strategic plan 2015-2018, *A healthier, happier and fairer Wales*

'...the way our health system is currently designed simply cannot meet increasing demands...Helping people to prevent their ill health in the first place and then preventing their exacerbations of ill health must be thoroughly addressed...'

The cuts to local authority public health funding in England provide the clearest example of how the shift towards a more prevention-based approach is not being achieved. The BMA believes these will have a devastating effect on the health of the public, and on primary care workload and sustainability. They have been described as short-sighted, counter-productive and a false economy – by the King's Fund,[20] House of Commons Health Committee[3] and House of Lords Select Committee on the Long-term Sustainability of the NHS[21] – and have inevitably led to reduced service provision. Analysis by The BMJ found that many councils in England disinvested in areas such as prevention, addiction services, sexual health, and weight management during 2015/16.[22] Similar findings were reported in a survey of Directors of Public Health in England, with a large majority stating that there will be a detrimental impact on health (78%) and health inequalities (75%) as a result of funding restrictions.[23] Of further concern is the analysis in this briefing of local authority planned expenditure for 2016/17 showing how cuts will continue to hit vital services, most notably for smoking and tobacco control, public health advice to NHS commissioners, and adult obesity (Figure 3).

Not only does a reduction in public health funding undermine a prevention-based approach, it is likely to result in greater costs in the long term.[24] As highlighted in the BMA briefing, 'Exploring the cost effectiveness of early intervention and prevention', this reflects how prevention and proactive management of many long-term conditions is more cost effective than down-stream treatment.

These benefits from prevention will not be realised if public health budgets continue to be cut. Doing so will increase pressures on other parts of the NHS and on social care services, with demand on these services already rising in line with the increasing prevalence of long-term conditions. For example, many cases of type 2 diabetes are entirely preventable through public health approaches; yet, its prevalence is increasing year on year in the UK. In 2010/11, the direct cost to the NHS in the UK of type 2 diabetes (including treatment/intervention and complications or adverse events) was estimated at £8.8 billion, and predicted to rise to £15.1 billion by 2035/2036 on current projections.[25] Across England, the cost of caring for people with diabetes in social care settings has been estimated at £1.4 billion per year.[26]

There is also a more immediate concern, that cuts to services funded by local authority public health budgets (such as sexual health, smoking cessation, and drug and alcohol services) will adversely impact on patient care. For example, a 2017 King's Fund report found clear evidence that access to GUM services, and quality of patient care, had suffered in some parts of the country, at a time of rising demand.[27] The report noted that around one in four local authorities have reduced GUM spending by more than 20% between 2013/14 and 2015/16; and that in some areas, services were being tendered with significantly lower budgets, resulting in clinics being closed, moved to less convenient locations, or operating with reduced opening hours.

Stubbing out smoking cessation services in England?

While action to reduce smoking rates is known to be one of the most cost effective of all preventive strategies,[28] a 2016 report – by Cancer Research UK and Action on Smoking and Health – found that 59% of local authorities in England cut smoking cessation budgets last year.[29] This is despite smoking being the biggest cause of preventable death in every part of England. The report also found that specialist smoking cessation services are no longer universally available to smokers in England. Although these services are being sustained and developed in many areas, contraction is common in those local authorities where the smoking cessation budget has been cut. One in five local authorities (20%) have replaced their specialist service with an integrated 'lifestyle' service of some kind, and 5% no longer provide a substantive smoking cessation service beyond that offered by GPs and pharmacists.

A further concern is how the cuts act as a disincentive for integration and partnership working. As noted in Figure 3 (page 6), one of the local authority functions most affected by the cuts is that of public health advice to NHS commissioners. This function requires local authorities to provide clinical commissioning groups with support in protecting and improving the health of their local population. In practice, it involves the development of collaborative relationships (led by the director of public health), input from registered specialists in public health, and an agreed specialist capacity devoted to the service.[30] A reduction in funding for this function is therefore likely to discourage strong working relationships between local authorities and clinical commissioning groups.

It also has the potential to adversely impact the move towards Sustainability and Transformation Plans, which are being developed through partnership between local NHS organisations and local councils. Inadequate public health advice in developing these local plans will mean they do not sufficiently recognise the need to take a population approach to improving and protecting health.

A disproportionate focus on treatment over prevention

The proportion of health funding spent on prevention and public health activities in the UK is significantly lower than that spent on treatment services. This is illustrated further by data showing that, in England in 2013/14, the average spend per head on treatment services was £1,742, compared to £49 per head for average public health spending;[24] and that 70% of total expenditure on health and care in England is on managing long-term conditions.[31] This disparity needs to be addressed to support a shift towards a more preventative-based approach and move away from a system that prioritises downstream, episodic treatment of ill-health. This is key to reducing the demand for services, and the associated pressures on NHS resources and staff.

It is also vital that action is taken to prevent the tendency for public health funds to be used for short-term savings to alleviate pressure on treatment services. For example, as the BMA has previously highlighted, a substantial part of the 'additional' funding allocated to the NHS in England as a part of the 2015 Spending Review comes from cuts to 'non-NHS funding', including public health.[32] And this is not a new phenomenon, with public health spending being one of the areas targeted by primary care trusts as a way of tackling their deficits in the mid-2000s.[33]

While it is clear that cuts to funding for treatment services, particularly at time of rising demand, will have immediate adverse impacts, it is counter-intuitive to use public health funding to support greater investment in acute services, or re-balance financial deficits. In the short term, a more integrated, system approach is needed for funding decisions that reflects the interdependence between prevention activities and demand for treatment services.

The need for greater overall investment in health and social care

With the increasing pressures on the NHS throughout the UK, and rising levels of demand for services, there is an urgent need for greater overall investment in health and social care. The BMA has called for UK health spending to be brought in line with the average spent by Europe's 10 leading economies: increasing it from the current level of 9.8% to 10.4% of GDP.[34]

As the Association has noted elsewhere,[35] such investment has an especially high fiscal multiplier (a measure of the effect of government spending on economic growth), and is therefore key at times of austerity. Investment in prevention is cost effective, and can be cost-saving, as highlighted in the BMA briefing 'Exploring the cost effectiveness of early intervention and prevention'. It is vital that this overall increase in funding does not come at the expense of reduced funding for services and other budgets that adversely impact on health and wellbeing (such as education, housing and communities).

A long-term aspiration for funding prevention and public health activities

Beyond establishing a more integrated, system approach to funding decisions in the short term, there is a need to consider future funding levels that prioritise prevention and public health activities, as well as sustained action to reduce health inequalities. As this necessitates a long-term approach, it will require a move away from short-term or annual budgets.

While this briefing does not attempt to set out what future funding levels for prevention and public health should be – as this needs to be agreed and developed with input from a wide range of stakeholders (across government, political parties, and the range of organisations across the health and social care system in the UK) – there are a number of key factors to consider.

Firstly, it will require a clearer understanding of what is spent on prevention. This includes expenditure across the health and social care system, as well as funding for activities not part of defined public health programmes. For example, investment in the transport sector on improved cycling infrastructure will contribute to higher physical activity levels; and, investment focused on improving pupils' education attainment or active labour markets will impact on health inequalities. At a practical level, greater consistency in the way data are collected across the UK on public health expenditure would be beneficial. As the analysis in this briefing has highlighted, this varies significantly between countries, making it difficult to get a clear picture of overall spending or consistently provide detail of specific funding allocations.

Secondly, there will need to be agreement on what proportion of total spending should be allocated to public health funding in order to support a care model of preventing illness and action to reduce health inequalities. As the preceding section notes, this will need to address how current spending on prevention is disproportionately low compared to spend on treatment services. Finally, consideration will be needed as to how this funding is divided between primary prevention and secondary[h] prevention.

Brexit and public health

The decision to leave the EU is likely to have wide-ranging consequences for public health in light of the UK's involvement in European-wide public health initiatives. These include cross-national approaches to addressing the social determinants of health, tobacco and alcohol control, air pollution and climate change, food regulations, chemical hazards, road safety, and emergency preparedness. After formal exit from the Union, it is vital that the UK and EU maintain a high level of cooperation in these areas to ensure all countries continue to be able to effectively address health inequalities, tackle chronic diseases and protect against serious health threats.

Future decisions about public health and prevention will need to recognise that exiting the EU will have financial implications for accessing funding from initiatives such as the EU Health Programme 2014-2020. This programme has a budget of over £350 million, which can be used for activities for promoting good health and disease prevention. The EU is also a major source of research funding for UK health and public health researchers. The need to secure ongoing access to EU research programmes and research funding, that will maintain the UK's world-leading science and research base, will therefore be a vital part of Brexit negotiations.

h Primary prevention activities aim to reduce the incidence of disease and ill-health within a population, either through universal measures that reduce health risks and their causes or by targeting high-risk groups. Secondary prevention is the process of systematically detecting the early stages of disease and intervening before full symptoms develop (eg measures to reduce high blood pressure such as being more physically active and improving dietary patterns).

Appendix 1

Expenditure (£ million, cash terms) by Local Health Boards in Wales by selected programme budget category, 2011/12 to 2015/16

Abertawe Bro Morgannwg University Health Board	2011/12	2012/13	2013/14	2014/15	2015/16
'Healthy individuals' programme	22,162	17,596	15,014	15,126	17,367
Total for all programme budgets (including 'Health individuals' programme)	911,190	917,181	940,765	979,847	1,043,028
Proportion of total expenditure on all programmes spent on the 'Healthy individuals' programme	2.4%	1.9%	1.6%	1.5%	1.7%

Aneurin Bevan Health Board	2011/12	2012/13	2013/14	2014/15	2015/16
'Healthy individuals' programme	27,255	27,015	22,587	22,364	24,340
Total for all programme budgets (including 'Health individuals' programme)	1,000,778	1,008,392	1,031,905	1,068,575	1,126,973
Proportion of total expenditure on all programmes spent on the 'Healthy individuals' programme	2.7%	2.7%	2.2%	2.1%	2.2%

Betsi Cadwaladr University Health Board	2011/12	2012/13	2013/14	2014/15	2015/16
'Healthy individuals' programme	25,069	20,629	22,979	23,741	20,024
Total for all programme budgets (including 'Health individuals' programme)	1,226,968	1,241,266	1,253,524	1,326,421	1,379,256
Proportion of total expenditure on all programmes spent on the 'Healthy individuals' programme	2.0%	1.7%	1.8%	1.8%	1.5%

Cwm Taf Health Board	2011/12	2012/13	2013/14	2014/15	2015/16
'Healthy individuals' programme	23,397	15,339	15,399	10,461	11,028
Total for all programme budgets (including 'Health individuals' programme)	559,923	560,711	575,414	595,555	621,513
Proportion of total expenditure on all programmes spent on the 'Healthy individuals' programme	4.2%	2.7%	2.7%	1.8%	1.8%

Cardiff & Vale University Health Board	2011/12	2012/13	2013/14	2014/15	2015/16
'Healthy individuals' programme	21,105	18,551	18,754	19,703	21,873
Total for all programme budgets (including 'Health individuals' programme)	758,012	764,074	783,662	822,743	891,212
Proportion of total expenditure on all programmes spent on the 'Healthy individuals' programme	2.8%	2.4%	2.4%	2.4%	2.5%

Powys Teaching Health Board	2011/12	2012/13	2013/14	2014/15	2015/16
'Healthy individuals' programme	8,672	6,796	5,173	4,214	4,498
Total for all programme budgets (including 'Health individuals' programme)	243,427	242,344	258,129	268,775	275,705
Proportion of total expenditure on all programmes spent on the 'Healthy individuals' programme	3.6%	2.8%	2.0%	1.6%	1.6%

Source: Data from NHS expenditure programme budgets. Available at: https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Health-Finance/NHS-Programme-Budget (last accessed 26 April 2017).

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