Reflections from UK Public Health Network summit on fiscal and economic planning for investment in public health: 28 September 2018.

The problem

- There is a need to think differently about funding and where different fiscal policies such as tax and price regulation could play a role. For example: half the costs of alcohol to society are currently seen in the criminal justice system.
- There is a bi-directional link between health and the economy; forecasting should try to take account of demand pressures, including looking at disease profiles. However, there is a choice for society on quality/quantity of health it requires.
- Projections forecast increasing demand in health and social care and consequent funding gaps; this sits alongside recent reductions of funding in public health (24% real cut since 2014) and wider decreases in local government funding.
- A forthcoming evidence review (November 2018) from PHE looks at fiscal and pricing policies across nine areas. It shows the strength of the evidence base and where opportunities lie for action.
- The financial imperative is to shift towards prevention but this needs cross-government support. NHS should also be focusing on systematic prevention at scale where the evidence base is strong.
- System issues:
  1) Coherence of messages – public health professionals tend to speak on behalf of their organisation not on behalf of the public health system.
  2) Do we know what works? Or are we not good at mobilising it? Lots of research but there is an implementation gap.
  3) Linear process at moment rather than engaging with stakeholders from outset. Soft drinks industry levy is good example: PHE did science, UKHF did modelling and advocacy.

What is happening around UK?

- Devolved administrations have the power to introduce taxes in any area of devolved responsibility.
- Scotland is piloting a citizens' basic income scheme and has also recently published a rapid evidence review of taxation and pricing strategies on tobacco.
- The Office for Budget Responsibility has some formal interaction with Scottish Fiscal Commission but the degree of alignment varies because each uses different methodology.
- The Office for Budget Responsibility produces more forecasts for Wales as the Assembly is less interested in a separate fiscal commission.
- Wales is reviewing the evidence base.
- PHE is currently developing its non-communicable disease modelling capacity and capability alongside continued outsourcing / partnering work. It is important to

identify key knowledge gaps and which parts of the system are currently active in such modelling (including the forthcoming UK PRP research programmes of work). No one model will provide all the answers.

- There could be much to learn from the devolved administrations.

The requirements

- Do we need someone to look at a theme every year (eg from PHOF) rather than have to address the whole of public health? Such a body could then have a mandate to look at advice / evidence or take a macro view (eg what is causing the life expectancy gaps / state of nation review) like the CMO's report – although it has a challenge function it carries no follow-up or accountability.
- Is this about one annual report to focus action? Or should it be a duty for each government department to focus on health impact? Hard to get cross-department action because of the way secretaries of state operate.
- A trade-off is required between such a body being advisory or providing the evidence base for others to make decisions; the more advisory the role, the more contentious it is likely to be. The choice is likely to be to provide "number-crunching" (though forecasts will be contested) or to create a political body. For comparison see the equivalent body in The Netherlands which has 80 staff, scrutinises all parties' budget proposals and can dictate when a general election is called.
- If there is a separate body, it must:
    - be independent
    - be apolitical and be able to survive beyond its initial champion
    - report directly to Parliament not ministers and
    - continually look 10- 15 years ahead to be realistic.
    - provide much better evidence base on investment to change outcome
- Do we want one body with expanded remit or are there bits of system that should be performing these functions now?
- Setting up such a body with a wide mandate will just create one more body with yet another voice – needs to have more credibility.

The solutions

- Could this be through the Cabinet Office? This could test the policies in non-health situations but would need to avoid danger of every government department ending up with its own scrutiny body.
- The House of Lords Long-term Sustainability of the NHS Committee recommended an OBR-type body because of overwhelming evidence of short-termism with no-one taking responsibility for future planning. Current policies are leading to a feast or famine approach.

- An OBR-type body could safeguard health and social care with three roles: 1)monitoring of authoritative data on demographics/disease profiles 2)workforce implications 3)stability of social care funds including alignment with health.
- The Office for Budget Responsibility is a non-departmental body with 30 staff. It looks at individual tax and spending measures and how much they will cost as well as long-term stylised forecasts to check sustainability and fiscal risks. It assesses current Government policy but not other policy options. It is unable to say if policies are good or bad or if targets are sensible. It has led to increased transparency of public finances, helps force officials be more rigorous in their costings and changes behaviour of government. It works because of its narrow remit and specific role in the system for analysis.
- The Migration Advisory Committee produces reports when commissioned by government and has its own research budget. Could OBR functions be performed by something MAC-like with wider remit to undertake own research?
- A Commissioner model would provide more of an advocacy approach but whoever occupies the role is likely to shape the focus. Eg: The Future Generations Commissioner in Wales can hold government to account as well as produce forecasts, although is heavily dependent on legislation.

Conclusions

- This is the first time there has been a collective discussion and it is important to keep connecting on the topic.
- Long-term population health is currently not being considered. Because most planning is short-term many crises in non-communicable diseases are of own making.
- Hit and miss approach from the system at the moment but a range of bodies with different configurations are able to answer variety of issues. Build on successes – PHE's evidence reviews have had good impact and influence.
- OBR is not the only model and it is possible such functions could be realised within the system. A Commissioner for Fiscal Responsibility for Population Health may be an option (cf Future Generations Commissioner in Wales). To be sustainable, the function must be apolitical and be able to survive beyond its initial champion.
- Map and gap exercise required to look at other government departments and the ecosystem of public health modelling and forecasting capabilities.
- Although there are 40 countries with independent financial institutions broadly equivalent to the UK Office for Budget Responsibility, there are currently none with a specific health mandate. However, countries such as New Zealand may offer a model strategy.

23 October 2018

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