

RETURN TO INVESTMENT:

Can an Office of Budget Responsibility for Population Health improve fiscal and economic planning to improve the public's health and well-being?

Discussion paper

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“What is morally false cannot be economically correct.”
Cardinal Oscar Rodriguez Maradiaga

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Note:

This analysis is intended as an apolitical briefing to inform debate by the UK Public Health Network. Any errors are the responsibility of the authors. This work does not represent the views of the UK Public Health Network.

Summary

“Independent fiscal institutions are considered among the most important innovations in the emerging architecture of public financial management,” according to the OECD. Given that Westminster’s powers lie in scrutinising public money **after** it has been spent rather than **during** budgeting and planning, the need for an independent fiscal institution to support health spending is of growing interest. This briefing focuses on how an OBR for Population Health could help improve fiscal and economic planning to raise investment in public health and wellbeing - of particular importance because non-communicable diseases have been identified as one of the top three macro-economic risks to the global economy.

The OBR was first set up in 2009 and is now a statutory body. It makes no subjective comments on government policy but its five roles cover:

- economic and fiscal forecasting.
- evaluating performance against targets.
- undertaking sustainability and balance sheet analysis.
- evaluation of fiscal risks, scrutinising tax and welfare policy costing.
- analysing and reporting on the sustainability of the public finances.

Currently the public health system lacks strategic analytical tools for assessing the absolute and relative value of public health interventions/ investments. There is also a lack of demand-side modelling and no links between epidemiological and economic models, resulting in a lack of public health input into Treasury or OBR reports. The equivalent public health functions of an OBR for Population Health would therefore need to be:

- Health, disease and risk factor forecasting and the economic and fiscal impacts on public services and the economy.
- Analysis of the impact of interventions on public services and the economy.
- Analysis of the contribution of health capital to the nation.
- Analysis of the impact of health considerations in public policy and sectors out-with Government.

There are a number of operational options for an OBR for Population Health:

- 1. Within some or all of the national public health agencies in the UK.**
- 2. Agency of OBR.**
- 3. IFS model.**
- 4. Joint initiative between OBR and some or all UK national public health agencies.**

Credibility and independence of thought are possible by establishing the institution as a non-departmental body with separate accountabilities to those of HM Treasury, although care would need to be taken that a government body was not subject to the mandate of the government in office. Mechanisms such as the newly established four nations committee would avoid an OBR for Population Health being seen as an England-only body, enabling it to operate effectively across the UK and in accordance with the OECD’s principles for an independent fiscal institution.

The OBR was established to remove some of the politics from government fiscal planning. The same now needs to happen to ensure investment in the population’s health.

1. Introduction

- A recent briefing by the House of Commons Libraryⁱ points out that, unlike the US, German and Swedish legislatures, the UK Parliament has limited oversight of public spending and the budget. Westminster's powers currently lie in scrutinising public money after it has been spent. However, interest in financial scrutiny of the public budget is increasing with recognition that much needs to change.
- In June 2018, the Public Administration and Constitutional Affairs Select Committee repeated its earlier findings that "management information in the public sector had been "poor for a number of years" and that this "has consequences... for the success of individual policies and the success of any overall fiscal policy." The Committee encouraged both the Cabinet Office and HM Treasury to provide "better information on the costs of public services and... realistic forecasting".ⁱⁱ
- Alongside the need to improve financial management of the public purse, a review by Public Health Walesⁱⁱⁱ on the returns on investment in public health policies to support the UN Sustainable Development Goals felt that current investment policies are unsustainable because of the cost not only to individuals and families but to society and the economy.
- These factors suggest that the time is ripe to consider establishing a mechanism to inform greater investment in the public's health and wellbeing through an Office for Budget Responsibility for Population Health. This briefing focuses only on how such an OBR for Population Health could help the public health community improve fiscal and economic planning to raise investment in public health and wellbeing. The role of such an office to support investment in healthcare or social care will need to be addressed elsewhere.

2. The current state

- **"The miscalculation of sublime dimensions."** When the NHS was first established its architect Aneurin Bevan made the argument that the cost would decrease over time as the reservoir of ill health would be decrease over time through its creation and universal access. Enoch Powell subsequently called this the "miscalculation of sublime dimensions"^{iv} because the system failed to consider the changing nature of the demand side pressures - not least because the public health sciences in relation to non-communicable diseases (NCDs) was only just beginning to be understood. The health care system is wonderful from the supply side perspective but largely helpless to address what we now know to be the real determinants of health, which lie largely out-with the health care system.
- **Sir Derek Wanless** undertook several reviews (2002^v and 2004^{vi}) for the Treasury and argued for the development of improved analytical capabilities within DH and HM Treasury and the return on investment (RoI) for the NHS on a range of engagements to scale up investment in public health measures.

- **House of Lords Committee on sustainability of health and care services (2017).**^{vii} The NHS is becoming progressively unsustainable and unaffordable against GDP predictions by the Office for Budget Responsibility (OBR) who now believes it to be the biggest long term risk to the UK economy.^{viii} The report recommended an “OBR for Health and Care” which was favourably received by senior officials in DHSC, NHS England, ministers and shadow ministers and more recently by the Institute for Government.^{ix}
- **The Institute for Government**^{ix}, **the Lord Darzi review**^x and **The Health Foundation / Institute for Fiscal Studies**^{xi} have all argued the need in recent months to identify publicly acceptable alternative funding sources for public services such as the NHS, public health and social care, just to maintain provision of services at current levels.
- **WHO Macroeconomics and Health: investing in economic development report (2001)**^{xii} led by Jeffrey Sachs assessed the contribution of health in global economic development. This showed the pivotal importance of investing in health to promote economic development. The analysis was based on access to health services and conventional health protection measures. Unfortunately there was no analysis of the impact and potential for reducing the non-communicable disease epidemics.
- **Non-communicable disease (NCD) prevention.** The main escalating demands on publicly funded health and social care services will continue to be the anthropogenic NCDs which, from a public health perspective, are avoidable and /or could be postponed and morbidity compressed to later life. NCDs are the main causes of mortality, morbidity, disability and related health inequalities. They have a major negative impact on healthy life expectancy and the 20 year gap between social groups and UK productivity and prosperity. Derek Wanless called for a scaling up of public health to reduce demand on the NHS. Analysis from Willis Towers Watson reveals that medical inflation is likely to add 6% per annum to NHS costs.^{xiii} The importance of addressing NCDs was identified by the UN^{xiv} in 2011 in the UN’s high level political declaration which identified the major risks to economic development. This was echoed by the World Economic Forum in 2010^{xv} who identified NCD’s as one of the top three macro-economic risks to the global economy.
- **Short term perspectives.** Most public sector health planning is short term and focused on containing health service costs. It is based on the unassessed assumption that public health will not contribute significantly to reducing NCD care costs in the short and medium term.
- **Health planning.** Health and diseases are fundamental determinants of health and sustainable prosperity. However, there are currently no formal transparent arrangements for planning for health with HM Treasury / OBR. DHSC is seen as a spending department and only recently has public health been seen as strategically important to reducing demand on health and care services as well as contributing to wider social policy benefits. There has been poor utilisation of the public health

sciences, especially forecasting health and disease trends and the multiple social and economic impacts of interventions to reduce demand-side pressures on public services.

- **HM Treasury and OBR** do not have the analytical capabilities and are not provided with the macro health and related economic assessments required to inform fiscal and economic planning and the development of health in other Government policy areas. By its own admission, HM Treasury^{xvi} needs detailed high quality impact assessments and economic modelling analysis. In 2012, the Civil Service set up a review of “the quality assurance of analytical models that inform policy across Government.” Led by Nick Macpherson, former Permanent Secretary at HM Treasury, the review aimed to improve decision-making, identify Government’s “business critical” models and outline best practice to ensure quality modelling is being used. Recommendations in the final report^{xvii} highlighted the need for models that are used for “strategic investment decisions” to be robust with an appropriate quality-assurance framework in place.
- **Broader benefits of public health** The existing OBR reports do not consider the broader benefits of health on productivity/prosperity and other social and environmental policy goals or consider equity and health inequalities or healthy life expectancy. There is an urgent need to raise the importance of population health and its fundamental and enduring contribution to the performance of the State and the economy. Currently such analysis is not routinely considered. Other Government priorities lead to health being given a low order consideration. The DHSC is not considered to be a policy development department but is dependent on the engagement of other government departments.
- **The potential of public health is not being realised.** The benefit of public health interventions is under-appreciated and under-assessed. The focus is on short term return on investment and cost savings related to health and social care. The Government’s policy focus should be on increasing healthy life expectancy, particularly for the working population and compressing any morbidity towards the end of life and assessing the broader social policy benefits. In times of austerity this has never been more crucial as investment in health is key to national economic recovery and security, sustainable prosperity and deficit reduction. Most of the most effective public health improvement interventions are low cost or no cost to the State with some, such as the soft drinks industry levy or the tobacco duty escalator, being capable of generating Government revenue. Without the functions of the OBR equivalent for population health these will not be weighed highly enough in economic, fiscal and social and environmental public policies. These functions need to be mainstreamed across Government and the ideological and vested conflicted interests effectively taken out at the objective assessment and advisory stages of policy analysis.
- **Systems working:** To date, NCD prevention policy has focused on the expensive and mostly ineffective downstream behavioural interventions – termed by some as the inverse public health law. Upstream public health interventions, which offer potentially

incredible returns on investment, are challenges to some powerful vested interests and ideological perspectives. Indeed there is an anti public health nanny state narrative and lobby by those with vested and ideological interests. Ideally the state should have public health-led health and care and such considerations in the development of wider public services. A 2017 study showed that public health interventions had a RoI of around 17.5.^{xviii} Tackling NCDs at scale and expeditiously requires a more whole system and systematic based response and should be a national priority. Extensive analysis by Public Health Wales on achieving a sustainable economy through preventing ill-health and reducing health inequalities calls for a system that “aligns public policies, financial flows and accountability with local public, private and third sector delivery and shared assets and outcomes.”^{xix}

- **Strategic positioning of public health at Government level.** There is a need for a longer-term basis for planning for UK PLC and the UK social model. The public health system has failed to inform fiscal, economic and market planning in a systematic and strategic way and there are limited “health in all policies” mechanisms. Health impact assessments are not required or sought by Government except within Wales.
- **Public Health England’s role.** The establishment of PHE has made public health more mainstream within Government but the potential has not been fully realised as yet. PHE has key core health impact analytical functions on the evidence base, data, information, epidemiological and economic modelling. PHE should be providing system leadership on the big health and economic development policy questions. The narrative should be based on national need, prosperity, and the reduction of demand on all public services.

3. Fiscal and economic planning for public health

3.1 What is currently provided by the state?

There needs to be a comprehensive role, function and gap analysis for the different options. For example:

- [NICE](#) currently has a niche role in independent systematically reviewing the evidence base for local level interventions and developing service standards for organisations and public sector workers.
- The [Chief Medical Officer](#) (CMO) provides the challenge function within Government and produces the annual independent report on the public’s health for the nation.
- [PHE](#), [Public Health Wales](#), [NHS Health Scotland](#) and the [Public Health Agency NI](#) all undertake national monitoring and surveillance functions and national level intervention analysis.
- The [Office for National Statistics](#) and [NHS Digital](#) undertake national surveys and provide data and information on health and care across the UK.

- According to its remit, the [National Information Board](#) provides leadership across health and care organisations on information and information technology. It is also charged with developing and promoting innovation in informatics.
- The [DHSC](#) has an analytical and health economic support function.
- The [NIHR](#) and [UK Research and Innovation](#) (formerly the Research Councils) fund public health intervention research.
- PHE has a national leadership role for the public health system and the development of evidence based public health and analytical capability. Similar functions also exist in other national public health agencies and in Public Health Wales and NHS Health Scotland in particular.

4. What are the implications of increasing healthy life expectancy for pensions and benefits policies OR why is an OBR for Population Health needed?

4.1 The big public health and economic development policy questions

There are lots of myths and unfounded assumptions made about the social and economic value of public health. In order to address this, the public health community and HM Treasury need to be able to answer the following questions:

1. How does healthy life expectancy and morbidity compression impact on the use of public services and UK productivity?
2. What are the long term economic benefits of reducing the gap in healthy life expectancy across the social gradient?
3. How is human health capital linked to a healthy workforce and economic productivity?
4. What are the implications of increasing healthy life expectancy for pensions policy?
5. What are the current trends for NCD risk factors and the disease, public service and economic consequences?
6. What interventions will substantially reduce the epidemics of NCDs and over what timescales? What are the short, medium, and long term health and economic benefits of a range of NCD reduction scenarios such as the Wanless partly or fully engaged scenarios? What is the return on investment in interventions on NCDs?
7. What are the full costs to the state and society of tobacco, alcohol and ultra-processed foods and what costs are recovered by the state?
8. What interventions will reduce consumption of unhealthy commodities and what are the economic and fiscal consequences?
9. What economic incentives could be used to invest in prevention?
10. What are the implications of increasing healthy life expectancy for disability and other related benefits?

11. What are the key mechanisms for raising funds from profitable but health-damaging industries?

12. What are the optimal fiscal and pricing policies to achieve policy objectives and raise the necessary funding? A review by the UK Health Forum for PHE of fiscal policies is due to report very shortly and will provide some intelligence in this area.

The answers to these questions will go a long way in effective prevention of NCDs. However, the ability to answer the questions depends on the degree to which the UK public health system can draw on the following attributes:

- Health impact assessments of social, economic, fiscal and environmental Government policy both for new developments and retrospectively.
- Forecasting risk factor and disease trends and their economic, fiscal, social and environmental impacts.
- Assessing the scenarios and potential impacts of new and emerging health threats.
- Comprehensive monitoring and surveillance of health risks and protective factors for current and future populations (and their vectors).
- Undertaking evidence reviews of effective and cost effective interventions and the analysis of the need to intervene at local, national and international levels.
- Comparisons of health and disease status and health and social care and other related Government interventions with other OECD countries.
- Independent communications to the nation – regularly assessing and promulgating the overall state of the nation’s health.
- Commissioning applied public health research, including policy informing research.

4.2 The challenge in establishing proportionate investment to improve the health of the public

Unfortunately some of the attributes listed in section 4.1 are currently challenging for the UK public health system. There are varied reasons for this, including:

- A lack of strategic analytical tools for assessing the absolute and relative value of public health interventions/ investments across Government departments, at local level and through and within other sectors.
- A higher standard of proof being required to allocate investment in public health interventions, according to the Head of Public Services at HM Treasury.^{xvi}
- A lack of demand-side health modelling capabilities. Most health models are supply service and treatment based.
- No link up of epidemiological and health economic models with OBR and HM Treasury.
- A lack of information on the commercial and market determinants of major human health risks.

- The need for trend analysis on risk factors and diseases and their health and economic impacts.
- A lack of accurate health and care service cost data and information.
- A lack of utilisation of very expensive health and disease data lakes.
- A very limited history of expert public health input into the Treasury and OBR reviews and reports.

5. Functions of an OBR

5.1 The Office for Budget Responsibility

- The OBR was established to correct problems that were occurring in fiscal planning which led to systematic under-estimation of deficits whilst at the same time tax receipts were being over-estimated. An independent body was felt to be needed to both oversee the balancing of the budget and to ensure that budget-planning rules were observed.
- The OBR began as a Conservative Party organisation, set up by the then Shadow Chancellor, George Osborne in 2009. It was made a statutory body following the 2010 election “to provide independent and authoritative analysis of the UK’s public finances provides independent and authoritative analysis of the UK’s public finances.” A five year funding allocation began in 2016/17.
- The OBR undertakes five main roles:
 - economic and fiscal forecasting.
 - evaluating performance against targets.
 - undertaking sustainability and balance sheet analysis.
 - evaluation of fiscal risks, scrutinising tax and welfare policy costing.
 - analysing and reporting on the sustainability of the public finances.
- The OBR makes no subjective comments on government policy. It uses a large scale macro economic model which is jointly maintained and developed by HM Treasury and OBR covered by a Memorandum of Understanding to develop both “pre-policy” and “post policy” forecasts. These are coordinated with the OBR, HM Treasury, HM Revenue & Customs and the Department for Work and Pensions to ensure consistency.
- The OBR is accountable directly to Parliament and is not allowed to analyse alternative policies. A Westminster Hall debate on 24 July 2018 expressed interest in extending the OBR’s remit but this is not currently being considered by the Government.^{xx}
- The OBR is at: <http://obr.uk/>

5.2 The Institute for Fiscal Studies

- An alternative to an OBR would be a body similar to the Institute for Fiscal Studies. The IFS describes itself as a leading independent micro-economic research institute and has an ESRC centre for the microeconomic analysis of public policy. It was founded in 1969 as an independent research institute to inform public debate on economics in order to promote the development of effective fiscal policy.
- Through the establishment of rigorous independent research, for example [the IFS Green Budget and Post Budget analysis](#), IFS has opened up debate about public policy to a wider audience and influenced policy decision making.
- The [research remit](#) for the IFS is one of the broadest in public policy analysis, covering subjects from tax and benefits to education policy, from labour supply to corporate taxation. Its research not only has an impact on policy makers, think tanks and practitioners but contributes to the development of academic scholarship in the field of microeconomics.
- IFS also hosts the [ESRC Centre for the Microeconomic Analysis of Public Policy](#) which analyses fiscal policy to determine its effects on households and companies. The Centre's work covers the full extent of policy impact, investigating the ways in which policies influence human capital investments, work and occupational choice, firm behaviour, saving and retirement decisions, consumer choices and the public finances.
- The IFS is at: <https://www.ifs.org.uk/>

5.3 Equivalent OBR or IFS national level population health functions

The equivalent public health functions required of an OBR for Population Health would be:

- Health, disease and risk factor forecasting and the economic and fiscal impacts on public services and the economy including risks.
- Analysis of the impact of interventions including scenarios on public services and the economy.
- Analysis of the contribution of health capital to the nation.
- Analysis of the impact of health considerations in public policy and sectors out-with Government.

Modelling capabilities

- Forecasting along with many analytical functions need the development of powerful modelling capabilities of the type utilised by the OBR and IFS with HM Treasury. This capability would be a large microsimulation model that conforms at a minimum to the Macpherson modelling standards required of Government, particularly around the need for transparency, accountability and clear leadership.^{xvii}
- PHE now has a microsimulation model with the required capabilities through its collaboration with the UK Health Forum.

5.4 A four nations approach

- As part of fiscal devolution in UK, health became a devolved issue in 1998 with the passing of legislation to establish governments in Scotland, Wales, and Northern Ireland. By 2003, as Greer points out, there were “four quite strikingly different approaches to health policy.”^{xxi} Divergent health agendas across England, Scotland, Wales, and Northern Ireland have resulted in marked differences in public health policies and priorities, along with supporting legislation.
- The OBR has no direct involvement in block grant allocations under the Barnett formula but currently provides devolved tax forecasts.
- The [Scottish Fiscal Commission](#) was created in 2014 and became a non-ministerial statutory body in 2016. It produces independent analyses of Scotland’s revenue, social security expenditure and Scotland’s gross domestic product. The [Council of Economic Advisers](#), was established in 2007 with one of its remits being to “tackle inequality within Scotland.” The former Chief Medical Officer for Scotland serves on the Council to provide health input. The Council produces an annual report on the state of Scotland’s economy.
- The [Welsh Assembly](#) considered a number of options for its independent fiscal forecasts, including an equivalent fiscal commission for Wales, and in July 2018 opted to continue using the OBR.
- There is no specific equivalent function for the Northern Ireland Assembly as yet.
- It is worth noting that, if an OBR for Population Health operated across all four nations it would be in an ideal position to provide comparative, independent, forecasts of the impacts of differing public health policies.
- There is scope, therefore, for all four public health agencies in the UK to investigate the potential for a collaborative arrangement.

6. Options for an OBR for Population Health

- There is no single model for an independent fiscal institution. By 2016 a number of types of independent fiscal bodies had emerged:
 - Statutory but with varying independence (eg Belgium chaired by Minister of Finance to UK that is a standalone agency with dual reporting to both government and Parliament).
 - Academic (eg Ireland, Sweden).
 - Parliamentary (Australia, Canada, Italy, Korea, Mexico, United States): these were more likely to have a costing role).
 - Autonomous units connected to the national audit function (eg Finland, France).
 - Linked to national bank (Austria, Slovakia).

- Cabinet Office guidance on setting up a public body^{xxii} would need to be examined. However, there would seem to be a number of operational options for an OBR for Population Health:
 - 1. Within some or all of the national public health agencies in the UK.**
 - 2. Agency of OBR**
 - 3. IFS model**
 - 4. Joint initiative (eg between OBR and some or all of the national public health agencies in the UK.**
- If an OBR for Population Health sat within Government then that only might cover what is within the elected Government's mandate and its ideologies. Health policies are often compromised by trade-offs within Government when weighing up options against other policy goals that it wishes to set.
- Lessons from reviews of the OBR^{xxiii} suggest that credibility and independence of thought are possible by establishing the institution as a non-departmental body with separate accountabilities to those of HM Treasury.
- Siting an OBR for Population Health within PHE would carry the risk that the Office was seen as applying to England alone. However, PHE has a number of mechanisms for reaching across England, Scotland, Wales and Northern Ireland which would provide mitigation. These include the newly established Four Nations Committee, designed to foster stronger working relationships between the statutory public health agencies.
- Establishing an OBR for Population Health out-with Government would allow a broader coverage and a greater sense of independence, more long term analysis and stability of arrangements, greater innovation due to less political interference, validation or challenge to Government analysis and expert Governance. However, this is likely to carry funding implications with the risk that the OECD's principle of adequate resourcing may not be met.

7. Funding

- Von Trapp, Lienert and Wehner examined current funding levels of independent fiscal institutions as part of an extensive review.^{xxiv} In 2016, there were roughly three tiers of institution, as shown in Figure 1. Tier 1 institutions tend to have policy-costing responsibilities which are considered more resource-intensive.
- Funding for national independent financial institutions appears to be allocated entirely from central government funds. However, in the UK, this would depend on how an OBR for Population Health was established.

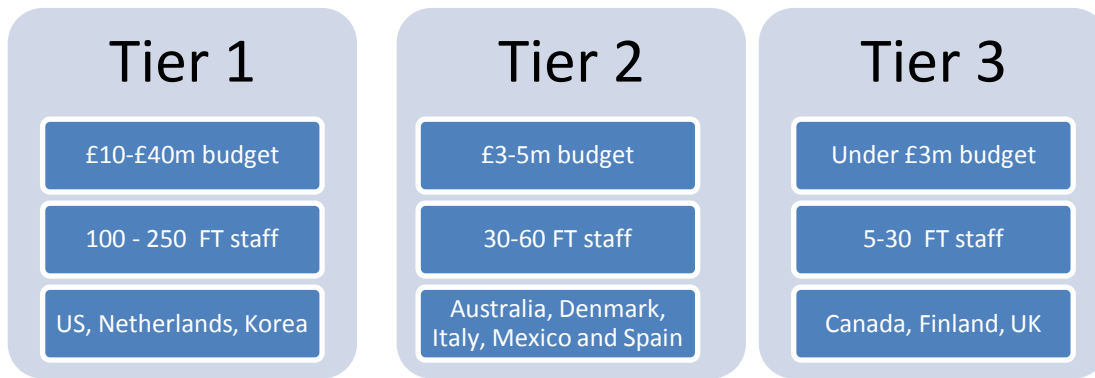


Figure 1: National independent financial institutions by size

8. International models

- There are a growing number of national independent fiscal institutions, in accordance with the move to greater transparency on public finances. The International Monetary Fund estimates that there are around 39 such bodies, two thirds of which are in Europe.
- The IMF published a review of these agencies in 2018,^{xxv} concluding that, although little is known of their effectiveness, independent fiscal institutions (councils) have become good practice for national fiscal frameworks.
- The precise remit of each institution varies although the role of watchdog for public finances is common to all of them, along with independence from “partisan politics” and being built on legal safeguards. The IMF points out that these institutions are “expected to raise the reputational and political costs of financially irresponsible choices.”
- The IMF has not identified any independent national fiscal institute solely for health.
- In 2014, the Organisation for Economic Cooperation and Development (OECD) published its 22 principles for independent fiscal institutions, in recognition that they have “the potential to enhance fiscal discipline, promote greater budget transparency and accountability and raise the quality of public debate on fiscal policy.”^{xxvi}
- The principles are grouped under:
 - **Local ownership:** legislature, political system, the fiscal framework and a country’s specific issues should determine the design of an independent fiscal institution.
 - **Independence and non-partisanship** as pre-requisites for success.
 - **Mandate:** clearly defined by law that may include economic and fiscal projections, monitoring compliance with fiscal rules, costing of major legislative proposals and analysis of budget proposals.
 - **Resources:** “multiannual” resources may provide protection from political pressures.
 - **Relationship with the legislature:** to secure accountability.

- **Access to information:** legal assurance or an MOU to guarantee full and timely access to methodologies, assumptions and data underpinning budget planning.
- **Transparency:** to build public credibility and authority.
- **Communications:** with media, civil society, governments etc.
- **External evaluation:** peer review by an advisory board or international panel.
- These principles would need to apply to an OBR for Population Health in order to safeguard its transparency, accountability and authority.

9. Conclusions

- Optimising the public's health depends upon i) informing economic, fiscal and market polices and ii) being clear about the contribution of health in all the policies of Government.
- The public health system needs to raise its game and invest at a national level in independent health impact analytical capabilities that inform the work of the Treasury and/ or OBR and thus other Government departments.
- The Treasury and OBR do not have the technical capabilities to realise this ambition.
- Both the public's health and wellbeing and fiscal sustainability of the economy have been damaged by this current deficit.
- There is the potential to provide fiscal analysis across all four nations in collaboration with the UK's four public health agencies as well as existing fiscal institutions of the OBR and Scottish Fiscal Commission.
- The OBR was set up in order to remove some of the politics that surround government fiscal planning. The same now needs to happen to take the politics out of fiscal planning for the country's health and wellbeing. The notion of an OBR for Population Health appears to be gaining traction with politicians^{xxvii} and officials expressing support for the idea in the last few years.^{vii}
- The cost of developing such capabilities is relatively modest. One key component will be the development of a large micro simulation epidemiological and economic model which meets the Macpherson modelling standards as a minimum. PHE, for example, has such a model through its modelling collaboration with the UK Health Forum.
- Many countries are now interested in developing this health and economic impact analytical capability. The interest is mainly coming from national information agencies. PHE, along with Public Health Wales, Health Scotland and the Public Health Agency NI, could play a key leadership role for such roles with functions being rightly placed within a national public health agency.
- These functions will be the most enduring, future-proofed functions for a national public health fiscal agency.

- Such an arrangement will place population health considerations centre stage and inform short and long term planning to ensure sustainable prosperity.
- “Independent fiscal institutions are considered among the most important innovations in the emerging architecture of public financial management” according to the OECD.

Glossary

CMO:	Chief Medical Officer
DHSC:	Department of Health and Social Care
ESRC:	Economic & Social Research Council
IFS:	Institute for Fiscal Studies
IMF:	International Monetary Fund
NICE:	National Institute for Health and Care Excellence
OBR:	Office for Budget Responsibility
OECD:	Organisation for Economic Cooperation and Development
NCDs:	Non-communicable diseases
NIHR:	National Institute for Health Research
PHE:	Public Health England
Rol:	Return on investment

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