Unmet Need and the Public Health Grant

A Data-Driven Tool for Local Authority Spending Decisions

EPH270

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INTRODUCTION

The Public Health (PH) grant is a ring-fenced subsidy for public health functions allocated to local authorities (LAs) across England by the Department of Health and Social Care (DHSC). The PH grant was created in 2013/14 following the Health and Social Care Act 2012[1] which saw responsibility and funding of public health services move from the NHS to LAs; Children's 0-5 public health commissioning was the last function to be transferred on 1st October 2015[2].

In 2025/26, the grant increased by £209 million (3% in real terms) to £3.869 billion[3], though this remains well below historical levels. Compounded by inflationary pressures and demographic shifts, public health services face outdated procedures, historic allocation disparities, and acute backlogs. These factors have led to increasing Unmet Need, where services fall short of statutory requirements, current demand, or peak provision. Directors of Public Health (DPHs) further lack standardised tools and pertinent data to inform spending decisions as demand on public health functions has evolved over time.

OBJECTIVES

The aim of the ongoing research is to identify, characterise, and measure Unmet Need across LAs in England. A mixed methods approach has been employed; the quantitative component is focused on trends across LAs, whilst the qualitative component carried out a national survey of DPHs in England and is currently interviewing a sub-sample of LAs. A digital tool is under development to provide stakeholders with information on public health trends over the past decade, help analysts identify areas of Unmet Need, and enable DPHs to better target resources and advocate for funding.

RESULTS

LA PH expenditure data were obtained from the General Fund Revenue Accounts (GFRA): Revenue Outturn 3 (RO3) datasets published annually between 2015/16 and 2024/25. These data were combined with Office for National Statistics (ONS) mid-year population estimates and Gross Domestic Product (GDP) deflators to produce real-terms per-capita figures.

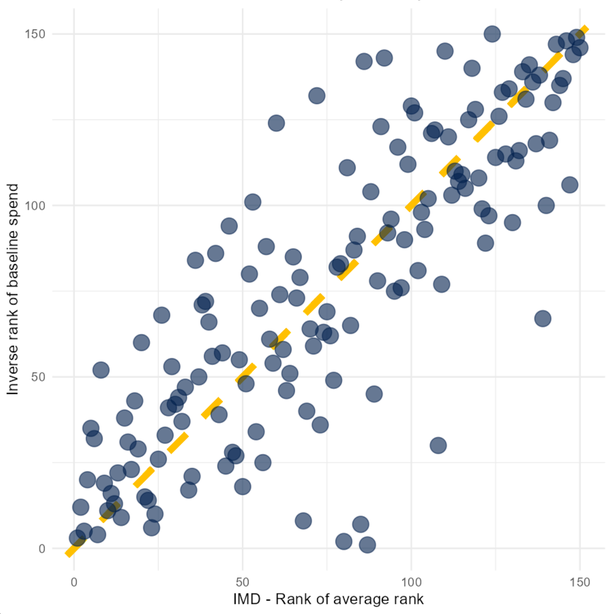

Figure 2. Inverse rank of baseline spend vs. IMD – Rank of average rank.

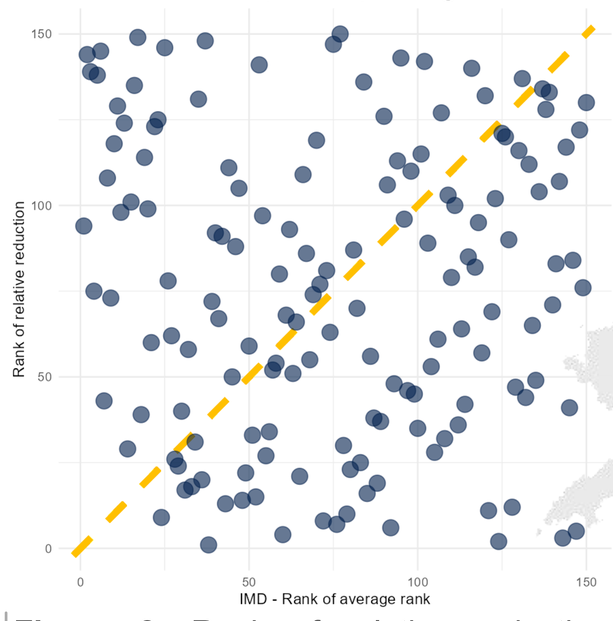

Figure 3. Rank of relative reduction vs. IMD – Rank of average rank

A linear regression model was fitted to the real-terms per-capita data for each LA, and trends in PH expenditure were analysed over time. No significant geographical clustering was observed in the ranking of LAs based on relative reduction in total PH expenditure — defined as the average annual change divided by baseline spend (see **Figure 1**). Only three LAs showed a relative increase in total PH expenditure: Torbay, the East Riding of Yorkshire, and Bracknell Forest. LAs with higher levels of deprivation[5] tended to start from a lower baseline in terms of per-capita PH spending (see **Figure 2**); however, no clear relationship was identified between deprivation and relative reduction between 2015/16 and 2024/25 (see **Figure 3**).

The distribution of cumulative percentage reduction in expenditure since peak was analysed across PH provisions (see **Figure 4**). If reductions had been applied equitably, the pie chart would appear balanced. However, PH provisions with larger budgets — Children's 0-5, Substance Misuse, & Sexual Health — have tended to be shielded from cumulative funding cuts.

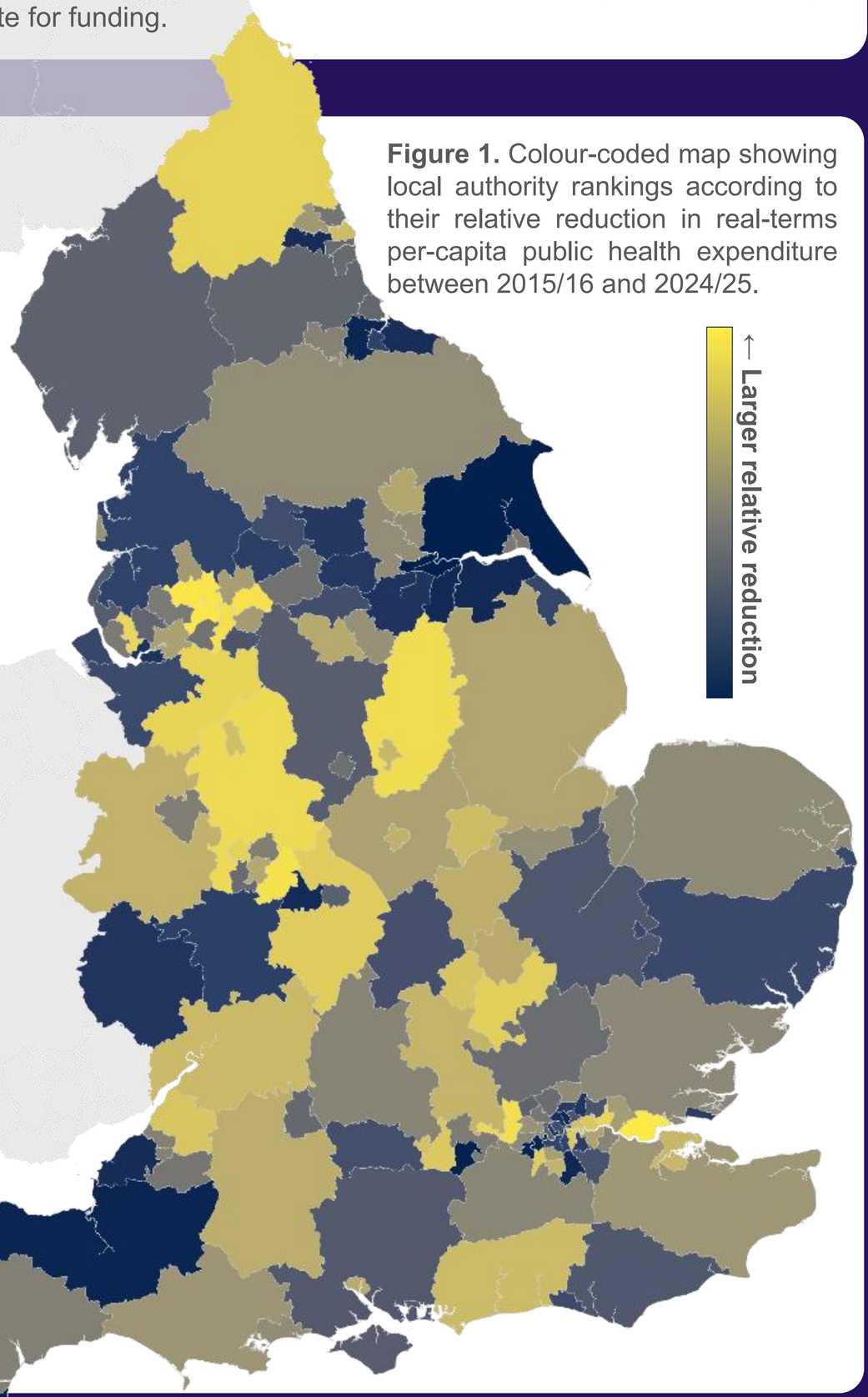

Figure 1. Colour-coded map showing local authority rankings according to their relative reduction in real-terms per-capita public health expenditure between 2015/16 and 2024/25.

CONCLUSIONS

Since PH provisions were transferred to LAs, expenditure has declined in real terms per capita; however, reductions are not geographically clustered. LAs with higher deprivation consistently started from lower per-capita funding levels, potentially reflecting historic NHS funding disparities.

Analysis of cumulative reductions across PH provisions suggests mandated services are not protected. Instead, those with the largest budgets appear most shielded from funding cuts, potentially diverting resources from other areas.

Future work will explore multi-level modelling of expenditure, develop digital tools, and update analyses using the Indices of Multiple Deprivation 2025.

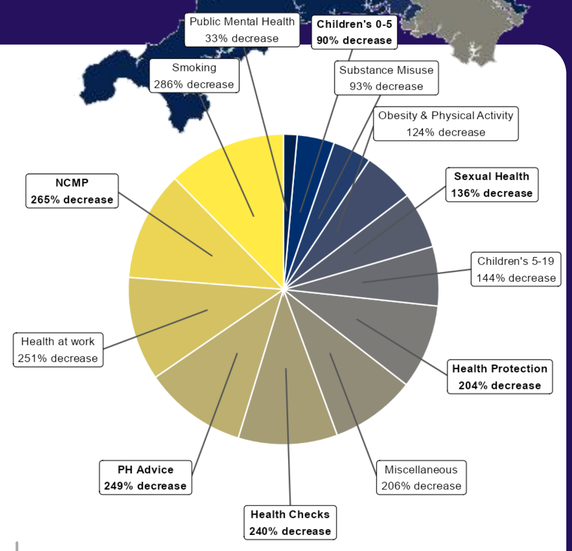

Figure 4. Distribution of cumulative percentage reduction in expenditure since peak **(mandated provisions)**.

REFERENCES

[1] Health and Social Care Act 2012 c. 7. Available at: https://www.legislation.gov.uk/ukpga/2012/7/contents/enacted (Accessed: 30/10/2025)

[2] Overview of the transfer of the 0-5 Service from NHS England to local authorities. Available at: https://www.gov.uk/government/publications/transfer-of-0-5-childrens-public-health-commissioning-to-local-authorities

[3] Public health grants to local authorities: 2025 to 2026. Available at: https://www.gov.uk/government/publications/public-health-grants-to-local-authorities-2025-to-2026 (Acc.: 30/10/2025)

[4] Local authority revenue expenditure and financing – individual local authority data – outturn. Available at: https://www.gov.uk/government/collections/local-authority-revenue-expenditure-and-financing (Acc.: 30/10/2025)

[5] Ministry of Housing, Communities and Local Government (MHCLG). (2019). *English Indices of Deprivation 2019.* Available at: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019 (Acc.: 30/10/2025)