



Workshop – Health Funding of cycle schemes

30th September 2014

Organised by the Transport & Health Study Group, the Greater Manchester Public Health Network and Transport for Greater Manchester

Chaired by Dr. Stephen Watkins CoChair (Policy) Transport and Health Study Group and Lead DPH for Transport, Greater Manchester

Investment in cycling infrastructure is needed to create in every part of the country a cycle network which all cyclists, experienced or novice, aged 8, 18 or 80, can feel safe using. The sums required for this, and for parallel investment in walking, are very large in comparison with what the UK has traditionally spent but very small in comparison with what has traditionally been spent on other forms of transport. A single road scheme will often use up as much money as it would take to make the entire county cycle friendly. We could make the whole of the UK a cycle friendly environment for a fraction of the cost of Crossrail or HS2.

THSG believes that walking should to a large extent replace the car for journeys of under a mile, the cycle for journeys of a few miles, and the train/cycle combination for longer journeys. This would address the obesity epidemic, the burden on the NHS of escalating rates of diabetes, mental ill health, carbon reduction and air quality and would make our cities pleasanter attracting inward investment from knowledge based industries which will locate where it is pleasant to live. As walkers and cyclists are more likely to stop at shops which they pass it would revive high streets and local shops.

Yet Government transport spending is focused much more on road schemes. This is often based on the belief that road schemes reduce congestion and improve economic performance. This may be true in areas which are sparsely populated or have very poor road networks but it is not true in urbanised developed economies. In such economies road schemes simply generate pressure for relocation and ease congestion only temporarily.

Recently some money has started to flow into cycling and the workshop received a presentation from TfGM on work within Greater Manchester.

Presentation by Nick Vaughan



THSG Workshop
30.09.14.pdf

However the money made available falls well short of what is needed to achieve the kinds of levels of cycling that has been achieved in some European cities.

Public expenditure in the UK is under considerable pressure. The basis of the austerity programme can be challenged. There are those who advocate unconventional monetary policies which recognise that whilst an individual may be unable to spend money they do not have, or incur debt without having to repay it, for an economy money is a measure of the economy's total capacity and borrowing by a state from its own central bank is just a means of creating money, governed by economic prudence not financial prudence. The work of Stuckler & Basu showed that countries which follow such unconventional policies perform better, both in health and in economic growth, than countries which do not. Despite the power of these arguments they are not supported by any of the parties likely to form part of the Government under any likely election result, so they are for the moment off the political agenda. For the immediate future, austerity will be with us.

Whatever economic framework existed it would be desirable to develop new ideas about how to obtain value for money from public services by greater interagency cooperation, a focus on outcomes, a focus on service transformation and a commitment to prevention. In a setting of austerity such ideas are not only desirable – they are essential.

Greater Manchester has been at the forefront of thinking about such ideas and the meeting heard a presentation of its approach from Kirstie Haines, Director of the Greater Manchester Public Health Network.

Presentation by Kirstie Haines



Cycling and PSR GMv
3ppt.ppt

In such a context it becomes sensible to ask whether investment in cycling infrastructure can be funded from health benefits, using health service funds. The health service consists of three elements – local authority public health funded by public health grant, Public Health England (PHE) funded by a national budget and the s66(4) NHS funded by NHS England either directly or through Clinical Commissioning Groups (CCGs). NHS bodies derive their funds from the monies that flow through NHS England, CCGs and local authorities as commissioners. These are the funding streams which this workshop had in view.

Capital investment can best be considered in four stages

1. Cost/benefit – does the investment produce benefits which make it worth the money?
When you buy a house with a mortgage, the cost/benefit is your judgment that the house is worth the money
2. Benefit capture – do the benefits translate into a flow of funds. When you buy a house with a mortgage the benefit capture comes from your decision to spend your money on the running costs and the mortgage payments to secure for yourself the benefits of the house.

3. Funding – what are the monies which each year will pay the running costs and service the capital. When you buy a house with a mortgage the funding comes from your salary.
4. Finance – raising the money for the investment. When you buy a house with a mortgage the finance comes from the mortgage.

The difference between funding and finance is crucial yet it has often been neglected in the way public investment is considered.

COST/BENEFIT

There is ample evidence of the benefit of walking and cycling. These can be found in chapters 2 and 3 of Health on the Move 2 (obtainable on www.transportandhealth.org.uk) dealing respectively with physical activity and with carbon change. There are also benefits from better air quality, from the greater social interaction in traffic free streets and from more tranquillity (especially now that the link between stress and cancer has been documented at a molecular level).

Using these benefits in a cost/benefit model for walking and cycling is also well developed. The HEAT tool is officially acknowledged by WHO and by DfT and places a value on the health benefits of walking and cycling infrastructure.

Nick Cavill, Vice Chair (Policy) gave a presentation on the use of this tool, and its application to potential cycling investment in Greater Manchester. It was also noted that Adrian Davis had written a report issued by DfT.



TfGM initial results
HEAT and SE.pptx

BENEFIT/CAPTURE

Health service funds can capture these benefits in two ways

1. Public health grant or the PHE budget can pay for them directly as outcomes
2. NHSE and CCGs can pay for them as a way to avoid the cost of the health services which would be needed to treat the consequences of the adverse health outcomes.

Whilst the former is theoretically the easiest the amount of health service money flowing into public health is so limited that it is not a realistic option. This might change if a more rational and long term approach to public finance led to sustained investment in prevention. At the moment however the money committed to public health is insufficient to sustain such an allocation.

The alternative approach – of investing against future savings in health service expenditure – requires trust that the savings will materialise and a willingness to reshape services so as to capture them, since experience has shown that otherwise the vacated capacity will be filled in some way.

To explore these issues the workshop split into groups which sought to pitch such an approach to a fictional CCG. The remit was to persuade the CCG to commit £1,000,000 a year recurrently to service a capital investment in cycling infrastructure.



Exercise on CCG
pitch - flip charts.doc

The groups differed in the approach that they took. None of them came up with a convincing pitch nor could that have been reasonably have been expected in the time available. Issues that emerge from comparing the proposals are

- The need to balance investment in network improvement and the servicing of the consequent capital with work to promote and support behaviour change
- The opportunities that would arise if Health and Well Being Boards had more power. One group assumed that this will come to be the case and that it will be possible for the Boards to move money between different parts of the system.
- The need for an approach to risk sharing between health bodies and transport bodies

A second exercise involved backcasting – working back from a chosen goal to identify what needed to have happened for that goal to be achieved.



Exercise in
backcasting.docx

Risk is an important element of the decision and needs to be understood. There are three levels of risk

- Failure to achieve behaviour change
- Failure of behaviour change to achieve health gain
- Failure of health gain to manifest itself in NHS savings

The first of these is clearly a risk. There is a need not just to provide a network but also to understand all the processes which will ensure that it is used. In principle this risk could be externalised to the private sector by the use of social development bonds but the problem is that externalising real risk to the private sector entails increases in the necessary capital costs which strike at the roots of affordability.

The second of these can probably be discounted as biologically implausible.

The third is a serious problem, which bedevils attempts to solve health care funding problems by prevention. Although there are many areas of healthcare where need is finite and can in principle be entirely met, there are other areas where the potential to do things which do good is infinite (or if not infinite certainly far in excess of anything society can afford without detracting from investment in other areas that produce greater health and well being benefits). The BMA has listed examples of this category as including treatment of minor musculoskeletal problems, counselling, services that enhance well being, reassurance, services that perfect human beings instead of just making them normal, individualised lifestyle support, last ditch attempts to seize treatment opportunities that have some prospect of success but not much, use of expensive treatments that offer limited additional advantages over cheaper ones, dissemination of experimental advance. Because of the potentially limitless scope for this category of care, reductions in the finite category will

simply lead to facilities being used to dig deeper into the infinite category. Until we develop a way to manage this process there is a real risk that savings in need due to prevention will simply manifest themselves in the provision of some other service in its place. This isn't helped by a commercial business model which incentivises providers to do more.

FUNDING

Once the commitment to benefit-capture is achieved the funding flows would be technically straightforward to achieve. From the first route spending from public health grant or from PHE would be committed to service the capital. The necessary powers to use the money for this purpose exist. From the second route the money would first need to be transferred to a body which has powers to use the money in this way. This could be done by a CCG entering into a s75 agreement with a local authority.

FINANCE

In principle once the funding flow has been set up the local authority has the necessary power to borrow. To pay back money over 20 years at an interest rate of 4% requires a funding flow of 7% of the capital sum each year for 20 years.

In practice it would be more complex than that because of the need to take account of risks to the security of the funding flow.

These risks might include

- Reorganisation – NHS change / Devolution / Change in public health responsibilities
- The risks of failure listed in the benefit-capture section
- Personal travel might increase so much that increased cycling is a drop in the ocean
- Virtual lives around computer screens means less walking , cycling and physical activity
- Extreme events –eg extreme weather events destroy the infrastructure,
- Events external to the process produces poor trend data disrupting the risk share process.
- Economic catastrophe unrelated to this process
- Changed leadership
- Changes in public policy
- Failure to roll out enough infrastructure
- Investment badly designed
- Political change abandons the process half completed.

These risks interact with legal issues relating to binding long term financial dealings between public authorities to increase the complexity of what should be a simple process. Addressing these problems needs to be an important aspect of public service reform.

FURTHER ACTION

All participants will consider the application of the ideas from the workshop in their own strategies.

TfGM and GMDPHs will consider further use of these ideas within Greater Manchester.

THSG will discuss further work on this subject at its forthcoming AGM