The Scottish Parliament
Pàrlamaid na h-Alba

Health, Care and Sport Committee

Angela Constance MSP
Cabinet Secretary for Health and Care
Scottish Government

13 November 2026

Dear Cabinet Secretary,

Pre-budget scrutiny 2027-28: Preparing for future challenges in the health, care and sport sectors

I am pleased to enclose a copy of the Health, Care and Sport Committee's pre-budget scrutiny report. This sets out a summary of the evidence received and our conclusions and recommendations.

I look forward to a response once the Scottish Government's budget has been published.

Yours sincerely,

Helen McDade

Helen McDade MSP
Convener

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Pre-budget scrutiny 2027-28: Preparing for future challenges in the health, care and sport sectors

Introduction

1. Each year, Scottish Parliament committees take evidence and make recommendations to the Scottish Government on its spending priorities, before these are set out in the Scottish Budget. The aim of pre-budget scrutiny is to influence the formulation of spending proposals while they are still in development.

2. For this first pre-budget scrutiny of the Parliamentary session, the Committee agreed to explore how the Scottish Government is preparing for future challenges in the health, care and sport sectors.

3. We took oral evidence over three meetings in October and November, with each session focusing on a specific area of our remit. We heard in person from the following witnesses:

   7 October

   - Richard Robinson, Senior Manager at Audit Scotland
   - Professor Linda Bauld, Professor of Public Health and Co-Head of Population Health Sciences, University of Edinburgh
   - Robbie Pearson, Chief Executive of Healthcare Improvement Scotland
   - Alison Payne, Research Director, Enlighten

   28 October

   - Professor Martin Knapp, London School of Economics
   - Professor Catherine Needham, University of Birmingham
   - Professor Derek Feeley, Former Chair, Independent Review of Adult Social Care

   and

   - Forbes Dunlop, Chief Executive Officer, **sport**scotland
   - Gregor Muir, Acting Chief Executive, Scottish Sports Association
   - John Lunn, Chief Executive, Scottish Swimming
   - George Hunter, Director of Libraries, Sport and Physical Activity and Communities, Glasgow Life

   4 November

   Angela Constance, Cabinet Secretary for Health and Care, Scottish Government, supported by Scottish Government officials:

   - Christine McLaughlin, Director General for Health and Social Care
   - Richard Foggo, Director of Population Health
   - Fiona Bennett, Chief Finance Officer, Health and Social Care Finance

4. In addition, we heard from COSLA, Scottish Care, the Coalition of Care and Support Providers in Scotland, Carers Trust, Self-Directed Support Scotland and the Care Inspectorate on 9 September 2026.

5. Many of the witnesses have also submitted written evidence ahead of the meetings. Their submissions have been invaluable in informing our questioning[1].

6. In addition to oral evidence, the Committee also requested written evidence from a cross-section of organisations. We asked specific questions on spending priorities, capital investment, prevention and funding for sport and physical activity. The questions and the responses received as part of this limited call for views are available on our pre-budget scrutiny webpage, alongside a summary of the key issues raised by stakeholders.

7. During our scrutiny, we also received additional correspondence and briefings, which have likewise been published on our webpage.

8. **The Committee thanks everyone who took the time to contribute to our pre-budget work, whether with oral or written evidence, and to give their views. These have informed our questioning throughout, and our conclusions and recommendations, as set out in this letter.**

The financial and policy context

9. The health and social care portfolio represents the largest area of Scottish public spending, with the health budget accounting for 33% of the Scottish Government budget for 2026-27, just below £22.5bn.

10. The majority of this is passed on to NHS boards. In the current financial year, NHS boards received 79% of the budget, amounting to £17.6bn. The remaining health budget was shared between the primary care sector (£2.5bn), capital projects (£1bn) with the remaining £1.3bn retained centrally for other purposes.

11. Although funding for the health and social care sector has increased steadily in recent years and is set to continue to increase over the current Parliamentary term, an increasing number of health boards are at Stage 3 or 4 of the Scottish Government's performance escalation framework, indicating that there are considered to be significant risks to delivery, quality, financial performance or safety.

12. Since the creation of integration authorities in 2016, NHS boards allocate some of their annual budget to the integration authority (or authorities) within their area, as do local authorities. The integration authorities then direct the use of their budgets to deliver the health and social care services that have been delegated to them.

[1] These submissions have been published and are available alongside the papers for each Committee meeting.

13. According to the most recent Audit Scotland reporting, the majority of integration authorities reported operational overspends in 2024-25, and although funding increased on the previous year, Audit Scotland suggested that this did not necessarily go beyond covering inflationary pressure and wage increases.

14. The most recent Scottish Spending Review, published alongside the Scottish Budget 2026-27, outlines the Scottish Government's indicative spending plans up to 2028-29 for resource, and up to 2029-30 for capital. It sets out an expectation of £1.5bn public sector efficiencies and reforms, with over £1bn of the total planned savings coming from the health and social care sector. NHS Boards are expected to achieve recurring annual savings equivalent to 3% of their baseline revenue resource limit. The Audit Scotland report NHS in Scotland 2025 shows that boards achieved recurring savings of 2.2%. While the levels of savings were unprecedented, Audit Scotland said that "Boards are still struggling to break even, with seven territorial boards requiring Scottish Government loans".

15. The Infrastructure Delivery Pipeline, published at the same time, noted that a number of projects listed in the 2021 Infrastructure Investment Plan had not been carried forward, including projects which had begun the business case process but then been paused such as remaining National Treatment Centres and the Gilbert Bain Hospital. The Scottish Government explained that it was working with all health boards to develop a whole system infrastructure plan, which would in turn identify investment priorities across NHS Scotland. The Scottish Government also announced before summer recess that it would pause the Monklands replacement project.

16. Health and social care spending is projected to grow as a share of the budget. Based on current trends, health and social care spending is projected to rise from around 40 per cent of Scottish devolved public spending in 2029-30 to almost 55 per cent in 2074-75[2].

17. In its NHS in Scotland 2025 report, Audit Scotland concluded that "Even with increased funding, the NHS in Scotland is not in a financially sustainable position". It added that "The delivery of efficiencies and reform within the health and care system will play an important role in both the NHS's and Scotland's overall medium-term financial sustainability."

18. Health and social care is one of the areas where significant public service reform has already been attempted, most notably through the integration of services, and an unsuccessful attempt over the last Parliamentary term to create a National Care Service. It is an area which has also been the focus of attempts to better understand prevention and preventative spend. Both reform of the sector

[2] The Scottish Fiscal Commission's Fiscal Sustainability Report (April 2025)

and prevention emerged as key themes during our scrutiny, alongside immediate pressures faced by the health, care and sport sectors.

19. In the Programme for Government 2026 to 2031, the Scottish Government outlined its intentions which positioned health and social care at the centre of its public service reform agenda. This included signalling an intention to simplify the NHS by replacing the current 14 territorial Health Boards with two mainland territorial Health Boards and to build on planned reforms to further reduce the number of special Health Boards.

20. The Government also suggested that the governance and delivery of social care would be reconsidered, and committed to engage with local authorities, trades unions, and healthcare and service providers over autumn 2026 to reach agreement on reform of social care. The First Minister, in his statement to Parliament, said that he did not "seek to be prescriptive", but suggested that he saw a solution with "a single line of decision-making, accountability and funding, with the NHS taking the lead".

21. In relation to sport, the 2026-27 Budget referenced a £40.1m cash uplift including combined funding for **sport**scotland and for Active, Healthy Lives[3]. **sport**scotland was allocated £54.6m, an increase of 49.1% from the previous year. The increases were described as "part of [a] commitment to increase investment in sport", however, it has been confirmed that the majority of funding allocated for the Summer of Sport, under the Active, Healthy Lives budget line, is non-recurring.

22. The Cabinet Secretary in evidence to the Committee, set out a challenging position for the upcoming budget. She said—

> "We all know that rising demand for health and care services outstrips the increase in front-line staff and in the resource that we have made available.
>
> We will feel the pressure of various issues as we go into this budget period. The block grant is projected to fall by around £450m in 2027-28, and I have real concerns about capital over the spending review period in relation to that real-terms reduction. The increase in employer national insurance contributions continues to present a challenge. We all continue to live with the consequences of Scotland being dragged out of the European Union against our will. It has been well established that the hit to Scotland's revenues has been about £3.3bn. I would not underestimate or underplay the financial challenges in future."

[3] This represents the change against 2025-26 Autumn Budget Revision figures, as per the baseline used by the Scottish Government in Budget documents.

Summary of evidence received

Shift to prevention

23. Our pre-budget scrutiny was framed around preparing for future challenges in the health, care and sport sector. Prevention emerged as the key theme and was highlighted as an essential area for improved and sustained funding.

24. Professor Linda Bauld, in her submission to the Committee, explained that—

> "Scotland has taken important steps toward a prevention-first approach through our Health and Social Care Renewal Framework and PHF [Public Health Framework], both of which provide an evidence-based focus on improving health and reducing inequalities. […] Achieving these ambitions will depend on prevention and early intervention, action across the wider determinants of health, and effective collaboration between partners across the system.
>
> Prevention must be at the heart of how we plan, budget and invest across the public sector. A preventative approach supports investment not only in services that respond to need, but also in the local services, community assets and wider determinants that help people stay well, support early intervention and reduce inequalities."

25. We have heard that decisions as to what constitutes prevention are subjective, and that the Scottish Government should gather as much data as possible on how different parts of the public sector are working together towards a health outcome. Tracking, monitoring and reporting against the population health framework intentions will contribute to clarifying the benefits from preventative measures. It was also noted that policy commitments have not always been matched by resources, and that sport and physical activity needs to be embedded more directly as preventative in the budget.

<u>What constitutes prevention</u>

26. Public Health Scotland defines prevention as "keeping people healthy and avoiding the risk of poor health, illness, injury, and early death", and we have heard from Professor Linda Bauld that "we need to think about turning off the tap earlier in the system. We need to try to support people to be healthier early in life and during their working life. That will prevent some of the declines later in life that have happened in recent years."

27. She emphasised that investment is most effective in the early years, and that Scotland requires "a twin-track approach: we need to focus on older people and their quality of care, but Scotland needs to focus a lot of its attention on the early years plus preventative interventions in the working-age and midlife population. You see a lot of that in the commitments that the Government has made, but I am sure that more could be done."

28. Professor Martin Knapp explained that prevention is more difficult to define in a social care context. He said, “Conceptually and operationally, the term is very vague, and that vagueness serves a purpose in that people can relabel something as prevention one year and relabel something else as prevention the next year”. Evidence received from social care providers in September suggests that prevention to alleviate pressure on the NHS should not be the only lens through which social care is perceived and evaluated.

29. Prevention is defined differently by others in a less health-specific way. The Scottish Government’s own Prevention Unit defines prevention as “activity intended to stop the establishment, escalation or recurrence of problems that lead to negative outcomes for people.”

30. Definition and understanding of what prevention is matters, as evidenced by a survey by the Association of Directors of Adult Social Services in England, quoted by Professor Catherine Needham, which shows that one of the barriers to prevention is “the lack of a good business case for it”.

Delivery of preventative action

31. Evidence suggests that prevention should be embedded and prioritised in policy decisions regarding health and social care, and that this should shape budgetary decisions around both day-to-day spending and capital investment.

32. Many organisations highlighted that prevention aims have not been matched with sufficient funding. The Coalition of Care and Support Providers in Scotland said that preventative budgeting has been “limited and uneven”, Public Health Scotland said it “does not have sufficient evidence to conclude that the balance of investment has shifted materially upstream”, while the Health and Social Care Alliance noted that “our members have repeatedly expressed frustration at the gap between positive rhetoric on prevention and their experience of funding and service delivery”.

33. Health and social care are grouped as one overall area of spending in the Scottish Budget. However, local authorities are the public bodies responsible and accountable for provision of much of Scotland’s social care and support services. Evidence heard by the Committee suggests that it is in these areas of spending that most impact might be felt in primary prevention of poor health, and the promotion of healthy life expectancy.

34. While spending on the NHS has increased over the years, local government and third sector spending, where much prevention work takes place, have reduced, and we have heard that not enough is being done to work across silos to deliver cross-sectoral support. We further heard that services delivered by the third

sector are sometimes cut because integration authorities do not understand their significance[4].

35. Alison Payne of Enlighten highlighted that there is an opportunity to learn lessons and work with partners in the third sector, who bring a range of skills and experience. She noted the role that third sector organisations such as Chest Heart & Stroke Scotland and the Scottish Huntington's Association have in delivering services, ranging from preventative interventions and education, through to specialist and financial support for people after diagnosis. She argued that many of these organisations are delivering cross-sectoral support which public services could learn from. She said "We should stop trying to do everything ourselves, to reinvent the wheel and to centralise. We should learn from partners who are trying to juggle those issues. As you said, there is firefighting and there is prevention, but many incredible organisations in our communities are doing just that."

36. Several organisations, including the Coalition of Care and Support Providers in Scotland, the Health and Social Care Alliance, and Public Health Scotland, suggested that third sector organisations (including social care providers) should be recognised as equal partners in decision-making and resource allocation. They recommended greater joined-up thinking and noted that decisions and allocations are still largely based on organisational boundaries rather than people's needs or focusing on health and care outcomes.

37. The Health and Social Care Alliance suggested moving investment 'upstream' in health care and in social care to "prevent avoidable ill health, reduce inequalities and ease pressure on acute and crisis services".

38. Several organisations noted that sport and physical activity need to be embedded more directly as part of preventative measures and interventions in the budget. The Scottish Football Association and Scottish Swimming called for sporting and community infrastructure to be explicitly recognised as essential preventative health infrastructure rather than discretionary spending.

39. Nevertheless, Alison Payne also noted that not every preventative intervention requires additional investment, and that it should be possible to prevent health problems before they arise through interventions such as public education programmes.

40. It is important to point out that several witnesses mentioned the National Performance Framework as an important document that should set the direction for policy in this area.

[4] Scottish Huntington's Association submission

Investment in social care

41. Scottish Local Government Finance Statistics show that spending on social care in 2024-25 was £1.05bn higher than in 2021-22, a 28% increase on 2021-22 figures. Adjusted for inflation[5], however,– over the period shown – total social work expenditure increased by £669m, or 16% in real terms.

42. Several organisations, as well as the Scottish Government and the Independent Review of Adult Social Care in Scotland (the Feeley review) propose that social care is regarded as an investment rather than a burden to society.

43. The Feeley review, published in 2021, recommended annual additional expenditure on social care of £0.66bn per annum, or a 20% increase in real terms over 2018/19 levels and twice the total real terms increase in adult social care expenditure over the whole of the previous ten years (£0.3bn). The review stated that—

> "We need to start by challenging some of the prevailing narrative about social care support. […] Strong and effective social care support is foundational to the flourishing of everyone in Scotland. It is a good investment in our economy and in our citizens. […] The additional expenditure we are recommending here should not be seen in economic terms as a revenue cost but rather as an investment that encourages job creation and provides economic stimulus."

44. In oral evidence to the Committee, Professor Derek Feeley noted that some gaps that were identified in the report have been difficult to close, with unmet need being a good example. He also highlighted that despite additional investment it is clear that provider organisations "are still finding it difficult to deliver the kind of support that they would like to deliver to people".

45. Prevention in a social care context partly links to social return on investment, although a broader perspective would be to explore shifting the balance of care, and how this can prevent pressure on acute services.

46. According to the Improvement Service "[Social return on investment] SROI measures social, environmental and economic change from the perspective of those who experience or contribute to it. Through the use of financial proxies, it is possible to identify and apply a monetary value to represent each change that is measured."

47. Professor Martin Knapp argued that "there is less cost-effectiveness evidence in social care compared to health care, but it is accumulating and it can be employed to good effect". His definition of cost-effectiveness is centred around achieving a socially acceptable balance between outcomes.

[5] Adjusted using HMT GDP deflator as at 30.06.26

48. We heard that workforce is the biggest investment associated with social care. Evidence from the Coalition of Care and Support Providers in Scotland, Scottish Care and UNISON highlighted that limited capacity in the social care sector is strongly related to recruitment and retention, itself tied to pay and conditions within the sector. Witnesses noted that social care is a skilled, regulated profession but that pay does not currently reflect this, noting wide discrepancies in pay between equivalent levels of skill in the NHS, local authority provision and commissioned social care.

49. Care providers also highlighted financial challenges for providers associated with marketised commissioning, which can drive down contract value, high variability in commissioning process across local authorities, and timely payment.

50. In her submission to the Committee, Professor Catherine Needham pointed out that the visible parts of social care and the NHS sit on top of an often invisible care infrastructure of unpaid care and community activities. She argued that "the contribution of this invisible structure is impossible to measure in its totality. But it is here that people find the relationships and purpose that support wellbeing." Her submission highlighted findings that voluntary and community activity in Scotland was limited by poor relationships with public sector partners, short-term and inflexible contracts and procurement and reporting requirements that advantage large organisations over smaller, local ones. Professor Knapp also called for investment in the unpaid workforce. He said, "We know that the unpaid care inputs to the care system are greater than those from any formal care support, so investing in family and other unpaid carers would be hugely influential."

51. The Coalition of Care and Support Providers in Scotland and the Health and Social Care Alliance raised issues relating to the social care workforce, and the significant unpaid care work that takes place across the health and social care sectors.

52. Professor Feeley, referring back to the Independent Review of Adult Social Care in Scotland, explained that a particular concern raised was a lack of transparency about funding flowing from the public to the private sector as part of the commissioning of services. Professor Needham suggested that more could be done to explore the landscape in which care providers were being asked to deliver services, and whether more could be done to support the not-for-profit providers in this space who were evidenced to provide higher quality of service, but struggled to compete with larger, for-profit providers.

<u>Investment in sport and physical activity, including social prescribing</u>

53. Social prescribing through sport and physical activity has been raised as an important part of a preventative, person-centred and community-based health and care system.

54. A report published by Public Health Scotland estimated the physical and mental health burden of physical inactivity in Scotland. The report stated that 24,000 disability-adjusted life years (years lost to disability or ill health) are lost in Scotland each year due to the impact of physical inactivity. Half of these lost disability-adjusted life years are attributable to musculoskeletal conditions and mental ill health.

55. Access to sport and physical activity can help to improve health outcomes and increase healthy life expectancy. However, people experiencing socioeconomic deprivation can face barriers to being physically active, including the cost of accessing sport and leisure opportunities, and fewer opportunities for participation. According to the most recent Scottish Health Survey, 73% of adults living in Scotland's least deprived quintile met the recommended physical activity level of 150 minutes of moderate exercise or 75 minutes of vigorous exercise per week, compared to 53% in the most deprived quintile. Socioeconomic deprivation disproportionately impacts some marginalised groups who may face additional barriers to physical activity, such as people with disabilities. People experiencing socioeconomic deprivation are also less likely to be able to access high-quality green spaces for physical activity.

56. Local government investment in sport, leisure, and culture in Scotland has decreased by 20% in real terms since 2010-11, according to a 2024 report commissioned by Community Leisure UK, **sport**scotland, and Creative Scotland. Leisure facilities have been negatively impacted by increasing energy bills and staffing costs, and the cost-of-living crisis. A November 2022 report by Community Leisure UK Scotland found that 95% of Scotland's leisure facilities are at risk of closure, with 63% involved in active discussions and planning the impact of closures.

57. In its written submission to the Committee, Glasgow Life called for the recognition of community facilities, including leisure centres, swimming pools, sports pitches, schools and community venues, as part of the wider infrastructure supporting prevention, rehabilitation, and social connection.

58. We would welcome clarification from the Scottish Government on plans for strengthening the role and function of social prescribing as a vehicle for ensuring the funding for prevention reaches communities directly, and how this might best be delivered.

Availability of data and scaling best practice

59. Audit Scotland has previously stated, in their report on general practice, that the data that the Scottish Government had to make decisions on planning and investment in general practice was inadequate. Richard Robinson of Audit Scotland, referring back to the Auditor General's report, suggested that more data

was needed for the Government to understand issues around demand, workload, the workforce and the quality of care.

60. NHS Healthcare Improvement Scotland, looking at primary and community health services, also identified gaps in good quality and "consistent data and intelligence across all services".

61. The issue of data availability is more acute in the care sector. Professor Feeley explained the difficulties in obtaining a consistent data set for all localities during his review, to the extent that "people did not know what the important data to collect was." He explained that "more consistent, nationally reported data would help us better understand where we are getting value from the money that we are investing and whether the outcomes for people are consistent. Such information about the quality of care would help us to make our financial allocations."

62. Professor Needham added that, in England, the localities that the Care Quality Commission rated as being of outstanding quality had really data-led preventative strategies with the ability to track outcomes.

63. The availability of data is also essential for scaling up best practice. Professor Feeley told the Committee of his experience talking to the chief executive of a third sector organisation that had demonstrated positive interventions for people with early-stage dementia and proven that approach in two local authority areas—

> "I asked him what the plan was to scale it up across the whole country and he said, 'I have to go and sell it to another 30 local authorities'. We have no mechanism to move from promising local practice on prevention to national-level implementation."

64. Scaling up, as explained by Professor Feeley, requires a scientific approach to implementation and socialisation (bring people together to learn from each other), both of which are not happening enough in Scotland.

65. Similarly, the Scottish Health Equity Research Unit's central recommendation to the Committee was "that significant preventative spending commitments should be shaped by 'implementation intelligence' (i.e. the knowledge held by local areas, frontline services and communities about what makes policies deliverable and preventative)".

<u>Budget tagging</u>

66. Prevention and moving away from acute and reactive services towards a preventative approach is a key theme in the Scottish Government's Public Service Reform Strategy. The Strategy recognises that "current budgeting processes are a key barrier to shifting resources to preventative spend", and commits to re-designing its "approach to identifying, tracking and monitoring preventative spend". A clear and shared understanding of what constitutes

prevention, availability of reliable data and the ability to scale best practice are essential to effective preventative budgeting.

67. The Scottish Government's recent work on a budget-tagging pilot to better understand its investment in prevention is therefore welcome. The approach involved developing a Preventative Budgeting Tool which provides a method for "tagging" budget information against a consistent definition of prevention and allows this spend to be linked to outcomes and drivers of public service demand.

68. In her submission, Professor Linda Bauld explained that "An HSC Reform Preventative Investment Advisory Group has been established to build on the pilot outputs, explore how cross-cutting prevention issues are considered in funding decisions and generate insights on how preventative investment can be embedded more effectively."

69. The Scottish Government has previously signalled that it will combine this work with data from the Population Health Framework and upcoming work on drivers of demand to help to inform future budget-setting decisions, and that the tagging approach would be extended to the entirety of the Budget.

70. Richard Robinson argued that "The Scottish Government needs to get a better understanding of all its current preventative spending in its budget, and it is encouraging that it is starting to do that. Before it thinks about future preventative spending, it should be certain on where all the preventative spending is going now."

71. COSLA noted that preventative impacts must be acknowledged across policy areas and in other budgetary areas, including in education, housing, leisure, parks, active travel and culture. The future development of preventative tagging must enable tracking across portfolios and "enable budgets to be clawed back to where the preventative investment was initially made".

72. During evidence to the Committee, the Cabinet Secretary was asked about tagging in the upcoming budget. She stated that "[The pilot] learning needs to be built on. The pilot covered a selection of Government spend; the plan for the prevention unit is to broaden that out across the whole budget and for the pilot work to really inform the budget process as regards both how we understand things and what choices have been made." However, she stopped short of confirming what level of tagging can be expected in the upcoming budget.

73. The Committee recognises and welcomes the development of budget-tagging for preventative spend and the work of the prevention unit. We hope that tagging goes beyond existing policy and forms new preventative action. As the Parliamentary session progresses, we expect to see more detailed budget-tagging and impact assessments used across the budget following the evaluation of current pilots. We would expect to see this

aligned with preventative spend tagging in other portfolios in line with the current evaluation taking place.

74. We are keen to see where significant new spending on prevention is implicated in addition to the application of tagging of current spend. We hope to see a spread of preventative spend across primary, secondary and tertiary prevention, acknowledging that prevention saves money and lives.

75. We would also welcome regular updates on the work of the HSC Reform Preventative Investment Advisory Group.

Monitoring progress and outcomes

76. In their submission to the Committee, Public Health Scotland suggested that "classifying expenditure as preventative improves visibility but is not the same as changing the conditions and systems that generate demand. Future budgets should show both how much is classified as preventative and whether investment is narrowing inequalities and reducing avoidable demand".

77. Audit Scotland noted that a system-wide approach is needed to tackle a range of demands and pressures while also protecting long-term preventative initiatives. The Scottish Government will also need to align its implementation plans for health and social care with its Public Service Reform Strategy, Financial Sustainability Delivery Plan, Health and Social Care Service Renewal Framework, Population Health Framework and outstanding commitments from the NHS Operational Improvement Plan. In addition, it will be important to "monitor and transparently report on how these plans and strategies are delivering the required improvements".

78. In the context of frameworks, the National Performance Framework (NPF) is likely to play a key role in monitoring outcomes across the public sector. Richard Robinson explained that "if there are issues with how you balance, explain and scrutinise what you are spending on immediate issues and what you are spending on preventing issues that might arise, having an NPF front and centre that sets out how you are making decisions about how to spend money and how to balance the levels of funding that go to the NHS, local government or whomever helps the cause by ensuring a greater degree of ownership and visibility."

79. The Committee seeks clarity on when the refreshed NPF will be published, and how the plans, strategies and frameworks highlighted above have been written or updated within the context of investment in prevention or the proposed structural reforms.

80. The Committee also notes that wellbeing outcomes may be more pertinent to evaluating social care and community based services than prevention alone.

81. Scottish Government frameworks and strategies need to be accompanied by clear milestones and measures of success to be effective. As Richard Robinson stated, “it will be important for the Scottish Government to set out what you can reasonably expect to see next year, in five years’ time and in 10 years’ time.”

82. Setting out clear milestones and measures of success is important to enable scrutiny and further investment in prevention. Several witnesses highlighted the difficulties in measuring prevention and justifying spending that might not deliver immediate benefits, as well as “the extent to which the jagged nature of accountability and the pointed need to do something today in relation to responding to pressure can crowd out the longer-term achievement of broader cross-sectoral ambitions and objectives”[6]. However, regular reporting, clarity and transparency and the justification of spending, can help support investment in long-term, preventative investment by providing a stronger evidence base.

83. The Cabinet Secretary herself acknowledged the importance of data and monitoring, particularly in relation to investment—

> “I want to be able to see the impact of Scottish Government investment, irrespective of where it lands, whether it is going to health boards, IJBs or local government. […] It is important to be able to evaluate outcomes, and that approach and philosophy should apply across all public services.”

84. The Committee welcomes recent work in developing a budget tagging process, and the commitment in the Programme for Government to development of a Scottish Prevention Investment Framework.

85. We remain unclear as to the extent to which the upcoming budget will include tagging across the health, care and sport sectors, and recommend that the Scottish Government works at pace to further develop tagging to cover the entirety of the health, care and sport budget.

86. The Scottish Government should gather as much data as possible on how different parts of the public sector are working together towards a health outcome, to ensure the right measures are tagged as preventative, and the impacts of these measures can be monitored, and to enable scaling up best practices to national level.

87. More generally, we ask that the Scottish Government ensures, in the upcoming budget, that prevention policy commitments are fully supported by adequate funding.

88. In short, in order for this Committee to be able, across the rest of this Parliamentary session, to track progress on a shift towards greater preventative spend, it is essential that the relevant budget lines are

[6] Robbie Pearson, Healthcare Improvement Scotland

identified (tagged) as such so we can see year-on-year what spend is happening and if this is having the wider health outcomes expected.

Structural reform

89. Shortly before the Committee commenced its pre-budget scrutiny, the Scottish Government announced major structural reform, affecting health, care and local government. These announcements will form the backdrop for the upcoming Scottish Budget, which will be delivered in a context of uncertainty, change, and opportunity. The Scottish Government will have the important task of delivering reform, while also balancing the preventative action discussed above, and a number of current and pressing challenges.

Preparing for reform – evidence base and engagement

90. The Scottish Government's proposals for NHS reform, including the anticipated reduction in the number of mainland territorial health boards from 11 to two, aims to build on the successes of subnational planning by dismantling bureaucratic and geographic obstacles. Audit Scotland explained that "The purpose of the subnational arrangements is, in effect, to allow the better flow of treatment and patients between areas of Scotland to alleviate pressures in some parts of the country."

91. During evidence, we have heard about the importance of having a solid evidence base for reform, and we would welcome evidence on how subnational planning has so far contributed to the Scottish Government's aims and improved health outcomes, and how changes will be reflected in the Budget.

92. We understand a business case is yet to be developed, however, the Cabinet Secretary has now expressed clearly her "very strong preference is for two boards". She argued the proposed reform "is not about centralisation" and explained that "there is the possibility that we could continue with the current split between east and west in subnational planning, but no definitive or absolute decision has been made on that yet".

93. **For reform to be effective, it must be informed by evidence, with a full and proper exploration of options, costs and benefits. The Committee is expecting to see the evidence that supports the Government's proposals as soon as possible**.

94. In the case of NHS and local government reform, the Government has made initial proposals to inform discussions. The Cabinet Secretary has confirmed in correspondence to the Committee[7], that "work will be developed in partnership with staff, staff representatives, trade unions, stakeholders and the public, with a strong focus on the needs of rural and island communities" and that engagement

[7] Plans to reduce the number of health boards and planned timetable

has already begun. **Throughout our scrutiny, there has been significant confusion as to the parameters of the engagement currently taking place, which has not been fully clarified.**

95. A similar, initial proposal has not been made for the reform of social care services. Instead, the Scottish Government stated[8] its view "that all options for social care services and social work be considered, taking into account new organisational structures for the NHS and proposals for Regional and Community authorities."

96. We understand that a three-month period of engagement on wider public sector reform, including social care, "has already begun and Ministers and officials have been having various discussions with stakeholders, including COSLA", with "plans to ensure engagement with groups including disabled people's organisations and those with lived experience"[9].

97. There appears, again, to be some confusion as to the timeline and extent of the ongoing consultation. The Committee has sought information on the start and end dates of the consultation, as well as its scope and format, but two months after the announcements in the Programme for Government, we are yet to receive additional information.

98. Confusion also remains in relation to the scope and implications of reforms for integration authorities and arm's length organisations, both of which are essential to the delivery of preventative action.

99. In evidence to the Committee, the Cabinet Secretary stated that—

> "No decisions have been made about the future of IJBs. However, the frustration that I hear from members representing their communities—and, indeed, from those who are working hard in our services—is about the fragmentation of care. I hope that addressing that will be a significant objective of reform. Irrespective of the structures that will be negotiated and agreed for the future, we should have a single, co-ordinated care journey across the health and social care system."

100. The Cabinet Secretary committed to returning to Parliament "in the not-too-distant future" to make a statement regarding the reform process. She further committed to "pull together a range of information that we can put in the public domain […] That would include clear information about the aims and objectives of what we are doing."

[8] Public sector reform: proposal - gov.scot
[9] Plans to reduce the number of health boards and planned timetable

Considerations for social care reform

101. The First Minister stated, in his Programme for Government speech, that while not seeking "to be prescriptive […] I cannot see us resolving the fundamental challenges that social care faces without a single line of decision making, accountability and funding—with the NHS taking the lead".

102. During our scrutiny, we heard from experts in social care who noted concerns raised by service users about the potential medicalisation of social care should it move to sitting within NHS services. Professor Catherine Needham argued that it was hard to see a convincing case for sitting social care within the NHS, citing Northern Ireland as an example which did not demonstrate better outcomes for service users. She said "What do we see there? We see that social care is often forgotten and is there to serve the health service; there is no evidence of better outcomes coming through that route. The idea that you can mainstream social care by putting it within the NHS, as a way of bringing more attention to it and getting better outcomes, is an unproven case."

103. She also noted instances in England where integration approaches had disintegrated and highlighted the importance of buy-in from local government. This is particularly pertinent given the experience of the proposed National Care Service, which failed to secure support from local government in the previous session, and was ultimately not delivered.

104. Professor Martin Knapp spoke about the wider needs of social care service users and the risk of losing the connection to services often facilitated by local authorities (such as education, housing and transport).

105. Professor Derek Feeley, author of the Independent Review of Adult Social Care in Scotland, also expressed mixed views on the proposal. He explained that the proposal for a National Care Service, which first appeared in his report, stemmed from the idea of closer integration with the NHS. Accountability, reductions in variation and scaling best practice could also be supported by having the NHS take lead responsibility. However, his experience of talking to people who receive social care support shows there remains nervousness around the medicalisation of social care. Ultimately, he said, "we have to recognise that social care and healthcare are two different things".

106. Professor Feeley also noted that many of the recommendations in his review did not require structural change, such as ethical and collaborative commissioning. He suggested that rather than looking at structural changes as a first step in reform of services, the Government should be looking at outcomes it wants to achieve for people who use health and social care services, and work back from there.

> "The most important thing right now is investment in new thinking and proper investment in social care, and the committee can influence that through its

advice to the Government on where to invest. It bothers me a bit when people say that we should invest in social care to save the NHS. No, we should invest in social care because people need good social care support. A good society in Scotland needs good social care support. That is why we should invest in social care. It is a good investment and the necessary precursor to any structural change. Let us first think differently about social care and then make the right structural change, designed for the new way of thinking, not the old way."

Monitoring progress and outcomes

107. As discussed above, monitoring progress and outcomes is essential to delivering effective reform, and to justifying the expense that this will inevitably entail.

108. As explained by Richard Robinson during evidence, "the Scottish Government's work on flow, which was announced recently, is going to be important. Unpicking those blocks in the system to make sure that you are getting the most effective and efficient use of your funds will be central. Monitoring how new initiatives such as flow navigation pathways and national treatment centres are helping to unblock those issues will also be central."

109. The Scottish Government must set out clear benchmarks for progress and commit to regular reporting against those. The Government should consider these benchmarks now, and embed them into the process, building on the ongoing work on subnational planning.

Parliamentary scrutiny

110. The reform announcements led to considerable uncertainty and speculation regarding changes to legislation and opportunities for parliamentary oversight. While proposals for social care reform are still to be developed, the Cabinet Secretary confirmed that a move to two new territorial health boards can be effected using existing powers under the National Health Service (Scotland) Act 1978 and does not require primary legislation. Should the proposals go ahead, these are expected to be implemented via secondary legislation.

111. The implementation of reform via secondary legislation raises concerns in relation to the extent to which the Parliament will be able to fully scrutinise the changes. Secondary legislation provides limited opportunities for scrutiny compared to primary legislation. Secondary legislation has strict, limited timescales which do not allow for extensive consultation by the Committee, and does not allow Parliament to change or shape the proposals.

112. **Proactive engagement from the Scottish Government, in the form of advance information, sharing business cases, impact assessments and**

expected timeframes for the introduction of secondary legislation will be essential to ensure that any changes receive adequate Parliamentary scrutiny.

Opportunities and costs

113. The proposed structural reform will provide opportunities to improve integration, service delivery and reduce duplication in all three sectors of our remit. The Scottish Sports Association suggested that public service reform is an opportunity to strengthen partnerships between sport governing bodies, Active Schools, education and leisure providers. Reform can also enable the much-needed shift to prevention, discussed earlier.

114. It is also likely to have significant impact on budgets. As public bodies consider and focus on major reorganisation, there could be an impact on service delivery across health and social care, potentially diverting resources towards structural change, or potentially stalling some innovation. These costs are likely to impact on future budgets and are therefore an unavoidable consideration in our pre-budget scrutiny.

115. The Cabinet Secretary has stated that the costs and benefits of reform will be set out in the programme's business case and "will complement existing plans to improve financial sustainability and support Boards in returning to financial balance"[10].

116. At the time of writing, the Committee has received no information of the likely costs of reform and how these are expected to be met.

117. Audit Scotland told us that—

> "Without clear priorities, robustly costed and adequately resourced policies, agreed delivery timelines, and well understood measures of success, meaningful reform will be difficult to deliver. It will also make scrutiny of annual budgets more difficult".

118. Our pre-budget scrutiny was completed on a background of significant reform announcements with scant details around scope, costs, engagement and evidence.

119. The need for reform is well recognised and accepted, and the Committee is keen to work with the Scottish Government on a cross-party basis to ensure this is delivered.

120. Nevertheless, we are concerned that proposals for such substantial changes have been made before a business case has been developed and we wish to see this as soon as possible.

[10] Plans to reduce the number of health boards and planned timetable

121. The Scottish Government should ensure the proposals are subject to a full and proper consultation. Given the significant implications of the reforms, we would expect much more clarity and transparency around the process, timescales and the opportunities available for consultation.

122. The Scottish Government should publish the evidence base for its initial proposal on NHS reform and set clear outcomes and benchmarks for monitoring progress on ambitions. We note that a lesson from deliberations around the proposed National Care Service shows that reform that starts with structure can lose sight of leadership, culture, practice and cause resistance to change.

123. We share the concerns expressed by many witnesses regarding the medicalisation of social care and ask that the Scottish Government takes full account of these. We are worried that proposals from the Scottish Government that the NHS takes the lead on social care could exacerbate this.

124. We seek clarity about the role and funding of integrated joint boards through this period of NHS and local authority transition.

125. The Committee seeks assurances that reform will be subject to full parliamentary scrutiny. Should this be implemented via secondary legislation (SSIs), we recommend that the Scottish Government provides the Committee with advance notice of planned introduction of SSIs, and that these are accompanied by detailed financial and impact assessments, to allow for effective scrutiny. We further ask that while proposals are being developed, the Committee is kept informed via regular, detailed updates on progress.

126. As plans are developed, we encourage the Scottish Government to consider how reform can address well known current and future challenges, including demographic changes and unmet need. We also urge the Government to retain prevention at the forefront of the reform agenda and to use reform as an opportunity to improve data collection across the health and care sectors.

Immediate pressures

127. Our pre-budget discussions were dominated by a focus on prevention and framed by the expectation of reform. Among these, immediate and urgent pressures arose, most of which are long-standing, and which need to be addressed in the here and now, irrespective of structural changes.

128. We would appreciate clear indication of how the shift towards prevention and away from acute services will be funded during a likely

transition period in which demand for acute services continues to be immediate and high.

Budget pressures in the health, care and sport sectors

129. Recent Audit Scotland reports have pointed to continuing demand and sustainability pressures in the health and social care sector. In his 2025 report, the Auditor General highlighted that despite a real-terms funding increase, the NHS in Scotland was not financially sustainable, and performance has not improved as the Scottish Government had intended. As explained by Richard Robinson during evidence, "the Auditor General concluded that while NHS boards achieved unprecedented levels of savings they are still struggling to break even. In addition, ambitions such as shifting the balance of care to the community are long-standing and this persistent implementation gap, between policy ambitions and delivery on the ground, needs to be addressed".

130. Scottish Fiscal Commission projections suggest that spending pressures on health and social care are expected to increase, and "the Scottish Government will face significant challenges funding devolved public services in the future, particularly over the next twenty-five years […] because the population in Scotland will age earlier than in the rest of the UK"[11].

131. Audit Scotland explained that "There are issues around prevention and people needing services in the future, but we know that there are issues with delayed discharges now, and they are not cost neutral. We estimate in our report that it costs around £440 million a year to keep people in beds when they are technically ready to leave the hospital".

132. Alongside Audit Scotland, COSLA also highlighted a very challenging position for local authorities, with other organisations pointing to the impact that budget pressures is having on the health, care and sport sectors.

133. In the context of existing shortfalls and pressures on health and social care services, most evidence received by the Committee suggests that the proposed spending review savings are going to be challenging to achieve through efficiency savings and will not necessarily make health and care sustainable if avoidable demand continues to rise. In a recent survey of local authority leaders, chief executives and directors of finance[12], the Local Government Information Unit found that social care is the biggest pressure on council finances. COSLA noted that eligibility for social care has now moved largely to critical need only, limiting the availability of care packages and shifting away from preventative delivery. Meanwhile, Integration Joint Boards have less than a week's running costs in reserves.

[11] Fiscal Sustainability Report - Corrected Summary - December 2025
[12] 2025 State of local government finance in Scotland - LGIU

134. Sporting organisations also noted the significant and growing impact of budget pressures on the provision of sport and leisure services across Scotland. According to research cited by **sport**scotland, local government spending on sport/leisure has reduced by 25% in real terms between 2010-11 and 2022-23, and one-third of councils and leisure operators have closed facilities since the pandemic, including sports centres, swimming pools and outdoor sports facilities, with fewer coaches and staff available.

135. The Scottish Governing Body for Sport CEO/COO Forum stated that "many governing bodies report that a disproportionate time is spent trying to find affordable facilities" as local authorities have increased prices to deal with funding challenges. The Scottish Sports Association similarly found that the cost of access remains a barrier to participation, with many sports governing bodies being priced out of local authority facilities.

Demographic pressures and health inequalities

136. As highlighted by the Scottish Fiscal Commission, Scotland faces significant risks from demographic change and an aging population. These demographic pressures are not unique to Scotland. However, Scotland differs from neighbouring countries in its decline in healthy life expectancy. Healthy life expectancy – the number of years a person can expect to spend in good health – is low compared to the rest of the UK or other countries in Western Europe and continue to decrease. According to the most recent National Records of Scotland data, in 2022-24 healthy life expectancy at birth in Scotland was 59.4 years for females, and 59.1 years for males. Since 2014-16, women have lost almost four years of healthy life expectancy, and men three years.

137. There is a significant gap in healthy life expectancy between Scotland's most and least deprived communities. Women born in Scotland's most deprived areas are expected to spend 26.7 years less in good health than those in the least deprived areas. For men, the gap in healthy life expectancy between Scotland's most and least deprived communities is 25.6 years. Meeting the recommended guidelines of 150 minutes of moderate physical activity per week has been identified as a key factor in improving healthy life expectancy.

138. Scotland continues to have acute issues with alcohol harm and drug deaths. The most recent statistics published in September show an 11% rise in drug deaths on the previous year.

139. As highlighted by Cancer Research Scotland in a briefing to the Committee, "Cancer is also one of Scotland's starkest inequalities challenges. Cancer death rates are around 80% higher for people living in the most deprived areas of Scotland compared with the least deprived. Around 4,300 cancer deaths each year are associated with deprivation, equating to around 12 avoidable deaths every day."

140. Waiting times, long-term conditions and palliative care all remain areas that require significant attention and investment now, and the Committee will return to these issues for further scrutiny. **It would be helpful for the Scottish Government to highlight where preventative spend will address stubborn health inequalities**.

141. While there are differences of opinion as to whether legislation is necessary, there is consensus across the Parliament – and among the Committee – that urgent action is needed to better support people with learning disabilities and neurodivergent people. **The Committee would hope to see significant, sustainable spend attached to the Scottish Government's commitment to improve neurodevelopmental assessment, diagnosis and support. We welcome recent announcements regarding funding to support children and young people but would hope to see that funding placed on a sustained footing as well as greater resource allocation to support adults through assessment and ongoing support, particularly given the withdrawal of adult neurodevelopmental assessment pathways in some parts of Scotland.**

<u>Infrastructure, facilities and capital investment</u>

142. Infrastructure and facilities were highlighted in evidence as significant challenges that can hinder preventative action as discussed earlier. Revenue budgets have generally been protected at the expense of capital budgets, which would fund investment in equipment and estate.

143. Audit Scotland highlighted that capital expenditure in health has fallen by 22% since 2021-22. It noted that capital spend is not keeping up with maintenance requirements and called on the Scottish Government to be transparent about how much of its capital budget is meeting ongoing maintenance and other obligations, how much is allocated to ongoing projects, and what is available for new initiatives.

144. Many sporting organisations raised the ageing physical infrastructure to support sport and physical activity, and that this requires considerable further investment to prevent net losses of sporting facilities. Some of these facilities, such as aquatic facilities and swimming pools, have high operational costs (e.g. energy costs).

145. In October 2025, **sport**scotland conducted an estates review of sports facilities in Scotland. The review concluded that an investment of £15.5bn over the next 25 years is required to address the findings associated with the age and condition of the sport and physical activity infrastructure, position the estate to meet net zero targets, and deliver a desirable level of accessibility and inclusion.

146. Swimming Scotland identified that 122 of 195 public pools are over 38 years old (the average life span of a pool) and warned that by 2040, Scotland could have a net loss of 150 pools. An annual investment of £40.5m is required to build

four pools per year to maintain current provision. Meanwhile, **sport**scotland found that 40% of built facilities are beyond their typical design life. Funding pressures on local authorities are also preventing regular maintenance of services.

147. Scottish Swimming argued that "Scotland cannot credibly shift from treatment to prevention while the sporting infrastructure that helps people remain active deteriorates, is not accessible and is increasingly unaffordable".

148. It proposed two complementary mechanisms to help sustain swimming pools: a Swimming Pool Sustainability Fund for maintenance, refurbishment, energy efficiency and transitional support; and a Swimming Pool Development Fund for replacement and new facilities where demand, growth, capacity or geographical access justify investment.

149. The Scottish Football Association called on the Scottish Government to co-invest in 'Pitching In' alongside football stakeholders to match-fund.

150. Witnesses also highlighted the value of linking major events to capital investment and community sports provision.

151. The Committee wishes to see in this budget and over the longer term an increase in the capital budget for sportscotland and other bodies to invest in facilities, including urgent repairs and maintenance. We also note the urgent need for greater investment in aging swimming facilities.

152. **The Committee wishes to see continued investment following major sporting events in Scotland to encourage greater participation in sport, particularly for young people from less-well off communities.**

153. Capital investment was also highlighted in relation to digital provision. The Coalition of Care and Support Providers and NHS24 noted the importance of improving digital infrastructure and emphasised the acceleration of digital alignment across public sector organisations to reduce duplication. NHS Borders called for accelerated implementation of the Digital Prescribing and Dispensing Pathways Programme to reduce reliance on paper, administrative burden and re-keying.

<u>Workforce</u>

154. Workforce remains an area of concern, with several health and care professions highlighting the need for comprehensive workforce plans. The Association of Anaesthetists, for example, wrote to Committee stating that "there is currently a shortage of around 170 anaesthetists in Scotland which is preventing an estimated 128,000 procedures and operations taking place each year. However, at the same time, we know that training places are oversubscribed with many resident doctors unable to access either core or specialty training". This issue is mirrored across other specialisms within the NHS.

155. As explained by Richard Robinson, “workforce is essential to delivering services, and […] workforce costs are one of the main areas of cost pressure in the health sector. That means that it will be important for the Scottish Government to be clear about the cost implications of potential changes, as well as the implications for regulation.”

156. **Going forward the Committee would like to see improved workforce planning in the NHS. We would like to see greater representation of all the different health disciplines in decision-making about workforce planning and training budgets**.

157. **The Committee would like to see the Scottish Government commit to improving the pay and conditions of the social care workforce in the forthcoming budget. We have heard from witnesses that better pay and conditions could improve the recruitment and retention of skilled care professionals and, in turn, greater continuity and quality care for people who rely on social care services. In particular, we note the current disparity of pay between professionals working in commissioned care services, those directly employed by local authorities, and those of equivalent skill in the NHS.**

158. **The Committee recognises commitments to sectoral bargaining and supports greater pay parity across the health and social care sector. We note that better workforce recognition and reward need not wait for reform of governance arrangements in social care**.

159. **We look forward to an implementation plan and associated budget commitment to unpaid breaks for carers, given the rights enshrined in the Care Reform Act and the Scottish Government’s undertaking to bring forward proposals following the consultation that ended in May 2026. We note that consideration will need to be made for how infrastructure for respite care is built up on a sustainable footing given a current shortage of places. This may necessitate core funding for some services**.

160. In the sport sector, the lack of sufficient coaches and volunteers is impacting on provision. Forbes Dunlop explained that of the new funding received this year, **sport**scotland invested £5m in clubs, some of which will go towards paying coaches. It will also go towards paying part-time administrators: people who are happy to do the protecting vulnerable groups checks and ensure that the pitch is booked and fixtures lists are up to date”. Long-term planning, however, including in relation to workforce, requires multi-year funding.

<u>Multi-year funding</u>

161. Almost all evidence received during our scrutiny noted the importance of multi-year funding settlements as opposed to one-off or single-year allocations,

which are significantly impacting long-term planning, resilience and stability in the health, care and sport sectors.

162. Witnesses emphasised that multi-year funding can support both public bodies and delivery partners to take a more strategic, long-term approach to designing and delivering services, recruiting and retaining staff, giving certainty over contracts, considering options for investment in facilities and undertaking planned maintenance. The Health and Social Care Alliance explained that such an approach "would enable preventative and community organisations to retain skilled staff, plan effectively and sustain support rather than operating through repeated short-term funding cycles", while COSLA warned that "single-year settlements, ring-fenced funding and fragmented reporting have forced resources towards crisis response".

163. Sport organisations also noted the bureaucratic impact on organisations and groups of having to apply annually for funding, and the challenges that could arise from funding not being delivered until part way through the year.

164. Funding uplifts, while welcome, are often temporary and in danger of being absorbed by acute pressures, including pay pressures, inflation and increasing demand, which may limit the extent to which resources can be directed towards longer-term transformation.

165. As explained by **sport**scotland, preventative outcomes appear over years as opposed to months. Single-year funding, therefore, affects both prevention and performance. They said, "planning for Duncan Scott to swim at the Olympics does not mean thinking about the next nine months; it means thinking in four, six or eight-year periods."

166. Organisations have found ways to partially work around yearly cycles. Glasgow Life has trialled initiatives to improve efficiency and reduce financial pressures, while **sport**scotland has taken an approach of "almost […] hedging our bets because […] We work with local authority and governing body partners on four-year cycles. They tend to produce a four-year plan and, in principle, we invest against that. We can give a hard legal commitment for only one year, but we will, in principle, invest for a four-year cycle."

167. The Committee recognises that not all preventative spend will be in health services and notes the role of third sector and community-based support in the role of prevention. We therefore support the wider roll-out of as many multi-year funding arrangements as possible to ensure that the staffing and provision of such services is sustainable and guaranteed.

168. As clearly evidenced during our inquiry, the Scottish Government must balance structural reform and prevention with addressing significant immediate pressures.

169. Before embarking on reform, the Scottish Government should clearly state how reform will help achieve improvements in these areas.

170. We also recommend that the Scottish Government builds on its Fairer Funding Pilot, to extend multi-year funding across the health, care and sport sector as part of its approach to preventative budgeting.

Final conclusions

171. The themes highlighted by our evidence, from the focus on prevention to the need for better data, are not new. They have been raised by previous committees in successive pre-budget letters and reports. We are clear, however, that without adequate investment now, the acute challenges discussed above will continue and add pressure on future budgets.

172. The structural reform proposed by the Scottish Government to the health and social care sectors provides unique opportunities to review current practices and consider whether they deliver for the people of Scotland. To this end, it is imperative that any changes are accompanied by clear outcomes for people who rely on health and care services, benchmarks and ongoing monitoring of progress. Without an improved flow of information to the Committee, we run the risk of not being able to scrutinise these plans and their impact properly.

173. Our Committee will track the progress of reform, as well as the implementation of our recommendations more generally, throughout the Parliamentary session. We will also return to many of the issues highlighted above in separate inquiries, consultations and evidence sessions.