Scrubinising preventative spending in healthcare
BMA Scotland written submission, February 2017

The British Medical Association is a politically neutral registered trade union and professional association representing doctors from all branches of medicine. The BMA has a total membership of over 168,000. In Scotland, the BMA represents over 16,000 members.

We welcome the opportunity to provide written evidence to the Health and Sport Committee on scrutinising preventative spending in healthcare.

Increased spending on preventative measures can make a significant difference to health outcomes. This can range from population level measures to improve the health of people across Scotland to reducing the likely need for emergency or unscheduled care through better advanced planning and community-based support.

However, it is essential that expectations over the extent that care can be shifted to community-based services and any anticipated cost savings are realistic, particularly given the rapidly increasing needs of Scotland’s population.

Shift in spending to community based care
The 2020 vision committed the Scottish Government and NHS boards to care for more people in the community and where possible to shift from acute to community-based care. However, moving the location that care is provided is not in itself preventative spending and we would strongly caution against regarding it as such. To be preventative, it must reduce a patient’s need for unscheduled acute admissions and achieving this takes more than simply changing the setting where routine care takes place.

Moving more care into community settings is a significant challenge that faces a number of structural difficulties and progress towards it has been slow. As Audit Scotland warned last year1, a continued focus on secondary care targets is ‘counterproductive’ to such an approach and is one such example.

Health boards are under a great deal of political and media pressure to meet waiting time targets and that inevitably affects spending decisions. BMA Scotland has warned for some time that inflexible targets can overshadow clinical advice when decisions are made over patient care, but it is also the case that the focus on targets disincentivises boards from putting resources into areas not covered by targets.

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The current review into NHS targets that is being conducted by Sir Harry Burns is an opportunity to consider the impact that existing targets have on moves towards greater community based healthcare and alternative approaches to measuring quality improvement in the health service.

While it is important not to pre-judge this review and any recommendations that may emerge from it, the committee may wish to consider for itself the extent to which targets are acting as a barrier to change in the NHS.

It is also the case that there remain other very significant impediments to successfully achieving a shift away from hospitals and towards greater community based care which the committee may wish to look into.

Community based care relies heavily on GPs and the wider primary care team, but general practice is currently facing enormous workload pressures and significant difficulties in recruiting and retaining staff. Around 28% of practices reported having at least one GP vacancy in a recent BMA Scotland survey. Without sufficient staffing and financial resources already in place and operating in communities, there is often little prospect of achieving any substantial shift from hospital to community based care.

Meanwhile, many NHS services operate with fixed costs meaning that marginal reductions in demand for these services do not automatically free up resources that can be spent on equivalent community-based services. It is only the outright closure of such services that would allow resources to be moved, but this is often extremely unpalatable for local residents and politicians and is reliant upon first achieving sufficient reduction in demand so that a hospital-based service is no longer required.

Even if the volume of care provided outside of hospital does increase, this may not be sufficient to significantly reduce demand on acute services. Scotland’s health needs are not static, they are increasing rapidly as the country’s demographic profile ages. It is therefore likely that even with a greater focus on community-based care, coming years will still see growing demand on both community-based care and acute, secondary care, and both will need increasing resources if a deterioration in patient care is to be avoided.

Currently, neither secondary care nor community based care has sufficient financial or staff resources to meet anticipated future patient demand. Both parts of the health service need greater resources and simply moving resources from hospitals to community settings is not a realistic alternative to adequate resourcing.

The decision on where patient care is required is one that should always be based on the particular needs of a patient and what is clinically in their best interest. It may often be the case
that care at home or in a homely setting is the best option and there are strong reasons to ensure that this can be provided whenever it is the most appropriate option. However, it should not simply be regarded as a cheaper alternative to providing sufficient resources for acute hospital services to meet the needs of those patients that will continue to need such care. Indeed, good quality community care will often cost as much, or more, than hospital care and is likely only to be cheaper than providing the same care in traditional settings if the quality of that patient care is lower.

**Prevention and public health**

Some of the most potentially significant public health interventions that Government and health services can make may take decades to produce measurable financial outcomes. For example measures that successfully reduce levels of overweight and obesity in children and young adults might not lead to financial savings to health services until those children reach middle to older age, when weight-related health complications would otherwise be more likely to occur. Public health interventions are more likely to have an impact when they are long-term and substantive. Short-term, one off policies that do not recur have only limited opportunity for changing population behaviour.

Where improved health outcomes are identifiable, it can also be very difficult to attribute particular outcomes to specific public health policies. For example, a variety of policies have been introduced to try and reduce tobacco consumption, but this multi-stranded approach can make it difficult to attribute success to any particular policy intervention. This makes measuring the cost-effectiveness and efficacy of individual approaches a challenge.

We would therefore caution against any approach that discards public health interventions that do not produce immediately measurable outcomes when assessing ‘value for money’. By their nature, long-term public health interventions can make tempting targets for funding reductions in financially straitened times, but such an approach is short-sighted and can lead to additional financial pressures elsewhere in the health system or at a later date.

The reduction in funding for alcohol and drug partnerships is one example of where public health services are facing cutbacks that will affect service delivery. Reducing the availability of addiction support services is likely to also have the knock-on effect of further increasing the pressures faced by general practice, particularly in more deprived areas.

The committee may therefore wish to look in more detail at examples of cuts that have already been made to public health budgets and the impact such decisions are expected to have on population health and other parts of the health service.

**Health inequalities**

Preventative spending to reduce inequalities could make a marked difference to what are often referred to as the social determinants of health. The most deprived communities in Scotland
are the most likely to have the highest prevalence of overweight and obesity, alcohol abuse and tobacco use. This in turn means that lifestyle related ill-health is particularly prevalent in areas of greater deprivation.

Reducing inequalities through measures that are generally considered not to be health policy such as improving education and housing, boosting employment and providing adequate financial support through social security to those who need it could achieve significant improvements to the health of people in more deprived areas. However, inequalities have remained persistent and cuts to welfare support in particular have undermined progress that might otherwise have been made in this area.

The committee may wish to look at ways in which preventative spending in the wider public sector could have the effect of reducing health inequalities. Adopting a ‘health in all policies’ approach of assessing likely health impacts of all public policy decisions would be a particularly welcome step forward.

Additionally, the cost of healthy food relative to less healthy alternatives, its availability in more deprived communities and the disparity in access to sport and exercise activities between wealthier and less-affluent areas are all inequality issues that could make a significant difference to public health.