Scottish Parliament Health and Sport Committee

Health Inquiry into Preventative Agenda: Call for Evidence

February 2017

NHS Health Scotland is a national Health Board working with public, private and third sector organisations to reduce health inequalities and improve health. Our strategy A Fairer Healthier Scotland¹ sets out our vision of a Scotland in which all of our people and communities have a fairer share of the opportunities, resources and confidence to live longer, healthier lives. Our primary role is to work with others to produce, share and implement knowledge of what works to improve the health of the people in an equitable way, thereby reducing health inequalities.

NHS Health Scotland welcomes the Health and Sport Committee’s inquiry into preventative spend. Prevention is often proposed as the best way to help manage financial pressures on the health and social care systems (as well as other areas of public expenditure) whilst improving health outcomes and tackling persistent inequalities in health. However, the debate is sometimes confused and confusing, and it is timely for the Committee to try and address some of the reasons for this to ensure that the second part of the inquiry is as clear and useful as possible.

NHS Health Scotland has argued in previous reports² ³ that prevention can:

- Improve health in a cost-effective way
- Help reduce health inequalities

The reports cited evidence that the most cost-effective forms of prevention and the most likely to reduce health inequalities are:

- measures tackling the social and economic determinants of health, such as programmes that ensure adequate incomes, reduce poverty and reduce income inequalities
- measures that use fiscal, regulatory or legislative levers to encourage behaviour change, such as minimum unit pricing or tobacco taxation.

¹ NHS Health Scotland (2012) A Fairer Healthier Scotland
http://www.healthscotland.scot/publications/economics-of-prevention
It also made the point that prevention has the potential to help reduce demand for services arising from poor health and other social outcomes but that the ‘savings’ arising from this are less certain. In light of the emphasis on savings sought from investing in prevention, it would be useful for the inquiry to explore this in more detail and address some of the challenges that arise from adopting this perspective. We enlarge on this below in response to the specific questions posed by the committee.

1. Which areas of preventative spending/ the preventative agenda would it be most useful for the Health and Sport Committee to investigate?

First of all, we think it is important that the Committee clearly defines the scope of prevention. Our perception is that different stakeholders define prevention in different ways. Some define it in terms of measures to prevent admission to, or prevent unnecessary use of, hospital and other health care facilities through provision of alternative forms of care. This is clearly important to help manage pressures on the acute sector and to ensure people are looked after in the most appropriate settings, but it is primarily a debate about how to meet established needs.

We would encourage the Committee to adopt a more public health focus on primary or secondary prevention that identifies ways of pre-empting the need for treatment and care in the first place by preventing the onset or development of disease. This requires measures within or beyond the health sector, intervening early to improve health, well-being and economic outcomes.

Our second point is related to the first. The focus on the role of prevention in reducing demand for and cost of public services is understandable in the current climate, but poses risks for prevention because the potential savings from prevention may be overstated.

In the shorter term, savings are limited by the scope to ‘strip out’ resources to make financial savings. Useful ‘time releasing’ savings may be possible by easing demand and therefore reducing capacity pressures. However, the overall change in financial cost will depend on what is done with the staff, beds, etc. ‘freed up’ by effective prevention.

Longer term, improving life expectancy can lead to additional pressures on the health and social care system as people age and experience the diseases and social care
needs associated with ageing. To offset this, it is important that prevention increases healthy life expectancy so that the length of time people spend in poor health as they age doesn’t increase.

Although it is challenging to make savings from prevention, this is not an argument to cut investment in prevention. Prevention seems to us (and others) to be unique in having to justify itself in terms of savings. We do not expect heart surgery or social care to demonstrate they save money. We invest in them because they improve health and well-being. Some services generate more health and well-being in relation to their cost than others (i.e. they are more cost-effective) and there is ample evidence, much of it summarised in NHS Health Scotland’s previous reports on the economics of prevention, that prevention is often (but not always) cost-effective. We would urge the Committee to focus on cost-effectiveness rather than cost savings, to use evidence to identify the most cost-effective preventative services and to encourage health boards and local authorities to prioritise these.

2. How can health boards and integrative authorities overcome the (financial and political) pressures that lead to reactive spending/ a focus on fulfilling only statutory duties and targets, to initiate and maintain preventative spend?

We would suggest this is partly about changing or supplementing current targets and performance management processes more generally. The current review of performance measures is relevant here. Many of the National Indicators in the National Performance Indicators make sense in terms of encouraging investment in prevention but some of the Local Delivery Plan (LDP) standards to which local boards are held to account encourage further investment in hospital or other health service-based activity to meet existing needs. Whilst this is clearly important to current patients, it also limits room for manoeuvre in trying to invest in more preventative approaches. Statutory duties and targets need to be more in line with what we want to achieve with respect to prevention and a shift in the balance of care and we suggest that this would be a useful area for the Committee to explore.

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https://publichealthmatters.blog.gov.uk/2016/03/07/investing-in-prevention-counting-the-cost/

Political will is also important in shifting towards prevention. Realising substantial savings for reinvestment in prevention is likely to require scaling back of some hospital or other healthcare facilities, in order to ‘free up’ resources to invest in preventative services. There are obvious political challenges in effecting such changes, but there is also evidence from the National Conversation on a Healthier Scotland that the public has an appetite for more preventative approaches to promoting health and for changes in how care is delivered. Responses called for “more focus on preventing illness rather than just curing it … the need to tackle the underlying causes of ill-health, many of which fall outside the traditional boundaries of health and social care, … There was general recognition that the current system of health and social care is under financial pressure, that change is necessary, and that clear priorities need to be set. The need to shift the balance of care from the hospital setting to the local community was highlighted.”

There is also some evidence that involving people in tough decisions, including explicit comparisons of options and opportunity costs (what you forego if you decide to maintain existing services) makes people more willing to accept the outcome of the process even if they don’t agree with it. The Committee might usefully reflect on how the public can be further engaged in this debate in order to create and inform a political climate in support of prevention and the actions required to promote it.

3. How could spend that is deemed to be preventative be identified and tracked more effectively? What is required in terms of data, evidence and evaluation to test interventions for producing ‘best value for money’?

More precise measurement of current spend on prevention would be a good thing in principle but challenging in practice. Much of the spending on preventative activities is not categorised as such because, for example, it takes place in routine primary and secondary care or because the primary goal is not prevention, in particular for services outwith the health sector. For example, housing is not primarily a preventative activity but to the extent that good housing is part of ensuring children have a good start in life, it helps to prevent some of the negative health, social and consequences associated with growing up in poor environments. NHSSHS believes that the scope of prevention should be defined widely. However, this means that a lot of time and energy could be taken up trying to define and measure preventative spend when it is not really feasible to do so and without moving us forward in terms of understanding what we should do about it.

We would suggest that the emphasis should be on using data and evidence to identify what we think are the drivers of (inequalities in) preventable mortality and morbidity, many of which we already know well enough, and then use evidence and evaluation to identify the most effective and cost-effective ways of tackling these.

To identify interventions that represent good value for money, rigorous economic evaluation is required and we need to make more effective use of the evidence generated by economic evaluation. The NHS Health Scotland publications mentioned earlier summarise some of the best available evidence.

This is particularly important to guide investment in prevention because it is often claimed that ‘prevention is better than cure’ and that prevention saves money. However, the results of rigorous economic evaluations are more nuanced than that. For example, a review of the economic evaluations carried out to inform the Public Health Guidance published by the National Institute of Health and Care Excellence (NICE) looked at 200 public health interventions such as workplace interventions to stop smoking, school based mental health and wellbeing interventions etc.\(^8\) Only 30 were estimated to be cost-saving, including NHS and workplace based smoking cessation services. The vast majority (but not all) were cost-effective, in particular those aimed at the population as a whole, such as legislation to reduce young people’s access to cigarettes. A few were very costly in relation to the health improvement they achieved and there were even some that were more costly and less effective than the alternatives against which they were compared. Similar results were found in perhaps the most extensive assessment of the cost-effectiveness of prevention carried out in Australia.\(^9\)

Both studies, and a large body of other evidence, provide a very strong economic case for prevention, but the case needs to be based on careful interpretation of the evidence and specific recommendations about the best forms of prevention in which to invest. This raises a more technical point about the need to be clear what the evidence tells us. One of the main reasons studies make different claims about the cost-effectiveness and cost-savings arising from prevention is that they use different methods. For example, ideally, studies should measure costs and benefits that fall on


services and beneficiaries beyond the health system, but this is not always possible and it is not always done. Some people argue that we should include the costs of treating people for the illnesses they experience because they live longer as a result of successful prevention. In general the effect of this is to reduce the estimated cost savings (if any) from prevention, but if we don’t consider them we are ignoring the financial consequences of greater longevity arising from successful prevention due to the increasing prevalence and cost of diseases associated with old age. We would encourage the Committee to use the opportunity afforded by the inquiry to get a greater shared understanding:

- of what we should be measuring regarding the economics of prevention
- of what has been measured when evidence is cited for or against more investment in prevention.

4. How can the shift of spending from reactive/acute services to primary/preventative services be speeded up and/or incentivised?

Many of the comments in response to question 2 are relevant here. The only additional point we would wish to make is that there is a need for ways of funding prevention that break the current cycle of high pressures on hospital and other public services that make it hard to find the resources to invest in prevention that would in turn help reduce some those pressures. The phrase ‘double running costs’ is sometimes used to capture the idea that we need to invest upfront in prevention whilst current services continue to meet existing needs. The longer term aspiration is, of course, that the preventative services will ease pressures on acute services such that resources can be shifted from acute into additional preventative services and create a virtuous circle revolving around a more prevention-focused system.

Scottish Government has created transformation funds to achieve this and different approaches have been tried elsewhere.10 11 12 We suggest that the Committee should focus on learning from these experiences to replicate or expand those that work and amend or avoid those that don’t.