Western Isles Director of Public Health/Health Improvement response to Health and Sport Committee

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

We would like to establish and clarify the definition of prevention and preventative spend.

Previous reports on prevention have shown that the most cost-effective forms are measures that tackle the social and economic determinants of health, mainly through programmes that ensure adequate income, reduce poverty and reduce income inequalities. There is a risk of focusing prevention efforts predominantly on individual health behaviour change when the evidence shows the powerful influence of social and economic factors. Most of the factors influencing health lie outside the immediate reach and traditional remit of the health system – early-years experiences, education, working life, income, physical and environmental conditions.

There is good evidence that economic conditions, social and physical environments are the most significant factors in creating and driving health inequalities. Actions on fiscal policy, legislation and cultural change are therefore going to be important in reducing the impact on health. There appears to be a social gradient closely linked to health outcomes. It would be useful to understand which elements and what combinations have the most impact on preventing poor health.

Within the NHS, actions that improve equity of access to services and facilities, and that focus on improving health in the most vulnerable groups, can make important contributions to preventing further increases in health inequalities. To have a clearer understanding of the contribution of; activities to improve health literacy, the impact of ‘proportionate universalism’, the importance of assessing and improving mental wellbeing within primary care, and the role of NHS staff in assessing patients for poverty and referring and advocating on their behalf. There is a body of evidence on the effectiveness of behavioural interventions. The Health Inequalities Policy Review demonstrated these are less effective in reducing health inequalities.

There is good evidence to support the importance of early years in children’s development and outcomes in later life. Adverse childhood experiences, stress, childhood poverty and poor mental health contribute to unfavourable lasting health deficits. Recognising the limited resources available it would be useful to have a focus in the investigation on preconception, pregnancy and the first 1000 days of a child’s life. A focus on alcohol and foetal alcohol harm, tobacco use, mental health and the associated impact is likely to produce better outcomes from the investigation.

We would recommend:
That the committee does not limit the investigation to specifically address spend within the NHS system but includes spend from other sources.
The committee assesses spend that improves population health by reducing the incidence of health problems (emphasis on early years) rather than a focus on reducing the progress of health problems and reducing the impact of disease.

The committee assesses which forms of preventative spend impact positively upon reducing inequalities in health.

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?

The current targets and standards for healthcare and treatment create an imperative to meet government and public expectations on treatment and do not emphasise the preventative role of health boards. The emphasis is upon improved service quality and reducing unmet need. Preventative spend would have to be identified as a specific amount or proportion of health board overall budgets, with a minimum spend identified for each NHS Board or IJB.

The emphasis of that spend should be on activities to reduce public spending demands in the future by reducing avoidable health and social problems (‘failure demand’). The evidence would suggest that preventative spend must also reduce the length of time people spend in ill health, not just increase life expectancy. When these conditions are met then some of the pressure from treatment services will reduce. That excess spending would then have to be able to be identified and allocated to preventative spend.

This would require a health economic assessment of techniques that establish a suitable methodology.

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’?

A very useful model for ‘Informing investment to reduce health inequalities in Scotland’ was developed by ScotPHO. Eleven interventions were modelled based on the available literature. Modelling approaches were developed that used the best available data and evidence at the time to estimate reductions in hospitalisations, YLL and health inequalities associated with a range of public health interventions. A transparent and usable interactive tool was developed that allows users to model a range of interventions designed to reduce
health inequalities. They found that Interventions have markedly different effects on mortality, hospitalisations and inequalities. The most effective (and likely cost-effective) interventions for reducing inequalities were regulatory and tax options which affect income. Interventions focused on individual agency were much less likely to impact on inequalities, even when targeted at those in the most deprived communities.

A similar model should be developed to identify and track preventative spend. This model would also allow estimates of future effectiveness and prioritisation of ‘best value for money’

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

Points made in question 2 are also relevant to this question. The recent Health and Social Care Delivery Plan lays out a strategy to improve our health and our health and social care system. It states that:

To improve the health of Scotland, we need a fundamental move away from a ‘fix and treat’ approach to our health and care to one based on anticipation, prevention and self-management. The key causes of preventable ill health should be tackled at an early stage. There must be a more comprehensive, cross-sector approach to create a culture in which healthy behaviours are the norm, starting from the earliest years and persisting throughout our lives. The approach must acknowledge the equal importance of physical and mental health as well as the need to address the underlying conditions that affect health. This is supported by a target to shift resources to the community

By 2021, we will: Ensure Health and Social Care Partnerships increase spending on primary care services, so that spending on primary care increases to 11 percent of the frontline NHS Scotland budget. Again, the annual reports produced by Health and Social Care Partnerships and regular monitoring data will be used to assess progress.

While it concentrates on health services, it recognises that aspirations will only be delivered through a wider focus on the support provided by a range of services. It acknowledges that change must take place at pace and in collaboration with partners across and outside of the public sector, and that partnership working is essential for the planning that will deliver the actions.

The strategy of identifying a financial target with a timescale attached to an action plan is useful.

Policy decisions across Departments in Scottish Government must consistently support the wide range of services that will be required to take pressure off acute services and prioritise those agencies that support prevention.