Health & Sport Committee call for evidence on preventative spend

February 2017

About Arthritis Care Scotland
Arthritis Care Scotland is the country’s largest charity providing information and support to those living with or affected by arthritis. We provide a number of online and face to face services to ensure that no one faces arthritis alone. We also have branches and groups all throughout Scotland.

About arthritis
Arthritis means inflammation of the joints and it can cause pain, fatigue, stiffness, and difficulty moving. Arthritis can affect people of all ages, including children, and there are over 200 types of arthritis and rheumatic disease.

In this response, we also use the term, musculoskeletal synonymously with arthritis.

- There are approximately 800,000 people in Scotland living with osteoarthritis and this number is set to double over the next 15 years
- It is estimated that 60,000 people in Scotland have rheumatoid arthritis, and every year just over 2,500 people are diagnosed
- 1 in 5 people in Scotland live with chronic pain
- Reduced musculoskeletal health increases cardiovascular disease and early mortality and leads to poor mental health

Main points

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

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1 Musculoskeletal conditions and public health in Scotland - policy statement, Arthritis Research UK, October 2016
The Health and Social Care Delivery Plan commits to ‘Supporting a More Active Scotland’, including a refocusing of resources. For people living with musculoskeletal conditions, support for physical activity is likely to be central to avoiding unnecessary medical interventions and community-based targeted activities, such as Arthritis Care Scotland’s walking and tai chi groups, are a key resource. However, assessing impact of community based activities remains problematic as these are often seen as ‘soft’ interventions separate from formal models of health and social care. Building up new community based models of service delivery needs to reflect these less formal approaches and the Health and Sport Committee should focus attention on these. This should include investigating support for community-based initiatives in primary care, particularly through the new clusters.

**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?**

“... public health interventions can suffer from a lack of what is usually deemed to be ‘high strength’ evidence, such as randomised controlled trials (RCTs). Unfortunately there will be many situations where we will never have such evidence, but we nevertheless have to use the evidence available to us, including less robust evidence like case studies, and make assumptions in order to invest in areas that we know are likely to be cost-effective.”²

Those case studies and the underpinning of those assumptions are a key part of the third sector’s contribution to understanding the best locations for preventative spend. In seeking out this information it is important that those front line organisations which provide support for people with long term conditions are engaged directly and not only accessed through intermediary bodies.

Arthritis Care Scotland’s Stepping Out Project (funded through Paths for All) is a good example of the kind of activity that can demonstrate impact from relatively modest amounts of spend. The committee should seek out information in relation to: development of confidence and self-esteem in individuals who access these types of initiative; development of local capacity, including leadership; and the embedding of sustainability in local communities. The focus should also be on perceived return on investment by funders and those who access the services.

**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’?**

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² [https://publichealthmatters.blog.gov.uk/2016/02/22/investing-in-prevention-the-need-to-make-the-case-now/](https://publichealthmatters.blog.gov.uk/2016/02/22/investing-in-prevention-the-need-to-make-the-case-now/)
20% of GP consultations relate to musculoskeletal conditions\(^3\). As such, primary care data should make a significant contribution to identifying what does and doesn’t work. Unfortunately, this is not yet the case.

Current work on use of ‘administrative data’ in developing an evidence base for policy around preventative spending is largely concentrated on high tariff service areas (e.g. accident-related hospital admissions for people with dementia) and level of dependency is a common criteria. However, we also need to explore ways of identifying data from ‘soft interventions’ (like walking and exercise), which reveal potential benefits in the formal health and social care system and in relation to secondary prevention. The Civil Society Data Partnership and the Administrative Data Research Network are currently exploring some of these opportunities and the committee should investigate their work in this area.

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

Thinking around preventative spend can be snarled up by the language of opportunity costs, double accounting and discounting\(^4\). In other words, the deferment of results to the long term will always be an issue. However, the experience in mental health, where institutional care has largely been replaced by community-based care, should offer some insights and the committee should investigate what lessons can be learned from that historical process. In particular, it should look at the role of patients and carers as champions of change.

The committee should also look at arthritis/musculoskeletal conditions as a potential exemplar for challenge and change. These are conditions that affect a significant proportion of the population in Scotland but have less public health profile than, for example, diabetes. It is becoming imperative, particularly with the anticipated growth in numbers, to scrutinise their impact in relation to individuals, families, communities, the workplace and services and the committee’s thinking may benefit from this specific focus.

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February 2017

\(^3\) Musculoskeletal Health – a public health approach, Arthritis Research UK, June 2014

\(^4\) [https://publichealthmatters.blog.gov.uk/2016/02/29/investing-in-prevention-is-it-cost-effective/](https://publichealthmatters.blog.gov.uk/2016/02/29/investing-in-prevention-is-it-cost-effective/)