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

Prevention can be a cost effective way of improving health and also help to reduce health inequalities. The Christie Commission noted that as much as 40% of all spending on public services is accounted for by interventions that could have been avoided by prioritising a preventative approach. However, the issues that drive the need for so much of our public sector funding to be spent on reactive and crisis interventions are complex and usually cut across sectors and require collaboration over a long period of time. They are issues that cannot be resolved with a ‘quick fix’ and need sustained and coordinated efforts from all sectors and elements of society.

Within this context it can be difficult to focus on particular areas of the preventative agenda as the scale of change that is required is huge. It is important to define what we mean by prevention i.e. is it about the full range of primary, secondary and tertiary prevention? However we define it, we must acknowledge that it will not be about focusing on a single solution or a limited set of responses, but will require system wide changes to support a move to prioritise prevention. It is changes in systems and ways of working, and building prevention into the design and delivery of all public services that are likely to be required to increase investment in prevention.

Available evidence points us to some areas of preventative spend that have been successful or that have potential to have a positive impact on reducing demand for costly interventions further down the line. Policy and activity in relation to smoking has been a positive story and like a number of preventative measure are considered to be cost effective. However, achieving this has taken time and has required a concerted effort across a number of policy areas, multiple strands of activity and action at all levels across the public sector. Similarly there is evidence that having broad programmes of preventative work on alcohol, physical activity and healthy weight are likely to reap benefits. It is important to ensure parity between physical and mental health and wellbeing across the life course; with mental health and wellbeing often not gaining the same attention in relation to prevention as physical health.

There is a strong case for investing in the early years, with evidence citing benefits in terms of both health and financial returns. Similarly evidence on the ‘cost’ of adverse childhood experiences suggests that preventative activity in this area is likely to reduce demand for interventions later in life. Conflict and violence is perhaps an area that would benefit from further detailed thought. There is also evidence that preventative work with adolescents has the potential to reduce interventions further down the line and this important area of the life course may also be good to focus on.

Further, evidence suggests that focusing on programmes that ensure adequate income for health, reduce unemployment, improve physical environments and provide intensive services for vulnerable people have the potential to improve
health in a cost effective way and reduce demand for more expensive interventions and public services\(^5\).

Scottish Fire and Rescue Service have been successful in making a shift towards prevention across the organisation as a whole. In recent years they have moved from being a reactive organisation designed to put out fires to an organisation that focuses mainly on fire prevention and community safety. Their experience shows that significant gains can be achieved by a shift to prevention and learning from their experience may be helpful to other organisations in making a similar change.

It is not clear how successful the recent preventative funds in relation to older people, early years and early intervention and reducing reoffending have been in creating system wide change and sustaining efforts to move towards the preventative agenda. It would be useful to learn from experiences of recent attempts to introduce preventative spending in these areas.

Specific preventative spend funds have been helpful in getting organisations to focus on prevention but the biggest gain is likely to come from ‘bending’ mainstream activity and resource towards prevention. To make this happen will require political buy in at all levels and engagement of public sector staff, the media and the wider public. In essence we will need to change the conversation that we have around public services.

In summary, it would seem sensible to focus on areas where there is a body of evidence about what is likely to be most effective in relation to prevention, whilst also considering how we can build evidence in areas where there is currently little evidence available. It will be helpful to learn from recent experiences of preventative spending and organisations that have successfully made a shift to prevention.

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?

As mentioned above, there is a need to change the conversation that government, health boards and integrative authorities have with the public in relation to models of delivery and sustainability of health and social care services. Taking a public health approach to service design and delivery will be helpful. Political buy in at all levels to these messages will be essential to allow a mature and well considered response to the current pressures faced by boards and integrative authorities. Good community engagement is essential and boards and integrative authorities should be supported to develop and use the skills and resources necessary to do this in a meaningful way.

The current system of targets and performance management for health boards does not lend itself well to encouraging a shift to prevention. Instead they encourage investment in hospital services and interventions that are about meeting existing demand. They are short term and limit flexibility in relation to shifting to prevention and preventative spending. A review of targets and
statutory duties that better support the preventative agenda would be useful to support a focus on public health for the whole population.

The one year break even rule that health boards have makes it more difficult to make investments that do not have an immediate impact. If boards were able to carry forward reserves, it could allow them to build up an investment fund that could then be used for prevention. Checks and balances would need to be in place to ensure that this funding would not be used to invest in services to meet existing demand, but in theory once a reserve is established it should not impact on boards’ ability to meet the normal short term duties. This would be challenging when significant savings targets are in place.

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'?

Tracking preventative spend is by definition an input measure. The implicit danger of this is that there is focus on a narrow range of ‘definite’ or ‘obvious’ preventative spend and that in itself becomes the focus and target. Greater opportunity lies in how we can ‘bend’ mainstream activity and therefore spending towards prevention but this would probably be impossible to track or measure.

It is important to recognise issues in relation to testing and delivering preventative services and initiatives in remote and rural areas, particularly in relation to de minimis costs. Having flexibility on how to deliver and in the use of single stream funding is important in this context.

Currently much of the spending in health boards and integrative authorities that relates to preventative activity is not ‘badged’ as such because it is part of delivery of routine services, for example primary care. There are also services, particularly out with health services whose aims are not about prevention but their activities will nonetheless have an impact on preventing poor outcomes. For example education or housing where services can help to prevent some of the negative health outcomes that comes from having poor housing or poor educational attainment.

In this context, it will be very difficult to track and identify preventative spend, and efforts to do so may not be worth the effort in terms of resources versus what we will gain from such an exercise and is likely to distract from what we want to achieve in relation to prevention.

There is a body of evidence that makes a strong economic case for prevention but we do need some way of making decisions about where to invest to make the greatest impact. Good economic evaluation of preventative measures will be required but will not be sufficient to make the fundamental and system wide shift to investing in prevention. Other measure already mentioned in relation to targets and performance management, changes to financial and other systems and ways of working will also be necessary. Small tests of change may be helpful in providing supporting evidence in relation to best value but it would be very difficult to scale this up to make it meaningful to the wider system.
4. **How can the shift of spending from reactive/acute services to primary/preventative services be speeded up and/or incentivised?**

As previously mentioned, an overhaul to the current target and performance management system which pushes health boards and integrative authorities towards reactive services and activities would support a shift to prevention. Taking a public health approach to service design and delivery and strengthening partnership working across the public sector will help. Developing a system that would allow health boards to build up a reserve for use in prevention would also be helpful in supporting new ways of funding preventative activities and services.

Whilst most people would support the idea that prevention is a good thing and has benefits to individuals, communities and services, it is often difficult to change ingrained ways of working (and thinking) that supports a fundamental shift to prevention. As well as a focus on ‘the money’, sustained efforts to move to prevention will require:

- a strong and clear political message at all levels of public life
- a commitment to prevention from all public sector professionals that is embedded in all training and professional CPD frameworks and supported by a system of objective setting and review that strengthens their role in delivering the preventative agenda
- a strong statement from public sector organisations to commit to prevention and embedding that commitment in organisational objectives, priorities, targets, performance management and funding arrangements/decisions

**References**

3. Wave Trust in collaboration with the Department for Education. *The economics of early years’ investment*. 2013  
   [https://www.wavetrust.org/sites/default/files/reports/economics-appendix-from-age-of-opportunity_0.pdf](https://www.wavetrust.org/sites/default/files/reports/economics-appendix-from-age-of-opportunity_0.pdf)