Scottish Health Promotion Managers 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?

A starting point would be to have an agreed definition of prevention and the preventative spend. We would like to see preventative spend on a permanent footing and an agreed minimum level of preventative spend determined for each NHS Board / IJB. The primary call on this resource should to reduce the inequalities gap and tackle social determinants of health to mitigate and prevent inequalities. Consideration also needs to be given to an agreed level of earmarked preventative spend for local authorities and other community planning partners as currently if one partners makes a financial saving, e.g. financial inclusion services, it is assumed another partner will address this.

The Health and Social Care Delivery Plan (1) notes that one of the main public health challenges for Scotland is to tackle key health harming behaviours that affect population health outcomes across age groups in Scotland (diet, physical activity, tobacco and alcohol) and that have significant implications for health and social care needs and for care costs. An example of this is the recently reported impact on maternity services of the pregnancy complications associated with obesity. There is an opportunity to consider the development of a more integrated approach to prevention across these health topics, which have tended to be addressed in isolation. The SHPMG would encourage the Committee to take an integrative approach to prevention, not least because of the need to avoid over specialization. These health harming behaviours are risk factors for a number of preventable diseases including diabetes, heart disease, stroke and some cancers. Many of the health-harming behaviours that characterise the health of the population in Scotland are also associated with poor mental health.

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. Prevention should include system or environmental prevention; targeted prevention with vulnerable groups; early intervention with those with known risk as well as population prevention to address culture, skills and social norms.

There are powerful policy levers for prevention: through legislation and regulation and through policy and strategy. We also need to learn from assets based approaches and the factors that help keep people well. We also need to appreciate the value of community and group interventions and actions.

Health literacy is a prerequisite for maintaining wellbeing and in the effective self management of long term conditions and disability. It is promising to see the growing interest in Realistic Medicine as context to promote health literacy through more effective engagement and communication between clinician and service user / patient about management of conditions and desired outcomes. The opportunity to connect service users/ vulnerable groups with a wide range of community services/ opportunities is important for person centered care planning. Dedicated roles such as community connectors/ link workers have a place alongside mainstream health and social care roles but all are underpinned by multi agency collaboration and referral pathways.

The fact that 1 in 10 children and young people experience mental health problems has a considerable personal, social and economic impact. Poor mental health in adulthood frequently starts during adolescence. Unidentified and untreated problems lead to poorer health, educational and social outcomes with significant costs to the public sector.
There is now considerable evidence on the life situations and circumstances which increase risk of poor mental health – adverse experiences in childhood, experience of loss, change, ill health, social isolation and exclusion, prolonged financial stress and insecurity. There is an important role for community and the voluntary sector in supporting families and communities and in building social connectedness and resilience. There is also a vital preventative role for public policy in reducing child poverty, promoting attainment, good employment opportunities and thriving communities. The prevention of poor mental health is an area that warrants further attention as part of a wider preventative agenda.

The importance of early years experiences is now well accepted in Scotland and is a recognized priority for policy and delivery with a range of positive outcomes so far. The continuation of this is required in order to have a meaningful long term impact. Public Health Wales (2) has recently reported on a study on the impact of adverse childhood experiences on adult health outcomes which has relevance for Scotland. It is understood that it is proposed to conduct similar research in Scotland which would undoubtedly further understanding of the case for prevention.

There is growing interest in Scotland in preconception care as it is now acknowledged that the health of the mother before or early in pregnancy impacts on the health of the child long after infancy. Preconception care would aim to improve health for all women of childbearing age and to target support for women at highest risk of poorer medical or social outcomes.

With the attention to early years, the importance of youth health as a focus for preventative work can be overlooked. Youth health influences health outcomes in later life. Youth health data can: describe the current health and health needs of young people; indicate the medium term outcomes from early childhood; and predict likely future patterns of health and health needs. The inter-generational nature of health outcomes is also significant. Young people may already be parents, or are likely to become parents. Their health and health behaviours can have a profound effect on outcomes for the next generation. Factors that are important in this regard include parental mental health, alcohol consumption, nutrition, physical activity and substance use.

There are opportunities to consider the preventative agenda in relation to health of young people that could also support the Scottish Government’s goals of closing the attainment gap.

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?

More dialogue between the public and policy makers and planners on the pressures facing the health service and the need for more focus on maintaining health and preventing disease i.e. Realistic Health Policy.

Preventative spend should have the same importance as the 4 hour waits at A&E. There should be shared targets with Community Planning Partnerships. More use should be made of economic evaluation of treatment options where evidence can be presented on the most effective use of spend. e.g. Healthier Wealthier Children (financial inclusion initiative) has an impact on reducing poverty, therefore reduces the need for HSCP & NHS services, especially mental health and addiction services.
More transparency on reporting on preventative spend would be welcome. Monitoring of spend on prevention could be undertaken through outcomes framework. A clear and robust framework for resource allocation and decision making needs to be available to Health Boards and CPP’s, as well as a recognisable way of assessing the shift towards prevention and levers for transforming our systems towards prevention and early intervention rather than the current focus on reducing demand on the health care system; e.g. delayed discharges; 4 hour waits at A&E.

The more recent approach to increase the discretion for local NHS Boards to make decisions about the allocation of the public health budgets in bundles has advantages but does also lead to Boards taking different approaches. When other budgets are under pressure, monies for prevention can be at risk if not ring fenced. SHPMG would welcome more national discussion about the challenges in protecting resource for prevention, among IJBs and CPPs.

In short term, it is as important to protect preventative services as it is to ‘make the shift’ to preventative spend. There is a risk, particularly in a relatively small organization / partnership that a critical mass of preventative services becomes unviable if they drop below a critical scale.

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’?

The argument for prevention has been well established e.g. The King’s Fund and Local Government Association estimate that preventing or reducing smoking, obesity, alcohol or physical inactivity could deliver savings to the £14 billion spent on treating the impact of these issues in the UK every year. Health economist assessments have shown that earlier and earliest interventions offer best value for cost per outcome. As an example every £1 spent on preventing teenage pregnancy is estimated to save health and care service £11.

WHO Europe (WHO, 2014) estimates that only 3% (range 0.6 – 8.2%) of national health sector budgets was spent on public health and that those countries that invested more also experienced stronger health outcomes.

The Public Health review (2015) calculated that around 2.6% of the NHS budget was used for dedicated public health activity in 2014/15 (including health visitors and school nursing), 1.3% excluding these disciplines.

There are three key economic principles that underpin the importance of preventative objectives:

- Prevention is cost-effective;
- Prevention will save the health service money in the long-term; and
- The benefits of prevention reach far beyond the health system to society as a whole.

Yet the health care system in effect rewards hospitals for dealing with the very complications of disease that we are trying to avoid. by increasing budgets for treatment services at the expense of investing in
prevention and early intervention. This may alleviate short-term pressures, but failing to invest in preventive measures is a ticking time bomb for the treatment services we are funding now.

These perverse incentives exist in many other areas of public health and can only be tackled by adopting a system-wide approach, rather than budgets for treatment and budgets for prevention operating in silos.

Economics is an aid to decision-making; it will not provide all the answers, but its value does lie in structuring problems. Pragmatically, faced with making the business case for investing in prevention, we must consider:

- Long-term return on investments in prevention (including social returns);
- Incentives for investing in prevention and early intervention activities; and
- The evidence on the cost-effectiveness of public health interventions.

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

The Kings Fund recently produced a report on how to transform community services (3). Key messages included:

- Remove the complexity that has resulted from different policy initiatives over the years. A simple pattern of services should be developed, based around primary care and natural geographies and with a multidisciplinary team. These teams need to work in new ways with specialist services – both community and hospital based, to offer patients a much more complete and less fragmented service.
- Community services need to reach out into communities more effectively. The opportunity to harness the power of the wider community to support people in their own homes, combat social isolation and improve prevention is not being fully exploited.

The recent Scottish Government Health and Social Care Delivery Plan sets out the strategic direction for shifting spending from acute to community care. This states that in 2017, Health and Social Care Partnerships – with NHS Boards, local authorities and other care providers – should make full use of their new powers and responsibilities to shift investment into community provision by reducing inappropriate use of hospital care and redesigning the shape of service provision across hospital, care home and community settings.

2. [http://www2.nhs.wales.nhs.uk:8080/PRIDDocs.nsf/7c21215d6d0c613e80256f490030c05a/d488a3852491bc1d80257f370038919e/$FILE/ACE%20Report%20FINAL%20(E).pdf](http://www2.nhs.wales.nhs.uk:8080/PRIDDocs.nsf/7c21215d6d0c613e80256f490030c05a/d488a3852491bc1d80257f370038919e/$FILE/ACE%20Report%20FINAL%20(E).pdf)