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

- A lack of priority given to prevention is bad for inequalities – groups with high levels of social need and low resources have the most to gain from prevention and from early intervention. In the context of prevention it is essential to consider inequalities in poor outcomes not just the average. It takes significant social or fiscal change, a long time series, or all of these to see a rapid step change.

- The question should be – ‘Which preventative activities reduce health inequalities as well as improving aggregate health outcomes?’

- To explore this further it is essential to explore why there is a reluctance to use the most cost-effective forms of prevention and the most likely to reduce health inequalities [Macintyre S. Inequalities in health in Scotland: What are they and what can we do about them? Glasgow, UK: MRC Social and Public Health Sciences Unit, 2007, Working Paper #17] o measures tackling the social and economic determinants of health, such as programmes that ensure adequate incomes, reduce poverty; reduce income inequalities [Morris JN, Minimum income for healthy living. https://www.ucl.ac.uk/icsl/publications/op/op1.pdf] o measures that use fiscal, regulatory (such as licensing) or legislative levels to reduce exposure to harm - for example addressing the commercial determinants of health e.g. the sale and distribution of tobacco, alcohol, addressing fast foods through consumer protection. Several studies by Scottish academics demonstrate the social gradient in tobacco and alcohol outlet density, and their co-location. This highlights the extent to which current approaches to licensing contribute to the social patterning of harm. [Shortt et al. BMC Public Health (2015) 15:1014, EA Richardson et al. Health Place 33, 172-180. 2015.] o measures that use fiscal, regulatory or legislative levers to encourage behaviour change, such as minimum unit pricing or tobacco taxation.

- Why less effective methods that increase inequality, such as individual behaviour change or education on lifestyle are favoured when they should be only a small part of a comprehensive approach.

- Why prevention and treatment are not seen in practice as part of a comprehensive, integrated approach to investing in health and reducing health inequalities. Even if we have optimal preventative services there will still be a need for ‘rescue’ – while approximately 60% of chronic disease is preventable, everyone is likely to get sick and need some care and treatment eventually. This is not necessarily a failure of preventative services.

- What should be the proportion of the recurrent health budget – non-ring fenced- for preventive spend?

- How do we ensure that ring-fenced monies are additional, focused on priorities agreed by stakeholders and guided by public health professional input?

- What is the evidence base for short term targets? Can we learn from countries that have taken a longer term view of investing in prevention: there may be lessons to be learned from examples of longer term, structure investment in Canada, Australia and New Zealand, mainland Europe and elsewhere?
- Are we investing non health monies wisely – taking a Health in All Policies approach? To prevent poor health and reduce inequalities, therefore, needs investment in the social determinants – education, housing, income, physical and social environment, but these are mostly funded from non-health budgets.
- We should also recognise that prevention is needed across the life course. There is a danger that the focus is solely on early years’ activities and that older young people and adults are forgotten. We have seen this with recent shifts in resources towards early years’ activities; in a society in which overall child poverty levels are 22%, there is little recognition that even with a good start in life things can go wrong - we must invest in securing a healthier future for young adults and those of working age.
- Prevention is often cited as being cost saving and, at population level, minimising the burden of vaccine preventable disease, reducing the prevalence of childhood neglect and abuse, improving school attendance and attainment, ensuring that all have a minimum income for healthy living and shaping the fiscal and regulatory environment to reduce exposure to harm and addictive substances would reduce the burden of premature and avoidable ill-health. Currently, the onset of multimorbidity occurs 10-15 years earlier in the poorest and most stigmatised groups; properly funding these interventions would be likely to reduce the overall prevalence and the inequality gap.
- Preventive approaches are cost-effective in the short (life-time of a Parliament) as well as longer term. Social protection, immunisation, the ban on smoking in public places, increasing income, tackling air pollution, investing in walking and cycling, housing interventions (insulation and indoor air quality) are examples.

[http://www.euro.who.int/__data/assets/pdf_file/0009/278073/Case-Investing-PublicHealth.pdf]. There is also evidence for the increase in harm that arises from cutting or failing to invest in prevention e.g. in the UK reductions in housing benefit and increasing symptoms of depression [Reeves et al DOI: 10.1093/aje/kww055] and seen most starkly in the adverse health outcomes and increase in inequalities experienced in Greece with stark increases in depression, infant mortality, infectious disease including HIV. [Karanikolos et al http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(13)60102-6.pdf]. In the capital we experienced an avoidable HIV epidemic [Robertson & Richardson https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2099412/] and there is some evidence of an emerging increase in risk markers for a potential future HIV outbreak. In addition, based on local review, our preliminary data indicate a significant acceleration (40% increase) in drug-related deaths from 2015 to 2016.

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 NHS (Scotland) Act 1978 already sets out the core purposes of a comprehensive and integrated health service [http://www.legislation.gov.uk/ukpga/1978/29]. These include promoting and securing improvement in the physical and mental health of the people of Scotland and preventing disease. Integration Joint Boards have the same duties.
- While the Local Government (Scotland) Act 2003 includes the discretionary power to advance wellbeing, this is secondary to the duty to secure best value.
- In both cases, the requirement to break even or stick to an annual budget emphasises and rewards short-termism. Best value rewards immediate benefits but more sophisticated
modelling enables future benefits, equity and sustainability to be recognised and weighted appropriately.

- Scotland, with a significant burden of avoidable and amenable ill health, premature death and socioeconomic gradient finds itself close to the bottom of the table of established Western European democracies when it comes to the proportion of GDP and of health and welfare funding that is spent on prevention. In terms of health, it sat below the 3% average health spending in the European Union before the reductions in ring fenced allocations of 723%. Changing this will require serious effort – ensuring the action required remains a priority and devoting time to think, act and finance things differently. A one year funding cycle and local delivery plan does not allow for this.

- Probably the most important thing we could do to prevent future ill health and also prevent future health inequalities is to invest substantially in universal public services; to shift the discourse about public services to the point where we see them as a societal asset, an investment in all of us, to which we all want to contribute our tax revenues, rather than a drain on public finances that we need to squeeze as much as possible.

- The reasons why spending on prevention and reducing inequalities get squeezed are well-rehearsed in analysis of the impact of funding initiatives rather than allocating the required proportion of spending at source and building capacity. The current approach to prevention is akin to that of traditional donor aid to developing countries as outlined in the 2005 OECD report [http://www.oecd.org/dac/effectiveness/34428351.pdf]. Our governance systems mean that there is no evidence of corruption but funding for prevention is provided after other commitments have been addressed, is short-term or non-recurrent and subject to the same pressures of dilution, diversion, delay and substitution.

- It could be argued that a structural reliance on short-term funding for long-term interventions, while common internationally as well as in Scotland, is incompatible with a commitment to health equity and securing the right to health as poorer individuals, stigmatised communities and those with protected characteristics are disproportionately disadvantaged by loss of funding and short-term interventions.

- For example, austerity has impacted more on preventative services because ‘rescue’ services that address established need get prioritised - understandable as they generate demand and meet current expressed needs, whereas prevention does not - but this is storing up problems in the future. In some areas where provision of closed /secure units for children has been reduced or closed altogether, we have argued that that money could be reinvested in children and put back into prevention. We agreed at one children’s services partnership that this would be a measure of success, but this has not occurred despite the places being closed and the budget being released.

- A focus on addressing outcomes and fulfilling core purposes would help shape resource allocation at source. There are currently few incentives for health boards and local authorities to invest in prevention. Despite the statutory responsibility for prevention that Health Boards, Local Authorities and Integration Joint Boards already have, this is not given prominence in spending or debate. Not all funding for prevention should be NHS funding but currently we underinvest in reducing exposure to the upstream risks of harm and in comprehensive prevention as an integral part of a universal service.

- Stronger incentives for investment in prevention would be welcome. This should sit alongside a similar statutory duty on health and local authorities to address the socioeconomic gradient in health, well-being and participation, to provide guidance on how the right to health should be addressed locally, regionally and nationally. Establishing a proportion of the transport budget to be spent on walking and cycling and clean public transport, % of economic development to be spent on micro development, % energy budget
to be spent on clean energy, % education budget to be spent on language classes etc.,
maintaining universal access to free school music lessons would be a good start.

• We should invest in line with ability to benefit and in cost effective services. The current performance system seems to encourage competition between prevention and rescue for funding rather than seeing both as essential for good outcomes and requiring all investment to be cost effective and based on ability to benefit.

• The main drivers of the increasing cost of healthcare are technology and medicines, not an inevitable cost of ageing or palliative care in frail older people. Without directing attention to the cost–effectiveness, opportunity cost and prioritising ability to benefit across the life course, funding diverted indiscriminately towards specific interventions is likely to increase treatment rates among more affluent patient groups who are more able to take advantage of the opportunities for planned treatment.

• In addition, the loosening of the cost-effectiveness and quality of life criteria for funding of new medicines and technologies, incurs significant cost and these areas are increasing the proportion of resources available to patients with some conditions and at later rather than earlier stages of their disease.

• There has been little attention to the waste of human and financial resource associated with repeated tendering of services individuals and communities require long term and that should be universal services rather than targeted initiatives. Targeted initiatives usually do not address underlying causes, result in stigma and misses a significant proportion of those who could benefit. For example, in Lothian, crude geographical targeting misses about half of socio-economically disadvantaged people who are hidden in larger population groupings, let alone the people who are disadvantaged or stigmatised by other factors.

• Proportionate universalism doesn’t just mean targeting more resource to the places and people that most need support (this is an essential but partial response) but also investing in the types of service from which people with the highest levels of social need are most likely to benefit. For example, in a particular youth service that provides universal youth work open to all in their area, some young people need more than this and respond well to cross generational work and mentoring support but still within the universal provision which is less stigmatising and more empowering than their engagement in social work/targeted services. Attendance at these additional services is usually short lived with young people moving on to greater use of universal provision.

• To scale up this example requires that universal services have equity designed in rather than being ‘inequalities-sensitive’ as an afterthought. While this should already be a requirement on services, and NHS Scotland has traditionally been more equitable than health services in many other countries, this should not be taken for granted.

• Greater attention should also be paid to the role of the third sector and the quality of partnership between statutory and third sector services and communities. The third sector is adept at bringing in additional resource from across a range of funding sources, can deploy resource rapidly and should be seen as a key arm of public sector service provision, particularly since many NHS staff also volunteer in third sector organisations in their own time. They are also experiencing a reduction in funding for prevention and capacity building. For these organisations to remain effective, we should also ensure that they are not inadvertently incentivised to become pseudo-corporate rather than community focused organisations that can tell truth to power by virtue of their ability to make a difference locally.

• Short term funding and misunderstandings regarding how best to provide our procure services also leads to the use of ‘market-style’ approaches that reduce the effectiveness of prevention, early intervention and harm reduction. Underserved and stigmatised individuals
and communities do not develop trust in services easily, so complex eligibility criteria, means testing and lack of continuity mitigate against early engagement with interventions and services designed to prevent ill-health, to intervene early and to mitigate the impact of adverse life events on health and ability to participate in society. The current arrangements are a source of avoidable harm.

- In general prioritising prevention in health and social care means prioritising early years, primary and community care. This is the opposite to what has happened in recent years - for many reasons, one of which is that 'cutting edge' acute, particularly planned care services – and the professionals that work in those settings - have a higher status than services closer to the community despite the fact that universal access to neighbourhood primary care contributes more to population health gain.

- Reorienting resources to community is made harder because politicians have resisted advice to close hospitals, even where healthcare outcomes could be improved. There are two main reasons other than concern about public opinion. The first reflects the importance of hospital services to local economies. There are lessons from countries such as Norway that have taken a national approach to provision of specialist services so that equity and close links between local and national services are maintained. The second is the impact of the long term and costly contracts associated with the private finance initiative, that distort health service spending and the distribution of services.

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’?

- WHO and others have summarised the current evidence base and identified a range of essential interventions and implementation methods [http://www.euro.who.int/__data/assets/pdf_file/0009/278073/Case-Investing-PublicHealth.pdf] but these should be seen as part of the core responsibility of services, not something to be funded afterwards.

- Traditionally this has been undertaken by Scottish Government and external bodies through the use of ring-fenced funding and specific allocations. There is a tension between ring fencing of preventative interventions – which means they are seen as separate and not the responsibility of mainstream services, whereas there is a spectrum of preventative activity – and mainstreaming them within other services – which makes them very vulnerable to service cuts in the current climate. This reinforces the need to ensure that universal services understand the social determinants and the role that they and their work can play in addressing issues. We have seen changes in practice from teachers following the 1 in 5 work in Edinburgh about poverty proofing the school day. Many teachers had not previously had the opportunity to consider the issues in this way so genuinely didn’t understand the issues or see what role they could play.

- Year on year cuts to public spending [inevitably] mean universal public services have been cut. Behind these services lie the valuable relationships, public and professional support that underpin sustainable improvement. Therefore, by cutting universal services, we have been increasing health inequalities. We need to track cuts and their impact on avoidable harm, not just investment in prevention.

- Long term investment needs to be matched by long term tracking. Scaling up our investment in high quality secure longitudinal data from birth, such as already exists in Manitoba [see
e.g. Nickel et al doi: 10.1093/ije/dyu190 where data can be drawn from different sectors, can address the common situation of e.g. investment in one sector leading to benefits to population benefit elsewhere. Routine evaluation needs to capture this.

- Finally, to improve future prospects, a clear priority for prevention in research and development funding is essential, including capacity building to develop practitioner researchers, develop and evaluate complex social interventions, implementation research and development of the data systems that would support quality improvement and longer term evaluation using routine data.