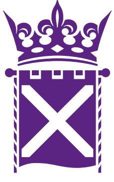

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Health, Social Care and Sport Committee

Pre-Budget Scrutiny 2026-27

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Health, Social Care and Sport Committee

To consider and report on matters falling within the responsibility of the Cabinet Secretary for Health and Social Care.

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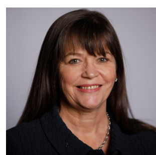

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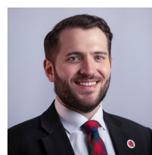

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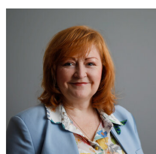

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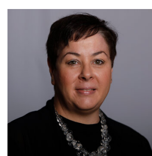

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Introduction

1. In line with the recommendations of the Budget Process Review Group (BPRG) report, Scottish Parliament subject committees undertake pre-budget scrutiny in advance of the publication of the Scottish budget. The intention is that Committees will use pre-budget reports to influence the formulation of spending proposals while they are still in development.

2. As part of this scrutiny, committees are required to publish pre-budget reports at least six weeks prior to publication of the Scottish budget. The Scottish Government has announced its intention for the next Scottish Budget to be presented to the Scottish Parliament on 13 January 2026.

   This is a month later than the date when the Scottish budget would ordinarily be published. This is as a result of the UK Government setting the UK Budget date as 26 November 2025.

Summary of recommendations

Spending priorities

3. While acknowledging there is general support for the priorities set out in the Scottish Government's Mental Health and Wellbeing Strategy and accompanying Delivery Plan, the Committee regrets that it remains very difficult to identify links between those priorities and how mental health budgets are spent.

4. The Committee considers there may be opportunities to make those links through the Population Health Framework and the Service Renewal Framework. It calls on the Scottish Government, in responding to this report, to provide additional data to illustrate how and to what extent expenditure of budgets for mental health can be linked back to the priorities identified in the Mental Health and Wellbeing Strategy.

5. Following its initial pilot of PBMA approaches to budget prioritisation, the Scottish Government decided not to pursue this model further. The Committee would be interested to understand why the Scottish Government decided not to pursue this model further. It further calls on the Scottish Government, in responding to this report, to set out what actions it is taking, if any, to encourage the use of budget prioritisation approaches such as PBMA with health boards and integration authorities.

Data availability

6. The Committee has been disappointed to hear evidence of an ongoing lack of transparency in the way that data is collated and disseminated in relation to mental health spending. It highlights evidence from stakeholders that there remains substantial data which is not centrally collated or published that could improve transparency around how mental health budgets are spent. It therefore calls on the Scottish Government to set out what further action it plans to take to provide greater clarity as to how mental health spending aligns with agreed policy priorities.

7. The Committee would also ask the Scottish Government to outline what plans it has to evaluate the impact of spending on mental health services to help better inform spending decisions. The Committee would also ask the Scottish Government to provide data on actual spend on mental health services.

8. Given the overall lack of service level data on mental health spending and the complex landscape that, in some ways, has been further complicated by the process of integration of health and social care, the Committee calls on the Scottish Government to commit to undertaking the more detailed analysis of current spending necessary to enable appropriately informed budget decisions to be made around mental health, now and in the future.

Prevention

9. The Committee notes some support amongst key stakeholders for separately identifying "preventative spend" as a mechanism for driving progress towards allocating a greater share of funding towards prevention over time. The Committee remains convinced of the need for consistent benchmarking data and clearer and more consistent definitions to be able to monitor progress towards prioritising preventative spend.

10. The Committee further notes that the Population Health Framework already emphasises the importance of a preventative approach and the need to gather evidence to demonstrate a progressive shift towards prevention in health-related spending. With this in mind, the Committee calls on the Scottish Government to provide clearer guidance to health boards and integration authorities regarding those mental health interventions that are considered to constitute prevention.

11. The Committee calls on the Scottish Government to commit to regularly publishing baseline data on preventative spend to enable progress in this area to be objectively assessed.

12. The Committee calls on the Scottish Government to set out what actions it is taking or plans to take to ensure budget decisions are made in a way that better reflects the cross-cutting nature of prevention in allocating funding.

13. Finally, the Committee calls on the Scottish Government to provide reflections on the potential need for additional funds to be allocated to mental health in the short term to help manage the transition towards a more preventative approach to mental health spending in the long term.

Evidence base

14. The Committee asks the Scottish Government what plans it has to ensure that Government strategies are following a solid evidence base, and whether it will carry out an impact evaluation on spending decisions, particularly in the area of mental health.

15. The Committee further calls on the Scottish Government, in responding to this report, to set out what actions it is taking to improve the evidence base on preventative spending to enable more effective decision-making on mental health budgets.

Ring-fencing

16. The Committee calls on the Scottish Government, in responding to this report, to address directly the concerns of those contributing evidence to the Committee who have argued the case for elements of mental health funding to be ring-fenced. In the absence of ring-fencing, it further calls on the Scottish Government to set out what alternative actions it is taking to address these concerns.

Spending review

17. The Committee highlights the negative impact a lack of long or even medium term certainty around budgets has on the provision of mental health services, particularly with respect to the many services provided by third sector partners.

18. With this in mind, the Committee seeks reassurance from the Scottish Government that the Spending Review will provide a degree of longer term certainty for mental health budgets and budgets for health and social care more broadly.

Background

19. Health and social care is the largest portfolio area in the Scottish Government's budget, accounting for over £21 billion of spend, equivalent to around a third of the entire Scottish budget. Within this total, spending on mental health services now stands at around £1.5 billion and has risen in recent years.

20. Spending plans for the health and social care budget are often subject to revision during the year, for example to reflect the receipt of health Barnett consequentials from the UK government, or to reflect unanticipated events, such as the Covid-19 pandemic, rising inflation or new pay settlements for health and social care workers.

    However, despite the scale of the budget and the frequency of revisions, it can be very difficult to understand the rationale for spending decisions or the impact of changes to spending plans.

21. In this context, the Committee decided to focus its scrutiny on programme budgeting marginal analysis (PBMA) approaches, specifically in the context of the mental health budget.

22. As explained in further detail later in this report, programme budgeting and marginal analysis (PBMA) offers a framework for analysing spending decisions in the context of scarce resources and identifying how resources could be allocated differently to achieve better outcomes.

23. The Committee issued a call for views on the mental health budget, the priorities evident in current patterns of spending and the extent to which the balance of spend was considered appropriate (including any focus on preventative spend).

    The call for views ran from 26 June 2025 until 15 August 2025 and received 54 published responses. SPICe has also produced a summary analysis of responses.

    The Call for Views asked 6 questions under different headings:

Current mental health spending

In 2023-24, spending on mental health services totalled £1.5 billion, equivalent to 9% of total NHS expenditure.

1. Is the level of spending on mental health services appropriate?

2. What information can help support assessment and evaluation of the allocation of the mental health budget?

Preventative spend on mental health

The Committee is interested in preventative spend. Public Health Scotland has set out a classification of preventative activities, describing activities as primary, secondary and tertiary prevention.

3. Do you consider there to be evidence of preventative spending activities in relation to mental health (and if so, can you provide examples)?

Priorities for mental health spending

The Scottish Government has set out its priorities for mental health services in its Mental Health and Wellbeing Strategy. This strategy identifies the following priorities for investment:

- Child and Adolescent Mental Health Services (CAMHS) and psychological therapies
- Addressing waiting times backlogs
- An extension of support for distress
- Ongoing implementation of the Scottish Government's Suicide Prevention Strategy
- Delivering improved community-based mental health and wellbeing support for children, young people and adults

4. Do you consider these to be the right priorities for mental health investment?

5. To what extent are these priorities reflected in mental health service delivery?

Decisions on mental health spending

6. How could transparency in relation to decisions around mental health spending in Scotland be improved?

24. To help further inform its pre-budget scrutiny for 2026-27, and reflecting the lack of any granular detail on mental health spending at local level, the Committee also issued a survey to Scotland's 31 integration authorities. This survey sought to establish how much is currently being spent on mental health services, and on what type of services, including identified spend on preventative mental health services.

The survey also sought to understand how decisions on spending on mental health services are taken.

This survey was conducted over summer recess, with results analysed and a summary of responses produced by SPICe. A total of 24 responses were received.

25. The Committee then took oral evidence as part of its pre-budget scrutiny for 2026-27 at its meetings on 9 September 2025 and 16 September 2025.

On 9 September, the Committee heard evidence from one panel of witnesses with expertise in PBMA approaches to prioritising budgets, comprised of the following:

- Dr Danny Ruta – AI Clinical Lead at Guy's Cancer Centre, formerly Director of Public Health at London Borough of Lewisham and Newcastle City. Dr Ruta has published research on the use of PBMA approaches in health budgeting.
- Professor Neil Craig – Professor of Public Health Economics at Glasgow Caledonian University. Professor Craig has worked at Audit Scotland and Public Health Scotland and has published research on PBMA approaches.

On 16 September 2025, the Committee heard from two panels - one with expertise in mental health policy and spending and one comprising representatives of selected Integration Joint Boards (IJBs)/Health and Social Care Partnerships (HSCPs).

Panel 1

- Emma Congreve - co-lead of the Scottish Health Equity Research Unit (SHERU) at the University of Strathclyde
- Professor Colin McKay - Centre for Mental Health and Capacity Law (Napier University)
- Calum MacLeod - Senior Policy & Public Affairs Office - Mental Health Foundation (MHF)
- Craig Smith - Public Affairs & Policy Manager - Scottish Action for Mental Health (SAMH)

Panel 2

- Duncan Black - Chief Finance Officer – Glasgow City Health and Social Care Partnership
- Hamish Hamilton – Chief Finance Officer – West Lothian Integration Joint Board

26. It should be noted that the Committee also made reference during its scrutiny to previous evidence taken at its meeting on 10 September 2024, where PBMA approaches were discussed in the context of the Scottish Government's periodic review of its National Outcomes.

Programme Budgeting Marginal Analysis (PBMA)

27. Programme budgeting and marginal analysis (PBMA) offers a framework for analysing spending decisions in the context of scarce resources and identifying how resources could be allocated differently to achieve better outcomes.

28. The approach has been explored in various health settings, both locally, UK-wide and internationally, but it is difficult to see whether or how the methodology or approach is being actively applied. Some examples – from Scotland and other locations – of the approach being tested, recommended or more actively applied, include:

    - In 2012, the Scottish Government piloted the PBMA approach, but it does not appear to have been subsequently adopted more widely.
    - When the integration joint boards were established, guidance was issued that recommended adopting a prioritisation approach to allocating resources – either PBMA, or alternative similar approaches. As part of the survey of integration authorities, IAs were asked whether they used this guidance, or employed similar approaches in budget decision-making.
    - There appears to have been some use of a National Programme Budgetingapproach in the NHS in England and also some use of the approach in Wales.
    - There is also evidence of specific examples of use of the technique e.g. in the UK (Newcastle, Norwich, Canada).

29. Giving evidence to the Committee as part of its separate scrutiny of the proposed National Outcomes, Professor Cam Donaldson described his experiences of using the PBMA approach:

    > In my experience as a health economist, we have usually worked with different parts of the NHS to help them to plan use of their next year's, or their next few years', resources. Programme budgeting is just a statement of where we are now in terms of how we are spending our resources. It is completely unthreatening—it is just saying how we currently spend our resources. The marginal analysis bit...then leads us into thinking about how we might move those resources around to get more benefit in total. That, in plain language, is what programme budgeting and marginal analysis are about.

    At this same evidence session, both Professor Cam Donaldson and Emma Congreve, from the Scottish Health Equity Research Unit,highlighted that even to make progress on the first stage – programme budgeting – whereby a detailed analysis of current spend is made available – would be beneficial to budget decision-making:

> When you are linking budgets to outcomes, it is critical that you are able to analyse what is going on under the bonnet. You have to understand why spend might be increasing. Is it a short-term thing? Is it to get on top of an issue, then spending will fall? We have to be much more forensic in how we track these things. Even understanding programme budgets properly, which Professor Donaldson spoke about, would be a step forward.

30. In evidence to the Committee at its meeting of 9 September 2025, Dr Danny Ruta also highlighted:

> I would add that the attractiveness of PBMA to healthcare, and to the national health service in particular, is that, if you have a fixed finite budget, you are essentially dealing with scarcity. Any expenditure on service A means that there is an opportunity cost; there is a sacrifice, because you have not been able to spend that money on service B. PBMA embraces the notion of sacrifice and opportunity cost, which is an alien concept to doctors—and to many NHS managers, to be honest. It is essential to making the best use of the resources that are available within a healthcare system, which is what makes it such an attractive approach—in theory.

31. In response to the separate call for views, several submissions called for health economic analysis to be carried out to support policy learning around how to allocate budgets. Although not specifically mentioning PBMA, other similar approaches incorporating evidence and evaluation into allocation of scarce resources were referenced, such as the use of quality adjusted life years, or Societal‑perspective Cost‑Effectiveness Analysis.

Common Themes in Evidence

Spending priorities

32. The Scottish Government's Mental Health and Wellbeing Strategy and the accompanying Delivery Plan sets out the Scottish Government's long-term vision and approach to improving the mental health and wellbeing of the population of Scotland. It sets out the priorities for action, including the following priorities for early investment:

    - Child and Adolescent Mental Health Services (CAMHS) and psychological therapies
    - Addressing waiting times backlogs
    - An extension of support for distress
    - Ongoing implementation of the Scottish Government's Suicide Prevention Strategy
    - Delivering improved community-based mental health and wellbeing support for children, young people and adults.

33. The Committee's call for views asked respondents for their views on the Scottish Government's priorities for investment. Overall, respondents thought the priorities reflect current pressures and address the most urgent needs within mental health. However, support for the priorities was often qualified. For example, some commented that terms like "support for distress" and "community-based support" are vague and lack definition.

    In evidence to the Committee at its meeting on 16 September 2025, Calum MacLeod from the Mental Health Foundation indicated that, in his view, the overall focus of priorities in the strategy was broadly "appropriate" but added:

    > There is a challenge in how we connect the priorities of the strategy itself to wider policy portfolios, get a cross-cutting dimension and make sure that implementation happens and makes a real and genuine impact for communities and individuals when we are, frankly, in the midst of a mental health emergency.

34. As part of the survey submitted by the Committee to integration authorities, IAs were asked whether, in making decisions on how to allocate their mental health budget, they had made use of the guidance issued by the Scottish Government in 2016 that recommended adopting a prioritisation approach to allocating resources.

35. The Scottish Government guidance was also referenced as part of oral evidence to the Committee at its meeting on 9 September. Asked whether he was aware of a PBMA approach still being piloted by the Scottish Government, Professor Neil Craig responded:

> My understanding is that its use was not continued. Before the Covid pandemic, guidance was issued to integrated joint boards requiring them to use programme budgeting and marginal analysis approaches to help to identify where resources were going and whether there was scope to change the way in which they were allocating the money. I was speaking to one of the officials who was involved in that just last Friday. His sense was that, although people in integrated joint boards were beginning to embrace the idea of PBMA, Covid derailed it, as it did so many things.

36. Use of the prioritisation approaches described in the Scottish Government's guidance note would imply encouragement of the use of approaches similar to Programme Budget Marginal Analysis (PBMA) in budget decision-making. In response to the Committee's survey, a number of IAs explicitly stated that they were not making use of this guidance. Conversely, several IAs responded that they were using the guidance or were following the principles set out in the guidance note.

37. Renfrewshire indicated that it followed the principles of the Scottish Government guidance on prioritisation as a tool for determining the allocation of its mental health budget, but noted particular challenges in doing so in the context of constrained budgets:

> Renfrewshire HSCP/IJB continue to follow the principles of the [Scottish Government guidance] but highlight the inherent conflict within the current financial climate... However, within the current financial climate of increased need and complexity against a backdrop of reduced funding and overall IJB budget pressures, the requirement to make efficiency savings has created a disconnect with this approach, leaving primary care/proactive and preventative services and approaches vulnerable which will have unintended and critical implications across system wide mental health services.

38. Many submissions to the Committee's separate call for views highlighted difficulties with understanding how budgets for mental health are spent. Respondents attributed this to a fragmentation of management and accountability, describing a complex matrix of responsibility between the Scottish Government, NHS Boards, Integration Joint Boards (IJBs), Health and Social Care Partnerships (HSCPs), and third sector organisations. Respondents agreed that this makes it difficult to trace who makes decisions, how funds are allocated, and to what extent spending aligns with local need. Social Work Scotland argued:

> To improve transparency, we must first understand how opaque the current system is. Headline figures may dominate public discourse, but without clarity on which services benefit, which lose out, and how decisions are made, it is impossible to assess whether spending is fair, effective, or aligned with need.

39. Separately, the survey of integration authorities asked for information about how priorities for spending on mental health services are agreed. Most responses made fairly general references to ensuring alignment with strategic plans, both at local and national level and to engagement with a range of stakeholders as part of the process of determining priorities.

40. In evidence to the Committee on 16 September 2025, Craig Smith from SAMH stated:

> It goes back to what has been said about how we link positive national strategy and policy to local delivery and how we get accountability right when it comes to Scottish Government national policy pledges. For example, we have not achieved the target of spending 10 per cent of the national health service budget on front-line mental health services, and there is a lack of accountability around that. The Scottish Government, I suppose rightfully, says, “We can’t dictate to boards what proportion they spend.” However, it set that policy, so is there space for more ministerial direction?

41. While acknowledging there is general support for the priorities set out in the Scottish Government's Mental Health and Wellbeing Strategy and accompanying Delivery Plan, the Committee regrets that it remains very difficult to identify links between those priorities and how mental health budgets are spent.

42. The Committee considers there may be opportunities to make those links through the Population Health Framework and the Service Renewal Framework. It calls on the Scottish Government, in responding to this report, to provide additional data to illustrate how and to what extent expenditure of budgets for mental health can be linked back to the priorities identified in the Mental Health and Wellbeing Strategy.

43. Following its initial pilot of PBMA approaches to budget prioritisation, the Scottish Government decided not to pursue this model further. The Committee would be interested to understand why the Scottish Government decided not to pursue this model further. It further calls on the Scottish Government, in responding to this report, to set out what actions it is taking, if any, to encourage the use of budget prioritisation approaches such as PBMA with health boards and integration authorities.

Data availability

44. The Public Health Scotland “Cost Book” is the main source of detailed data on health spending. The latest edition is for 2023-24, with no date yet confirmed for the publication of 2024-25 data. While the Cost Book provides comprehensive data that is produced on a consistent basis across all health boards, it is limited to providing spending data under broad categories.

45. On this basis, the data does not provide any further insights on the types of services being delivered via mental health budgets. In responding to the Committee’s pre-budget call for views, the Mental Health Foundation noted:

> Data gaps and inconsistencies such as those highlighted in Audit Scotland's 2023 report are perennial challenges in relation to the design and delivery of mental health services in Scotland and elsewhere. Nevertheless, there is obvious merit in addressing these gaps and inconsistencies to better support allocation and evaluation of the mental health budget. We note that the Committee called on the Scottish Government to set out what it is doing to make improvements to the availability of data and data sharing arrangements in health and social care in its 2025-26 pre-budget scrutiny report. We also note the Scottish Government's response to the Committee's recommendation. However, it is not clear that the measures highlighted in the Scottish Government's response adequately address the data gaps and inconsistencies highlighted above.

46. Other respondents to the Committee's call for views also highlighted a lack of disaggregated data. For example, in their response, Senior Medical Managers in Psychiatry commented:

> There is currently no clarity on what mental health services are included when coming to the £1.5 billion figure… What is meant by 'Mental Health' needs to be more clearly defined. In grouping 'mental health services' under one umbrella, the vastly heterogenous range of presenting needs and types of services are unhelpfully homogenised, making meaningful benchmarking and assurance on spending 'levels' impossible. Highly specialised services for those with very complex clinical needs are placed in the same category as services to support milder, potentially self-limiting, presentations.

47. To improve transparency and enable spending to be more effectively tracked, the Committee received many submissions which called for a detailed breakdown of spending to be routinely provided, including by service type, population and/or age groups, delivery model (NHS or third sector), geography and prevention tier (primary, secondary and tertiary).

48. The survey issued by the Committee to integration authorities had been intended to help to fill the gap in understanding of how mental health budgets are spent by gathering more detailed information on mental health spending at individual service level. However, as the separate report on the survey results demonstrates, it ultimately proved challenging to draw any firm conclusions from the data gathered and it was not clear that data had been provided in a format that was comparable between different integration authorities. The variation in the extent of delegation of mental health services added a further layer of complexity in analysing the survey results.

49. Many submissions also called for the development of outcomes-based data and evaluation to help inform budgets and spending. For example, SAMH noted that there is currently "no public data on the impact of the treatment itself." Lynnor Byers, an individual respondent to the Committee's call for views, argued there should be a process of "moving beyond simply reporting on inputs (spending) and outputs (number of appointments) to demonstrate tangible outcomes for individuals".

Craig Smith from SAMH, in oral evidence to Committee, stated that:

> We think that the new population health framework and the health and social care service renewal framework are fairly positive documents. However, we would definitely welcome indications of a move towards a more needs-based assessment of the health and social care, on which a pledge has been made, and towards a more outcomes-based model for service design. We need to see much more detail of what the frameworks will mean in practice and whether they will be fully inclusive of mental health and wellbeing and, beyond health outcomes, of people's individual outcomes across all aspects of their lives.

50. In oral evidence, Hamish Hamilton, Chief Finance Officer at West Lothian Integration Board, highlighted particular challenges with improving data gathering at IJB level given current budget constraints:

> On our systems and data, I reference again our £23 million budget gap over the next three years. That means that, as I said, we are looking at what we have to provide and what our statutory services are. We would like to do something in the background that will focus on data and potentially give us a benefit further down the road, but I do not think that I would be able to convince my board to support that, given the fiscal environment that you have highlighted.

Duncan Black, Chief Finance Officer at Glasgow City HSCP, expanded on this point, raising concerns that, even with additional resource, improving data collection was still likely to prove challenging.

51. The Committee also received evidence which highlighted a lack of cooperation and uniformity between Health Boards, particularly regarding data sharing. Professor McKay told the Committee:

> The mental health law review said that there is certainly a problem in not having good data, but we also found that "different bodies across the system are sitting on large pockets of data that cannot be accessed easily and are not routinely published or analysed".
>
> The issue is not that there is no information; it is that the information is in the wrong place and is not accessible. The review recommended creating a formal network of the many scrutiny bodies in the field, including Public Health Scotland and the Mental Welfare Commission for Scotland, and that they should develop a cross-agency framework for monitoring outcomes in mental health care. That may be a glimmer of a way forward in some of this.

52. The Committee has been disappointed to hear evidence of an ongoing lack of transparency in the way that data is collated and disseminated in relation to mental health spending. It highlights evidence from stakeholders that there remains substantial data which is not centrally collated or published that could improve transparency around how mental health budgets are spent. It therefore calls on the Scottish Government to set out what further action it plans to take to provide greater clarity as to how mental health spending aligns with agreed policy priorities.

53. The Committee would also ask the Scottish Government to outline what plans it has to evaluate the impact of spending on mental health services to help better inform spending decisions. The Committee would also ask the Scottish Government to provide data on actual spend on mental health services.

54. Given the overall lack of service level data on mental health spending and the complex landscape that, in some ways, has been further complicated by the process of integration of health and social care, the Committee calls on the Scottish Government to commit to undertaking the more detailed analysis of current spending necessary to enable appropriately informed budget decisions to be made around mental health, now and in the future.

Prevention

55. In responses to the call for views, some respondents commented on the desirability of a shift from acute to preventative spend. For example, Dr Will Ball argued:

> A significant proportion of current spending may be absorbed by crisis-driven and unplanned care, which is costly and often less effective than early intervention. There is a strong case for rebalancing spending towards earlier, preventative, and community-based support to reduce reliance on acute services and improve outcomes.

56. In evidence to Committee on 16 September, Mr MacLeod flagged the importance of tracking preventative spend, stating:

> ...we need to be in a situation where Government departments are able to identify what lines of activity they are undertaking—in relation to good food or physical exercise, for example—that have a preventative dimension to them. They need to be able to quantify and document that. Until we have that, it will be very difficult to move forward beyond the warm words about prevention and actually put that into practice.

57. Mr MacLeod also made reference to the Committee's previous pre-budget scrutiny recommendations around preventative spend, stating:

> One of your recommendations to Government was about the scope to have a budget line on preventative spend. I think that the response was fairly amorphous, but there is scope for the committee to return to that, if I may say so, given that we now have a population health framework...that has a focus on prevention and a public services reform strategy that is absolutely saying that we need to move definitively and decisively towards a preventative focus. If we are going to do that, we need to have the mechanics in place to track how funding and resources are being used in practice.

58. The Committee's survey of integration authorities also highlighted a wide variety of interpretations of what would be categorised as "preventative spend". Duncan Black from Glasgow City Health and Social Care Partnership touched on this same point in oral evidence to the Committee:

> It was interesting to read the responses that you received from the IJBs on what is meant by the term “preventative spend”. SPICe picked up on those as well. In Glasgow, we came up with the figure of £10 million, but, to be honest, it depends on where we draw the line. There is an important point about the language and what we are referring to.

59. Commenting on the cross-cutting nature of preventative spending, Emma Congreve told Committee:

> ...we have little understanding of spend related to prevention in mental health outwith the health budget. I think that we struggle to understand the breadth and the ups and downs of the budgets in that space, such as those that relate to housing, people who live in poverty and people in the criminal justice system.

60. When asked what better data may look like, witnesses emphasised the need for cross-portfolio data in assessing effective spending in mental health contexts. Calum MacLeod stated in oral evidence:

> We also need to be clear about what the throughput is and the outcomes of other elements across different aspects of government. For example, what difference is the housing provision for people having? What are the impacts of affordability and the capacity to access housing? What are the impacts of other measures across different portfolios with a trackable element? We have challenges there at the moment, and a more coherent, structured approach with consistent indicators would allow us to track that in practice. If you look at it from a macro level through to the more meso and micro levels, part of it is about the national performance framework and where that sits. That is potentially up for review as well.

61. Professor McKay also highlighted the importance of shared accountability, stating:

> It is about how we align the incentives across the system and develop truly shared accountability, so that we do not have the situation that we have now, which is, “I’d like to help those people but I can’t, because I have to concentrate on my core group, who are these people over here". It’s very sad, but that other organisation doesn’t want to help those people either, because it has to concentrate on its own core group. Unless we can think about shared accountability for outcomes, it is difficult to see how we will make progress.

62. The Committee also heard about the challenges in achieving a shift to preventative spending. Dr Danny Ruta, in oral evidence, stated:

> The only time that we have ever managed to radically transform a part of our healthcare system in the entire history of the NHS is when we closed down the huge asylums. The only way we did that was to double run. You could not close down an asylum until the last person had left the building, so you had to build all these community-based mental health settings while the asylums were still open. We double ran for quite a long time—we spent double the money that we needed to until we were able to get there. That is the only way we will move from cure to prevention. It will never happen otherwise—it never has.

63. The Committee notes some support amongst key stakeholders for separately identifying "preventative spend" as a mechanism for driving progress towards allocating a greater share of funding towards prevention over time. The Committee remains convinced of the need for consistent benchmarking data and clearer and more consistent definitions to be able to monitor progress towards prioritising preventative spend.

64. The Committee further notes that the Population Health Framework already emphasises the importance of a preventative approach and the need to gather evidence to demonstrate a progressive shift towards prevention in health-related spending. With this in mind, the Committee calls on the Scottish Government to provide clearer guidance to health boards and integration authorities regarding those mental health interventions that are considered to constitute prevention.

65. The Committee calls on the Scottish Government to commit to regularly publishing baseline data on preventative spend to enable progress in this area to be objectively assessed.

66. The Committee calls on the Scottish Government to set out what actions it is taking or plans to take to ensure budget decisions are made in a way that better reflects the cross-cutting nature of prevention in allocating funding.

67. Finally, the Committee calls on the Scottish Government to provide reflections on the potential need for additional funds to be allocated to mental health in the short term to help manage the transition towards a more preventative approach to mental health spending in the long term.

Evidence base

68. Emma Congreve also emphasised the need for a solid evidence base in order to ensure Government strategies are effective. She stated, in oral evidence, that:

> We must be careful, in trying to do the right thing in identifying how prevention works for health, that we do not oversimplify things. Unfortunately, that means a lot of quite nuanced work is needed to understand the evidence that comes from good-quality evaluations that show where particular interventions feed through into longer-term health outcomes.
>
> The Scottish Government’s evaluation of the effect of the five family payments on child poverty said that it was a mixed-method evaluation. However, it was mainly a qualitative evaluation in which parents were asked how they felt about what the payments had done for them. That is totally valid evidence, but it is not enough in itself to determine whether the Scottish child payment is impacting on health. To do that, you need to compare it with a group that did not get the Scottish child payment, such as a group in the north of England that shares similar characteristics, in order to look at the differences in their health outcomes. There needs to be a lot more evidence-based thinking about how you do this. I know that the Scottish Government is thinking about preventative spend, and the public service reform strategy talks about it.

Ms Congreve further stated that:

> The first place to start when you are trying to build an evidence base is to understand what your logic model is. A lot more transparency is needed when decisions are being made to cut services, to scrutinise—without needing a peer-reviewed journal that says this will have a negative impact on health—what impact will logically follow that decision.

69. The Committee asks the Scottish Government what plans it has to ensure that Government strategies are following a solid evidence base, and whether it will carry out an impact evaluation on spending decisions, particularly in the area of mental health.

70. The Committee further calls on the Scottish Government, in responding to this report, to set out what actions it is taking to improve the evidence base on preventative spending to enable more effective decision-making on mental health budgets.

Ring-fencing

71. Witnesses in oral evidence to the Committee commented on the potential of ring-fencing in mental health budgets. Dr Danny Ruta stated:

> I have come to the conclusion that the only way that we are ever going to invest in prevention in our healthcare system is to completely ring fence money so that it can be used only for prevention...If you have somebody who is dying in front of you and someone who has not even been born yet, you will save the person who is dying in front of you rather than spend money on improving the quality of life of people who have not even been born yet. Acute services will always win out because that is human nature. There would have to be a political decision to ring fence money and spend it only on prevention, and to tell people that they cannot touch it for anything else.

72. Craig Smith, from SAMH, also commented on ring fencing, stating:

> I know that ring fencing is quite a contested concept, but is there a role for it, particularly around areas such as suicide prevention? Rightfully, suicide prevention is a priority, but there is very limited direct budget for it and it is very difficult to track what is being spent locally. For example, in Aberdeenshire, suicide prevention spending has been cut entirely because there is no statutory obligation on the local authority or the integration joint board to deliver the service. There is probably something that we can do to tie accountability to strategic objectives and policy.

73. The Committee calls on the Scottish Government, in responding to this report, to address directly the concerns of those contributing evidence to the Committee who have argued the case for elements of mental health funding to be ring-

fenced. In the absence of ring-fencing, it further calls on the Scottish Government to set out what alternative actions it is taking to address these concerns.

Spending review

74. The Committee heard evidence from witnesses that the forthcoming spending review offers an opportunity to provide some longer term certainty around mental health spending. Emma Congreve from the Scottish Health Equity Research Unit, told Committee:

> We are looking for the spending review and budget this autumn to start to set out from the Government's perspective how it will shift to preventative budgeting in a way that is robust and on which there is consensus. There are roundtable discussions happening with Public Health Scotland support. There is activity happening here, but there is no easy solution. It is not just about moving numbers around on a page; it is about really understanding the good-quality evidence that exists that helps us to understand what the long-term outcomes could be.

75. Duncan Black, in oral evidence to Committee, also highlighted the challenges of longer-term planning in the current financial climate, stating:

> ...it is certainly fair to say that the scale of the financial challenge that we have faced in recent years and are facing over the foreseeable future is such that it is enormously difficult to find investment in activity that is not delivering immediate services in statutory care and so on. A huge proportion of our budget is set against providing statutory levels of care or care that is very hard to shift to be delivered in a different fashion without time, space and, frankly, the money to do it. I agree with the assessment that it is very hard to do that.

76. Hamish Hamilton, in oral evidence, also added:

> One-year budgets are very challenging. Certainly in my area, we had earmarked what we were calling our transformation fund, which was to enable good pieces of work that would transform services to be taken forward for the benefit of people in West Lothian. That fund ended up having to be used to go to the bottom line to balance the budget because of the day-to-day pressures that we were under—I think that you called it "firefighting"...We would appreciate three or five-year budgets that would allow us to do some longer-term planning and to do the sort of scenario modelling that Duncan Black has highlighted.

77. The Committee highlights the negative impact a lack of long or even medium term certainty around budgets has on the provision of mental health services, particularly with respect to the many services provided by third sector partners.

78. With this in mind, the Committee seeks reassurance from the Scottish Government that the Spending Review will provide a degree of longer term

certainty for mental health budgets and budgets for health and social care more broadly.

Annexe A - Extracts from the Minutes of the Health, Social Care and Sport Committee Meetings

20th meeting (Session 6), Tuesday 24 June 2025

4. Pre-Budget Scrutiny (In Private):

The Committee considered its approach to Pre-Budget Scrutiny for 2026-2027.

The Committee agreed a focus on mental health spending, to undertake a targeted survey of integration authorities, to issue a call for views over summer recess and to take oral evidence in September.

22nd meeting (Session 6), Tuesday 9 September 2025

2. Pre-budget scrutiny 2026-2027:

The Committee took evidence from—

Professor Neil Craig, Professor of Public Health Economics, Glasgow Caledonian University;

Dr Danny Ruta, Consultant in Public Health, NHS Grampian.

Emma Harper declared an interest as a registered nurse and former NHS employee.

Dr Sandesh Gulhane declared an interest as a practising NHS GP.

3. Pre-budget scrutiny 2026-2027 (In Private):

The Committee considered the evidence it heard earlier under agenda item 2.

23rd meeting (Session 6), Tuesday 16 September 2025

2. Pre-budget scrutiny 2026-27:

The Committee took evidence from—

Emma Congreve, co-lead of the Scottish Health Equity Research Unit, University of Strathclyde;

Professor Colin McKay, Professor of Mental Health and Capacity Law, Edinburgh Napier University;

Calum MacLeod, Senior Policy & Public Affairs Officer, Mental Health Foundation;

Craig Smith, Public Affairs & Policy Manager, Scottish Action for Mental Health;

and then from—

Duncan Black, Chief Officer, Finance and Resources, Glasgow City Health and Social

Care Partnership;

Hamish Hamilton, Chief Finance Officer, West Lothian Integration Joint Board.

3. Pre-budget scrutiny 2026-27 (In Private):

The Committee considered the evidence it heard earlier under agenda item 2. The Committee agreed to consider a draft report in private at a future meeting.

Annexe B - Official Reports of meetings of the Health, Social Care and Sport Committee

- 24 June 2025 - Official Report
- 9 September 2025 - Official Report
- 16 September 2025 - Official Report