

Health, Care and Sport Committee
 Tuesday 07 October 2026
 7th Meeting, 2026 (Session 7)

Pre-Budget Scrutiny – Preparing for future challenges in the health, care and sport sectors

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Background

This meeting will allow Members to hear from a range of people with knowledge and background in both the challenges and opportunities for the health sector. Witnesses should be able to comment on existing and potential strategies for addressing those challenges and leveraging opportunities, and making best use of the resources available to the Scottish Government and local government. At this meeting, the Committee will hear from:

- Richard Robinson, Audit Scotland
- Professor Linda Bauld, Professor of Public Health and Co-Head, Population Health Sciences, University of Edinburgh
- Robbie Pearson of Health Improvement Scotland
- Alison Payne, Enlighten

The Committee will take further evidence, on social care and sport, on Wednesday 28 October. It will then have the opportunity to question the Scottish Government on its findings on Wednesday 4 November.

The Scottish Budget will take place on Thursday 3 December, following the UK budget on 28 October.

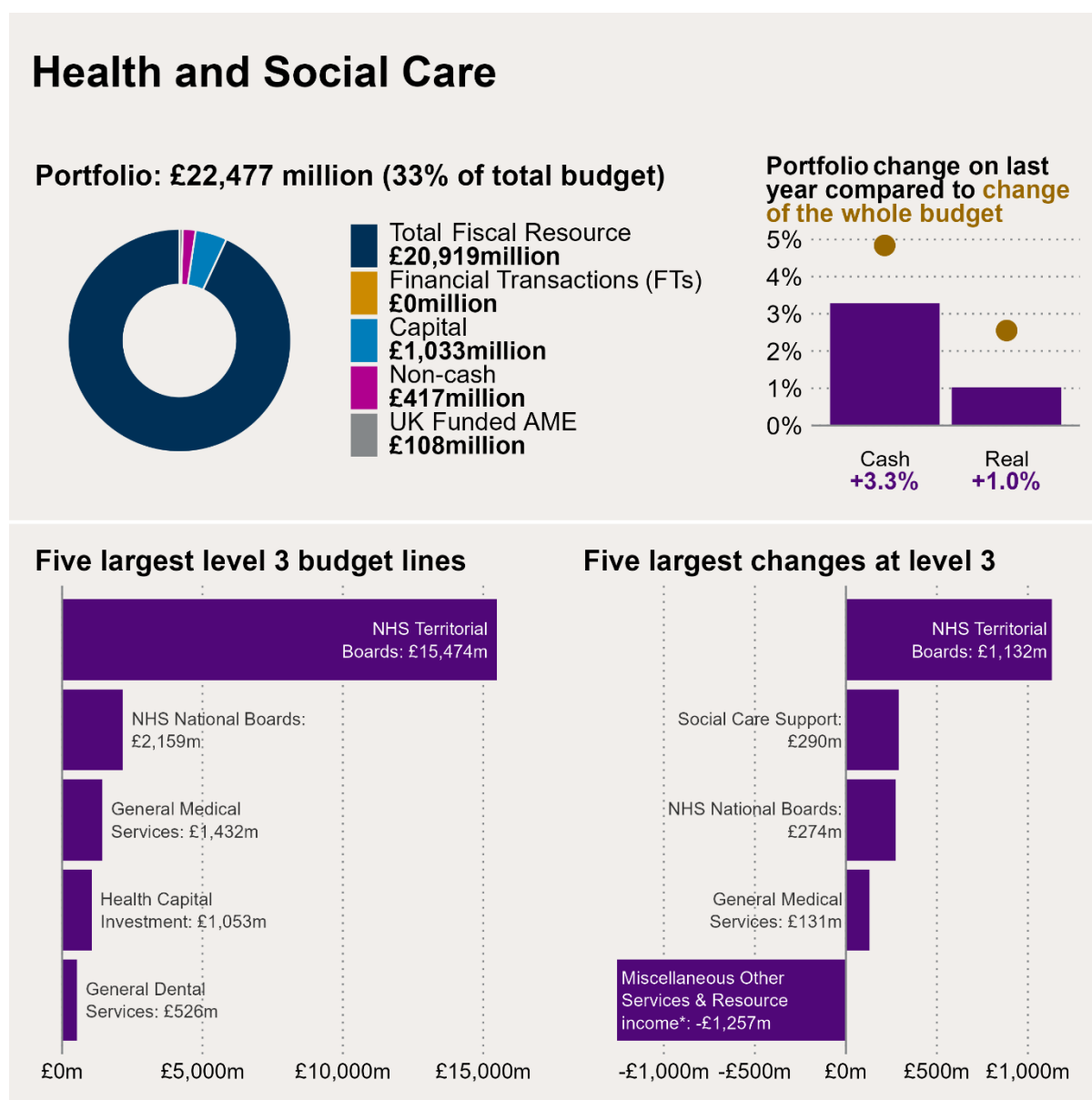
Members might wish to refer back to the pre-budget scrutiny approach paper from 9 September which provided comprehensive background, context and Scottish Government planned efficiencies and savings for the health and care portfolio. The paper suggested a number of themes: Financial sustainability, intended outcomes from budget decisions, integration and prevention.

The Scottish Government has announced major public service reform, which will entail structural reform and could have significant impact on budgets as the parliamentary session progresses. As public bodies consider and focus on major reorganisation, there could be an impact on service delivery across health and social care, potentially diverting resources towards the structural change, or potentially stalling some innovation in the prevention agenda for example. For this budget period therefore, there is the opportunity to consider where focus should be to ensure services are resilient and responsive to the prevention agenda.

Financial data

Please see Annex A for a subject profile for health finance (as accompanied the pre-budget approach paper).

Figure 1 – overview of the Health and Social Care budget



Demographics

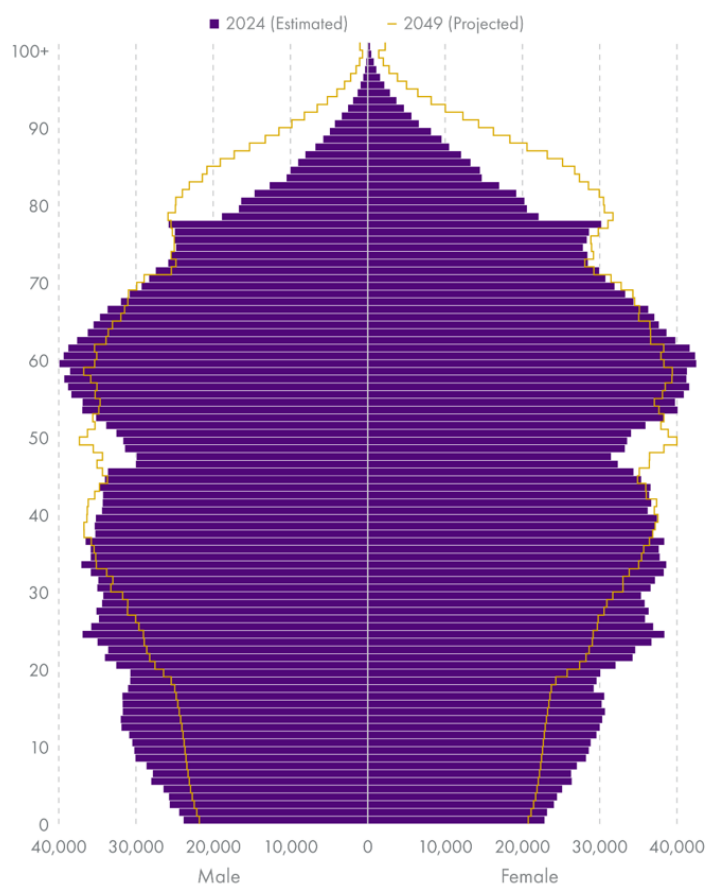
The Cost of an Ageing Population (reproduced from SPICe briefing: [Promoting Healthy Ageing in Scotland](#))

As Scotland's population is ageing and older people tend to have higher healthcare costs, the amount of health and care expenditure is expected to continue to rise, leading to budget pressures in the future. Promoting healthy ageing in Scotland is key to reducing health and social care expenditure, and increasing the amount of people who remain active in the labour market and wider economy. [Increasing ill health in the population could negatively affect income tax revenue, through rising inactivity, and people in work with a work-limiting illness working fewer hours](#).

Health and social care spending is projected to grow as a share of the budget. Based on current trends, health and social care spending is projected to rise from around 40 per cent of Scottish devolved public spending in 2029-30 to almost 55 per cent in 2074-75. [The Scottish Fiscal Commission's Fiscal Sustainability Report \(April 2025\)](#) shows that health and social care spending will grow as a share of the budget in the coming decades.

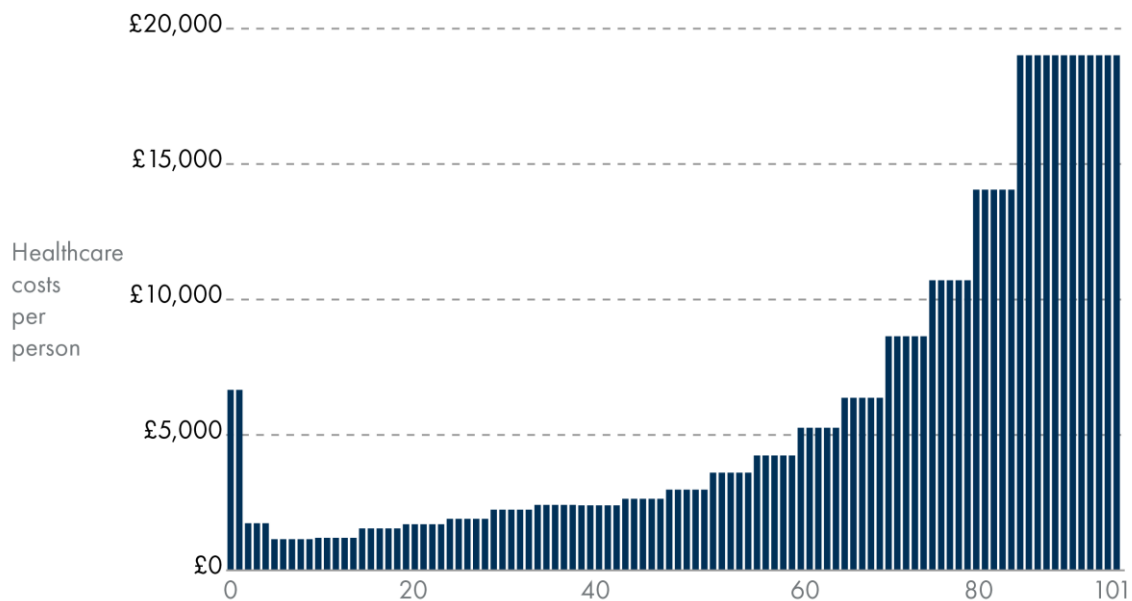
The chart below shows projected population trends. This shows a reduction (narrowing) of people below the age of 40 by 2049, compared with 2024 estimates (2021 census based). It also shows an increase (widening in the chart) in the number of people over the age of 80. Health spending tends to rise with age, meaning an ageing population could lead to more health spending in the future. Future costs will also be impacted by the extent to which older age groups experience a 'healthy life expectancy' (HLE).

Figure 2: population of Scotland trend estimate up to 2049 for males and females



Source: SPICe using data from National Records for Scotland

Figure 3 illustrates the extent to which health spending is higher for older age groups.

Figure 3: Healthcare costs per person is shown by age group (years).

Source: SPICe briefing, [Promoting healthy ageing in Scotland](#) using data from [Scottish Fiscal Commission's Fiscal Sustainability Report 2025](#)

Piloting an approach to identifying preventative spend

In March 2026, SPICe published [a briefing on preventive spending in Scotland](#). It examined preventive spending across public services, based on the premise that effective prevention can improve population health and wellbeing and reduce demand for public services.

Public Health Scotland defines prevention thus: “Prevention in public health is about keeping people healthy and avoiding the risk of poor health, illness, injury, and early death.”

As the SPICe briefing points out, prevention is defined differently by others in a less health-specific way. The Government recently set out its own [definitions of prevention-related terminology](#). It defines failure demand as being “demand for services that arises after problems have emerged - often because earlier intervention was absent, insufficient, or ineffective - and therefore reflects avoidable or system-generated need. Failure demand represents the downstream consequences of unmet need or system shortcomings, and typically necessitates reactive, often more costly, responses.”

Between December 2025 and May 2026, the Scottish Government undertook work on a budget-tagging pilot to better understand its investment in prevention, and [reported on its findings in June 2026](#). This pilot approach involved developing a Preventative Budgeting Tool which provides a method for “tagging” budget information against a consistent definition of prevention and allows this spend to be linked to outcomes and drivers of public service demand. This tool was tested through a pilot programme focusing on identifying planned preventative spend within

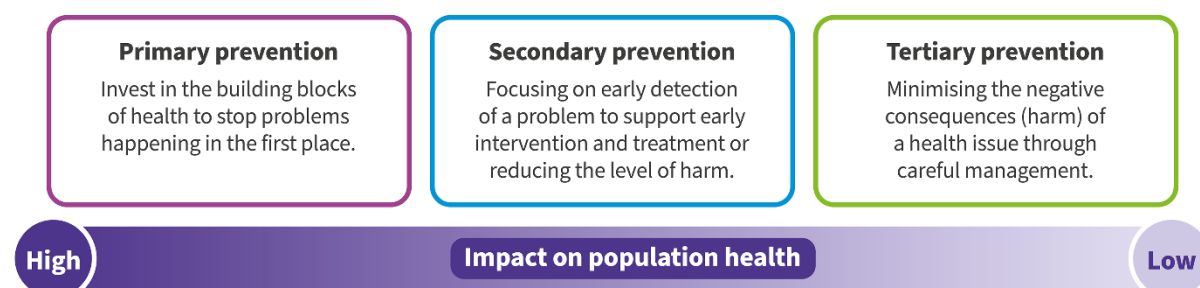
a selection of 99 “Level 4” lines (the most detailed published data available) across different portfolios in the Scottish Budget 2025-26. The level 4 budget lines explored accounted for around 21% of the total Scottish Budget lines, and 41% of Scottish Budget spending. As part of this work, the Government also carried out separate pilots in healthcare, with a number of Health Boards, and one focused on the health and care portfolio excluding Health Boards.

The Government has committed to extending the tagging approach to the entirety of the Budget. The expectation is that, for the 2027-28 Budget, this data will support a baseline understanding of the extent and spread of preventative spending in the budget. Going forward, the Government has signalled that it will combine this with data from the Population Health Framework and upcoming work on drivers of demand to help to inform future budget-setting decisions. Professor Linda Bauld, in her submission to the Committee, explained that:

“An HSC Reform Preventative Investment Advisory Group has been established to build on the pilot outputs, explore how cross-cutting prevention issues are considered in funding decisions and generate insights on how preventative investment can be embedded more effectively.”

In the pilot, specific budget lines were selected for using the tool. Prevention was classified using public health prevention levels: Primary, secondary and tertiary.

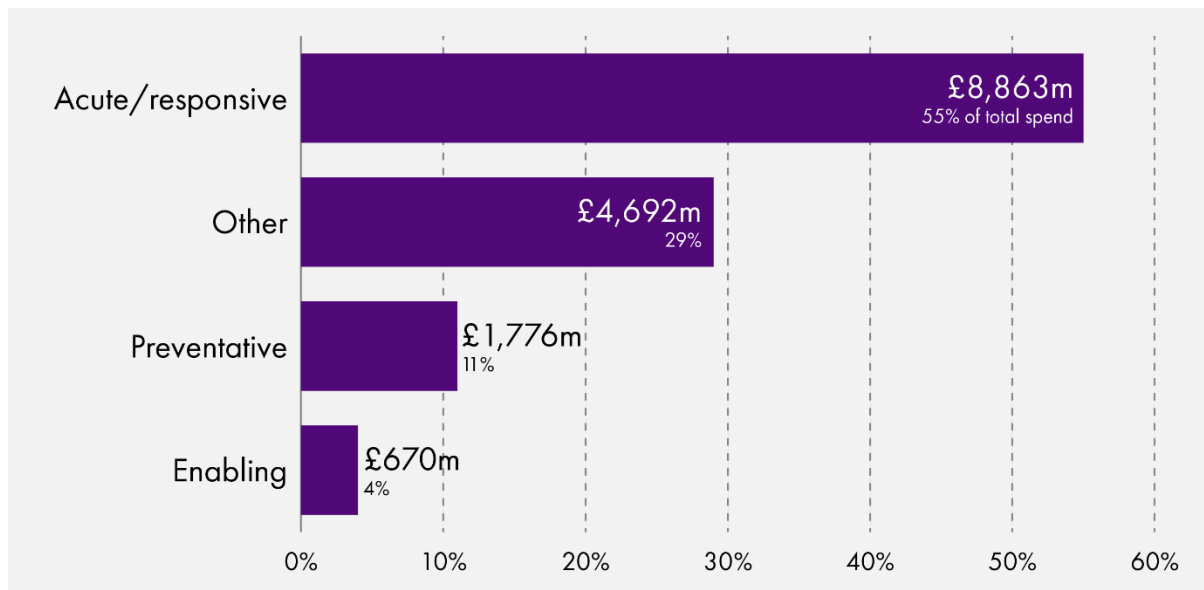
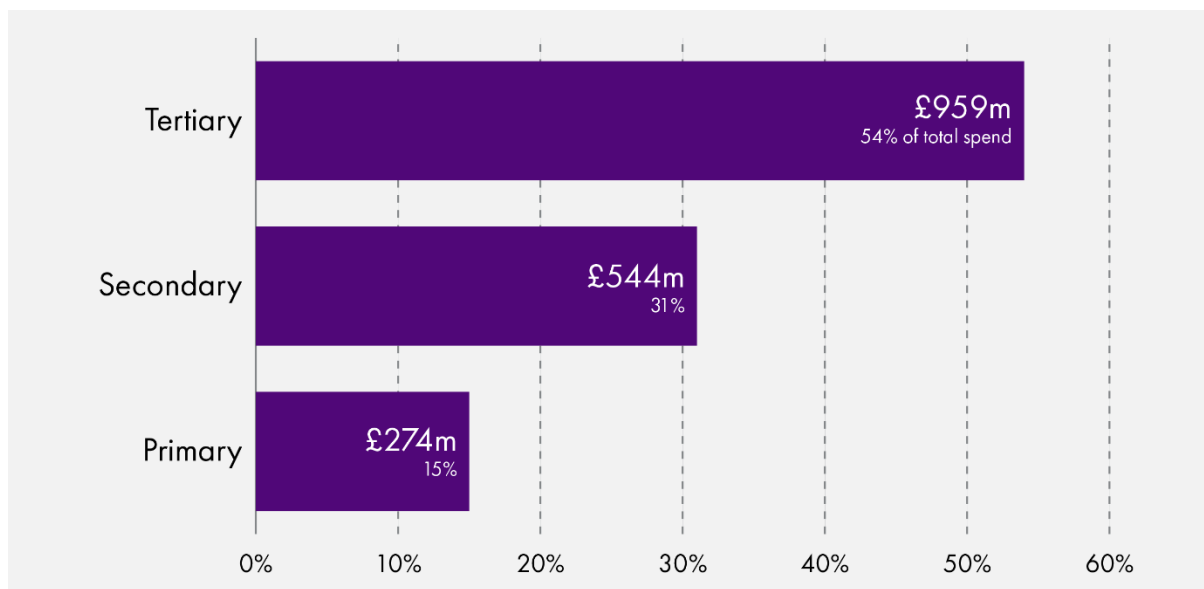
Figure 4: Public health levels of prevention



Source: Public Health Scotland

The pilots were all based primarily in health interventions and categories, even in the lines excluding Health Boards, such as primary care, vaccinations, mental health and wellbeing and tobacco control for example.

The report on the Pilot set out the results in a series of tables according to spend and level of prevention. These are set out on the following pages.

Health Board Pilot results:**Figure 5: Planned spend for NHS Boards 2025/26****Figure 6: NHS Boards 2025/26 planned preventative spend by level of prevention.**

Note that the bulk of spend is anticipated at the tertiary level, which is the least preventive, and that only 11% of spend was anticipated to be preventative.

Figure 7: Pilots excluding Health Boards, health and social care portfolio planned spend

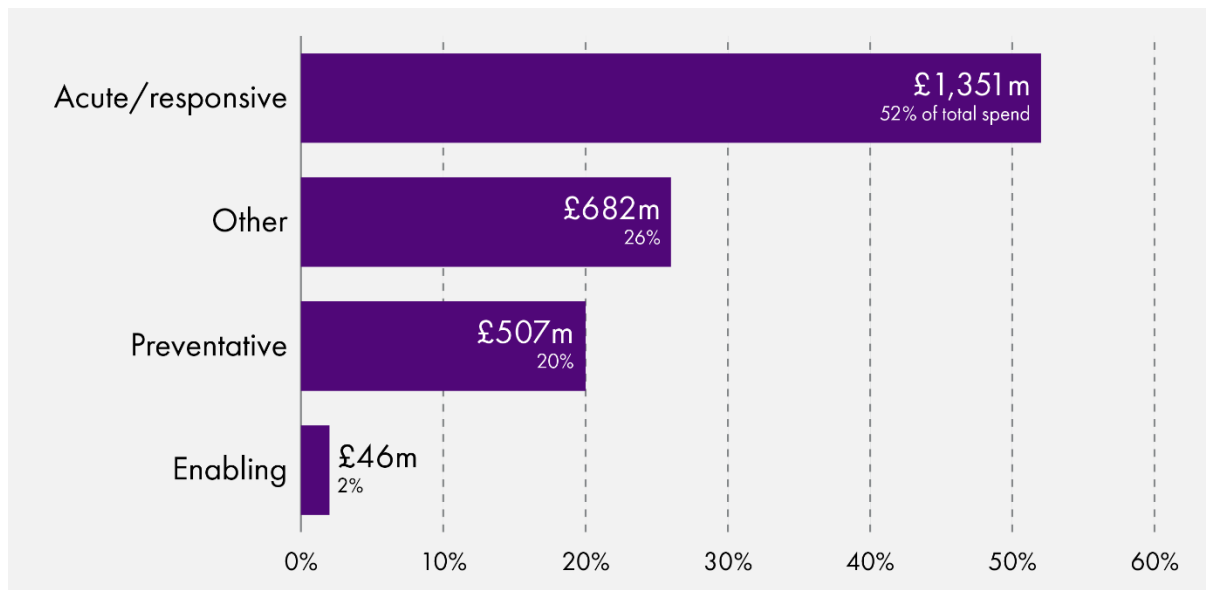
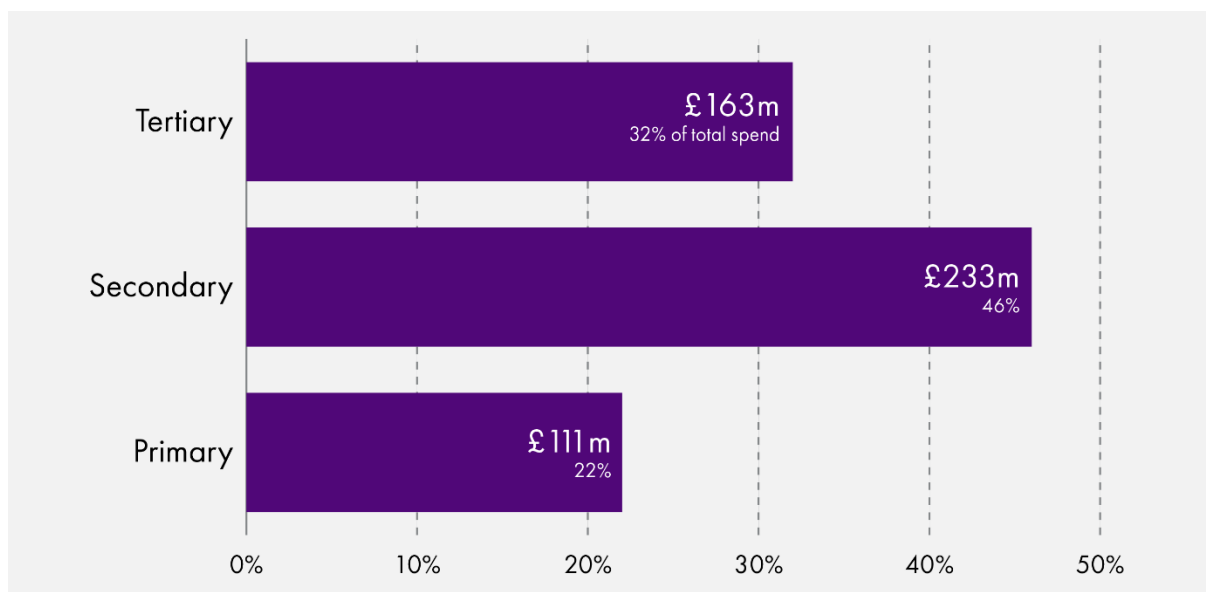


Figure 8: Health and Social Care Portfolio 2025/26 (excluding Health Boards) planned preventative spend by level of prevention



Theme 1 – Financial sustainability

Although funding has increased steadily in recent years and is set to continue to increase over the current Parliamentary term, an increasing number of health boards are at Stage 3 or 4 of the Scottish Government's [performance escalation framework](#), indicating that there are considered to be significant risks to delivery, quality, financial performance or safety and a need for senior level external support.

In [January and March 2026 the Public Audit Committee](#) considered [Audit Scotland's NHS in Scotland 2025: Finance and performance report](#). The Auditor General provided a short briefing for the Committee ahead of the meetings. He highlighted:

- Health spending (totalled £20.6 billion, 37.5% of overall budget) is projected to continue to grow over the medium term and the longer term, with cost pressures from workforce pay, new medicines, and procurement, as well as from growing demand for health and care services, from an ageing population and due to health inequalities.
- Unprecedented loan funding required by seven NHS boards, totalling £230 million, in order to break even. Boards' financial plans show that a number of boards are facing recurring financial difficulties and carrying forward significant underlying deficits. Although the forecast deficit position had improved over the previous year.
- NHS boards have made unprecedented levels of savings and reduced their reliance on one-off savings.
- Overall expenditure increases are largely due to increased spend on staffing, with a 3.7 per cent increase since 2023/24 and 31 per cent increase since 2018/19. Increased spending on staff is due to both an increase in staff numbers and real terms increase in pay.
- Capital spending fell again in 2024/25, four proposed national treatment centres remain paused and the maintenance backlog continues to grow.

Brokerage

Until 2024-25, the Scottish Government would support Boards, if required, with repayable loans, in order that Boards met their requirement to break even at the financial year end. Not all Boards required brokerage and were able to 'balance their books'. When multi-year (3 year) funding was introduced, the Scottish Government wrote to Boards (in December 2024) explaining that it was replacing brokerage with 'sustainability funding; deficit support funding; and financial support funding'. It was deemed inequitable that some Boards were effectively financially penalised for operating within their budgets, because the 'loans' (brokerage) was not being repaid.

When [Stephen Boyle spoke to the Public Audit Committee](#) about the NHS in Scotland Report in January 2026 he said:

“history suggests that, given the amount outstanding—which is now half a billion pounds—and given that only one board, NHS Tayside, has ever repaid brokerage, it (plotting the repayment of the loans) will be challenging and a significant departure from the arrangements that we have had up to now.”

Sustainability funding totalling £250 million was allocated to all boards in 2025 on the basis of the NRAC (NHS Scotland resource allocation committee formula). However, it was not clear how deficit support funding would be allocated, if required. It comprised a total pot of £166 million and was for the boards already on the support and intervention framework.

Capital spending

In February 2024, the Scottish Government [announced that all new NHS capital projects would be put on hold](#). The Government released a new [Infrastructure Delivery Pipeline](#) in January 2026, which noted that a number of projects listed in its 2021 Infrastructure Investment Plan had not been carried forward to the new plan, including projects which had begun the business case process but then been paused such as the remaining National Treatment Centres and the Gilbert Bain Hospital. The Government explained that it was working with all health boards to develop a whole system infrastructure plan, which would in turn identify investment priorities across NHS Scotland.

Productivity

[NHS Productivity was covered in the Key Issues for Session 7 SPICe briefing](#), relevant sections of which are replicated below.

Why the productivity paradox?

This ‘productivity paradox’ is evident across the UK and has been much discussed but is not well understood. [Suggested reasons](#) include:

- Patients are sicker, older and have more complex problems.
- Social care has not had the same level of investment and this has delayed hospital discharges and had a knock-on effect on hospital activity.
- The workforce is less experienced and burnt-out in the wake of covid.
- A lack of management levers, complex governance and unclear accountability.
- Investment has been in people rather than places.

In relation to this last point, revenue budgets have generally been protected at the expense of capital budgets, which would fund investment in equipment and hospitals. Staff productivity depends directly on the tools, systems and space in

which care takes place, but the prioritisation of the revenue budget has resulted in under-investment in buildings, beds, equipment and IT. The maintenance backlog for the NHS estate alone [is estimated to be £1.5 billion](#), and that is before we consider the potential costs of the opportunities afforded by technology and AI.

Regardless of the reasons for the productivity challenge, [some, such as the Institute for Government, believe](#) it existed before the pandemic and will continue without significant change.

In the [meeting with the Public Audit Committee on 7 January 2026](#), the Auditor General said:

“Despite more money and more staff, NHS Scotland’s performance has not yet improved in line with the commitments made by the Scottish Government, particularly on eradicating long-term waits for treatment. Activity in secondary care increased last year but remains below pre-pandemic levels. However, waiting lists and waiting times are starting to fall. Improvements in productivity and reform of health and social care systems are needed if health outcomes are to get better, health inequalities are to be reduced, and service delivery is to improve...

That persistent implementation gap between policy ambitions and delivery on the ground needs to be addressed if the Scottish Government, together with health and social care leaders, is to realise its ambitions and take the opportunity to drive forward the necessary changes in direction this time around. The Scottish Government now needs to publicly set out detailed, measurable actions that will enable change and help everyone understand how a different health service in Scotland will work.”

NHS Performance and delivery plans

Historically, Health Boards aligned their delivery plans with a set of time-bound targets and waiting times, among other factors. The Scottish Government has moved its policy focus away from the set of ‘local delivery plan’ targets and waiting times. However, Health Boards are still required to report on certain metrics as they always have.

SPICe tracks this data through the [NHS Scotland Performance Standards Dashboard](#), which is updated as new data is published. SPICe has also published a [FAQ on waiting times in Scotland](#) which explains the different measures as well as how they are connected to the [Patient Rights \(Scotland\) Act 2011](#), and [Patients’ Charter](#). Additional publications on [Pulling back the screens on NHS performance reporting](#) and [Whatever happened to NHS performance reporting](#) provide some insights into the history of ‘targets’ and their skewing effect on what Boards prioritise. Both were published in 2025.

The King’s Fund, in March 2025, published a press release, highlighting a report and [calling for an overhaul of targets to rebalance funding towards primary and community services](#).

Financial transparency and data

Audit Scotland highlight in their submission to the Committee that there:

“remain difficulties in gaining the system-wide information to understand how different parts of the public sector are working together. The Auditor General’s joint report with the Accounts Commission on [community care](#) highlights the difficulties that a lack of comprehensive and consistent national performance information causes Integration Authorities (IAs) and Health and Social Care Partnerships (HSCPs).”

Some potential key areas to explore:

- **Additional financial support to Boards, and how some Boards are able to manage within their allocations when others are not.**
- **Productivity - there are more staff in the NHS, but the challenges and pressures remain.**
- **The impact of target-driven performance on Health Board decision-making, particularly at a financial level.**
- **How future performance on priorities, such as obesity and prevention might be baselined, measured and reported, and how this can be meaningfully connected to the Scottish Budget.**
- **System-wide information gathering and sharing to support financial planning locally and nationally.**

Theme 2– Structural change – outcomes, costs and savings of major public sector reform

The Scottish Government has announced substantial public service reform for this parliamentary session. The rationale for reforms is presented as a means to:

“rewire the state to help improve the delivery of public services and maximise the efficient use of public spending. The case for change is pressing and urgent, requiring public services that are modern, responsive, and person-centred. Put simply, we want to deliver improved services, rather than simply preserve the existing local governance architecture.”

The Government has stated that it envisages a reduction in the number of territorial health boards from 14 to two, and a [reduction in local authorities from 32 to six, with up to between 120 and 160 community authorities](#) created. At present these proposals along with consideration of how changes might change the way social care services are delivered, are presented as ‘an opening proposition for discussion’ over the next three months with local authorities, trades unions, and healthcare and service providers. The Cabinet Secretary for Public Service Reform suggested, in

evidence to the Public Service Reform Committee on 1 October, that further consultation and engagement with front line workers, service users and the wider public would follow the initial three-month consultation period.

The Government has also stated that, in relation to the health board reorganisation, the no compulsory redundancy commitment for NHS staff would remain. In [the announcement on local government reform, there was no reference to redundancy](#).

Negotiations about structural reforms between key stakeholders will not be concluded until after the budget so it will be challenging to predict how budgets will or should be focused and directed. However, Auditor General Stephen Boyle warned during [an appearance before the Public Service Reform Committee on 3 September 2026](#):

“implementing the scale of public service reform required in terms of the wider preventative-based model, including hospital at home and tackling child poverty, at the same time as implementing structural change is a significant undertaking.”

[Enlighten’s blog from 24 August](#) offers a reminder that public service reform is not the same as public sector reform, and that meaningful change must go beyond structural changes in the public sector. It highlights the importance of outcomes, shared accountability and genuine strategic partnership between sectors, and a need for the voluntary sector to be bolder in asserting their value. Finally, the blog also talks about the need for leadership behaviour that drives change, and for sectors to understand one another’s worlds. It concludes that success of public service reform should be measured by “whether people experience good services that feel joined up and centred on what matters to them”.

Some potential areas to explore:

- **Relationship between system reform, prioritising prevention, infrastructure and capital investment, productivity and sector (staff) uncertainty**
- **Anticipating costs and savings from structural reform such as reducing the number of Health Boards from 14 to 2.**
- **The scope of opportunity for structural reform to meet the Scottish Government’s dual aims of addressing fiscal challenges and creating more efficient public services.**

Theme 3 - High-level frameworks, quality of service, structural change and budget decisions

In the meeting with [the Public Audit Committee in January 2026](#), the Auditor General referenced the three key documents published to improve health and care services, as well as population health:

“The recent publication during 2025 of an [operational improvement plan](#), a [health and social care service renewal framework](#) and a [population health framework](#) are welcome steps forward in setting out the key principles for delivering reform. However, it is fair to say that some of the ambitions in those documents are long standing and have yet to be delivered, particularly the ambition to shift the balance of care to community and local services and away from secondary services.”

Professor Linda Bauld, in her submission to the Committee, explained:

“Scotland has taken important steps toward a prevention-first approach through our Health and Social Care Renewal Framework and PHF, both of which provide an evidence-based focus on improving health and reducing inequalities. The PHF is underpinned by an ambition to improve life expectancy while reducing the life expectancy gap between the most deprived 20% of local areas and the national average by 2035, and by two initial evidence-based priorities: embedding prevention in our systems and improving healthy weight. Achieving these ambitions will depend on prevention and early intervention, action across the wider determinants of health, and effective collaboration between partners across the system.”

Health Boards are now being expected to align their delivery plans with these plans and frameworks, along with the [Health and Care Improving Flow Plan 2026 – 2031](#), published in August 2026.

Alongside this, the Committee has been informed by letter via the Finance and Public Administration Committee, that there are a further 19 (potentially more) national strategies associated with health and care.

In the context of frameworks, the National Performance Framework (NPF) is likely to play a key role in monitoring outcomes across the public sector. The NPF is undergoing its most significant reform since 2018, with the Scottish Government proposing a shift to a smaller, clearer set of long-term wellbeing outcomes, a stronger focus on cross-cutting perspectives such as human rights and fairness, a refreshed and more coherent indicator set, and even the possibility of renaming the framework to improve public understanding.

The Cabinet Secretary for Public Service Reform [wrote to the Finance and Public Administration Committee](#), copying in all committees, on 15 September 2026 to offer an update on the National Performance Framework review – this did not provide any new information, but confirmed that the Government intends to launch the reformed National Performance Framework “soon”.

It is not yet clear how or whether any of these plans, strategies and frameworks have been written or updated within the context of investment in prevention or the proposed structural reforms, nor how they might be adapted.

As well as the territorial Health Boards, the non-territorial Health Boards are also required to align their work with these plans and strategic priorities. In recent years there has been some change in the structuring of non-territorial Boards:

[NHS NSS](#) and [NHS NES](#) merged in April 2026 to become [Public Services Delivery Scotland](#). Health Scotland, Health Protection Scotland and Information Services Decision merged to become [Public Health Scotland in 2020](#)

The National Waiting Times Centre is now known as [NHS Golden Jubilee](#) and has expanded its elective care programme as well as gaining university status. It now also hosts the [Centre for Sustainable Delivery](#) and the [NHS Scotland Academy](#)

Each Board has a distinct remit, but must deliver it within a wider policy context that emphasises prevention and anticipates further structural change.

In its submission, NHS Healthcare Improvement Scotland highlights its role in ensuring quality and safety of services through their assurance, inspection and scrutiny regime.

While it identifies that there is a wealth of good practice, it has observed gaps in the system such as “circumstances which enable high-quality leadership, culture and governance”. Also, in the context of primary and community health services there are gaps in good quality and “consistent data and intelligence across all services”.

HIS state that it is “developing (its) approach to evidence to play a more strategic role in supporting policy development, service redesign and system transformation, focused on addressing major health and care challenges and supporting decision-making across the system.”.

HIS also states that its current focus is on “working with the system” towards the ambitions for prevention and early intervention through a number of community care-focussed projects. It mentions the “[Scottish Approach to Change](#)”. However, this appears to be a uniquely HIS-based approach, and appears to follow its (HIS) traditional way of working which is to provide evidence-based improvement strategies more at a service level. It is not clear how this will or could be translated as a national, system-wide approach.

Some potential areas to highlight or query:

- **Collaboration between non-territorial Health Boards on overall strategic priorities and collaborative use of budgets to meet them.**
- **Cost savings since the mergers and structural reform of non-territorial Health Boards.**
- **Circumstances which inhibit high-quality care and how they are being or might be addressed.**

- **What data and evidence are required or being designed to support ‘system transformation’.**
- **Where budget decisions should be focused to fund prevention.**
- **The Scottish Approach to Change.**
- **Aspirations for the upcoming revised National Performance Framework and its role in relation to both existing frameworks and delivery plans, and in the public service reform process.**

Theme 4 – Investment in prevention

Voluntary Health Scotland (VHS) has written a briefing for the Committee and observe that both the:

“Population Health Framework and Health and Social Care Service Renewal Framework all recognise prevention as core principles, with the latter stating that ‘With growing demand for services, increasing health challenges, and financial pressures across the system, investing in prevention and early support has never been more important.’”

As the data above from the portfolio pilot budgeting exercise carried out by the Scottish Government last year shows, most of the anticipated Health Board funding identified as preventative spend was spent at the tertiary level of prevention and on acute and responsive/reactive services. Even when Health Board spending was excluded, the percentage of spend on primary prevention was low with 20% predicted spend on preventative services and 22% on primary prevention.

This illustrates the degree to which Scottish Government, Health Boards and services across the portfolio area will have to rethink their planning to pivot towards prevention.

Professor Bauld set out ways in which recent budget decisions had reflected a preventative approach, highlighting, from the 2026-27 Budget, “the £111 million on tackling child poverty, including increases to the Scottish Child Payment; an additional £40 million investment in sport and physical activity; and over £160 million to support the Alcohol and Drugs Strategic Plan.”. She explained that the Population Health Framework:

“supports this approach by promoting earlier action, targeting the drivers of poor outcomes and encouraging greater collaboration across organisational boundaries. Preventative budgeting is one example of how these principles are being embedded within decision-making and investment processes across the public sector.”.

SHERU, (unable to attend) provided a briefing for the Committee. This set out that recurring barriers to preventative action include short, restrictive funding cycles; workforce pressures and rising thresholds that ‘filter’ out some at-risk groups, including single adult men; fragmented accountability at service transitions; and

information systems that record separate contacts rather than people's journeys. SHERU suggest that, to rebalance resources towards prevention:

“Resources could be released for frontline support by reducing excessive and duplicative reporting, replacing multiple topdown performance requirements with fewer collaborative outcome measures, and improving incompatible recording systems. These changes could free staff time for coordination and sustained support.”

SHERU suggests:

“For each major preventative spending commitment, the Committee could ask how local intelligence shaped its design, who is responsible for transitions (of resources and people) between services, what capacity is funded and how delivery will adapt. Where budget decisions set out savings assumptions, the Committee could ask: What evidence supports the projected scale and timing of savings? Has the delivery model been developed and agreed with local partners? What implementation costs are included, and what happens if savings arrive later or do not materialise? Given limited progress with realising preventative ambitions, it seems sensible to also ask how progress will be assessed (we propose that people's experiences of timely support, reduced repeat presentations for key frontline services, and housing stability, are important markers of progress, alongside health outcomes, and that these should be disaggregated by population group to track inequalities).”

Some potential areas to highlight or query:

- **The progression and opportunities arising from the Scottish Government's development of its Prevention Unit and work on budget tagging.**
- **What meaningful use of budget tagging would look like in the upcoming budget.**
- **How data from the Population Health Framework can inform discussions on structural reform of NHS services.**
- **Targeted prevention and universal interventions – the pros and cons.**

Theme 5 – Models from elsewhere

Models relating to preventative spend vary widely. The OECD (Organisation for Economic Co-operation and Development) publishes policy briefs and published [Tracking spending on prevention, preparedness and response to global health threats](#) on 24 September 2026. It highlights that national spending on prevention, preparedness and response for pandemics and global health threats has diminished since the peak of the pandemic, but remains above pre-pandemic levels. Also high-income countries spend less than 2% of overall health expenditure on PPR.

They used an international health accounting framework which includes a variety of measures such as public information on health, immunisation programmes, early disease detection, healthy condition monitoring, preventive care. The observation is that all countries should look to creating more sustainable health systems, as well as improving transparency of financing to identify PPR gaps as they emerge.

The Health Equity Evidence Centre is based at Queen Mary University of London, looking to provide evidence-based solutions for equitable health and care. In 2024 they published a report: [What works: Payment mechanisms to improve prevention spending in health care settings](#).

They recommend that capitation fee models work best in health care, whereby a practitioner or organisation is paid a fee per person to provide healthcare services across broad parameters (as distinct from a pay for performance or fee for service models). For many years, GPs operated in this way to deliver primary care, and it still exists to an extent as the [Scottish Workload Formula](#) and the Global Sum on a practice basis, with payments are adjusted according to local factors, such as deprivation and age.

The [European Observatory on Health Systems and Policies](#) (WHO hosted partnership) carries out work on health systems across Europe, with programmes including health and economy, governance, integration innovation and performance. Health system topics include financing, workforce, delivery, public health, outcomes and resilience. It tracks and monitors health systems, system reforms and progress in addressing cancer.

It also publishes concise policy briefings including:

- [Lessons from a global review of health system resilience](#)
- [Implementing innovative care models in European countries: What are the implications for health and care workforce planning and training?](#)
- [Moving towards a resilient health and care workforce: How to institutionalize health workforce planning and forecasting](#)
- [Dealing with the challenges in urgent and emergency care: What are the policy options?](#)
- [Denmark is undergoing structural health reforms currently.](#)

Some potential areas to highlight

- Usefulness of comparisons with other models.
- Distinction between funding models/ mechanisms and structural reform.

Theme 6 – Drug and alcohol deaths – case study in preventive action and investment

Since 2020, when drug-related deaths were very high, and higher than elsewhere in the UK and Europe, the Scottish Government has sought to focus on reducing them.

The most recent [Drug Deaths in Scotland 2025 statistics](#) were published on 23 September and show an 11% rise in drug deaths on the previous year. This is the [National Records of Scotland \(NRS\) news release](#). More details on how NRS defines drug use deaths can be found in their [blog post](#).

- In 2025, the rate of drug use deaths in the most deprived areas of Scotland was 15 times as high as in the least deprived areas. In contrast, the rate is around two times as high for all causes of death.
- Over the latest year, the number of drug use deaths increased in 20 council areas across Scotland, decreased in 10 areas and was unchanged in two areas.
- The rate of drug use deaths was higher than the Scotland average in Glasgow City, Dundee City, North Ayrshire, Inverclyde, West Dunbartonshire, and East Ayrshire

The Residential Rehabilitation programme (2021–2026) was launched by the Scottish Government to help improve access to residential rehab for individuals who use alcohol or drugs. The Scottish Government has increased access to residential rehabilitation. [In a recent synthesis report](#), Public Health Scotland concluded that access to publicly funded residential rehab had improved significantly, and that the number of Scottish residents accessing rehab (both publicly or privately funded) was estimated have increased by around 60% between 2019-20 and 2025-26. PHS said:

“The available evidence suggests that the biggest change in terms of access to residential rehab since financial year 2019/20 has been in the source of funding, alongside a smaller change in terms of the total number of individuals accessing rehab. There has been a clear shift towards fewer individuals accessing privately funded rehab and more individuals accessing publicly funded rehab. There has also been a shift towards more Scottish residents (and fewer non-Scottish residents) accessing rehab in Scotland.”

The Government aims, through its [National Naloxone Programme](#) (NNP) to prevent fatal opioid overdoses. Naloxone is a drug which reverses the effects of a potentially fatal overdose with opioid drugs (heroin, morphine and similar drugs). Through this programme, kits are issued from community-based services (mainly specialist drug

treatment and non-drug treatment services), in prisons at the point of liberation, via community prescription, and by the Scottish Ambulance Service (SAS).

Public Health Scotland [monitors and reports on the distribution of kits through the NNP](#). A total of 36,955 THN kits were supplied in financial year 2025-26, the highest annual total since the beginning of the NNP. Long term statistics show that the number of kits issues since the launch of the NNP in 2011 has increased dramatically. The Government included the NNP [as a case study in its June 2025 publication, Learning from 25 years of preventative interventions in Scotland](#).

There are different ways that prevention work and direct work with drug and alcohol users are funded by the Scottish Government, and this approach is present in other policy areas. (See, for example: [Delivering Equally Safe](#).) The Scottish Government will also directly fund third sector organisations through dedicated funding streams such as the [Whole Family Support Third Sector Delivery Fund](#). In February 2026 the Scottish Government set up a [Fairer Funding](#) Pilot to reduce child poverty, through multi-year funding arrangements (2 years). Separate grants were allocated in April 2025 to 51 organisations, totalling over £130m for the years 2025-26 and 2026-27.

The [structure of funding, responsibility and organisation is described in Chapter 2 of the Alcohol and drugs partnership delivery framework](#). The document describes a complex set of interweaving arrangements and relationships.

- **Scottish Government:** provides strategic direction through consultation and evidence gathering; national policy frameworks; funding mechanisms; and national performance monitoring and reporting
- **Third sector:** Between national and local levels sit statutory and third sector partners operating on a Scotland-wide basis but delivering regionally or locally. National third sector or independent organisations are funded by the Scottish Government (SG) or its agencies to deliver specialist functions. Their role derives from commissioning/grant arrangements and organisational purposes. Corra Foundation manages partnership and delivery grants from a fund from the SG of [£36.9 million](#)
- **Integration Authorities:** facilitate local strategic planning through Alcohol and Drugs Partnerships (ADPs). ADPs operate within a wider landscape of local partnerships, often subordinate to Community Planning Partnerships (CPP) and/or Chief Officers Groups (COGs). ADP leadership relates to coordination, assurance, influence and escalation, rather than direct service delivery or statutory accountability.

Some potential areas to highlight

- **The effectiveness of the national approach(es) to funding for prevention and delivery of preventive services.**
- **Challenges in auditing preventive spend through the different routes to the third sector/frontline delivery.**

- **The role of national frameworks such as the Population Health Framework in identifying interventions which might reduce drug and alcohol harms and death further upstream.**
- **Feedback, monitoring and evaluation mechanisms.**

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Date: 02/10/2026

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Annex A – Health finance overview

Health budget

The health budget for 2026-27 was just below £22.5 billion. This represented 33% of the Scottish Government budget for the year and is the largest of the portfolio budgets.

Scottish Government health budget 2026-27

	£m	
NHS boards	17,633.2	79%
Primary care	2,444.4	11%
Other Scottish Government health	1,341.8	6%
Capital	1,032.7	5%
Total	22,452.1	100%

The majority of the health budget (£17.6 billion in 2026-27) is then passed on to NHS Boards for them to determine how best to allocate their budgets to address local needs. Around £1 billion is set aside for capital projects, and £1.3 billion is retained centrally for other purposes, although some of this is also distributed to NHS boards in-year to address specific Scottish Government priorities, such as mental health or alcohol and drug prevention programmes.

The primary care sector, includes GPs, dental, ophthalmic and pharmaceutical services accounts for close to £2.5 billion of expenditure.

Health service expenditure

Public Health Scotland compiles and publishes detailed information on [health service expenditure](#). This is known as the 'Cost Book'. The latest [high level information is for 2024-25](#) and some summary information is set out below.

Board Operating Costs, £m

Total operating costs	18,242	100%
- Hospital sector	10,363	57%
- Community sector	3,948	22%
- Family health sector	3,472	19%
- Resource transfer (to local authority)	458	3%

The hospital sector accounts for more than half of health service expenditure. Within the hospital sector, over two-thirds of costs (70%) are staff costs. Within the community sector, 59% of costs are staff costs. The family health sector includes GPs, dental, ophthalmic and pharmaceutical services where contracting arrangements differ, so staffing costs are not separately identifiable.

NHS board allocations

Allocations to NHS boards are informed by the [NHSScotland Resource Allocation Committee \(NRAC\) formula](#). The NRAC formula is used to calculate target allocations for each Health Board area on the basis of factors such as the age/sex distribution of the population, geographic factors and other health-related indicators.

When the NRAC formula was first introduced in 2009-10, the implied distribution of funding differed markedly from the allocation that had been in place previously (informed by a formula called the Arbuthnott formula). In order to ensure that no individual health board faced a real terms reduction in its allocation, the Scottish Government gradually moved towards the NRAC allocation, by awarding a standard increase to Boards who are currently above their NRAC allocation and an additional uplift to those whose allocation fell short of the allocation implied by NRAC. This process of alignment to NRAC means that no health board is more than 1% below the budget that would be implied by the NRAC formula, although some boards remain above their implied NRAC target budget.

The Scottish Government also makes some funding allocations to boards outwith the NRAC formula and these are determined by other factors. For example, any funding relating to social care uses a different allocation methodology. The Scottish Government has committed to a review of the funding formula.

NHS boards then determine how they will use the funds available to them in order to meet local needs. Their plans are set out in individual Local Delivery Plans (LDPs). The [Scottish Government provides guidance](#) each year to NHS boards in developing their LDPs, which are required to demonstrate how they will support the Scottish Government's priorities, as set out in the various performance frameworks and targets.

BOARD NRAC POSITION 2026-27

	NRAC Tar gets	Board Budget Alloca tions	Total allocatio ns for NRAC assessm ent	NRAC Tar get	Distance ntage	Perce ntage	Distan ce
NHS Board	%	£m	£m	£m		%	£m
Ayrshire and Arran Borders Dumfries and Galloway	7.3	1,094.8	993.4	996.3		(0.3)	(2.9)
	2.2	332.9	300.9	302.1		(0.4)	(1.2)
	3.0	462.8	409.9	412.4		(0.6)	(2.5)
Fife	6.9	1032.8	948.3	954.0		(0.6)	(5.7)
Forth Val ley	5.5	818.7	747.3	750.8		(0.5)	(3.5)
Grampia n	9.8	1,477.5	1,337.6	1,345.7		(0.6)	(8.1)
Greater Glasgow and Clyde Highland	21.7	3,364.7	3,025.6	2,983.2		1.4	42.4
	6.7	1020.0	911.6	916.8		(0.6)	(5.3)
Lanarksh ire	12.4	1,858.8	1,702.4	1,709.0		(0.4)	(6.6)
Lothian	15.1	2,300.5	2,057.6	2,070.0		(0.6)	(12.4)
Orkney	0.5	84.9	71.2	71.6		(0.6)	(0.4)
Shetland	0.5	86.6	71.0	71.4		(0.6)	(0.4)
Tayside	7.7	1,188.5	1,057.9	1057.1		0.1	0.8
Western Isles	0.7	117.2	99.9	94.1		6.2	5.8
Total	100.0	15,240.7	13,734.6	13,734.6			

Note: figures in red are negative values

Source: Scottish Government

Integration authority budgets

Since the creation of integration authorities in 2016, NHS boards have allocated some of their annual budget to the integration authority (or authorities) within their

area. Local authorities also contribute to the integration authority budgets. The integration authorities then direct the use of their budgets to deliver the health and social care services that have been delegated to them. There is a core set of services that all integration authorities must be responsible for, including emergency hospital care and adult social care. However, beyond this, partners can agree to delegate a wider range of services to the integration authority, and this will influence the overall budget required.

The latest [budget data for integration authorities](#) shows that, in 2024-25, the total net cost of services across all IJBs totalled £12.486 billion, an increase of five per cent on 2023-24. Of this, roughly 70% came from NHS health boards and the remainder came from local authorities. The majority of IJBs reported operational overspends in 2024-25, and although funding increased on the previous year, Audit Scotland's reporting suggests that this did not necessarily go beyond covering inflationary pressure and wage increases.

One of the aims of integration is to shift the balance of care away from hospitals and into the community. In principle, the source of the integration authority budget should not matter i.e. money that has come from the health board can be spent on social care and vice versa. [Audit Scotland's 2018 update on the progress of integration](#) highlighted that Integration Authorities had introduced more collaborative ways of delivering services and had made improvements in several areas of integration, however there remained significant concerns around financial planning, governance and strategic planning arrangements and leadership capacity, as well as the slow pace of integration.

Future plans and commitments

The Scottish Government made a range of commitments in respect of the health and social care budget in its first Programme for Government of Session 7. Many of these did not indicate investment plans, such as a commitment to deliver “New Integrated Navigation Centres ensuring NHS 24, the Scottish Ambulance Service and wider system partners provide coordinated triage and advice”. This may be a reflection of the Programme for Government setting out plans over a 5-year period rather than the single year typically covered in previous Programmes for Government. Of the measures that were costed, the Government said it would it would:

- “Progress investment of at least £10 billion capital spending over the next 10 years – funding new and renewed facilities, including building new Community Health and Care hubs across Scotland, with the first tranche focused in Lochgelly, East Calder and East Livingston, and Port Glasgow.”
- “Tackle long waiting times by investing at least £200 million each year to grow elective capacity, meaning more operations can take place.”
- “Tackle long waiting times by investing at least £200 million each year to grow elective capacity, meaning more operations can take place.”

- “Invest more than £530 million in a deal with GPs, with a focus on recruiting more family doctors.”
- “Provide an extra £175 million to enable adult social care workers providing direct care in commissioned services to earn at least the Real Living Wage alongside £13.9 million for those who provide direct care to vulnerable children and young people.”
- “Invest up to £20 million via Scotland’s Independent Living Fund to help people with learning disabilities and complex support needs to live well in their communities and helping to reduce delayed discharge and free up hospital beds for those who need acute care.”
- “Invest £144 million this year in community eyecare, as well as additional investment to support design and development work for a community low vision service.”
- “Allocate £4.5 million annually to support NHS Boards to develop new specialist support for people with Long COVID and Myalgic Encephalomyelitis (ME/CFS).”
- “Implement the second phase of our Women’s Health Plan and the National Plan for Gynaecology, backed by £13 million of investment to reduce waits, and invest in research in women’s health, funding new research into menstrual health and recognising endometriosis as a chronic condition.”
- “Support NHS pay parity for hospice staff with an increase of funding to £9.4 million in 2026/2027 and help ensure that pay parity is maintained throughout this Parliament.”
- “Expand Scotland’s NHS 24 Mental Health Hub to include Psychological Therapies and invest an additional £3.5 million to make it easier for people to get the help they need – reducing pressure on A&E and other emergency services – including developing emergency mental health responses through our new Crisis Framework for Children and Young People, and Crisis Intervention Fund.”
- “Work in partnership through the Suicide Prevention Scotland collective to ensure any child, young person or adult who has thoughts of taking their own life, or are affected by suicide, receive safe compassionate support that is free of stigma, expanding funding to £3 million.”

In addition, the most recent Scottish Budget, however, did include a statement of commitment to support fair pay settlements and invest in supporting the delivery of the reduced working week. In the Programme for Government, the Government also made a commitment to “Introduce sectoral pay bargaining into social care”.

There had previously been an expectation that longer term plans for health and social care expenditure would be set out in an update to the 2018 [Medium Term Health and Social Care Financial Framework](#). The 2018 Framework considered future health and social care funding requirements in the context of factors such as

demographic pressures (an ageing population) and rising costs of treatment (driven by higher expectations and more costly drugs and procedures). As of June 2025, the Government confirmed that it was working towards a publication date of late-2025-26, but there have been no updates since this timeframe passed.

The Scottish Government does, however, provide updated long term spending plans as part of its Scottish Spending Review (most recently in January 2026), and its Medium-Term Financial Strategy (most recently in June 2025, with an update expected alongside the 2027-28 Budget in late-2026).

The Scottish Spending Review 2026 suggested that Health and Social Care spending is anticipated to rise to around £23.9 billion by 2028-29.

Health & Social Care Spending Plans (Level 2) (Scottish Spending Review 2026, table 4.01)

Level 2	2026-27	2027-28	2028-29	2029-30 (Capital & FT)
	£m	£m	£m	£m
Health and Social Care	21,928.1	22,762.6	23,871.8	–
Food Standards Scotland	23.7	23.7	23.7	–
Total Health and Social Care*	21,951.8	22,786.3	23,895.5	–
of which				
Total Fiscal Resource	20,919.1	21,864.5	22,798.5	n/a
of which Programme Costs	20,804.1	21,750.8	22,687.2	n/a
of which Operating Costs	115.0	113.7	111.3	n/a
Capital	1,032.7	921.8	1,097.0	1,031.6
Financial Transactions (FTs)	–	–	–	–

*Note: Following the UK Autumn budget, the rate of growth in health over the UK Spending Review period has reduced, with negative consequentials applied in 2027-28 and 2028-29.

Financial sustainability

After suspending the requirement for medium-term financial planning during the pandemic, the Scottish Government resumed a requirement on NHS boards to submit financial plans covering a three-year period, with a requirement to break even by the end of that period. As of June 2026, six NHS boards were receiving formal support at levels three and four (of five) of the Scottish Government's [performance escalation framework](#) due to concerns around financial management and/or financial sustainability. (Another two boards are also escalated, but not in relation to financial management issues.)

The Scottish Government works proactively with health boards that are facing issues with financial management.

In its [NHS in Scotland 2025](#) report, Audit Scotland noted “Even with increased funding, the NHS in Scotland is not in a financially sustainable position”, adding:

“NHS boards did achieve unprecedented levels of savings. But boards are still struggling to break even, with seven territorial boards requiring Scottish

Government loans. Health spending is projected to continue to grow over the medium term but this will put pressure on other vital public services. The delivery of efficiencies and reform within the health and care system will play an important role in both the NHS's and Scotland's overall medium-term financial sustainability."

Ongoing issues for scrutiny

- There has been increasing spend over several years but no clear impact on outcomes.
- Challenges around data quality and consistency.
- The potential conflict between achieving long term outcomes vs meeting short-term targets.
- A lack of clarity around the rationale for spending decisions e.g. why 4% not 3% or 5%?
- The lack of a long-term strategic plan for the NHS.
- The balance of spending between certain areas e.g. health vs social care, primary care vs secondary care, preventative spend vs acute services.
- The financial sustainability of health boards and IJBs.
- The level of transparency of information on spend, for instance, the lack of detailed cost book information.