

**Draft Budget 2018-19**  
**Royal College of Physicians of Edinburgh**

- 1. Do you consider that the Scottish Government's health and sport budget for 2017-18 reflects its stated priorities (as set out in the [National Performance Framework](#), the [LDP standards](#) and the [National health and wellbeing outcomes](#))? If not, how could the budget be adjusted to better reflect priorities?**

The Scottish Government faces the dual challenges of meeting current demand for services and addressing well documented health inequalities associated with socio-economic factors, adversity in childhood and protected characteristics such as disability. It is difficult to meet both challenges given current budget pressures.

Mental health services should be given more resource with the prevention of mental health problems beginning in childhood. Resilient families, social cohesion and mental health promotion are increasingly important. Income maximisation and the prevention of child poverty through the Child Poverty Bill will help mitigate avoidable inequalities.

In relation to the National Health and Wellbeing Outcomes, the budget does not devote sufficient attention of resource to Outcome 1 – 'people are able to look after and improve their own health and wellbeing and live in good health for longer'. This is not a new problem. Very large resources go to health repair, and modest resources are devoted to prevention and health promotion. Indeed, due to underlying inequalities in income, also wealth and power, these differences between our relatively healthy wealthy population and the least wealthy persist and could widen as austerity pressures people to adjust. Wealthier people have the capacity to adjust and benefit, whilst less wealthy people have less capacity and will be left behind.

Outcome 2 deals with care at home or in a homely setting – this requires more resource: there is a commendable intention to place more care in these settings but the drivers of financial resources, including targets and indicators act in paradoxical ways against this trend unless sustained and bold intentions turn into resource flows. Integration bodies are new and have unclear accountabilities, with resources less transparently allocated. Health economist evidence strongly suggests that moving resources is difficult when a step change is required to disinvest in services; public and political leadership and consensus as well as budget changes are required for such a transformation.

Outcome 3 deals with positive experiences of services – this is a function of training, culture, standards setting, review and continuous improvement. NHS Scotland and its clinical professions are taking significant strides to assure and sustain quality, and resources already devoted in this area should continue to be valued, amidst competing pressures to allocate resource elsewhere. The recent Nuffield Trust

report<sup>1</sup> gave NHS Scotland credit for its strategic approach and signs of delivery of better quality for patients.

Outcome 4 concerns the quality of life of service users – this is crucial and stretches well beyond the health and social care budget, and is also connected to the Realistic Medicine agenda. Realistic Medicine should not be primarily a resource or savings issue but a quality of life matter, alongside components that encompass the removal of wasteful and inappropriate treatment and care. These are important clinical and political matters.

Outcome 5 is about reducing health inequalities. Again this is not a matter confined to the health and social care services but they can play their part; in location, the culture and disposition of services and the people who deliver them for those who need support most. Signposting patients to other supporting services, such as social security for income maximisation, and smoking cessation should be routine rather than discretionary components of holistic care. We also need to recognise that unscheduled care is a pattern of service use that poorer people engage with disproportionately, and we must understand the needs of people and communities before pressurising these services further. Physicians are particularly concerned that the service to people in urgent need be the best it can be. The budget could lead this change, although cultural change in service shape and practice must follow.

Outcome 6 relates to unpaid carers' needs – whilst this may not be a direct resource issue, it is a significant burden on the country through morbidity and lost productivity of carers as they meet their responsibilities. It is also worth noting that the substantial health and social care workforce are often unpaid carers themselves with family responsibilities.

Outcome 7 deals with safety from harm, and underlines the point that systems of safety should not be downplayed in the face of resource pressures elsewhere.

Outcome 8 focusses on continuous improvement, which emphasises that as medical science progresses, public expectations change, and pressure on resources for services gets in the way of inevitable progress.

Outcome 9 deals with the effective and efficient use of resource – NHS Scotland has much to do in this area. With limited national wealth, decision makers and influencers must realise that the removal of redundant, although cherished facilities, practices and remedies is essential. There is ample evidence about the right, and most valuable, interventions to prioritise. This involves choice, and taking a population approach in proportion to needs. The media's focus on exceptions and deficits, and the most vocal advocacy, must have a counter-weight in evidence-informed decision-making, taking judgement on comparative value.

## **2. For the health and sport budget for 2018-19 where do you suggest any additional resources could be most effectively deployed and where**

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<sup>1</sup> Learning from Scotland's NHS, The Nuffield Trust, July 2017

**could any further savings be found? What evidence supports your views?**

Additional resources should be deployed to sustain high value services, and interventions. Even these are under threat in the current environment, for example in the failure to meet targets for care for life-threatening and urgent conditions. Care should be taken with technological or pharmaceutical developments which deliver small marginal benefits.

Early years intervention, and those for people with complex conditions are cost-effective – a more detailed case is contained in NHS Health Scotland work (for prevention and inequalities) and Healthcare Improvement Scotland work (for treatment and care interventions).

To address inequalities, prevention must be given due prominence. This means investing in action on diet, physical activity, breastfeeding, sexual health, smoking, alcohol and drugs. Not only does exposure to harmful substances cause adult physical health problems but adverse maternal and child health outcomes. Inequalities begin at the pre-conception stage and the countries with the best health outcomes invest very heavily in women and children's health.

Prevention remains a highly cost-effective set of interventions in many cases, but not all – for instance, some elements of cancer screening have a finely balanced risk-harm ratio and may not in the long run be cost-effective – so we must question current practice as well as new interventions, issues which have been raised as part of the Committee's Preventative Agenda.

Savings should come from not adopting interventions of low value but focussing on areas of proven value. We must accept that closing treatment facilities and cutting down on some interventions shifts costs elsewhere. There are no magic prescriptions for treatment cost cuts, although there are efficiencies and waste, and the avoidance of mistakes, that we must address.

Investment in sport should concentrate on participation rather than elite competitive sport.

**3. Is sufficient information available to support scrutiny of the Scottish Government's health and sport budget? If not, what additional information would help support budget scrutiny?**

A breakdown of last year's budget would be helpful.

There is plenty of evidence, however this is sometimes not in a form that decision-takers feel able to use, or within decision-making processes that are robust. There is the background of media, public and political expectation that the care services will cope whatever the inputs – 'more doctors, more nurses, more ambulances and helicopters'. This is persistently misleading, and leads to inappropriate investment decisions and failure to take courageous decisions to set and stick with priorities. We should make the most of, heed and act on, the information we already have, ensure that it is in a useable format for stakeholders and decision-makers, and invest in

research and studies that help to derive values from interventions so that decisions can be increasingly well informed and arrived at.

We have low expectations that the current review of indicators and targets will help us to enter a new era of rational priority setting and decision making, based on new insights into information, although it may help us to shine a light on perverse incentives.

#### **4. What impact has the integration of health and social care budgets had on ensuring resources are directed at achieving the Scottish Government's desired outcomes?**

Although the principle of integrated care is attractive, the practice to date is often one of less transparent use of evidence, priority setting, decision-making and consistent commitment to prevention than before.

Integration offers potential for services to work together in new ways and act on links between services previously disconnected. Due to service pressures, services for health promotion and child health face similar budget savings as adult and older people's services. There is a case that these should be protected in view of the long lasting implications for health, and that deaths in childhood disproportionately affect life expectancy. Meeting care needs for people may prevent or delay onset of preventable ill health. For those with a disability transition to adult services is often suboptimal, and investment may avoid ill health and improve employability. The UK has a comparatively poor track record of care for those with disabilities, a significant proportion of the population, and enabling people to participate fully will have physical and mental health benefits.