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Sobering assessment of Scotland's NHS: leaders must prioritise prevention, primary care, and the social and commercial determinants of health

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Can we afford not to invest in prevention? The Audit Scotland report on the NHS in Scotland

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Audit Scotland's latest report on the Scottish NHS is sobering reading.[1] It highlights costs rising due to inflation, higher utility costs, and pay and prescribing pressures; demand for services rising faster than activity post-pandemic; and operational challenges impacting on patient safety and experience. It concludes that, without reform, the future financial sustainability of NHS services is in doubt. It calls for investment in prevention to address the causes of ill-health, and the development of a clear national strategy for health and social care. Without this, according to Audit Scotland, long-term planning will be more difficult for NHS Boards.[1]

Would this be enough to achieve financial sustainability? To answer this, it is important to understand why the NHS is under such pressure. The demand for healthcare is a function of need and supply. Need is largely determined by trends in population health and illness (although need can also increase through expansion of what is deemed 'treatable' over time). Like many high-income countries, including the rest of the UK, average life expectancy in Scotland stopped improving around 2012. It worsened for people living in the most deprived areas.[2] The causes are well understood, austerity and its impacts on social security benefits and public service funding being the most

important.[3–6] Trends in ill-health are similarly worrying,[7,8] exacerbated by the direct effects of covid-19, and the indirect effects of economic, social and healthcare disruption during the pandemic.[9,10]

Population ageing is adding to these pressures. How much this drives growth in demand and expenditure is contested, especially compared to price inflation and the adoption of new technologies. However, the impact of population ageing depends on the extent to which prevention activities delay the disease, disability and dependency more prevalent in older populations (so-called 'compression of morbidity').[11] Audit Scotland's warning that disease prevention is effectively being de-prioritised by current pressures and by the performance indicators currently being used to incentivise the system is, therefore, important. Along with inflation, workforce shortages, and continuing austerity policies, it is difficult to see how the NHS can improve population health and reconcile demand and supply in this context.[3,12]

How healthcare need translates into service demand is mediated by healthcare supply. Audit Scotland's report usefully highlights the potential role of 'Realistic Medicine' (RM) to change this dynamic and reduce healthcare that does not add value. The Scottish Chief Medical Officer's first report on realistic medicine in 2016 noted the influence of supplier-induced demand, driven by clinicians' varying interpretation of evidence on effectiveness and side effects, pressure from industry, perceived risks of litigation, and patient expectations, leading to care in excess of what clinicians or patients would choose for themselves when fully informed about the risks and benefits.[13] [14] Primary care has a key role to play in promoting realistic medicine but faces its own challenges in terms of demand and capacity. Disappointingly, there is scant mention of primary care services (including dentistry) in the report.

In response to the report the Royal College of Physicians of Edinburgh has called for a national conversation on NHS funding, priorities and whether we can afford to provide every treatment available, free of charge at the point of access.[15] The introduction of further NHS service charges has already reared its ugly head.[16] Proponents rarely make clear whether they expect NHS charges to

reduce demand for services (which would increase unmet healthcare need, especially amongst lower income groups), or raise income (which would be more efficiently and fairly done via existing taxes). Either way, it is unlikely to be effective, efficient or fair.[17]

Audit Scotland rightly highlight that measures to address the underlying causes of ill-health are vitally important. Notwithstanding the challenges associated with UK economic policy,[3,18] effective measures have been introduced that have improved health, reduced health inequalities, and mitigated (some) health service demands, including: vaccination programmes; the smoking ban; Minimum Unit Pricing for alcohol; and the 'Childsmile' dental intervention.[19] Further legislation and regulation to address commercial determinants of health (targeting for example the food, gambling, and social media industries),[20] as well as further measures to reduce poverty and provide good public services across the determinants of health, are all likely to be effective.[3] Prevention is no financial panacea: unmet healthcare need and the high proportion of costs fixed in buildings and specialist skills make it difficult to release or repurpose resources, even if prevention reduces some demands by improving the population's health.[21] But it will help, and there is ample evidence that prevention is cost-effective in its own right.[22]

Audit Scotland call for reform, but reform is a loose concept and specific reforms need careful evaluation. Scottish Government ministers may contemplate merging health boards to reduce administrative costs and increase efficiency, but this won't change service needs or demands, and would incur substantial costs and disruption. At a service level, reforms shaped by 'improvement science' and 'collaboratives' may help reduce low value services by supporting consistent application of what does and doesn't work, but they might also encourage proliferation of changes not based on robust evidence, or experimentation without robust evaluation.[23]

Financial sustainability is more likely to arise from stripping out ineffective or low-value services; reducing 'Failure Demand'[24–26] (reactive public spending on the consequences of persistent health, social, and economic inequalities); focusing on prevention, including action on poverty and robust

and comprehensive regulation of the commercial determinants of health; and by increasing capacity and quality in primary care.

However, managing need, demand and supply in this way will be made inexorably more difficult the longer UK economic and social policy continues to undermine funding for public services and social security.[3]

Competing interests

The BMJ has judged that there are no disqualifying financial ties to commercial companies.

The authors declare the following other interests: none

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