OFFICIAL REPORT
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Health, Social Care and Sport Committee

Tuesday 9 September 2025

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
22nd Meeting 2025, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

Joe FitzPatrick (Dundee City West) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Patrick Harvie (Glasgow) (Green)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Stephanie Callaghan (Uddingston and Bellshill) (SNP) (Committee Substitute)
Professor Neil Craig (Glasgow Caledonian University)
Dr Danny Ruta (NHS Grampian)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 9 September 2025

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the 22nd meeting in 2025 of the Health, Social Care and Sport Committee. I have received apologies from Joe FitzPatrick, and I welcome Stephanie Callaghan to the committee as a substitute.

Under item 1 on our agenda, does the committee agree to take items 3, 4 and 5 in private?

Members *indicated agreement.*

Pre-budget Scrutiny 2026-27

09:00

The Convener: Item 2 is an oral evidence session as part of the committee's pre-budget scrutiny for 2026-27. I welcome to the committee Professor Neil Craig, professor of public health economics, Glasgow Caledonian University; and Dr Danny Ruta, consultant in public health, NHS Grampian.

We will move straight to questions from Emma Harper.

Emma Harper (South Scotland) (SNP): Good morning. Before I start delving into programme budgeting and marginal analysis—PBMA—in healthcare, can you tell us what that is?

Dr Danny Ruta (NHS Grampian): I will defer to the professor.

Professor Neil Craig (Glasgow Caledonian University): Programme budgeting and marginal analysis are two techniques that complement each other. The programme budgeting bit is a way of assessing how resources are being allocated across different programmes within the healthcare and wider health system. Marginal analysis is the process by which you reflect on where those resources are going, posit possible changes to that, such as spending more in some areas and less in others, and then assess the strengths and weaknesses of the different expansions of resources in particular programmes or reductions in expenditure in particular programmes.

It is a process of understanding where resources are going and then sifting through the strengths and weaknesses of different ways of changing those existing programmes using criteria that, ideally, would be drawn up by the people who are involved in the decision-making process. It often has a health focus, but it often reflects on other potential consequences of health spending and decisions, too.

Basically, it is a priority-setting process that tries—we will probably come on to whether it can do this—to assess systematically where resources are going and the costs and benefits of changes in the way in which those programmes are funded.

Dr Ruta: 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.

Emma Harper: Okay. I forgot to mention that I am a registered nurse and a former employee of NHS Dumfries and Galloway. I have been a nurse for probably about 40 years.

I have type 1 diabetes and use an insulin pump. Part of the reason for investing in better blood glucose control using diabetes technology would be to reduce complications that lead to dialysis and eye problems that need laser treatment, which then lead to other complications. Can PBMA be used to show that, although insulin pumps and other devices will cost money, investing in them will reduce spend on potential complications?

Professor Craig: Yes. That is an issue that might come up in the marginal analysis. If you have looked at a programme and one of the suggestions is that it should expand to fund more of the services that you were describing, you have to weigh up the costs, benefits, advantages and disadvantages of expansion into a service area. You would consider the potential consequences of doing that. That would not just be the immediate consequences for the health of the patients who are involved but the knock-on consequences—potential sequelae—of that illness not being adequately treated. That would absolutely be part of the consideration of whether, at the margin, it was a good idea to spend additional money in a particular service area.

However, as Danny Ruta said, doing that would likely—certainly in the constrained environment that we are currently in—come at the expense of something else that is also probably beneficial. The argument would then be whether that is as beneficial as the thing that you are hoping to invest the additional money in.

It is not a new system, but decisions are not currently being taken using it. The system tries to make those potential changes transparent and explicit, then weighs up the costs and benefits of those changes as systematically as possible with the evidence that is available. It would take into account the additional consequences of potentially increasing investment in one area and reducing it in another.

Dr Ruta: Diabetes is a good example. When I was a director of public health in Newcastle, we tried to take a PBMA approach to looking at diabetes services in Northumbria. You can construct a programme budget—you can try to work out as best you can where we currently spend money for patients with diabetes. You can draw that programme budget across the entire diabetes pathway. You could start with prevention. As you know, type 2 diabetes has a strong correlation with obesity, so are we spending anything on weight management, for example, to help people to reduce their weight? You can go all the way through the types of treatment for type 1 and type 2 diabetics, which can include drugs, surgery and amputations, and look at what is spent on that. You can also consider all the complications of diabetes, such as heart disease and kidney failure.

The bigger you draw your programme budget, the harder it gets. People could just carry out a micro-PBMA, in which they simply look at one little bit of that service. If they are more interested in insulin treatments, for example, they could do a mini-PBMA on that. Equally, they could do a big macro one across the entire health authority, which has been done previously.

There is a challenge in trying to identify the costs and the outcomes—what benefits you are getting from each of those different parts of the service. However, as Neil Craig said, the real challenge is when you try to do the marginal analysis bit, which is about moving money around to see whether you can get more overall health benefit for the money that you have. That is where it becomes incredibly challenging for lots of different reasons, which we might touch on.

Emma Harper: Our papers talk about how the Scottish Government piloted the use of PBMA in 2012. That is a while ago. Does the Scottish Government continue to use PBMA in, for example, health and social care?

Professor Craig: 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.

Interestingly, since then, budgets have become tighter. It seems to be, maybe ironically—perhaps we will come back to this point—that the sheer fiscal constraint that everyone is dealing with at the moment makes it harder for people to sit back and take these strategic approaches to decision making, although, arguably, this is exactly the time when they should be doing it.

Danny Ruta mentioned that programme budgeting and marginal analysis is a framework that is designed to deal with scarcity. Things are pretty challenging in that regard. The framework enables you to say, "If we're going to spend more here, we're going to spend less here". However, to people who are involved in the system, the pressures that they face because of the constraints on public spending are such that it feels very difficult to take that strategic step back and use something like PBMA as a way of planning expenditure and how it is used.

I mentioned speaking to an official. His sense was that the resources were so tight that that derailed the Scottish Government's attempts to develop PBMA.

There are, undoubtedly—we will probably come back to this—data challenges, which means that PBMA is quite difficult to do in a way that generates intelligence that people have faith in because they trust that it is an accurate picture of what is happening. That is because the systems are complicated, particularly in an area such as mental health, and the data are not ideal. It is not a system that can readily provide you with very granular information about what is happening, and it takes a lot of time to try to improve the data that we have. The official's sense was that the approach petered out for those reasons.

The short answer to your question is no, PBMA is not continuing. It has been tried and thought about, and it seemed to be making progress, but that official suggested that circumstances conspired against it.

Emma Harper: No health board has successfully implemented or used it. You mentioned integration joint boards. In Dumfries and Galloway, we have health and social care partnerships, one health board and one local authority. Having only one health board and one local authority might make it easier for PBMA to work there.

Professor Craig: I think that there are isolated examples of where people have found it helpful, but it has never been used systematically or routinely.

Dr Ruta: Neil Craig and I were talking about PBMAs before the meeting started. I think that the first time that we ever did PBMA exercises was in the early 1990s. I did one for the Tayside Health Board that looked at children's services, and Neil did one in Newcastle. We repeated Neil's one 10 years later in Newcastle.

As far as I am aware, there is no jurisdiction in the world where PBMA has been embedded into a healthcare system for the long term. There have been lots of attempts, but it has never bedded in; it has never taken hold anywhere that it has been tried. Attempts have been made over more than 30 years. That begs the question why it has never become routine.

For about six or seven years, the Department of Health and Social Care in England got all the health authorities to construct programme budgets. That became a mandatory requirement. I was working in England at the time in one of the primary care trusts. However, PBMA was never really used by any health authority to make any decisions.

Emma Harper: Okay. Thanks. I will stop there for now.

Sandesh Gulhane (Glasgow) (Con): I make a declaration of interest as a practising NHS general practitioner.

One of the most important parts of the PBMA approach would be to know exactly how money is spent and where it goes. Is that correct?

Professor Craig: Yes.

Dr Ruta: Yes.

Sandesh Gulhane: I will take long Covid as an example. An announcement was made that £10 million was to be spent over three years. A series of freedom of information requests was made about how that money was spent. You could see where the money was allocated to a health board, but it was impossible to find out where it was spending that money.

Even if we did not embed the PBMA approach, would knowing how the money was being spent lead to a significant improvement in our ability to plan and strategise?

Professor Craig: I was thinking about that beforehand. If I was in a senior position in a health board, I would want that information. It was striking from reading the committee's meeting papers that many of the organisations that responded to the consultation on which the summary is based are saying, in different ways, that they need programme budgets. They want to understand better where resources are going, whether that is across geographical areas, care settings, age groups or diagnostic groups. It would appear from the papers that people in senior positions who are making strategic decisions want a better understanding of where resources are going. As Danny and I discussed before the meeting, that reflects the fact that the expenditure process is a mixture of managerial and clinical decisions, which means that a very devolved system ultimately determines where resources end up.

If you were a strategic decision maker, would you not want to know the sum effect of all those decisions? You need to know whether, strategically, spending in the system is going in

the wrong direction in relation to needs, developing demographic trends and epidemiological trends, and whether attempts to change the care setting, move upstream and do more preventative work are working.

PBMA could potentially give you that knowledge, but, in practice, that is difficult because of the quality of data systems and the time that it takes. It is also difficult because, as was raised in the papers—maybe this is a particular issue for a topic such as mental health—there are definitional issues in relation to the types of services where you might want to understand where the money has gone. Those services are not well defined with clear boundaries. Agreeing the definitions in order to compile programme budgets is quite difficult.

09:15

It is a difficult process, but it is an ideal that is attractive to many people. I thought that that was reflected in the papers that were circulated before the meeting.

The PBMA approach looks attractive in principle and it is therefore legitimate to ask whether it is something that we should aspire to and work to in the longer term, so that such data becomes a routinely available piece of the planning system that people can appeal to when they are trying to make strategic decisions and to understand where the big shift in spending in health and social care is going, which is sometimes inadvertent and not necessarily in line with either public health or other strategic priorities.

The short answer is yes, but it is not as easy as that, in that the information systems are quite hard to put together in a way that generates valid, reliable data.

Sandesh Gulhane: Just because something is difficult does not mean that it should not be done, in my opinion. Any business would know exactly, to the penny, where its money goes.

Professor Craig: Sure.

Sandesh Gulhane: How you spend your money is one aspect. My other question is about outcomes. When you make a strategic decision, do you need to know clearly and up front what you hope will be the outcome of that investment and how that outcome will be measured?

Dr Ruta: You are asking the right questions. If somebody from industry looked at the NHS, they would be shocked. They would start by asking simple questions. For example, how much money do we spend on people with diabetes? How much money do we spend on people with schizophrenia? How much do we spend on people with mild depression? How much do we spend on those with severe depression? It would be almost impossible to answer those questions, because our financial and accounting systems are not geared up to answer fundamental questions about how we spend healthcare resources.

Similarly, we do not measure health in the national health service. We do not routinely or systematically measure the most fundamental outcome, which is someone's physical and mental wellbeing.

Those two key metrics are not easily attainable. We have to ask why that is the case. We have now had an NHS for more than 80 years, but we still do not do that. That begs the question: why?

Sandesh Gulhane: I have not been published as much as the two of you—I have only a BSc—but I was taught that you should measure your outcomes before you start to look at the results from your analysis. You need to know what it is that you are looking for. You do not throw a ring over data once you have achieved it.

When we talk about a top-down approach, we can think about alcohol spend. In relation to how minimum unit pricing was introduced, it was not abundantly clear to me what the outcome data was prior to looking at the results and deciding what we had found for the money that we had spent. That was given as an example of a PBMA approach. What do you think about that? How would you have gone about that policy from a PBMA point of view?

Professor Craig: I am not sure that that is an example of what you are concerned about, in the sense that there was always a commitment to reduce the number of alcohol-related deaths and hospital admissions. If the objective was to reduce the number of alcohol-related deaths and hospital admissions and other potential consequences of excessive alcohol consumption, it is likely that a programme budgeting exercise would set off by seeking to measure those metrics, alongside carrying out an analysis of how big the programme budgets were—in other words, how much money was being spent on different areas that were relevant to achieving a reduction in the number of alcohol-related deaths.

Without wanting to get into the alcohol example specifically, I would argue that it is likely that reducing the number of suicides, for example, might be a strategic goal of increased investment in mental health services, alongside myriad other potential outcomes. It is likely that you would aspire to achieve that outcome, and you would continue to measure that through the process of compiling the programme budgets and try to understand whether those budgets were in the right place to have the maximum impact on that outcome.

Things such as alcohol-related deaths and suicide-related deaths are measured. The greater challenge is to link spending to outcomes and changes in outcomes. The old adage is, "association is not causation". Just because we spend more in an area and the number of deaths comes down does not necessarily mean that the reduction was due to that spending. If you observe a change in an outcome, you need mechanisms and processes to reassure yourself that it is plausible to attribute that change to the spending—in this case, the money from the programme budgets—that has been allocated to achieve the objective.

Dr Ruta: Just because we do not have precise and accurate data on costs and outcomes does not mean that we cannot try to make a better attempt at making more rational decisions than would be possible without using something such as PBMA. For example, in the mid-2000s, we did a PBMA exercise on drug and alcohol services in Tayside. It was led by the health board along with the drug and alcohol services of Perth and Kinross Council, Angus Council and Dundee City Council. Given that we did not have granular data on the actual outcomes for residents and patients, we looked to the literature, the research and the evidence, so we were at least able to say that there was an evidence base for a particular intervention and that research showed that it could deliver a certain reduction in the level of suicides or a certain improvement in mental health, even though we were not necessarily measuring those things directly.

One of the exciting things about the exercise was that we asked lots of different stakeholders across the local authorities, the NHS and the community and voluntary sector to go to a website that we had created to generate ideas for investment and disinvestment in drug and alcohol services. Some of the ideas were completely politically unfeasible—for example, disinvesting in accident and emergency services and spending that money on alcohol prevention. However, we said that whatever was suggested would be potential candidates for investment or disinvestment—we did not take anything off the table—so that the exercise was as inclusive as possible.

We created the website so that people had a notional budget of a couple of hundred thousand pounds and could drag and drop investments from a long list. For each investment, we gave a little description of what the benefits were. We went through a process to agree the criteria for the benefits, which included improvement in the quality of life, improvement in the length of life and improvement in the quality of services. One criterion was whether the investment or disincentive was practically feasible, and another was whether it was cost effective.

For each candidate for investment or disinvestment, if it was possible, we included numbers—if it was not possible, we just used words to describe in qualitative terms the nature of the benefit. We also tried to quantify the number of patients who would benefit. We summarised that information in a tiny vignette for each candidate, and people could then drag and drop the options.

As someone dragged an investment, the money that they had available went down. We told people that there was no new money, so, if they wanted to make investments, they had to choose from the list of disinvestments and take money away from certain things. A lot of the investments were also disinvestments, because some people wanted to spend money on a service and some wanted to disinvest in that service. We had different lists. It became really hard for people, because they realised that we cannot just spend more and more money—anything that we spend has to come from somewhere else.

The exercise got broadsided politically, because some new money became available from the Scottish Government for investment in drug and alcohol services, so the whole exercise changed to one about how we would prioritise the new money. That let everybody off the hook, if you know what I mean. That tends to be the story with PBMA, especially when we get to the MA bit. Everyone can quite easily do the investment bit, but, as soon as you ask someone where they will take the money away from, things start to run into the ground.

However, the process worked—you could see that there was potential. You do not necessarily need to have all the precise and accurate information. You can find ways of doing the process in a more subjective way, without making it too mathematical. That also means that you can do it more quickly and engage a lot more people, including the public.

Sandesh Gulhane: Thank you very much.

Paul Sweeney (Glasgow) (Lab): My thanks to the panel. I am finding this really interesting, because in the mental health context, it can be quite tricky to reconcile different approaches. What might suit a logistically rational top-down approach—say, a diabetes screening programme or vaccination programme—might not work as neatly with a mental health programme. There might be much more gradual and interrelated impacts with regard to housing, urban planning, the community, employment, training and so on. How rich is our data on mental health budgets and their impact on and interfaces with other public services to support the use of a top-down,

analytical, gradual, PBMA approach to allocating resources at a local level?

Professor Craig: Would you be better placed to answer that, Danny?

Dr Ruta: I honestly do not know—I am not able to answer that question. I am not involved in working directly with mental health services, I am afraid.

Paul Sweeney: Okay. I am just thinking about this from an urban planning perspective, which is a personal interest of mine. An American urban planner in the 1960s, Jane Jacobs, contrasted what she called cataclysmic money—that is, a sudden influx of capital spending to do something like slum clearance and building a new housing estate—with gradual money, or community-based investment made over a longer period. The latter might preserve a lot more of the rich, organic, intangible activity that is valuable, but it is the sort of activity that does not trigger any signals that might be recognised by urban planners looking down, godlike, on a situation. They might see building new housing as the simple solution, but it actually destroys rich activity and value in the process. From your own perspectives, are there any such risks in using PBMA in a mental health setting, given the much softer and more gradual and intangible aspect to how it works?

Professor Craig: My answer is that, in a way, it would be the converse of that. Programme budgeting would make plain some of those risks by documenting how money was being spent. One thing that struck me in the papers was this description of a very complex and fragmented delivery landscape, but the fact is that many of these fragmented services are probably very highly valued by the local communities and groups in receipt of them through, say, third sector organisations. It is important to understand the extent to which mental health services are delivered through those mechanisms, alongside some of the more traditional statutory services that might be delivered through traditional healthcare settings such as hospitals or other clinics.

Part of the purpose of programme budgeting is to make very transparent how services are currently being delivered, with a view to informing strategic decisions about whether the balance is right. In a way, one of its purposes is to try to respond to the sorts of risks that you have just highlighted and make it very clear how services are currently being delivered.

09:30

The challenge is whether you have the information to do that accurately, and the papers also refer to some of the challenges in that respect. What are the right definitions for different programmes of care relevant to mental health services and mental illness-related needs? How do we define those services in a consistent way such that those data can be compiled in a consistent way across different geographical areas and over time to allow you to make accurate comparisons between areas and from year to year? In principle, programme budgeting is designed precisely to do what you have been talking about—that is, to make it very clear where resources are currently being spent with a view to assessing whether that spend is appropriate. However, it is challenging to do, and perhaps particularly challenging in mental health services, because of their very nature.

Dr Ruta: Neil Craig is absolutely right. I am thinking only theoretically here, but if you applied programme budgeting to mental health services or mental health programmes, it would flush out some quite startling disparities. When we did the children's services PBMA in Tayside and constructed the programme budget, we were able to see certain things, perhaps for the first time. For example, we found that we were spending a lot of money on the special care baby unit for about 60 babies a year, and significantly less money on health visiting for thousands and thousands of babies a year. However you tried to quantify the benefit in terms of health outcomes such as quality and length of life, there was a huge disparity in the cost benefit ratio.

I am guessing that if you did the same for mental health, you might start to see the same things. You might start to see that acute care such as in-patient management of schizophrenia is highly expensive versus, say, a preventative approach to mental health issues or a public mental health approach, which, although very cheap and cost effective, is not something that we spend a lot of money on. A lot of that spend would have to come from outside the NHS—from, I guess, local government or national spend.

Therefore, PBMA starts to flush out some of those issues and disparities and leads you to having to make some difficult judgments or to decide what your criteria are. With the special care baby unit example, it is not just about the total amount of quality and length of life—it is about equity and having the chance of life itself as a criterion of benefit rather than just the number of people who are given a chance of life.

There are equity and access issues that can be benefit criteria in a PBMA exercise and which might justify why you are spending an awful lot more money on one area for relatively less benefit than you might be on another area of mental health. It is just that you are taking those other criteria into account.

Paul Sweeney: Are there, from a mental health perspective, risks in how you calculate cost avoidance, because you are trying to prove a negative that is, in some instances, hypothetical? Supporting people to stay in a home setting through giving them cooking and other lifestyle skills, companionship and so on might avoid addiction issues or entry into the justice system. However, it is very hard to say, hypothetically, that we have saved the country X thousands of pounds by investing a relatively small sum now in stabilising someone's situation.

Anecdotally, when I was at HMP Barlinnie two weeks ago, the governor was telling me about a young man who was back in on a short sentence. He had been so humiliated at not knowing how to pay his rent that he ran away from his accommodation, took drugs and ended up back in prison. What if someone had been there to support that young man to deal with the stress of a setting that most citizens would be able to deal with? He just could not deal with it; because of how he had been brought up, he was not taught that stuff. How do you prove that sort of thing? It might be a situation particular to that individual, but it has created a spiral of costs for the country that could have been avoided. It is hard to put that into a spreadsheet.

Professor Craig: It is, but those decisions are being taken anyway, so what programme budgeting tries to do is to make it transparent that those decisions are being taken. It highlights and identifies how much we are currently spending on, say, on rehab services for people in the hope that when they are released from prison they go on to lead more fruitful, more productive and more stable lives away from crime. In the marginal analysis phase, we will look at that area and if we think that the service might not be enough—for example, it has been diminishing over time or is very different in different geographical areas—and more spending on it might be justified, we will then consider the likely costs and benefits of doing so and the opportunity cost with regard to the services that we might need to withdraw or spend less money on to fund that expansion.

With the programme budget and marginal analysis process, we are simply trying to surface those issues and apply whatever evidence we have to assess the costs and benefits of any decisions made to address them. Those issues will not go away just because we choose not to do PBMA—PBMA is not making these challenges more challenging. Instead, the hope is that it will shed some light on them so that we can make them in a more evidence-informed way.

That is not to say that the approach does not have its own challenges—in relation to, for example, availability of data and evidence—but, in principle, it is trying to address the concerns you have just voiced with regard to particular groups, perhaps particularly vulnerable groups, not having their needs met, because they are a bit invisible and because we do not have perfect evidence to inform decisions that might improve those services.

Paul Sweeney: Who would own the gathering of that data? Does that need to happen at every level at which the data is gathered? Central Government, local government, local health boards and so on often dispute who is responsible for gathering such information. Moreover, is it always appropriate for transparency—including, say, putting it in the public domain—to ensure accountability with regard to the data picture?

Professor Craig: There are different ways of doing programme budgeting, but a distinction that is often drawn is between the macro and micro aspects. You might actually want to do this sort of thing at different levels. You might want the sort of strategic information that is available at board level for broad service programmes so you can compare those programme budgets across health board areas. In that case, you would want to do it at a national level according to agreed definitions.

You might also carry out what is sometimes called in the literature micro-PBMA, where you would take a service area, such as prison services in a particular health board or council area, and local people would work out what they were spending in different areas, such as the services you have just described. It would be a local exercise in which they would decide what, if anything, should change in relation to the local programme budgets.

It really depends on what you want to use programme budgeting for and the decisions that you want it to inform. That should determine the level at which you carry out the analysis.

Paul Sweeney: Okay. Thank you.

Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP): I am finding the conversation fascinating. Paul Sweeney's questions sparked off a thought in my head. Previously, I was community wellbeing spokesperson for the Convention of Scottish Local Authorities. When we looked at how to end homelessness, we decided to approach it through rapid rehousing transition plans, which are similar to the things that Paul Sweeney was just speaking about.

I was going to ask about how we ensure that the strategy applies to all the levels where decisions need to be made, but you answered that when Paul Sweeney asked about who was responsible for that. My argument to health and social care partnerships was that they would need to release some of their funding, which, traditionally, did not

include housing. My argument was that the strategy reads across everything.

How do we actually make sure that that happens? If every department is doing its own programme budgeting and trying to figure out the marginal analysis of that, how are those who are debating acute and preventative spend making sure that the read-across is there? I know that that is a big question, but I think that it is important.

Dr Ruta: It is a massive question, and it is the challenge for public health, is it not? Public health challenges do not respect institutional boundaries, whether in local government, the NHS and healthcare or social care. How money is allowed to be transferred across budgets is a challenge for Government. The more you are able to do it, the more overall benefit you are going to get, probably, for the resource that you have available, and the more siloed budgets are, the more inefficient your use of resources will probably be.

Professor Craig: It is a good question, in the sense that having lots and lots of micro-PBMA exercises in stand-alone areas does not answer the question of the strategic decisions that the board faces. The only solution to that particular challenge is that the board would be doing programme budgeting across the entirety of its services, such that it could then make decisions to invest more in one area and less in another. However, doing that would still run up against the same political—with a small p—challenges, in that nobody wants to relinquish resources in their area to enable the board to invest more in another area.

It is important to be clear about the limitations of PBMA. It does not solve those problems. It provides a framework for analysing some of the issues that are thrown up by, for example, making clear what you are spending across different programmes and then, through marginal analysis, saying what might be the costs and benefits of different ways of expanding or contracting those programmes.

Programme budget and marginal analysis does not answer the questions about change management issues that would flow from making those strategic choices to shift money from one area to another. It is a framework for deciding whether you want to try to address some of those challenges by reinvesting money and putting more money in one place rather than another. It does not overcome the challenges, other than by providing a clearly worked out and transparent rationale for making those changes.

Elena Whitham: Do you think that that framework would be of benefit to community planning partnerships? If, in the wider local community planning partnership in each local authority area, the partners that are striving for the same aims applied the PBMA approach to all decision making that affected things that the partnership was working on, could that be helpful? I include mental health, drugs and alcohol, health visiting and so on—everything that it is involved in population health.

Professor Craig: I think so, to the extent that these are very challenging decisions in terms of the politics. You would want to be absolutely clear that, if you are shifting resources from one place to another, which means that there will be losers, you have a clear rationale for those decisions and that they are evidence based.

Another point to make that is relevant to Mr Sweeney's questions relates to his sense that PBMA is a top-down exercise. That is absolutely not what marginal analysis is supposed to be. It is supposed to be an exercise that involves different stakeholders in the process of scrutinising the programme budgets, agreeing criteria for changing those budgets and reviewing the evidence that is brought forward in looking at the costs and benefits of changes. Through doing that, you get a legitimacy for what are often very challenging decisions. Change management is a bit easier—it is not easy, but it is a bit easier—if you have legitimised the changes that you are seeking to put into place.

PBMA is not a panacea and it is not a quick fix in the sense that it gives you a ready answer to these questions. It is based on an ideal: if we have worked through a process collectively, democratically and transparently in an evidence-informed way, one would hope that that would make the difficult decisions more likely to stick in practice.

Dr Ruta: I can think of a good example, actually.

The Convener: If you can be very brief.

Dr Ruta: Oh—sorry. I will be really quick. In Grampian, we had a problem with ice on the pavements and people falling—we had a quadruple increase in the number of patients admitted to A and E with fractures from falls. We came up with the idea of ice crews, through which we could try to help local community groups to sort their pavements themselves by providing them with grit and little wheelbarrows. NHS Grampian's public health department looked at the idea and did a kind of PBMA—it looked at how we would spend our budget that year and at the costs and benefits. We thought that it would be cost beneficial because it would reduce the number of fractures and orthopaedic stays. However, the feeling was that buying salt and wheelbarrows was not a good use of NHS money. Luckily for us, the health and social care partnership stepped in with a more cross-partnership approach and decided

that it was a good thing to do and, eventually, we were able to fund it through the partnership. That illustrates that siloed thinking and shows how using a PBMA framework can actually help.

09:45

Brian Whittle (South Scotland) (Con): Good morning. You have opened a door here. One of the things I want to delve into, having looked at some of the responses to the call for views, is the desirability of moving away from acute spend and towards preventative spend. I was struck by a quote from Dr Will Ball, who said:

> "There is a strong case for rebalancing spending towards earlier, preventative, and community-based support to reduce reliance on acute services and improve outcomes."

I have bored members lots of times with this before, but that reminds me of the Mental Health Foundation's publication, "Food for thought: Mental health and nutrition briefing" and how improving diet can improve mental health, and Scottish Action for Mental Health's quite hard push for the idea that being physically active improves mental health. It is very difficult to measure those things, but there is a certain level of intuition that says, "That has to be right." This really is at the margins, but how do we bring that thinking into the PBMA framework? We have to measure such things, because everything has to be measured these days, apparently, so how do we bring in that intuition? Intuitively, what Paul Sweeney was saying about housing and so on sounded correct. How do we bring that into the PBMA framework?

Professor Craig: Let me reiterate what I was saying about the marginal analysis stage of the process. A paper was produced recently on the experience of doing programme budgeting in, I think, the NHS Lanarkshire area, where there was a pilot that involved lots of people from different stakeholder groups in a process of defining options for change and thinking through what the benefits and disadvantages would be of those options for change. Such a process is informed by a mixture: it uses evidence where it is available and, sometimes, where evidence is not available, it uses "tacit knowledge", if I may use that phrase. I am talking about the wisdom that various stakeholders have gained through being a third sector advocate, a clinical professional or a management professional. There are sometimes gaps in the evidence that is needed to inform decisions, and those gaps must filled by the intuition of knowledgeable people, whether they have technical knowledge, lived experience knowledge or the knowledge that comes from representing people with lived experience. That has to be part of the picture.

To answer again the question whether this is a top-down process, it does not need to be, and ideally it should not be. The process should involve the marginal analysis being carried out by different groups that can bring to bear what will likely be a mixture of more formal evidence and—sometimes, at least—intuition, so that they can sift through the options for change that are on the table and assess which one is regarded by the group making the decision as being the most favourable. Inevitably, given that there are gaps in the evidence base, those gaps will sometimes have to be filled by intuitive knowledge. It is not random knowledge; it is knowledge that comes through advocating for, treating or being in the relevant group that the services are designed to serve.

Dr Ruta: I can give the committee an example of how we would do that in practice. Imagine that we are a PBMA advisory panel and we are trying to make a decision about how to spend money on mental health services in a particular area. We have a list of potential investments that are really good ideas and a list of disinvestments—areas where we think that we might be able to save money or services that we might reduce because they are not as beneficial as other services. We could make the decision in one afternoon quite easily as long as we have done a lot of homework.

On one sheet of A4 paper, we would try to describe each candidate for investment or disinvestment. Where possible, we would put down some numbers if we had research that showed that a particular intervention leads to an X per cent reduction in suicides or improvements in mental health or whatever.

I would take the first investment candidate and I would stick it on the wall. Then I would take the second one and I would say to you all as a group, "Do you want to put this one above the first one? Do you think that it is more or less cost beneficial than the first one?" Then we would debate it and all our intuition would come in—the intuition of all the different health professionals, social care professionals, patients or members of the voluntary and community sector who are on the panel. We would debate it, we would try to get a consensus and we would stick the second one above or below the first one. Then we would take the next one and the next one, and we would do the same with candidates for disinvestment.

In that way, which is transparent and inclusive, we have identified where we would spend money and where we would take money from. You could argue about how scientific or rational that approach is, but at least it is transparent, and it is a lot better than the current way in which we make decisions, which is completely opaque.

Brian Whittle: We are asking what the bottom line is. It is very easy for us to talk about shifting from spending on acute care to spending on

preventative measures, which I am a big advocate of, right up until there is an acute problem right in front of us. You gave the analogy of the spend on 60 very ill babies as opposed the spend on thousands of babies. The bottom line is this: how does PBMA help us shift incrementally towards preventative spend? The trajectory of the acute spend in front of you inevitably leads to less preventative spend, and so to more people needing acute care. It is an ever-decreasing circle. How do we utilise what we are talking about to try to reshape the way in which we think?

Professor Craig: At the risk of repeating myself, the answer that I gave to Ms Whitham's question is that PBMA does not solve that problem, in the sense that it will continue to be a very challenging problem to address. It provides a framework for making the decision more transparently and more clearly. It shows that, if you as a group were to decide that maybe there would be no further growth in acute settings because you were going to use further growth moneys in preventative settings, you have a rationale for doing that. It is a decision-making tool, but it does not make that decision for you. It is also not a change management tool. It provides a ready way of leveraging the money out of some very sensitive acute areas into other areas, but the challenges of doing that would still exist. It provides you with the ammunition, which is not a very nice word to use in these circumstances, to do that in a transparent, evidence-informed way. In that way, if you are making that decision, at least you can defend why you are making it and it does not seem like an arbitrary process of imposing cuts just for the sake of it. It is about making these decisions more transparent and as evidence informed as they can be, but it does not solve some of the challenges that you highlight so clearly.

Dr Ruta: Having spent almost my entire career in public health, from 1989 onwards, 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. As you said, Mr Whittle, it is human nature. 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.

However, that decision would mean that you would have to double run. That is the only way that we got people out of long-stay psychiatric asylums. 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.

Patrick Harvie (Glasgow) (Green): I will come in with a supplementary on that area, and in particular on the idea of a shift towards a prevention approach.

I take the point that you are describing PBMA for individual programmes, or how health boards or other parts of the NHS make their decisions about their budgets. However, it seems to me that that is not the bit that is missing in making a shift towards prevention. What is missing is a health impact analysis of the policy and spending on housing, education, criminal justice and all the other areas that are completely outside the processes that health boards or other parts of the NHS go through. Why are we thinking about it as a process that is internal to the NHS, when really the health determinants are everywhere else?

Professor Craig: I agree with the implication in your question. If we are thinking holistically about, for example, improving mental health outcomes, we absolutely should look upstream.

We could apply the same logic to the topic of today's meeting, which is programme budgeting and marginal analysis, by asking, "What are we investing upstream, while acknowledging any evidence that investment in, say, housing is likely to have a positive impact on mental health outcomes? Surely we should be including that in programme budgeting." The logic is exactly the same. If we were to find that an envelope of resources that we had at our disposal to invest in a certain area would do more to prevent mental ill health if we were to invest it in housing rather than health services, that logic would apply equally.

Patrick Harvie: Is any part of the Scottish Government's guidance that tries to encourage that approach actually taking the process outside the NHS and trying to join the dots? Is that happening?

Professor Craig: Health impact assessment is a process that enables that to happen. Dr Ruta, is the position on equality impact assessment similar?

Dr Ruta: Yes.

Patrick Harvie: The use of health impact assessments across government is pretty patchy, though, is it not?

Professor Craig: As I understand it, such assessment is not done retrospectively, in relation to the huge amount of money that is already being spent, but new policies and programmes are required to go through it.

I agree with the implication in your question, Mr Harvie. If we are thinking about preventative approaches to mental health problems and inequalities in mental health services, we absolutely should look upstream to see whether the public purse, rather than the NHS purse, is being used in places where such funding will do as much as it can to prevent mental ill health.

In relation to today's conversation, that approach—of understanding whether we are spending enough upstream—would apply equally if we were to adopt programme budgeting.

Dr Ruta: Absolutely. You could take a PBMA approach by taking the combined budgets of a local authority and a health board and creating a programme budget. If you could get both of those bodies to agree that their desired outcome was to improve quality and length of life, and quality of life chances, that would pretty much cover all the outcomes that they would want to achieve. If you could get them to agree on identifying those benefits you would then get them to examine where they were spending all that money and ask themselves, "Where could we invest or disinvest to maximise quality of life, length of life and quality of life chances for our population?" That would be a wonderful use of PBMA, which could even start to reduce suicides by, for example, providing people in need with subsidies for fuel or housing. Lots of innovative, creative ways of spending money could be used, which would have consequences for mental health improvement.

Professor Craig: In a way, the logic of measures such as single-outcome agreements and community planning was to get partners—whose collective actions impact on outcomes for which, traditionally, they might not have been held responsible—involved in those decisions, while recognising that local government is instrumental in determining community health and wellbeing.

10:00

David Torrance (Kirkcaldy) (SNP): Good morning. In a survey that the committee carried out, a number of integration authorities stated that they were not making use of the guidance. If PBMAs are not being used, are you aware of similar approaches to resource allocation being actively used by the Scottish health and social care service? How can we encourage better use and application of PBMAs in the health and social care sector?

Professor Craig: Those are tough questions. As for other approaches, over many years, the whole rubric around needs assessment was akin to that for programme budgeting and marginal analysis, in that its aim was to understand a community's needs at strategic level and then try to match resources to those needs. The PBMA approach is an extension of that, but it explicitly brings into the picture an understanding of where resources will go in relation to current needs.

As for how to make strategic approaches—such as using a better-resourced needs assessment or a fully fledged PBMA process—it can only come through the governance structures that are put in place to guide how health boards and local governments do business.

The community planning example that I cited earlier used such an approach. Community planning partners were encouraged to get together and work out how they could address outcomes collectively and where their combined efforts would impact those outcomes. I do not know whether the committee has discussed the community planning approach previously, but I would say that it has proved challenging to make it a reality in practice. That is probably because of the mix of governance frameworks, incentive structures and politics that is involved. It is an already challenging world, in which all the partners are expected to come round the table and agree not only their objectives but how they will get there. That is a really challenging expectation. Unless the Scottish Government expects those bodies to do things in that way, and to do so consistently over time, I do not think that it will happen, because of the pressures that the bodies face.

That is probably not a very precise answer, but I reiterate that any change would have to be at that level—in expectations about how such strategic decisions will be made, and in the Scottish Government's overall expectations of the organisations. It is quite understandable why that is a challenging process to adopt, given the pressures that the organisations face.

Dr Ruta: I have often reflected on why PBMA has not taken root in the context of the NHS. Why have we tried and failed to do that so many times? I think that there is a root-cause answer to that.

When I was a public health trainee in Aberdeen in the early 1990s, we had a tutorial given by Sir Ken Calman. At that time he was the chief medical officer for Scotland, and he later became chief medical officer for England. Members might know that his daughter is the comedian Susan Calman. He asked us, "Who decides how money is spent in

the health service?" We all put our hands up and said, "The Government" or "The chief exec of the health board". He said, "No, no, no. Money flows through the NHS through the individual, second-by-second decisions of doctors." What he meant was that, every time a doctor makes a decision—it is primarily doctors who spend the resources—money is spent. The only factor that controls that spend of money is clinical freedom. Even in 2025, a doctor does not really listen to a manager in that respect. They will make a decision because, to the best of their clinical knowledge, it is the right thing to do for their patient. That is how the money flows through the system.

If you were to put on a blindfold and walk into any NHS establishment, you would have to ask only two questions to find out whether it was in a well-funded or a dilapidated part of the NHS. The first question is: in this setting, is the emphasis on care or cure? The second is: for this patient, is the most important professional a doctor, a nurse or an allied health professional? If the answer to the first question is cure and the answer to the second is a doctor, you will be in a relatively well-funded, hi-tech part of the NHS. If the first answer is care and the second is a nurse or a physio, you will be in a relatively underfunded, neglected part of the NHS. That is how the money is spent in the system, and that is why we have the NHS that we have.

The only way to radically transform our healthcare system and make it more prevention orientated would be to have collective financial responsibility for resources. That would mean that doctors would have to think about opportunity cost. Doctors do not do so, because the Hippocratic oath says that they must do their best for the patient in front of them. That approach has not changed for 2,000 years, so that presents a challenge for the healthcare system. In particular, it has been the case since the 20th century, when we started to evolve healthcare systems to be the technologically advanced ones that they are today. However, that root cause still determines the way in which healthcare systems are structured. The situation is the same in the USA and in every western healthcare system. There are other differences that lead to inequities, and there are other causes.

Fundamentally, though, unless you can get doctors to take financial responsibility for their resource decisions and to think about outcomes and cost, you will not have a 21st century healthcare system that keeps people well rather than just treating them when they are sick.

Elena Whitham: I used to be a member of a community planning partnership and was involved with all the issues that we are discussing today. I am acutely aware of all the politics and the issues at play.

The committee has done a survey of integration authorities. In the integration authority that I was involved with when I was a councillor, things worked pretty well, and everybody was signed up to the same big aims, which meant that the decisions that were being taken aligned across the areas. However, we are now hearing from health and social care partnerships, including the one in Renfrewshire, that the current financial climate means that it is increasingly difficult to apply the principles in the Scottish Government's guidance when they allocate resources. I can see that in the health and social care partnership in my area, as it is taking tough decisions that really do not reflect its overall aims. Do you recognise that? Would a PBMA approach make the process easier with regard to disinvestment, as it would use input from all the stakeholders to inform how that marginal analysis is done?

Professor Craig: In principle, yes. At the risk of repeating myself, it does not make the decisions easier but it is a way of making transparent what the consequences are for some of the decisions that need to be made in constrained environments. Earlier, I discussed the initial attempts to get PBMA embedded in IJBs. One of the people who had been involved in that thought that difficulties had arisen precisely because the environment was so constrained fiscally that there is not the headspace or the time to make decisions or change radically the way in which they are made. It sounds like that is consistent with what is happening now. If anything, the situation is probably more challenging now than it was then. Ironically, it is in such a situation that, in principle, the benefits of PBMA could come to the fore, because it makes transparent where resources are currently going and the fact that, if more money is to be spent on a certain area, it has to come from somewhere else. It puts those options for change on the table and gets a group of stakeholders involved in the process of making that decision. However, the reality is that doing that in the current context is challenging.

So, yes, in principle, it would help. However, in practice, it will not solve the fundamental challenge that exists at the moment, which concerns decision making that is constrained by time and money. It would generate a form of intelligence, and there are examples of where, in practice, it has had a desirable effect and has helped to deal with some of the challenges that that context throws up.

Elena Whitham: Given the lack of headroom at the moment, because of the firefighting nature of the decisions that are being taken and some of the barriers that have already been spoken about in

terms of understanding the data gaps that we have and the lack of the deep analysis that we need to undertake in that regard, how are decisions about resourcing being made right now across the country? What decision-making process are health boards using to allocate resources at the moment if they are not employing that approach? That might be a difficult question to answer.

Professor Craig: I am less involved in that than I was, so maybe Dr Ruta could answer.

Dr Ruta: I guess, to be brutally honest, they are looking to where they can save money.

Elena Whitham: That is very helpful. Thank you.

Patrick Harvie: Convener, can I ask one final supplementary question?

The Convener: You can.

Patrick Harvie: Thanks very much. One of the features of the way that budget scrutiny impacts on local government in particular arises from the fact that the United Kingdom Government sets its budget and the Scottish Government then sets its budget or publishes a draft, and, only after that budget has been passed does it confirm to local authorities what their individual block grants will be. However, before that happens, local authorities have to start coming up with their plans, particularly for a worst-case scenario. What generally happens is that most of those worst-case scenario plans make their way into the press and become hugely problematic, which means that politicians have to start saying, “No, we will not do that; it was only a suggestion.”

It seems to me that, however logical the approach that you are suggesting might be, whether in good times or bad times financially, the reality is that, as soon as a health board or any other body starts coming up with all the various potential options for disinvestment, the political and media scrutiny will make those options impossible. Is our political landscape capable of doing what you are suggesting?

Professor Craig: I have my concerns that the political system does not allow that. In those circumstances, if people are being held to account for decisions, the issue comes down to what tools they have used to help them make those decisions. I think that they would be better able to defend their decisions if they could point to the evidence that they have for doing what they are doing and had evidence that shows that the consequences of withdrawing funding from one area will be less negative than the consequences of withdrawing it from another. That is the logic of the approach. In practice, however, people can be so constrained by time and politics—with a small p and, sometimes, a big P—that they cannot make those decisions, which must put them in a difficult position, to put it mildly.

I have a concern that the system is not such that it can use these techniques, despite their apparent appeal in terms of logic, being as evidence based as they can be and, by getting stakeholders around the table to make decisions, being as inclusive as they can be. I have a concern that we do not have an environment in which that approach to decision making can thrive. I think that, if I was in that sort of decision-making role, I would want to move more towards that approach than the current one, because I would want to be able to use a good, evidence-based narrative to explain why I had taken the decisions that I had taken, when some of those decisions are quite sensitive and painful decisions to have to take.

The Convener: Sandesh Gulhane has a very brief supplementary question.

Sandesh Gulhane: I will be very brief. Dr Ruta, you spoke about doctors needing to be responsible for the way that money is spent and the budgeting, and about the fact that they do not listen to managers. I would argue that that position is a bit too much, and that doctors should not listen to managers. However, how can you make doctors responsible for budgets?

10:15

Dr Ruta: You can start by teaching health economics in medical school. There is a good example in America. America has the most inequitable, inefficient healthcare system in the world but, paradoxically, it has these oases of 21st century healthcare. They are called accountable care organisations and they practise PBMA daily, although they would not call it that. Those organisations run primary and secondary care. They are subscriber based, so you pay an annual subscription, which means that, if you come into hospital, you start costing them money. Therefore, all the emphasis is on prevention.

The people who lead those organisations are doctors. It sounds bizarre, but they are not like ordinary doctors. Some years ago, I looked at Kaiser Permanente, which is an example of one of those big organisations, which each has more than 9 million patients, so they are like mini NHSs. They are all focused on prevention, and their care, which is of a high quality, is all standardised, guideline driven, evidence based and efficient. The doctors who lead those organisations all have an MBA from Harvard, they have a master’s in public health, they have done the advanced leadership course at Stanford and they still practise medicine. That is the way to do it: you create a new breed of doctor leader or doctor

manager. They do it in those places. You should go and visit one; they are extraordinary places.

The Convener: Thank you. I thank all our witnesses for their evidence this morning. That concludes the public part of our meeting today. At next week's meeting, we will continue taking oral evidence as part of the committee's pre-budget scrutiny for 2026-27.

10:16

Meeting continued in private until 11:37.

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