Scottish Health Equity Research Unit
Insights, analysis and action on the socio-economic factors that shape health

Prevention Watch

July 2026

In this edition we cover:

Prevention in the Scottish Government: recent work from the Government's Prevention Unit

In June, the Scottish Government launched their Prevention Unit, an internal hub which aims to connect prevention work across government bodies and to develop tools for embedding prevention in government.

This unit is part of Scotland's Public Service Reform Strategy, which aims to address fiscal sustainability and reduce costs through three identified pillars: prevention, delivering joined-up services, and efficiency.

Alongside this launch, the Unit released a series of publications, with the overarching purpose of understanding and embedding preventative approaches in local and national policy.

There are two particular areas that are interesting to us at this stage: Defining Prevention and Preventative Budgeting.

A further publication, the Prevention Toolkit, compiles various resources that the public sector can use to implement preventative approaches.

Defining Prevention

The Prevention Unit noted that, often, "prevention" lacks a consistent definition, making it difficult to measure and track it across government bodies.

In order to address this, they created a new one, defining prevention as "*activity intended to stop the establishment, escalation or recurrence of problems that lead to negative outcomes for people,"* and primary prevention specifically as "*Population-level action, or*

action which targets a large subset of the population, to build resilience and stop known risks from developing into problems."

This is slightly different from the standard three-tiered public health definition of primary prevention, which includes both targeted and universal action, and even from our own definition of primary prevention, which includes targeted action but excludes direct health interventions.

The difference here comes down to different philosophies behind prevention classifications, with the Prevention Unit definition blending elements of both the standard public health model and a risk classification model (wherein interventions are universal, selective for a high-risk subgroup, or indicated to specific individuals) (Table 1).

Table 1: Definitions of prevention

Standard public health model (PHS)	Risk classification model (Gordon, 1987, taken from Kutash et al, 2006)	Prevention Unit definition
Primary prevention is action that tries to stop problems happening. This can be either through actions at a population level that reduce risks or those that address the cause of the problem. **Secondary prevention** is action which focuses on early detection of a problem to support early intervention and treatment and reduce the level of harm. **Tertiary prevention** is action that attempts to minimise the harm of a problem through careful management.	**Universal Measures** are desirable for everyone in the eligible population. **Selective Measures** are desirable for a subgroup whose risk of negative outcomes is above average. **Indicated Measures** are desirable for an individual who is found to manifest a risk factor or condition that identifies them as being at high risk for the future negative outcomes.	**Primary Prevention** is population-level action, or action which targets a large subset of the population, to build resilience and stop known risks from developing into problems. **Secondary Prevention** is targeted action to identify and respond to early signs of a problem to prevent escalation. **Tertiary Prevention** is intervention once there is a problem to stop it from getting worse or recurring in future.

We also differ on what we are ultimately preventing. SHERU is specifically looking to prevent negative **health** outcomes, whereas the Prevention Unit are more broadly trying to prevent negative outcomes in general.

An illustrative example of this would be a targeted employability support programme. This would fall under primary prevention under our definition and in the standard public health model. This is because the goal is to prevent poor health outcomes, and employability is not a direct health intervention or treatment. For the prevention unit, where the goal is to prevent negative outcomes more generally, employability targets a specific, at-risk group, and so they classify it under secondary prevention.

In spite of this difference, we are broadly aligned with and supportive of their definition. There is often a lot of grey area between the tiers of prevention, and while the Prevention Unit and bodies like SHERU might differ in opinion on what constitutes primary and secondary prevention, ultimately, the purpose of having a definition is to ensure that contributors and users are aware of what the Unit means when it says "prevention."

However, it's not been without criticism. A recent paper from Enlighten, for instance, argued that the Government's definition fails to reflect the recommendations from the Christie Commission, especially around structural transformation and their definition of tertiary prevention. We agree with some of the sentiment in this report: it's important that throughout this budget tagging process, the Scottish Government remains aware of the big picture, moving towards a "*reorientation of public services away from reactive, siloed crisis management*," as the Enlighten report says.

Nonetheless, we recognise that this is an important step for understanding prevention in the Scottish budget, and, as our colleagues at the FAI said, "*it will not do to get bogged down in definitions – the Scottish Government has presented their definition and should now focus on how a preventative approach can be enacted*."

Preventative Budgeting

In the Public Service Reform Strategy, the Scottish Government included a commitment to track preventative expenditure, and to specifically track that preventative spending increases while acute or crisis spending decreases over time.

To support this, the Prevention Unit developed a preventative budgeting tool and piloted an approach to identifying preventative spend in the Scottish budget. In total, the Prevention Unit combed through 99 lines in the Scottish budget at Level 4 (the most detailed available), representing about 41% of budgeted spend for 2025/26.

We should avoid reading too much into the results, given they could change later this year when the analysis is extended to the full 2025/26 budget, followed by the budget for 2026/27. But they are nevertheless informative: around 15% of the £20 billion analysed was considered preventative in some capacity, though only 3% was considered to be primary prevention. Childhood development concerns and avoidable poor health – what

the paper calls “drivers of public service demand” – were the two most common outcomes impacted by preventative spend.

One potential issue could arise depending on how tagging is used. If the organisations that set budgets feel pressured to be seen as shifting spend to primary prevention, would they be incentivised to favour universal policies over more targeted approaches in areas like child poverty prevention? If so, it could put further pressure on an already-stretched budget and risk missing opportunities to target those most at risk. Of course, this remains to be seen - but it is something we'll be keeping an eye out for, especially as the prevention unit's work is integrated into the Scottish budget process.

Perhaps more than anything, the pilot demonstrates the challenge ahead. Not only does a relatively small proportion of the budget appear to be spent on prevention, but increasing this proportion, as per the PSR commitment, does not appear to be easy. Just over half of the £20bn was tagged as being “acute/responsive/treatment;” and of this, over 90% consisted of frontline health services. In the long run, an increase in preventative spend should reduce the demand for acute spend. But how to increase preventative spend in the first place, without reducing spend on services that are meeting current demands – and, in many cases, are already overstretched? This is no doubt the kind of question that Ivan McKee, the new Cabinet Secretary for Public Service Reform, will need to focus on.

Chief Medical Officer’s annual report

In June, the office of the Chief Medical Officer (CMO) released their latest annual report for Scotland, *Our Path Ahead*. The annual report is a publication from the Scottish Government, mainly aimed at healthcare professionals, which discusses the current and future state of the medical system in Scotland.

The report reinforces a central message for Scotland’s prevention agenda: the health system cannot meet rising need without a decisive shift towards long-term upstream action, trust-building and system redesign. While not explicitly framed as a prevention report, it contains strong signals aligned with the Population Health Framework, including its commitment to a Healthcare Inequalities Action Plan and wider public service reform.

The CMO describes Scotland’s health as being at a “critical juncture,” shaped by demographic change, widening inequalities and accelerating technological/digital disruption. Prevention is positioned as essential to sustainability: “*No health system has unlimited resources so stewardship is a core responsibility.*” The report argues that long-term health depends on “*the conditions of everyday life*,” reinforcing the need for action beyond clinical care.

A key theme throughout the report is the need to shift from reactive demand-management to purposeful prevention. Instead, systems should “*focus not on doing more, but on doing what matters,*” so that they align with outcomes that people value most. This framing

strengthens the case for prevention as a core strategy for system sustainability, not a discretionary ambition.

Although the majority of the report addresses preventative actions that we generally do not focus on through Prevention Watch (such as vaccines and health screenings), several other themes are nevertheless present under an upstream preventative umbrella. These include commentary on inequalities, the value of communities and lived experience in system design, and wellbeing among the health and social care workforce as central to long-term prevention both in and beyond the healthcare system.

Looking to persistent inequalities in healthcare outcomes, the report introduces the concept of *missingness*, which it describes as "*the repeated non-uptake of healthcare in ways that negatively affect health outcomes and life chances.*" It emphasises that often, people do not take up healthcare due to structural barriers rather than individual behaviour or choices, and that this in turn reinforces and exacerbates existing health inequalities. The CMO goes on to note, "*Missingness is shaped by life circumstances and structural barriers, not personal choice failure*."

This has clear implications for prevention: services must be designed around people's lives, not the other way around. The Population Health Framework's commitment to developing a Healthcare Inequalities Action Plan by the end of 2027 is cited as a key mechanism for embedding action on health inequalities across the system. The Scottish Government has stated that the plan will include actions such as developing the General Practice Healthcare Inequalities Programme to reduce barriers to accessing care, producing practical guidance on equitable care, and strengthening health inequalities training and education for health, social care, and social work professionals.

The report also focuses on community power and lived experience as important forms of expertise, placing strong emphasis on codesign arguing that prevention require systems to be built with communities. Within this, the report cited Homes, Heat and Healthy Kids as a case study which demonstrates how lived experience can shape upstream interventions on housing and child health. This exemplifies multi-sectoral prevention, across housing, health and community development. It also highlights the power of data linkage, with the project leading to the development of a dataset which integrates children's health records with their residential histories across Scotland, alongside data on home energy efficiency and use, smart meters, high street banking, air pollution, and climate - creating a richer evidence base for understanding how housing conditions influence child health.

Finally, the CMO discusses wellbeing in the health and care workforce as a prerequisite for prevention, arguing that wellbeing must be "*designed in, not left to personal resilience*." This is important: we have discussed health and work in general in previous prevention watches, and wellbeing and burnout among medical staff is a consistent problem, with nearly a quarter of doctors surveyed in 2024 reporting that they took a leave of absence due to stress.

Taken together, the report serves as a reminder that publishing frameworks and setting ambitions is only the first step. Many of the themes highlighted by the CMO are already reflected in Scotland's Population Health Framework and wider public service reform agenda, but the report underlines the need to translate these ambitions into action. The extent of future progress will depend on how effectively preventative principles are embedded in government decision-making, budgets and accountability structures.

Overall, the 2025–2026 CMO report provides further strong impetus for Scotland's prevention agenda: a call for systems that serve people, relationships that enable early action, and conditions that support health far beyond clinical walls.

Youth Employment and Health: developments in the wake of the Milburn Review

In May, the UK Government published the Milburn Review, which looks at the scale of youth unemployment and economic inactivity across the UK, albeit largely focused on England. This review discussed a wide range of challenges that young adults, aged 16-24, face in the labour market, in response to a rise in the number of 16-to-24-year-olds that are not in education, employment, or training, a group often referred to as "NEET." An important note is that in Scotland, we tend not to use the term "NEET," finding it to be stigmatising, focusing instead on a participation measure.

The review highlighted the ways in which the labour market, education and skills sectors, and the welfare system contribute to this trend. Health was also a strong focus throughout the report, citing mental health and disability as key drivers of non-participation across the UK.

A flurry of discussion, interpretation, and analysis came out surrounding this report, including our own response, which looked at the state of youth participation in education or employment in Scotland. Our report looked at labour market and participation statistics and reinforced the value of participation for preventing poor health in the long run, but did not discuss the intersection of health, especially mental health, and employment for young adults at length.

We reviewed the following recent reports on youth participation, mental health and employment:

- Lost in transition: An examination of why the UK NEET rate is high and rising, Resolution Foundation, April 2026
- Young people with mental health conditions are now more likely to be NEET, The Health Foundation, May 2026
- Raising the bar – why good jobs for young people are good for us all, Nuffield Foundation, June 2026

- 'Higgledy piggledy': Systems of support for young people aged 14–24 with poor mental health, Nuffield Foundation, June 2026
- Understanding factors linked to school absence in Scotland, Researchers from the ADR Scotland group, June 2026
- Take a chance on me: How can employers be incentivised to employ NEETs?, Resolution Foundation, June 2026

Findings on the relationships between health, education, and employment

Health is closely intertwined with education and employment, and improving individual's ability to participate can prevent negative health outcomes (or prevent current health conditions from worsening) in the long run. Often, young people's lack of participation can be blamed on mental health conditions, but the reality is more nuanced. It may be the case that young people aren't participating because of their mental health condition, or that their lack of participation is causing their mental health condition, or if a different circumstance is creating challenges with both participation and mental health.

A variety of recent publications illustrate the scale of the problem. A June publication from Dr Silvia Behrens from the ADR Scotland group explored the relationship between education participation and health, finding that mental health challenges and additional support needs are strongly associated with missing school among secondary school students. Another publication from the Health Foundation found that 22.4% of all 16-to-24-year-olds who were not in education, training, or employment (NEET) cited a mental health condition in 2025, compared to 5.6% of non-NEET young people.

At the same time, rising rates of mental health conditions do not necessarily force people out of the labour market – the combination of high rates of these conditions and high NEET rates is unique to the UK. As a report from the Resolution Foundation, published back in April, points out, "*young adults in the Netherlands are only slightly less likely to report anxiety disorders than young people in the UK […] but are dramatically less likely to be NEET than their UK counterparts.*"

A recent report from the Nuffield Foundation highlights barriers to addressing youth mental health, finding that the systems around mental health support for young people are often fragmented and complex. This report notes that effective mental health support in adolescence can impact later employment prospects, and that mental health needs are often most acute around transition points, especially as people move out of education and into employment.

There are also issues with hiring, training, and retaining young people and people with health conditions. The Milburn Review, the Nuffield Foundation, and the Keep Britain Working review all noted that employers are increasingly risk-averse and therefore increasingly unwilling to take on or train young people or people with health conditions.

These groups also face significant (and often unfounded) stigma, which further damages their job prospects.

Given the connection between - and the scale of the challenge with - mental health and employment participation among young adults in Scotland, what are the solutions?

Addressing labour market demand

Back in November, the Keep Britain Working review (which we cover in a previous prevention watch) discussed how policy makers, workers themselves, and employers are all responsible for solving health-related economic inactivity, but the review focuses in particular on incentivising employers to hire and retain workers facing health concerns (which we refer to as "demand-side" interventions).

However, labour market policy, which is partly devolved to Scotland, is largely focused on the supply side, including skills and employability policy, rather than on measures to increase employer demand for labour. As a result, securing meaningful employer engagement in supporting young people and people with health conditions remains an ongoing challenge.

To our knowledge, apprenticeships are among the few labour market interventions in Scotland that directly engage employers, making them an important demand-side lever within the devolved policy landscape. As we pointed out in our response to the Milburn Review, modern apprenticeship starts have been falling for people aged 16-24 over time. However, the programme appears to have played an important role for some young people with health conditions or learning difficulties, who accounted for 20 per cent of Modern Apprenticeship participants aged 16–24 in 2025/26. There are also some concerns about how these will be administered moving forward. Beginning in 2027, all apprenticeship funding will be consolidated under the Scottish Funding Council instead of Skills Development Scotland, where it has previously sat. This has caused concerns from business organisations, notably the CBI and Scottish Chambers of Commerce, who wrote to Parliament last year, praising SDS' relationship to business and urging them to reconsider this shift.

One new intervention is the Youth Jobs Grant, a UK Government programme that went into effect in June. This grant is available in Scotland and allows employers to claim £3,000 if they take on an eligible person aged 18-24 who has been out of work for at least six months.

Another programme, the Jobs Guarantee, "*guarantee[s] fully funded, six month paid jobs to all eligible 18 to 24-year-olds who have been on Universal Credit and looking for work for 18 months*." This programme also applies to Scotland and will be rolled out nationally later in 2026.

The Resolution Foundation voiced some possible concerns with regards to these schemes. An evaluation of a previous, similar scheme (the Youth Contract, in place from 2012-2015)

found that most of the young people who benefited from this scheme would have moved into employment regardless: 76% of employers said that the job would have existed without the wage incentive.

Health and labour market demand

There is also a question about the health impact of these programmes. The Resolution Foundation interprets the Youth Jobs Grant as exclusive of young people on UC Health benefits, strongly recommending that they extend this programme to include those young people. Based on our analysis of data in DWP's Stat-Xplore, in January 2026, 24,600 people aged 16-24 in Scotland were on UC Health benefits. This accounts for more than half of the 46,500 people aged 16-24 who are on Universal Credit and are not in work.

So what should the Scottish Government consider for demand-side interventions, if they are focused on addressing youth employment and health?

While there is room to improve this programme, as the Resolution Foundation pointed out, interventions which target labour market demand are undoubtably appropriate. We would agree with their recommendations, and indeed DWP's overall goal, which is to direct more effort, funding, and attention to vocational programming, both in Scotland and the UK.

Other levers to stimulate demand, such as tax incentives and infrastructure planning, are also worth considering.

As a recent Financial Times article noted, in response to news that Andy Burnham aims to overhaul the training curriculum in England for children over age 14, "*The absence of good vocational and technical training, like our Neet problem, is rooted in the labour market, not the classroom*."

As far as improving participation among young people, especially those with health conditions, the Scottish Government needs to continue to work with the population they are trying to support, and to continue to build a holistic understanding of their barriers to work.

Audit Scotland launches an audit into housing

In April, Audit Scotland announced that they would be undertaking an audit into the housing situation in Scotland. The audit will be published in early 2027, and will focus on two main areas:

1. How effectively are the Scottish Government and councils addressing the immediate housing needs of people facing homelessness?
2. How effectively are the Scottish Government and councils addressing long-term housing needs?

Housing is a key determinant of health, and housing quality, stability, and affordability are crucial in addressing long-term health inequalities that people in Scotland face. In 2024, Scottish Parliament declared a housing emergency, and to date, 14 local authorities have done so as well. There is not a consistent definition of a housing emergency, but high levels of people in temporary accommodation and long social housing waiting lists are often key factors.

In 2024/25, 34,067 households were assessed as homeless in Scotland. This included 53,720 people, 15,046 of whom were children. This number of households has continued to increase since 2020, although the overall number of applications has remained roughly the same since 2022/23. A further 17,240 households were living in temporary accommodation in 2025 – a number which has grown by 25% since 2021.

The average length of time people spend in temporary accommodation has also grown from 205 days in 2020/21 to 238 in 2024/25. Households with children face the longest lengths of time in temporary accommodation, averaging more than a year in many cases.

Meanwhile, 14,966 new build homes were started in 2025 – the lowest number of starts since 2013, and a 40% decrease from the 25,076 houses that were started in 2019.

Based on those figures alone, it is safe to say that the Scottish Government and councils are struggling to address long-term housing needs at present, and we expect to see the audit to acknowledge this.

Short-term housing needs are also a challenge across the country, given the volume, length, and often poor quality of temporary accommodation. And individuals faced with homelessness are not the only group that need more housing – a 2024 report found that up to 28% of all households in Scotland had some form of housing need, whether due to overcrowding, financial struggles due to high housing costs, or living in accommodations that are not suitably adapted to specialised needs or otherwise unfit.

An important outcome from the Audit Scotland report, therefore, will be their recommendations and examples of good practice.

We are also interested to see how they discuss regional challenges in housebuilding. For instance, in our policy implementation work over the last two years, local areas have

highlighted that there are challenges balancing building houses efficiently, versus building them in the areas that would best benefit their populace and wider infrastructure.

Building a lot of houses quickly is a challenge, and it's more efficient and less expensive to build a lot of them within a few areas. In urban local authorities, such as Edinburgh and Glasgow, this strategy makes sense. In rural local areas, however, we have heard that it would be better to build houses more widely across the local authority, rather than concentrating them in a single or a few towns. While this could ultimately yield fewer houses in these local authorities over a five-year period, it would allow people to remain in their communities and support challenges such as depopulation. This flexibility might be better suited to a local area's needs, while being at odds with Scottish Government's targets.

We are also keen to see how they address hidden homelessness and housing insecurity, which was highlighted in Scottish Government report last year. Some people meet the technical definition of homelessness and would be eligible for support, but do not contact statutory services for whatever reason, but are difficult to count and engage with for support.

More than that, it will be crucial to see how the Scottish Government responds, given that, in their 2026 Manifesto, SNP promised to deliver 110,000 affordable homes by 2032. "Affordable housing" is not strictly defined in Scotland, nor did the manifesto present a definition, but in the last five years, around 44,000 new houses have been completed under the Affordable Housing Supply Programme (which largely includes social housing, as well as small numbers of private rentals and home ownership opportunities that received certain grant funding from the government). This averages out to around 8,800 houses each year – a far cry from the 22,000 completions per year that the government would need to average to meet this promise.