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THE SCOTTISH GOVERNMENT'S HEALTH, SOCIAL CARE AND SPORT COMMITTEE INQUIRY ON HEALTH INEQUALITIES: RSE RESPONSE.

Summary

The recommendations in many reports and policies introduced before 2015 have not yet been implemented or fully considered in Scotland, which has inhibited progress towards improving health inequality over the intervening years.

Findings across research have found that health inequalities result from unequal access to wealth and power. Increasing income and reducing inequalities in income are likely to have the greatest effect on inequalities in health over the long term.

Governmental priorities for sometimes conflicting objectives such as economic growth, environmental sustainability and wellbeing of the population may need to be more carefully balanced. Health inequalities are driven by sectors outside of the health and social care remit. Therefore, successful approaches will require collaboration across governmental sectors, addressing policy issues in housing, education, environment, and economic strategy, all of which contribute to people experiencing disadvantage.

A clear strategy should be generated and applied across governmental sectors that have the remit to address the varied factors that result in health inequalities. With a clear line of accountability established and the Cabinet being responsible for its efforts in reducing health inequalities.

It is essential that there is a bottom-up approach as well as a top-down approach across government agencies. Local initiatives that will effectively address health inequality may vary across different communities and geographies, and attention needs to be paid to promoting the potential for local communities and local service agencies to work collaboratively.

More work should be done to understand how the general public experience, understand and value health equality since this is ultimately crucial for the success of the governmental policy. Studies that qualitatively and statistically record the experiences of the most disadvantaged groups and those caring for them may be especially important in informing the debate on health inequality.

Introduction

1 The Royal Society of Edinburgh (RSE), Scotland's National Academy, welcomes the opportunity to respond to the Health, Social Care and Sport Committee Inquiry on Health Inequalities. The RSE is well-placed to offer politically independent and expert supporting evidence to this consultation, given that our Fellowship and Young Academy of Scotland (YAS) members have wide-ranging expertise in medical practice and research, social sciences (as applied to health and well-being) and policy advice. The working group's in-depth consultation discussion has informed the response below.

Inquiry questions

Q1. What progress, if any, has been made towards tackling health inequalities in Scotland since 2015? Where have we been successful, and which areas require more focus?

2 The RSE want to draw to the committee's attention the fact that the recommendations in many reports and policies introduced before 2015 have not yet been implemented or fully considered in Scotland, which has unfortunately inhibited progress towards improving health inequality over the intervening years. We advise the Committee to observe the following reports; The *Marmot report* and *Health Inequalities Policy review for the Scottish Ministerial Task Force on Health Inequalities*. We would encourage the Committee to consider these earlier reports as part of its review of the available evidence, given we believe their recommendations remain sound and relevant.

3 Encouragingly, the *Long-Term Monitoring of Health Inequalities* report (2021) indicates that there have been some improvements in absolute inequalities over the long term. However, the report reveals a complex picture of health inequalities, with a narrowing gap present in some indicators and a widening gap, among others. For example, the gap in healthy life expectancy between females from the most and least deprived areas has decreased and is currently at its lowest point at 22.1 years. However, for males, the gap has increased and is now at its highest point, with the difference in the most and least deprived healthy male life expectancy standing at 26.0 years.[1] There remains a significant and unacceptable gap in health outcomes between relatively economically advantaged people and those who are disadvantaged.

4 Scotland has been exceptionally strong in its collation and application of data as compared to the rest of the UK. We noted that Scotland has what is probably the most advanced system in the UK for linking administrative data sets (e.g., extensive population samples from the population census and NHS and other administrative data) in ways that make it possible to chart health and health-related experiences over the life course of individuals, from a range of social and economic backgrounds in diverse residential settings across Scotland. For example, the work of the Scottish Centre for Administrative Data Research (https://www.scadr.ac.uk/) and the Centre for Research on the environment, society and health (https://cresh.org.uk/) allows for the consideration of factors that are important for health inequalities in isolated rural areas as well as in major urban settings and can track how residential mobility between areas contributes to health inequality between local communities in Scotland.

1 Scottish Government. (2021) *Long-term Monitoring of Health Inequalities 2021 report*. [online] Available at: https://www.gov.scot/publications/long-term-monitoring-health-inequalities-january-2021-report/

5 Policymakers will benefit from reviewing a wide range of data. While evidence from epidemiological studies and medical trials is very valuable, it is not the only valid source of evidence. It is also essential to consider findings from other research and inquiries. Examples of studies that qualitatively and statistically record the experiences of the most disadvantaged groups and those caring for them may be especially important in informing the debate on health inequality. Reports from the Deep End Project are good examples, and the Cross-Party Group on Health Inequalities has considered a range of other studies conducted by or in collaboration with non-governmental and non-medical agencies that work primarily with the most disadvantaged groups in the Scottish population.[2] Among others, the bodies of research on experiences of poverty (for example, from the Joseph Rowntree Foundation), being care experienced (for example, through the work of The Promise), and experiences of multiple disadvantages (for example, the Hard Edges report) provide invaluable insights into the drivers of inequality and the factors that facilitate or inhibit good health.

Q2. What are the most effective approaches to tackling health inequalities, and how successful is Scotland in pursuing such approaches?

6 Consideration needs to be given both to approaches that prevent and lessen health inequalities and those that mitigate their effects. In both regards, approaches need to be of a sufficient scale and sustained to have the necessary impact. Project-based approaches and those addressing specific issues or groups have their place, but without action on the systemic determinants of inequality, they will be insufficient to address the challenges Scotland faces.

7 Successful approaches should seek to provide individuals and families with easily accessible, unconditional, and multifaceted support. Such support would be best delivered through an NHS general practice closely linked with second-line services (including non-medical services such as social practitioners). The government's support for community link workers and financial advisors embedded within general practices (and not simply 'co-located') in deprived areas has recognised the value of both the contact, coverage, and continuity that general practices have with local populations and referral links which are quick, local, and familiar.[3] However, more government support is needed to increase funding in general practice for this system to be sustainable.

8 The committee should consider how other governmental sectors outside of health and social care can address health inequality. Health inequalities are driven by sectors outside of the health and social care remit. Therefore, successful approaches will require collaboration across governmental sectors, addressing policy issues in housing, education, environment, and economic strategy, all of which contribute to people experiencing disadvantage. The government should also work with non-governmental organisations to ensure addressing health inequalities is prioritised.

9 Furthermore, it is essential that there is a bottom-up approach as well as a top-down approach across government agencies. Local initiatives that will effectively address health inequality may vary across different communities and geographies,[4] and attention needs to be paid to promoting the potential for local communities and local service agencies to work collaboratively.

10 It may be helpful for the committee to note that a tool has been developed to evaluate health inequalities interventions. NHS Health Scotland produced the Triple I to help local and national decision-makers to assess interventions that can affect health and health inequalities by modelling the potential impact using the best available data.[5] It can evaluate the impact of both economic and public health policies and estimate resulting changes in hospital admissions and deaths.

2 University of Glasgow [online] Available at: https://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/

3 Scottish School of Primary Care (2019) *Tayside study 2019 report on provision of in GP practice financial advisors* [online] available at: http://www.sspc.ac.uk/media/Media_645960_smxx.pdf

4 The Royal Society of Edinburgh (2021) *Post Covid-19 Future Commission: A desk review of social prescribing: from origins to opportunities* [online] Available at: https://www.rsecovidcommission.org.uk/a-desk-review-of-social-prescribing-from-origins-to-opportunities/

5 Public Health Scotland (2021) *Informing interventions to reduce health inequalities (Triple I)* available at: http://www.healthscotland.scot/reducing-health-inequalities/take-cost-effective-action/informing-interventions-to-reduce-health-inequalities-triple-i/overview-of-triple-i

Q3. What actions would you prioritise to transform the structural inequalities that are the underlying cause of health inequalities?

11 Health inequality is underpinned by the unequal distribution of income, power, and wealth; therefore, the government should prioritise action to create a sustainable and more equitable economy. Fairer economic policies have the potential to address the root causes of health inequalities and are more likely to have a significant impact in terms of improving overall health inequality. Early life experiences, including Adverse Childhood Experiences (ACEs), should also be a clear area of focus, as these impact health outcomes throughout the life course.[6] We agree with the Marmot review's policy objectives which set out the priorities the government should focus on: giving every child the best start in life; enabling all people to maximise their capabilities and have control over their lives; ensuring a healthy standard of living for all; creating fair employment and good work for all, and creating and developing healthy and sustainable places and communities.

12 Governmental priorities for potentially conflicting objectives such as economic growth, environmental sustainability and well-being need to be more carefully balanced. The government should continue re-evaluating the values and principles that currently guide our economy and society to ensure they actively support wellbeing and equality. Recently discussed ideas such as broadening calculations of GDP to include factors such as wellbeing may help us achieve this.[7] We can also draw on examples from other countries, such as those in New Zealand, Scandinavia, and other European countries, where the wellbeing of the whole population is prioritised in ways that may further inform this process in Scotland.

13 We note that the inquiry calls for consideration of 'progress toward tackling inequality since 2015.' However, policies and cultural changes to address health inequalities may need to be considered and implemented over a longer time frame to be effective. Therefore, as mentioned above in our response to question nine, action is also required to monitor the progress of medium to long term mitigation strategies, such as improving community support structures and addressing the health effects of adverse conditions across the life course of individuals and communities.[8]

Q4. What has been the impact of the pandemic both on health inequalities themselves and on action to address health inequalities in Scotland?

14 The pandemic has reinforced and exacerbated the issues underpinning health inequality already present in Scotland. The *Marmot Review 10 years on* (2020) revealed a 'social gradient' in the proportion of a person's life spent in ill health, with those from deprived communities living longer in poor health within a shortened life span.[9] While the review is focused on the English context, we believe its general findings are also applicable to the Scottish context. Data for Scotland up to 2017 was already indicating an increase in mortality under age 65 due to worsening mortality rates in more deprived areas. This trend is likely to have been exacerbated during the pandemic.[10] This has been usefully characterised as a 'syndemic pandemic', particularly for the most disadvantaged communities, i.e., a co-occurring, synergistic pandemic that interacts with and exacerbates non-communicable disease (NCDs) and other social conditions.[11]

6 Scottish Government (2020) Adverse Childhood Experiences (ACEs) and trauma [online] Available at: https://www.gov.scot/publications/adverse-childhood-experiences-aces/

7 Smith, M. Herren, S. Et al. (2011) *More than GDP: Measuring what matters* [online] Available at: file:///C:/Users/RSEUser/Downloads/More-than-gdp-measuring-what-matters-report-of-the-round-table-on-measuring-economic-performance-and-social-progress-in-scotland%20(2).pdf

8 Pearce, J. (2018) *Complexity and uncertainty in geography of health research: incorporating life-course perspectives*. Annals of the American Association of Geographers, 108, 1491-1498. [online] Available at: https://www.tandfonline.com/doi/abs/10.1080/24694452.2017.1416280?journalCode=raag21

9 The Institute of Health Inequality. (2020) *Health Equity in England: The Marmot Review 10 Years On*. Available at: https://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on/the-marmot-review-10-years-on-executive-summary.pdf

10 Bambra, C., Lynch, J., Smith, K. (2021) *The Unequal Pandemic: COVID19 and Health Inequalities*. [online] Available at: https://library.oapen.org/viewer/web/viewer.html?file=/bitstream/handle/20.500.12657/51451/9781447361251.pdf?sequence=1&isAllowed=y

11 Bambra, C, Riordan, R., Ford, J, Matthews, F., (2020) *The COVID-19 pandemic and health inequalities* [online] Available at: https://jech.bmj.com/content/74/11/964

15 Alongside the direct impact of the pandemic, there has also been an unequal indirect impact, with lower-income families, women, and young adults more likely to have suffered adverse effects on their mental health. The catalysts to the observed higher rates of poor mental health among these groups have been higher rates of job losses, concerns about finances and fear of losing homes; concerns about caring responsibilities; and disruption to education and loneliness among these groups.[12]

16 Education disruption unequally impacted children from poorer backgrounds. Children from families with a lower income were less likely to engage with online learning platforms, with two thirds unable to work from home. One barrier was the lack of available space in cramped homes and the prevalence of digital exclusion among disadvantaged children. When the pupils returned to school, some reports noted a decline in children's confidence in their learning.[13] Poor educational outcomes are a known driver of inequality; therefore, this can increase the prevalence of health inequalities among disadvantaged children.

17 There are also concerns about clinically vulnerable children whose parents may have anxiety about returning to school while coronavirus is still present. These children face a longer duration without face-to-face education and social interactions, leaving them more vulnerable to inequality in the future.

18 Reassuringly, there were positive developments during the pandemic, namely the government's response to immediate needs such as job loss. The policy machinery and its implementation were much swifter than in normal circumstances. We have also seen encouraging responses from third sector organisations in helping communities in need during the pandemic. These responses were helpful and could be more widely applied to help close the health inequality gap. However, more support would be needed for these systems to be sustainable. Staff working in community organisations are at risk of burnout and are overstretched after years of austerity policies and disinvestment. They need more support and funding in order to continue doing their jobs effectively.

Q5. Can you tell us about any local, regional, or national initiatives throughout the pandemic or before it that have helped to alleviate health inequalities or address the needs of hard-to-reach groups? How can we sustain and embed such examples of good practice for the future?

19 The RSE has highlighted examples of initiatives that help communities engage in public policy development in our Post Covid-19 Futures Commission report.[14] Projects such as the Social Action Inquiry and the Scottish Approach to Service Design have helped give communities the chance to have their voices heard by decision-makers.[15] Our recommendations encourage academics and third sector organisations to learn from these projects to develop a national participation strategy. This could be achieved using methods such as citizen juries to gauge the perception of health inequalities and the causes and significance of this inequality. Projects like these can help relevant agencies engage with hard-to-reach communities and help put people at the heart of policymaking.

20 In addition, social housing providers such as housing associations can be a key connection to hard-to-reach groups in the community as they are often the first point of contact for those needing support. These organisations are critical to the bottom-up approach required to foster the collaboration needed to tackle health inequalities.

12 The Scottish Parliament (2021) *HEALTH INEQUALITY AND COVID-19 IN SCOTLAND*. Available at: https://digitalpublications.parliament.scot/ResearchBriefings/Report/2021/3/23/ee202c60-93ad-4a27-a6e7-67613856ba24#b1a528b5-c5cb-4e65-80ed-cfb7b373c553.dita

13 The Scottish Government (accessed 18/02/2022) *Scotland's Wellbeing: The Impact of Covid-19-Chapter 5 Children, Education*. [online] Available at: https://nationalperformance.gov.scot/scotlands-wellbeing-impact-covid-19-chapter-5-children-education

14 The Royal Society of Edinburgh. (2021) *Key Findings and Recommendations from the Post-Covid-19 Futures Commission*. [online] Available at: https://rse.org.uk/expert-advice/post-covid-futures-commission/

15 https://www.rsecovidcommission.org.uk/wp-content/uploads/2021/10/202110_Covid-Commission-Report_04-REPORT.pdf

21 Further findings from our Post Covid-19 Commission found initiatives that have helped alleviate inequalities through social prescribing. The report highlights the SPRING social prescribing programme, which combines three community organisations (Bogside & Brandywell Health Forum, the Healthy Living Centre Alliance, and Scottish Communities for Health and Wellbeing) with the objective of scaling-up social prescribing. The evaluation of the initiative found it to be cost-effective for GPs, and those who have accessed support have had less need for other services such as benefits.[16]

Q6. How can action to tackle health inequalities be prioritised during COVID-19 recovery?

22 A clear strategy should be generated and applied across governmental sectors that have the remit to address the varied factors that result in health inequalities. The strategy should include mutually supportive goals and a monitoring process to evaluate progress. A line of accountability should be established, with the Cabinet being responsible for its efforts in reducing health inequalities. The fundamental determinants of health inequalities are social inequalities, so every Cabinet member and their department has a role. Local authorities should also be accountable for their joint efforts. A clear strategy and line of accountability will help bolster awareness of health inequalities across government and deliver more coherent and consistent outcomes.

23 Audit Scotland has already drawn attention to the severe and continuing pressures on health services in Scotland and the need to enhance resourcing and improve data availability.[17] A key message from the report was that a lack of reliable data across areas, including health inequality, is hindering the NHS's recovery plan. Policymakers should implement the recommendations from this report to prioritise health inequalities during COVID-19 recovery planning.

24 Given the social gradients in health observed across society, it is clear that health inequalities are not restricted to marginal groups. Solutions need to be applied pro-rata based on need, across the whole population, the 'proportionate universalism' advocated by Professor Marmot.[18] The implication is that all members of the Cabinet, whatever their responsibility, have a contribution to make towards tackling health inequalities. Otherwise, current arrangements will continue to generate health inequalities across the spectrum. It is the interaction between the Cabinet Secretary responsible for addressing health inequalities and Cabinet colleagues which is necessary for proportionate universalism to be applied. Therefore, health inequalities are a cross-cutting issue similar to addressing climate change.

Q7. What should the Scottish Government and/or other decision-makers be focusing on in terms of tackling health inequalities? What actions should be treated as the most urgent priorities?

Tackling health inequalities in the health and social care sector.

25 In our previous response to the Scottish Government consultation on the National Care Service, we highlighted the need for 'broader cultural change' in Scotland's social care sector. We stand by that recommendation and urge the committee to look at building a health and social care service that prioritises person-centred care, matches individual needs, broadens the definition of what constitutes care and encourages feedback and learning for continual improvements.[19]

16 The Royal Society of Edinburgh (2021) *Post Covid-19 Future Commission: A desk review of social prescribing: from origins to opportunities* [online] Available at: https://www.rsecovidcommission.org.uk/a-desk-review-of-social-prescribing-from-origins-to-opportunities/

17 Audit Scotland. (2021) *NHS in Scotland 2021* [online] available at:https://audit-scotland.gov.uk/uploads/docs/report/2022/nr_220224_nhs_overview.pdf

18 The Institute of Health Inequality. (2020) *Health Equity in England: The Marmot Review 10 Years On.* Available at:https://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on/the-marmot-review-10-years-on-executive-summary.pdf

19 The Royal Society of Edinburgh. (2021) *Response to the Scottish government's 'a National Care Service for Scotland Consultation.*[online] Available at: https://rse.org.uk/expert-advice/advice-paper/rse-response-to-the-scottish-governments-consultation-on-a-national-care-service-for-scotland/

26 There is an urgent need for the government to address the gaps in healthcare services precipitated by the disruptions to healthcare provision caused by the pandemic. Many services were disrupted in the immediate response to the crisis leaving many areas of health and social care services unobtainable for the people who needed them. The resulting backlog in care and treatment will require additional staff resources to be resolved. Services such as routine operations, routine screening tests, physiotherapy and dental care were all reduced during the pandemic. Despite these services becoming less accessible for all of Scotland, people from lower-income families were again unequally impacted, with non-communicable diseases such as cancer being more prevalent among this group.

27 For gaps in healthcare services to be improved, the government must prioritise investment in the NHS workforce to ensure the service is equipped to address health inequalities. There is a real possibility of the collapse of core services due to workforce shortages amplified and accelerated by burnout.[20]

Tackling key drivers of health inequalities.

28 As mentioned in answer to question ten, the government should seek to address the unequal distribution of wealth and power that drives inequalities. However, the perennial challenge in addressing inequalities is whether public support for either increased taxation or wealth redistribution can be generated for measures to help others and produce a more equal society. More work needs to be done to develop a better appreciation of the public's understanding of health inequalities and how to mitigate them; this is crucial to identifying effective ways of framing the evidence and helping overcome political barriers to addressing the social determinants of health.

29 Focus should be given to addressing child poverty to reduce health inequalities among future generations. Research shows that children living and growing up in poverty have poorer health outcomes than their more affluent peers.[21] The Scottish Government have already set out ambitious targets to address child poverty;[22] however, given current progress, they are unlikely to meet them. A Joseph Roundtree Foundation report found that the interim targets were unlikely to be met within the next three years. [23] Scotland cannot address health inequalities without addressing poverty.

30 In addition, a swift response is required to combat further economic hardship due to Brexit, the COVID-19 pandemic and poverty. Fuel poverty, in particular, is already being adversely affected by the war in Ukraine and is likely to worsen. These and the resulting inflation increase are likely to significantly impact physical and mental health inequalities. Further strain on living standards and government finances is inevitable and will happen over a short period. The Health, Social Care and Sport Committee could advise the government on mitigating these effects, which may well be worse than COVID and are likely to interfere with COVID recovery significantly.

31 Policy priority should be given to addressing **'commercial determinants of health',** which the WHO has recently identified as a key driver of health inequalities.[24] Commercial determinants include a wide range of private sector activities (business actions and societal engagements) that impact our environments, such as supply chains, labour conditions; product design and packaging; targeted advertising; research funding; lobbying, preference shaping and others. Commercial determinants impact many of the key health challenges present in Scotland, including tobacco and alcohol use, cardiovascular health, cancer, obesity, diabetes, mental health and other NCDs. Commercial determinants of health impact everyone, but more vulnerable groups are at particular risk, and unhealthy commodities deepen pre-existing economic, social, and racial inequities. The Scottish Government has been bold in relation to passing smoking bans and minimal alcohol pricing; however, more bold action is needed to address the remaining challenges.

20 UK Parliament (2021) *Workforce burnout and resilience in the NHS and social care* [online] Available at: https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/22/2202.htm

21 Health Scotland (2018) *Child poverty in Scotland health impact and health inequalities* [online] Available at: file:///C:/Users/RSEUser/Downloads/child-poverty-impact-inequalities-2018.pdf

22 The Scottish Government (2017) *Child Poverty (Scotland) Bill* [online] Available at: https://www.parliament.scot/bills-and-laws/bills/child-poverty-scotland-bill

23 The Joseph Roundtree Foundation (2020) *Poverty in Scotland* [online] Available at: file:///C:/Users/RSEUser/Downloads/poverty_in_scotland_2020_0.pdf

24 World Health Organization (2021) Commercial determinants of health [online] Available at: https://www.who.int/news-room/fact-sheets/detail/commercial-determinants-of-health

32 Priority should also be given to addressing environmental factors that affect communities' wellbeing, such as poor housing, employment opportunities, air pollution, and lack of access to green spaces that disproportionately affect economically disadvantaged communities.[25] The physical environment can create severe disadvantages for people living in deprived areas, reinforcing health inequalities. This can disproportionately affect people who are limited in the choice of where they live, for example, people with low incomes or disabilities.[26]

Q8. What role should the statutory sector, third sector, and private sector have in tackling health inequalities in the future?

33 A cohesive and evidence-based approach across the statutory, third and private sectors, led by the government, will be needed to address health inequalities effectively. All the above sectors will play a crucial role in addressing health inequalities through early years provision, education, fair work, secure housing and improving the quality of places.

34 In order to ensure that the different sectors can have an effective role in tackling health inequalities in future, it will be important to ensure that there is good communication between representatives 'on the ground' in local areas most impacted by health disadvantages and those in central government. There is also a good case for establishing reliable funding streams which will support the third sector as well as statutory and private sector workers in these localities, for whom working contracts are at present often precarious and underfunded.

25 Mitchell, R, J. Richardson, E, A. Pearce, J, R. (2015) *Neighbourhood Environments and Socioeconomic Inequalities in Mental Well-Being* [online] Available at: http://www.ajpmonline.org/article/S0749-3797%2815%2900041-0/abstract

26 Public Health Scotland (2021) *Place* [online] Available at: http://www.healthscotland.scot/health-inequalities/impact-of-social-and-physical-environments/housing/housing-and-health-in-local-authorities

Additional Information

Any enquiries about this advice paper should be addressed to Stephanie Webb (SWebb@therse.org.uk).

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