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Submitted to Inquiry into health inequalities
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Organisation

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6 Name of organisation

Name of organisation:
SIPHER

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SIPHER is a consortium funded by the UK Prevention Research Partnership (UKPRP), which brings together scientists across six universities, three government partners at local, regional and national level, and ten practice partner organisations. It is led by Professor Petra Meier from the University of Glasgow's Institute of Health and Wellbeing.

SIPHER's vision is a shift from health policy to healthy public policy. This means all policy sectors working together to tackle health inequalities and improve the health of the public.

<https://sipher.ac.uk/>

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Question page 1

8 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?

Please provide your response in the box provided.:

As detailed in the most recent Scottish Government Long Term Monitoring of Health Inequalities report there appears to have been some progress in tackling absolute health inequalities (the gap between the most and least deprived areas) in relation to some specific measures related to non-communicable diseases. For example, the gap between the most and least deprived areas in the annual numbers of deaths attributed to both alcohol misuse and coronary heart disease (CHD) (in the 45-74 age range) whilst still very high, is at the lowest level since 1997. It is also notable that the

inequality gap for alcohol related hospital admissions in 2020 was at its lowest level since the time series of the report began in 1996.

The aforementioned report also shows that on the majority of measures, health inequalities have continued to widen since 2015. For example, the gap in healthy life expectancy for males has increased from 22.5 years in 2013-15 to 26.0 years and remained large for women (22.1 years, down only slightly from 23.8 in 2013-15). The gap in healthy life expectancy between individuals in urban areas compared to rural areas has also widened, with those in urban areas experiencing poorer health (National records of Scotland). Inequalities have also widened for cardiovascular conditions and while inequalities in cancer incidence declined, inequalities in cancer mortality increased (Public Health Scotland). Inequalities in hospitalisations due to alcohol and drug misuse and inequalities in mental health also remain high in Scotland. All of these areas require continued, long-term focused cross-departmental policy making efforts to avoid systemic health inequalities becoming further entrenched as Scotland emerges from the pandemic.

References:

<https://www.gov.scot/publications/long-term-monitoring-health-inequalities-march-2022-report/pages/1/>

<https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/life-expectancy/healthy-life-expectancy-in-scotland>

<https://publichealthscotland.scot/publications/cancer-incidence-in-scotland/cancer-incidence-in-scotland-cancer-incidence-and-prevalence-in-scotland-to-december-2020/>

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

Please provide your response in the box provided.:

The most effective approaches to tackling health inequalities are those that tackle the social determinants of health at an upstream level, particularly those that intervene early in life.

There is strong evidence that the social and economic conditions in which we grow, live, work and age determine our health to a much larger degree than lifestyle choices. These social determinants of health, such as income, good quality homes, education and work, are not distributed equally in society, which leads to health inequalities. Most social determinants of health are the responsibility of policy sectors other than "health", which means policymakers need to promote health in ALL their policies if they are to have a big impact on health. SIPHER would describe this approach as "healthy public policy". Without this, key decisions on key determinants may continue to marginalise health and health inequalities. Specific initiatives will always be homeopathic compared to prioritising the fundamental causes of social inequalities and the upstream determinants of health in mainstream budgets and decision making, including (but not limited to) education, housing, transport and welfare.

Long term reductions in health inequalities will require action on the social determinants of health, as well as interventions that directly address health related behaviours at an individual level. The Scottish Government has successfully implemented policies aimed at tackling smoking and excessive alcohol consumption, however it has been less obviously successful in addressing the 'causes of the causes' of health inequalities. Scotland remains a highly unequal country, with little improvement in income inequality since devolution, and increasing poverty over the ten years prior to the pandemic.

The Social Security (Scotland) Act 2018 was intended to create a 'distinctly Scottish system' of social security 'founded on dignity, respect and human rights,' and with the explicit aim of reducing poverty. Eleven social security benefits are now devolved to Scotland, and the Scottish Government has powers to top up reserved benefits, providing it with some levers for directly tackling poverty. The Scottish Government has been willing to use its powers, for example to promote the take-up of benefits and to provide enhanced child payments to low-income families. Whilst policies of this nature are welcome, they do not tackle the root causes of health inequalities.#

SIPHER's research has shown that decent work is crucial for health and health inequality outcomes. This should include job security, sufficient pay, safe working conditions, working hours to suit personal circumstances, opportunities for development/progression and supportive working relationships. These are currently unequally distributed in society. For those who are not in the workforce due to age or inability to work, income support policies that guarantee a basic standard of living are important public health policies to help avert the negative health impacts of poverty on both adults and children.

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

Please provide your response in the box provided.:

As noted in our response to the previous question, the most impactful ways to support health and reduce inequalities are upstream and require multi-sectoral action at all levels.

One successful example of this type of approach can be found in a wide-ranging national health inequalities programme which was developed and implemented by the UK government between 2000-2010. This was the first international attempt to address health inequalities through a widespread, long-term programme of cross-government action.

This entailed a wide variety of policies designed to reduce health inequalities including: a range of social programmes (such as the introduction of the Child Tax Credit; SureStart Children's Centres), the introduction of the national minimum wage, area-based interventions such as the Health Action Zones and Neighbourhood Renewal funds, and a substantial increase in expenditure on the NHS. The latter was targeted at more deprived neighbourhoods when, after 2001, a "health inequalities weighting" was added to the way in which NHS funds were geographically distributed, so that areas of higher deprivation received more funds per head to reflect higher health need.

The programme for action also included two public service agreement national targets to be achieved by 2010: (1) to reduce by at least 10 per cent the gap in infant mortality rates between routine and manual groups and the population as a whole; and (2) to reduce by at least 10 per cent the gap between the 20 per cent of local authorities with the lowest life expectancy at birth and the population as a whole. Research has found that the strategy was effective in meeting these targets.

Other successful examples of health inequalities being reduced at scale are documented in the below referenced article in the Scandinavian Journal of Public Health written by SIPHER investigator Professor Claire Bamba.

References:

Bamba C (2021) Levelling up: Global examples of reducing health inequalities. *Scandinavian Journal of Public Health*, 1–6
<https://journals.sagepub.com/doi/pdf/10.1177/14034948211022428>

Question page 2

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

Please provide your response in the box provided.:

National and international data and accounts show that the pandemic is unequal in three ways: it has killed unequally, been experienced unequally and will impoverish unequally long into the future. They also go to show that many of these inequalities are a political choice – recovery choices need to be designed to foreground concerns about how they contribute to the levelling up the stark inequalities between different societal groups and geographical areas that already existed pre-pandemic. The impact on the pandemic on health inequalities has been extensively documented in a book titled the *The Unequal Pandemic* co-authored by SIPHER investigators Professor Kat Smith and Professor Claire Bamba.

As the pandemic has clearly exacerbated pre-existing health inequalities, the absence of a cross-sectoral approach to managing the recovery will likely lead to the health of those with lower wealth resources continuing to deteriorate even if their income eventually recovers to pre-pandemic levels.

The overall increase in mental health difficulties experienced across the UK during the pandemic is also a real cause for concern. A trend towards deteriorating mental health, disproportionately impacting on the most deprived areas has been occurring across the UK since at least 2015. Sustained investment in mental health services at local authority level (above and beyond pre-pandemic levels) as part of a long term national strategy must be a priority for the Scottish Government.

References:

Bamba C, Lynch J, Smith KE. (2021) *The Unequal Pandemic: COVID-19 and Health Inequalities*. Bristol, 2021
<https://library.oapen.org/handle/20.500.12657/51451>

12 Can you tell us about any local, regional or national initiatives throughout the the pandemic, or prior to 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?

Please provide your response in the box provided.:

We would highlight the Community Wealth Building initiative piloted by Clackmannanshire Council as a policy which has potential to alleviate health inequalities at local level. Community Wealth is a people-centred approach to local economic development. It reorganises local economies to be fairer and aims to reduce wealth flowing out communities by helping local investment and assets to generate more and better jobs for local residents and businesses. It is a practical way to support the development of an economic structure centred on the ambitions of local people. Community Wealth Building policies (and related initiatives regarding the role of an anchor institutions) are likely to be very important in assisting equitable economic recovery as we move out of the pandemic.

With support from SIPHER, the Scottish Government and Clackmannanshire Council have committed to working together to co-create a vision for a local wellbeing economy that is tailored to the local community in Clackmannanshire. This pilot project is designed to refine an approach to understanding the wellbeing economy at a local level and develop a framework for improving evidence-based policy making to deliver better outcomes. Systems mapping exercises carried out by SIPHER researchers played a role in highlighting the connections within the local system and provided further data for use in the development of policy interventions.

The systems mapping data was used as part of the evidence base for a prioritisation exercise to assess the impact that interventions could have on unlocking wellbeing economy opportunities. As well as impacting on these broader local wellbeing economy themes, interventions developed to address these priority areas will be designed to concurrently address other identified priorities based on the interplay demonstrated within the systems map. As part of the final stages of the project, a set of recommendations will be drawn up and operationalised by Clackmannanshire Council and their local delivery partners.

It is our hope that the outcomes of this pilot project will provide a basis for producing a wider framework and toolkit that can be applied and adapted in other local authority areas across Scotland.

Other national initiatives that have helped to address health inequalities through increasing the income of low wage earners include the Coronavirus Job Retention (furlough) Scheme and the now abandoned Universal Credit uplift. The continuation of policies like these in some form will be vital to avoid more people in Scotland falling into absolute poverty.

We acknowledge that public resources are limited and that all policy decisions designed to address health inequalities involve difficult choices. SIPHER is using an innovative systems science approach which aims to develop a Decision Support Tool to help inform decision making around the likely long term effectiveness of cross-sectoral policy choices.

References:

<https://www.clacks.gov.uk/business/communitywealth/>

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

Please provide your response in the box provided.:

SIPHER's work on inclusive economy has highlighted the importance of decent work in relation to health and health inequality outcomes. Key components of decent work including job security, sufficient pay, safe working conditions, working hours to suit personal circumstances, opportunities for development/progression and supportive working relationships are currently unequally distributed in society. For those who are not in the workforce due to age or inability to work, income support policies that guarantee a basic standard of living are important public health policies to help avert the negative health impacts of poverty on both adults and children.

There is currently significant and growing attention on the climate emergency and action related to climate adaptation and mitigation action. Our work with local and national partners shows that beyond active travel and air quality, there is often little consideration of how intervention options, e.g. for achieving carbon neutrality targets, may impact on health inequalities. There is much potential to design climate action in ways that lead to co-benefits for health, but unless this is considered at early stages of policy development, the climate agenda may come at the expense of those who can least afford it, thereby deepening inequalities.

Actions to reduce recurrent COVID-19 outbreaks and preparedness for new outbreaks should also be prioritised. This is because disease outbreaks are associated with increasing health inequalities. Given the strong link between wealth and health, actions to increase income resilience during COVID-19 outbreaks are equally important.

Interventions to reduce the financial cost of health promoting activities of those with low wealth resources, for example via targeted subsidies of health promoting expenditure (such as gym membership, access to outdoor spaces, promotion of low-cost health-promoting activities, or healthy eating) can help to address health inequalities. This is particularly important following the pandemic because needing to recover household income to pre-pandemic levels means many individuals have less disposable income to use on activities which are likely to benefit their health.

Question page 3

14 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?

Please provide your response in the box provided.:

Focusing only on specific actions, in isolation is unlikely to be successful. Health inequalities are a systemic problem and prioritising a few parts of the system at the expense of others is unlikely to yield any measurable benefits to population level health inequalities and risks further increasing inequalities. As noted above, there is a need for health inequalities to be considered in all policy making efforts. Therefore, initiatives to reduce health inequalities should be prioritised in all mainstream budgetary decision-making including education, housing, transport, environment and welfare.

In terms of urgent priorities, the likely impact on long-term health inequalities of increased hours and better staffed public provision of early years care can barely be overstated. Then, free and nutritious school meals (breakfast and lunch), including over holiday periods, hugely mitigate the worst impacts of poverty on children and help their long-term educational attainment. Holiday activity provision would also hugely mitigate summer learning loss (and benefit parents), which mostly affects disadvantaged children and creates long-term educational gaps. More generally, poverty-reduction measures, such as more generous welfare benefits and anything that facilitates the availability of decent work can also act to reduce adult disadvantage at source. Many of the most effective approaches to tackling health inequalities are not within the typical remit of health policymakers. Therefore, specific attention to the social distribution of policy effects needs to be a focus across all departments.

A minimal income guarantee, which is something that the Scottish Government is currently exploring, could have a substantial impact on reducing health inequalities. Making linked health and benefit data available for use by Scottish Government analysts and by independent researchers should be prioritised. This would enable a Minimum Income Guarantee scheme to be developed – and scrutinised – against the strongest possible evidence.

15 What role should the statutory sector, third, independent and private sectors have in tackling health inequalities in the future?

Please provide your response in the box provided.:

We respond to this question by using the example of housing associations. Many UK housing associations are offering an increasing number of 'housing plus' services, with both direct and indirect impacts on health inequalities. Examples of this work include: supported and sheltered housing; aids and adaptations; extra care schemes and in-house teams of carers; employing clinical staff such as mental health practitioners and occupational therapists; food banks and community pantries; employment and skills training; debt and financial advice and support; accommodating GP surgeries and pharmacies; counselling; food and nutrition; holiday kitchens for children; nurseries; volunteering, training and apprenticeships; running community centres and libraries.

However, these services are inconsistent and fragmented, creating significant variation in the extent and quality of support available to tenants. In the austerity context of local government and public health budget cuts, much of the additional support provided by housing associations represents replacement, rather than additionality, to services that might previously have been universal. Changes to social housing demographics mean that many people who would benefit from additional social and wellbeing support are now housed in the private rented sector. The expanded role for housing associations (similar to increased responsibility for other non-statutory or voluntary sector organisations risks creating a 'two-tier' system of housing and

health that leads to additional and cumulative disadvantage for those who are excluded.

There is a need to guarantee a baseline housing standard that all citizens have a right to access and demand, to provide a foundation for good health. A universal housing service, in the same way as a National Health Service does, could demonstrate a commitment to providing a basic but fair system, from which to build meaningful additional support services, for those who require them. The obligation, or duty to ensure this, lies with the state. Housing associations, and other third sector organisations, do not have the means to solve health inequalities while working in such a challenging context, but in a more supportive environment, some of these organisations could, in principle, offer a valuable contribution.

The biggest contribution housing associations can make to health inequalities is to continue to provide safe and decent homes. However, they are experiencing tension between their (often conflicting) commercial and social responsibility. Housing associations may play a more powerful role in reducing health inequalities if this objective is defined separately and has an independent funded function (i.e. not funded by rental income, and not provided at the expense of their housing obligation).