Health, Social Care and Sport Committee

19th Meeting, 2022 (Session 6), Tuesday, 24 May

Inquiry on health Inequalities - Summary of evidence

Introduction

The call for views for the Health, Social Care and Sport Committee's inquiry on health inequalities ran from 11 February 2022 to 31 March 2022. Respondents were asked to respond to 8 questions.

113 responses were received. 85% of responses were from organisations.

Submissions were received from organisations that represent specific demographic groups (such as the LGBTQ+ community, those with disabilities, ethnic minority communities, and those with experience of homelessness). These submissions therefore mainly wrote about the health inequalities that these specific groups experience. Furthermore, submissions were received from organisations that represent or focus on a certain health issue or condition. These included Myalgic Encephalomyelitis (ME) or Chronic Fatigue Syndrome (CFS), mental health conditions, HIV, diabetes, oral health, alcohol misuse, coronary heart disease, and cancer. The experience of health inequalities was therefore often tailored to a specific condition or health issue.

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?

104 responses were submitted to this question.

Submissions were largely negative regarding the overall progress that Scotland has made in tackling health inequalities since 2015. When supporting this point,

submissions predominately referenced the disparities in Scotland's life expectancy and healthy life expectancy rates.

Almost all responses mentioned the social determinants of health, stating that it was a key contributor behind persistent health inequalities and an area that requires continued focus. The Queens' Nursing Institute Scotland wrote, for example:

> *"At the population level, progress has not been enormous, as least as measured by major indicators of mortality, morbidity and wellbeing. That is largely because health inequalities are profoundly connected to, and influenced, by larger socioeconomic and other societal inequalities (e.g. child poverty, homelessness and substance misuse)."*

The relationship between poverty and health inequalities was most frequently raised, with submissions expanding on the health impacts of child poverty, fuel poverty, inadequate housing, and employment. Organisations representing specific demographic groups also wrote of continued health inequalities experienced by these populations.

The submissions identified some successes. Submissions frequently referenced the positive impact of legislation (especially those related to tobacco, food, and alcohol) on health issues that disproportionately impact certain groups in Scotland.

Community Links Practitioners in Deep End GP practices (surgeries based in Scotland's most deprived 15% of areas) were provided as an example of a success that should continue, with several submissions stating a need for these to now be further embedded in GP surgeries. Community Links Practitioners were frequently linked to the valuable role that primary care has overall in mitigating health inequalities.

Furthermore, several submissions referenced the value of Equity Impact Assessments, Health Inequalities Impact Assessments, and Fairer Scotland Duty.

Finally, submissions reflected that there is now a greater awareness around health inequalities and an acceptance that it should be a priority issue in Scotland across Government, NHS Health Boards, Local Authorities, and the general public. In its submission, for example, South Lanarkshire Council commented:

> *"There is increased recognition of the impact and determinants of health inequalities, alongside greater use of a "common language" across disciplines and sectors. In Lanarkshire this is reflected by the fact that both Community Planning Partnerships in South and North Lanarkshire have agreed jointly that tackling health inequalities is a common priority locally."*

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

This question received 100 responses.

Overall, the approaches mentioned were largely concerned with tackling the social determinants of health, which were viewed as ultimately the 'root' of health inequalities. Frequent examples included:

- The use of legislation and policy.
- Taking a co-ordinated, cross-government approach (i.e. moving beyond health).
- Engaging and working closely with local communities.
- 'Proportionate universalism' (where universal services are provided proportionate to need with added intensive support for the most vulnerable populations).

As many submissions were from organisations that represent certain demographic groups or health conditions, it was also apparent that approaches to tackling health inequalities may need to differ depending on the group or health condition impacted.

Several submissions argued that targeting individual behaviour should not be prioritised. Obesity Action Scotland wrote that a "continued focus on individual behaviour change interventions will further entrench inequalities":

> *"This is because those who are the least deprived have more capacity and resources to respond to such individual interventions, compared to the most deprived. Further, focusing on population level public health interventions removes the focus on individualism and incorrect narratives which argue that adverse health outcomes, such as overweight and obesity, are the result of individual choices and fail to acknowledge the profound impact of environments on health outcomes and inequalities."*

In its submission, Public Health Scotland also cited actions which "focus on individual lifestyle change without accounting for the challenges in making these changes for those with the least resources" as one of the least effective ways of reducing health inequalities.

The success of Scotland's pursuit of these approaches was viewed as mixed. While developments such as the creation of Social Security Scotland were referenced in relation to tackling the social determinants of health inequalities, submissions highlighted the continued impact of wider economic structures and UK Government policy.

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

This question received 99 responses.

The actions outlined in the submissions to this question were varied and mostly general in nature. Submissions focused on:

- Improved housing, including suggestions of more affordable homes to be built in Scotland.
- Addressing homelessness.
- Improving educational attainment.
- Improving employment conditions.
- Raising income level, such as through a Universal Basic Income or an increase in the National Living Wage.
- Investing in key infrastructure, including improving public transport or patient transport services to ensure that attending consultation and treatment is cost-effective for the patient.

While not necessarily a specific action, it was frequently suggested that there should be a human-rights based approach to structural inequalities.

Equitable access to public services, including health services, also emerged as a prominent theme. In its submission, Age Scotland wrote:

> *"There are also other barriers which could be considered as structural inequalities which contribute to health inequalities. These include issues surrounding the accessibility of services, discrimination, cultural and linguistic barriers. They can impact someone's experiences of and engagement with public services and therefore their health."*

In relation to the accessibility of health and social care services, submissions suggested that there should be:

- Increased outreach to marginalised groups.
- Increased knowledge of health inequalities amongst the workforce
- More physically accessible and inclusive facilities.

The increased role of technology in healthcare was raised as an accessibility issue in some responses to this question but featured more prominently in the questions relating to COVID-19.

As with other questions, the use of equality impact assessments was mentioned. In particular, several submissions to this question suggested the use of Health Inequalities Impact Assessments in all policies. The submission by NHS Lothian described this as a "health in all policies" approach.

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

This question received 105 responses. Overall, the pandemic was viewed as having exacerbated existing health inequalities and the impacts of the pandemic were not felt equally.

Submissions stated that the pandemic had a disproportionate impact on older people, those in the most deprived areas, ethnic minority communities, those with disabilities, women, and those that were shielding, amongst others.

Mortality, infection, and vaccine rates were frequently raised, with the Royal College of General Practitioners in Scotland writing in its submission that:

> *"There were some particular issues relating to Covid mortality – overcrowding, the impact on some minority ethnic populations, a bigger vaccine gap. GPs at the Deep End refers to the "triple whammy of Covid risk", with deprived populations more likely to catch Covid, more likely to get sick or die from Covid, and less likely be to be vaccinated against it.*

As with the answers to the other questions, the impact of structural issues, like increased unemployment rates and loss of earnings, featured prominently in the responses.

The impact of the pandemic on access to health and social care services was a central theme, with responses highlighting both negative and positive impacts. The increased role of digital technology was an example of this, with some submissions highlighting that it, for example, improved access to healthcare for people with disabilities and those in rural areas. Other submissions, however, raised concerns over 'digital deprivation' and the inaccessibility of virtual services for some groups.

Furthermore, as with other questions, the impact of reduced access to services could also be dependent on the health condition or demographic group that submissions from organisations represented. For example, the British Dental Association in Scotland wrote specifically on the impact within oral health, stating concerns that lower levels of participation in dental services will "inevitably translate into a higher disease burden, with deep oral health inequalities expected to widen."

While the submissions highlighted a consensus that the pandemic had a negative impact, some of the positive impacts of the pandemic on health inequalities were raised in the submissions. These included:

- Innovation by health and social care services in responding and adapting to the pandemic context.

- Improved community resilience and an increased 'sense of community', especially in efforts to support the those in vulnerable and marginalised groups.

- Behavioural and lifestyle changes, such as increased physical exercise.

- Increased awareness and education around public health, through self-testing programmes and public health messages around infection prevention and control.

- Greater awareness around health inequalities and the pandemic's impact.

Can you tell us about any local, regional or national initiatives throughout 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?

There were 100 responses to this question.

The examples provided in the submissions varied. Many examples were related to the 'root' causes of health inequalities, such as initiatives aimed to reduce and alleviate poverty and emergency accommodation for rough sleepers.

Local examples

- *"Breast screening project with the Renfrewshire Disability Resource Centre - Women who attended the Disability Resource Centre were provided with transport to attend Nelson Mandela place for breast screening appointments. Although the mobile screening unit could offer longer appointments for people with disabilities, they couldn't accommodate electric wheelchairs and women had concerns using the stairs in wet/icy weather. They were also less likely to attend screening appointments as they would be reliant on friends/family to attend with them. They would prioritise other health appointments to reduce the ask of their support networks. Therefore, this partnership between Health Improvement & the Disability Resource Centre was crucial in enabling women to attend their breast screening appointments."* (Renfrewshire Health and Social Care Partnership)

Regional examples

- *"VASLan (the local Third Sector Interface) distributed small grants to a range of organisations across South Lanarkshire. These grants enabled the support to local community-based organisations and 'pop-up' support groups to provide food vouchers, activity packs, IT equipment and wellbeing packs to a wide range of residents who were isolated as a result of the lockdown."* (South Lanarkshire Council)

- *"During the COVID pandemic the Grampian Humanitarian Assistance Hub service assistance service provided psychological support access to food,*

access to sanitary products, prescription, psychological support etc. the service was widely used by members of the Aberdeenshire public over a number of months." (Aberdeen Health and Social Care Partnership)

- *"During the Covid-19 pandemic NHS Lothian undertook an Integrated Impact Assessment (IIA) of its COVID-19 vaccination programme. The IIA identified groups of people who would be more likely to encounter barriers to accessing a COVID-19 vaccination through mainstream pathways (which involved a posted letter and invitation to attend a mass vaccination centre) and made recommendations on how these barriers could be overcome. Building upon this work, NHS Lothian drafted an inclusive vaccination plan, and a public health sub-group of the COVID-19 vaccination programme board was set-up to fulfil the aim of ensuring that all who were eligible for vaccination would have equitable opportunity to receive and accept their invitation. The vaccination outreach programme in local authorities aimed to provide equitable and accessible opportunities for all to receive Covid-19 vaccinations and boosters."* (NHS Lothian)

National examples

- Community Link Workers within GP practices.
- The Scottish Government National Vaccine Inclusion Group.
- NHS Pharmacy First.
- Accessible COVID-19 information being produced by NHS 24 and NHS Inform – for example, multiple formats and different languages.
- Early medical abortion at home during COVID-19.

Regarding sustaining and embedding these examples, submissions highlighted or suggested:

- A need to continue the community resilience that was strengthened by the pandemic.
- Investing in the workforce development of health and social care staff to enable them to successfully work with communities.
- The creation of a national depositary of good practice.
- Additional funding for community-led and third sector supports, which is guaranteed for a longer period.

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

This question received 100 responses.

Many submissions focused on the necessity of harnessing the positive impacts of the COVID-19 pandemic to prioritise tackling health inequalities going forward.

Submissions wrote of a need to capitalise on the increased awareness and interest around health inequalities, especially within communities, and ensuring that there is a continued focus on tackling them. Public Health Scotland wrote:

> *"The pandemic has led to an increased awareness of health inequalities and their causes that may provide greater public support for effective action on their causes. Throughout the pandemic, the media covered the disproportionate impact that COVID-19 had on marginalised groups, including individuals in insecure work, those experiencing homelessness, care home residents, disabled people, and ethnic minority communities. This could help public institutions go further in ensuring universal services are provided proportionate to need. Public support has also increased for strong government action to protect the economy, health, and wellbeing."*

Engagement with the community sector and community organisations was frequently identified as important to ensuring that health inequalities are prioritised at a local level. The Community Health Exchange wrote:

> *"They will have an essential role in getting the message out about, and supporting people through, the changes needed to 'build back better'. The trust and reach of community organisations will be a key resource and should drive change locally."*

Furthermore, submissions referenced the necessity of collaboration across the Scottish Government's portfolio to ensure that tackling health inequalities are considered across all policy areas. The Royal Society of Edinburgh wrote:

> *"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."*

As with the responses to other questions, the use of Impact Assessments was suggested as a tool to ensure that health inequalities are prioritised across policy areas.

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?

This question received 100 responses.

Many responses referenced the actions provided in answers to previous questions and some stated that they had answered this question already.

Most responses included a reference to tackling the social determinants of health. The suggestions provided were therefore similar to Question 3, such as general action to target the educational attainment gap, reducing child poverty, and mitigating the impact of the cost of living crisis. As with the responses to the previous questions, these 'root' causes of health inequalities were viewed as requiring a cross-sector and collaborative approach.

In addition to tackling structural inequalities, responses were concerned with improving health and social care services in Scotland overall. Areas to be prioritised included:

- Ensuring that health and social care services take a preventative approach to health inequalities, especially by focusing on children.
- Utilising lived experience when designing services and ensuring a person-centred approach.
- Investment towards increasing staffing levels.
- Focus on workforce training on issues around health inequalities.

Many responses referenced the need for better data and/or suggested undertaking further research into health inequalities and, in particular, health and social care services. The Health and Social Care Alliance Scotland wrote:

> *"There is widespread experience and evidence that health and social care systems are themselves drivers of health inequalities. A thorough investigation would enquire into the mechanisms and processes by which this occurs, not only in primary care but also in mental health, addictions, hospital based services and social care."*

Regarding data, the Equality and Human Rights Commission wrote:

> *The importance of collecting data on protected characteristics became evident during the COVID-19 pandemic. In Scotland, the Scottish Government's Expert Reference Group (ERG) on ethnicity and COVID-19 found that the pandemic had highlighted the lack of adequate data to monitor the needs of different minority ethnic groups, particularly in relation to the health consequences of the pandemic. We now know that harms from COVID-19 were not spread evenly*

across society, and when Public Health Scotland analysed data looking at the second wave of infection, they found that people of South Asian background were three times more likely to die or be hospitalised than White people. This is an example of how collecting data on protected characteristics could have allowed a tailored approach to, for example, who was included in the priority groups for vaccination, or the advice and guidance given to different groups about how best to protect themselves."

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

This question received 91 responses.

The majority of responses wrote that cross-sector working was a necessity, with many responses commenting that tackling inequalities cannot be done by a single sector. Audit Scotland wrote:

> *All sectors have a role to play and must work together. In our NHS in Scotland 2021 report, we recommend that a cohesive approach is required to successfully tackle health inequalities. We know that health inequalities are intrinsically linked to other structural inequalities, which have also worsened since 2015. Health inequalities are not purely a health problem. The Scottish Government's Health and Social Care Directorate cannot reduce health inequalities on its own. A collaborative approach across government departments, the wider public sector, the third sector and the independent and private sectors is required to transform the structural inequalities that lead to health inequalities.*

Some responses suggested ways to achieve this, such as sharing information and good practice between sectors.

The third sector was raised as an important way to reach people within local communities. The third sector was singled out as having a good link to reaching marginalised groups, involving those with lived experience in efforts to tackle health inequalities, and linking those impacted by health inequalities to health and social care services. Food Train wrote:

> *"In particular, the sector's powerful role in reaching into communities, involvement and listening to the voices and lived experience of individuals experiencing health inequalities cannot be underestimated. They know their communities so well. The development of strategies, intervention and solutions which involve service users in shaping solutions will more successful and effective."*

Multiple submissions wrote of the need for more sustainable funding to be provided to the third sector.

Some submissions expressed caution over the role of the private sector, with a perception that the sector is focused on profit rather than wellbeing. This caution was

also linked to certain industries, such as the tobacco industry, and their relationship to health inequalities. One submission referred to these as 'Unhealthy Commodity Industries'. SPECTRUM Consortium wrote:

> *"Commercial Determinants of Health (CDOH) are those activities of the private sector that affect the health of populations. These can be direct, such as the marketing of unhealthy products, or more indirect, like industry lobbying against duty increases, donating to political campaigns, funding dubious research, and generating doubt around product harms."*

Other submissions, however, reflected that the private sector could have a positive role through contributing to economic growth and structural changes.

Many responses reflected on the legislative role of the Government and the importance of policy-making in reducing health inequalities, something that was also referenced in responses to Questions 1 and 2. Submissions also referenced collaboration within the statutory sector, such as NHS Boards working with Local Authorities and Alcohol and Drugs Partnerships.

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