Cross-Party Group on Improving Scotland's Health

Wednesday 6 December, 18:15-19:30, hybrid

Summary

Present

MSPs

Foysol Choudhury MSP (Chair)
Emma Harper MSP
Tess White MSP

Invited guests

Paul Johnston, Public Health Scotland

Non-MSP Group Members

Amanda Amos, University of Edinburgh
David Blane, University of Glasgow, Obesity Action Scotland
Marc Buchanan, Alcohol Focus Scotland
Lauren Carters-White,University of Stirling, SPECTRUM
Jeff Collin, University of Edinburgh
Emily Combet, University of Glasgow
Emma Crawshaw, Crew 2000 Scotland
Lorna Cudmore, ASH Scotland
Alan Dalziel, ASH Scotland
June Deasy, BPS
Elena Dimova, Glasgow Caledonian University
George Dodds, Public Health Scotland
Fiona Doig, NHS Borders
Sheila Duffy, ASH Scotland
Alison Douglas, Alcohol Focus Scotland
Sarah Edwards, The Breastfeeding Network
Niamh Fitzgerald, Institute for Social Marketing & Health, University of Stirling
Mathis Heydtmann, NHS Greater Glasgow and Clyde
Lesley Hinds, Scottish Parliament
Scott Hogg, ASH Scotland
Elinor Jayne, SHAAP
Paul Johnston, Public Health Scotland
Glenys Jones, Association for Nutrition
Fiona Lockett, Fife Health & Social Care Partnership
Andy MacGregor, Scottish Centre for Social Research

Ian McCall, Paths for All
Rebecca McColl Alcohol Focus Scotland
Nicola McIntosh, Society of British Dental Nurses
Fiona McIntyre, Royal Pharmaceutical Society
Nicola Merrin, Alcohol Focus Scotland
Jane Miller, NHS Lothian
Aidan Mitchell, Change Mental Health
Danielle Mitchell, University of Stirling
Andy MacGregor, ScotCen Social Research
Daniel O'Malley, Diabetes Scotland
Jamie Pearce, University of Edinburgh
Gillian Purdon, Food Standards Scotland
Helen Reilly, QNIS
Bushra Riaz, Kidney Research UK
Peter Rice, European Alcohol Policy Alliance
Pete Ritchie, Nourish Scotland
Bruce Ritson, SHAAP
Lesley Ross, Glasgow Council on Alcohol
Niamh Shortt, University of Edinburgh
Rebecca Sibbett, Alcohol Focus Scotland
Richard Simpson, CERT
Niki Stark, Royal College of Nursing
Tom Steiner, Obesity Action Scotland
Rebecca Stewart, Homelessness and Inclusion Health Society, University of Edinburgh
Alexandra Taylor, Alcohol Focus Scotland
Charlotte Wendelboe-Nelson, University of Stirling, SPECTRUM
Laura Wilson, Royal Pharmaceutical Society

Apologies

Jackie Baillie MSP
Emma Crawshaw, Crew 2000
Emilia Crighton, NHS Greater Glasgow and Clyde
Jacqueline Cunningham, REHIS
Jennifer Forsyth, Obesity Action Scotland
Colwyn Jones, British Dental Association
Dr Harpreet Kohli, SHAAP
Dr Jonathan Sher

Agenda item 1: Welcome from co-convenor Foysol Choudhury MSP:

Foysol Choudhury MSP (FC) welcomed in-person and online attendees. **FC** welcomed **Emma Harper MSP (EH)** and **Tess White MSP (TW)** to the meeting. Apologies were noted in the meeting minutes, as above. **FC** outlined the agenda.

Agenda item 2: Declaration of Interests

TW noted her role as a member of the Health, Social Care and Sport Committee. **EH** reminded members that she is Deputy Convener of the CPG on Scotch Whisky. No other interests were declared.

Agenda item 3: Approval of Wednesday 06/09/23 meeting minutes and any matters arising

FC asked members to propose and second approving the minutes. **Niamh Fitzgerald (NF)** proposed approving the minutes and **Colwyn Jones (CJ)** seconded their approval. The group unanimously approved the previous meeting minutes with no amendments.

Agenda item 4: Presentation by Paul Johnston, Chief Executive of Public Health Scotland

FC introduced **Paul Johnston (PJ)**, Chief Executive of Public Health Scotland (PHS). **PJ** began by explaining that the focus of PHS since 2020 was the data and intelligence needed around the COVID-19 pandemic, alongside prolonging healthy life and promoting health and wellbeing by strengthening the building blocks of health. PHS's ambition is a Scotland where everyone thrives. Two dimensions that will demonstrate progress in this are improved life expectancy and a decrease in the 12-year difference in life expectancy between the poorest and wealthiest neighbourhoods.

Currently, the poorest 20% of males in Scotland have, on average, 44.9 years of good health and will spend 23.7 years of their life in poor health. In comparison, the wealthiest males will have 71 years in good health and 11.3 years in poor health. For females, the data is slightly better, but the inequalities are incredibly stark.

Evidence from PHS research has found that the burden of disease is forecast to increase by 21% in the next 20 years. Two thirds of this increase will be due to increases in cancers, cardiovascular disease, and neurological conditions. This is partly due to our ageing population and wider demographic changes. However, a great deal of the predicted disease can be prevented. This will require determined action in areas of interest to the CPG including tackling unhealthy food, tobacco, vaping, and alcohol.

In Scotland, non-communicable diseases (NCDs) dominate the burden of disease. **PJ** noted how this data highlights that the disease burden is, to a large extent, attributable to poverty and inequalities. Therefore, many diseases are preventable if we tackle poverty and inequalities.

PHS is hopeful about the change that can and must happen because they have seen progress in the past when policies have focused on preventative action. Examples include:

- Minimum Unit Pricing: estimated to have reduced alcohol hospital admissions (4.1%) and deaths (13.4%) since 2018
- Smoke-free public spaces: reduced admission for child asthma (18%) and heart attacks (17%)
- COVID-19 Vaccines: More than 27,656 deaths were directly prevented in Scotland

PJ spoke about the three levels of prevention:

- Primary prevention: investing in the building blocks of health to stop problems happening in the first place
- Secondary prevention: focusing on early detection of a problem to support early intervention and treatment or reducing the level of harm
- Tertiary prevention: minimising the negative consequences of a health issue through careful management

PJ highlighted that Scotland needs more primary prevention, as the intervention which is likely to cost the least and have the greatest impact on Scotland's health. All levels of prevention are vitally important, but secondary and tertiary prevention often cost more and impact on smaller numbers of people than primary prevention.

Using the example of cardiovascular disease, **PJ** further explained the three levels of prevention. Primary prevention is all about stopping people from becoming ill in the first place. This can be done by stopping smoking, reducing alcohol consumption, increasing physical activity, and having a healthier diet. Many interventions are cost-effective, which is particularly important due to NCDs' high cost to the public purse and the NHS.

PJ spoke about two policies which PHS believes to be very important: minimum unit pricing (MUP) and smoke-free public spaces. MUP is estimated to have averted significant numbers of hospital admissions and to have saved lives. Smoke-free public spaces and earlier innovations have had phenomenally positive effects. Therefore, the question to ask our Parliament is, "what next?".

Taking the example of alcohol consumption, **PJ** explained that PHS is fully supportive of MUP and believes that it must be part of a package of measures to reduce harm from alcohol. PHS's recently published policy paper on alcohol highlights the various measures that PHS recommends local and national governments take. This includes a regulatory code for marketing to protect children and young people from prolonged exposure to alcohol advertising, reducing at home alcohol consumption, and legislating for standardised health

warnings on alcohol containers. Additionally, PHS recommends improving the availability of treatment services.

PJ noted that a series of interventions in Scotland from 2003 to 2019 have resulted in a significant decrease in the percentage of the Scottish population who smoke. **PJ** highlighted that although prevention is a long-term policy and preventative measures may take time to show results, they are still important and urgent, with a direct impact on Scotland's health through preventing disease in the first place.

Turning to health behaviours, **PJ** spoke about the four key dimensions of the building blocks of health:

- Social and economic factors: The evidence is clear that the biggest single factor causing Scotland's poor health is poverty, inequality, and deprivation. When poverty has been at lower rates in the past, health has increased, and health inequalities have decreased. **PJ** spoke about the work of Sir Michael Marmot, which highlights the impact of austerity and poverty on health across the UK. Scotland has several policies in place to support people, including the Scottish Child Payment, keeping the Promise, and investing in quality early learning and childcare. Long term investment in these areas is vital.

- Health behaviours: **PJ** asked how we can support people to make healthier choices by improving access to healthy foods, supporting smoking cessation and decreasing alcohol consumption.

- Health services: This includes equitable and timely access to high quality healthcare, treatment, and support when necessary.

- Physical environment: Climate and environment have an important role to play in health, from investment in active travel to the impact of Low Emission Zones.

PJ spoke briefly about the PHS Economy & Poverty Programme, underlining the importance of building a health and wellbeing economy. We need a way of supporting people to access good and fair work. PHS is trying to ensure that the NHS, as the largest public-sector employer in Scotland, does all it can to be a fair employer, supporting and protecting health. PHS is also working with local government for this same reason. Ideally, businesses should also be able to play their part, with people contributing to Scotland's economy and experiencing increasing levels of health and wellbeing.

PJ concluded that Scotland's health is in a perilous state. Scotland is lagging behind other countries in Europe in many of the metrics around life expectancy, healthier life expectancy, and crucially, the gap in health inequalities. **PJ** questioned how public health advocates can ensure real momentum for long-term, system-wide action that will secure improvement in

Scotland's health. **PJ** highlighted that we must be ambitious in relation to a suite of policy interventions. There is no single policy that will improve everything.

FC thanked **PJ** for his presentation and insights.

Agenda item 5: Updated CPG conflict of interest policy

Alison Douglas (AD), representing the CPG secretariat, presented the updated CPG conflict of interest policy paper which had been discussed with the Co-Convenors and circulated to members via email.

According to the Scottish Parliament's CPG policy, it is up to the CPG to decide what its membership criteria are. Due to the international evidence base which shows that health-harming commodity industries attempt to influence and undermine the most effective and evidence-based measures, the group should be allowed to exclude their participation given its purpose.

The remit of this group is specifically:

- To take a solutions-oriented focus on how to improve the health of the people of Scotland primarily by reducing the health harms caused by alcohol, tobacco, poor diet and obesity and
- To join up knowledge and learning, and to identify positive ways forward, with a range of stakeholders committed to improving public health and to preventing and reducing non-communicable diseases for the next generation.

When the CPG was first established in January 2017, members were concerned about opening membership to organisations involved in the production, sale, and promotion of unhealthy products which are risk factors for NCDs, due to the inherent conflict of interest with the CPG's purpose.

The expectation is that CPG members should be broadly supportive of evidence-based measures to improve public health and share information to improve the evidence base. There is also a presumption that commercial interests would normally be excluded from membership, but that the CPG could invite such organisations to join for discussions where their insight and information were considered to be relevant.

It was agreed in 2017 that the group would have a membership policy and a conflict of interest declaration form which asks people to sign up to the group purposes and asks if they have a specific and principal interest in preventing and reducing harm from tobacco, alcohol, and unhealthy diet, or are undertaking research in that space.

Members discussed the updated conflict of interest policy paper and arguments for and against allowing industry representatives to become members of the CPG.

The group noted that ‘tobacco’ had been updated to include ‘and related products’ and that the references evidence base had also been updated. No further changes to the policy were considered necessary.

Where there is a potential conflict of interest, the CPG secretariat will bring applications for membership to the co-conveners with a recommendation and rationale regarding membership of the CPG. The co-conveners may choose either to accept the recommendation or to bring such applications to Group meetings for consideration.

The CPG may consider inviting commercial representatives to participate in discussions if this is considered relevant, as indicated in the CPG’s policy. However, it was noted that there were many other outlets, including numerous other CPGs, for such participation, and given the limited time available to the Group it was important to maintain a primary focus on its core and unique purpose. One member noted that the COI policy developed and adopted by this CPG had been cited by several international academics as an example of good practice in protecting health policy development from commercial interference.

Agenda item 6: Any other business

There was no other business.

FC ended the meeting by thanking **PJ** for his presentation and insights, and participants for their questions and enthusiasm.

CPG members will be notified of the date of the next meeting by email.

END