Health, Social Care and Sport Committee call for views – Inquiry into health inequalities

Submission from the Glasgow Centre for Population Health (GCPH)

Question 1. 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?

This question can be easily answered using the Scottish Government's annual report into the 'Long-term Monitoring of Health Inequalities', the most recent instalment of which has just been published[1]. Considerable time and expertise have gone into establishing this series of reports, and the measures used within them. They provide up to date information on the scale of, and trends in, inequalities (defined by area deprivation) in different health outcomes. While there is considerable debate and academic discussion regarding the optimum way of measuring health inequalities (in terms of both how 'health' itself, and inequalities in such outcomes, are defined), the indicators included in these reports were agreed as being the most useful set of easily updated measures available. They have been published annually since 2008.

The most recent publication clearly shows a widening of both relative and absolute inequalities in numerous key measures of population health since 2015: for example, male and female healthy life expectancy, premature mortality (deaths under 75 years, and also younger deaths among 15-44 year olds), cancer mortality, drug-related hospital admissions, and more. There are some exceptions (e.g. alcohol-related hospitalisations and deaths), but inequalities have widened over time for the majority of indicators.

It is important to emphasise that the reasons for this are well understood. The 'fundamental causes' of health inequalities are socioeconomic[2-5], and there has been a continued widening of socioeconomic inequalities over the same time period[6-9]. Closely related to this, unprecedented changes to health outcomes such as mortality and life expectancy have been observed since around 2012: a stalling of improvement overall, alongside increasing death rates among the most deprived populations, with a consequent widening of inequalities[10-15]. These changes have been shown to have been caused in large part by the UK Government's 'austerity' programme that was introduced in 2010, and which has had a drastic impact on the income – and therefore health – of the poorest and most vulnerable populations[16]. This is not just a Scotland-specific issue: similar changes have been observed across all parts of the UK.

Question 2. What are the most effective approaches to tackling health inequalities and how successful is Scotland in pursuing such approaches?

It is important to recognise that we know what measures are required to address health inequalities. There is a wealth of evidence regarding what the most effective policy interventions are to narrow inequalities. In 2013 the Scottish Government itself commissioned NHS Health Scotland (now Public

Health Scotland (PHS)) to undertake a '*health inequalities policy review*': this was published the following year, and the findings and conclusions still apply[17]. The review built on previous work undertaken by the Chair of the advisory group, Professor Sally Macintyre, in identifying from international evidence the policies that are effective, and those which are not effective, in narrowing health inequalities[18]. The report emphasised the need to address inequalities at three levels: the aforementioned fundamental socioeconomic causes of inequalities (e.g. with policies such as progressive taxation to redistribute income in society); the 'wider environmental influences' (e.g. through housing, pollution, food/alcohol policies); and individual experiences of inequalities (by means of appropriate training, for example). However, the report also stressed that the first of those levels – the fundamental socioeconomic causes – was the most important: without meaningful policy interventions at that level, inequalities would not be narrowed. Indeed, McIntyre states in her 2007 paper *"some apparently promising interventions may not only increase inequalities in health, by benefiting the advantaged more, but may actually harm the more disadvantaged"* [18].

While, as stated, the findings of that 2014 review still stand, it is important to consider two further points. First, there is the question of whether Scotland has the necessary economic powers to meaningfully address the fundamental socioeconomic drivers of health inequalities[19]. Second, there is the need to understand the effects on socioeconomic – and therefore health – inequalities of the UK Government's austerity programme over the past decade. Specific additional measures are required to reverse the effects of this programme, some of which are discussed below.

In assessing progress in addressing health inequalities in Scotland, it is important to point out there have been a number of positive developments, including the Child Poverty Act 2017 and the introduction of the Scottish Child Payment, funded early learning and childcare is being expanded, good progress has been made on affordable housing provision and equity in public sector pay[19]. However, in some areas little progress has been made (e.g. the 'poverty premium') or changes have not gone far enough (e.g. the income tax system). There are also examples of policy programmes and directives which aim to mitigate and alleviate the immediate and acute impacts of poverty and austerity, such as increases in the Carers Allowance, the Scottish Welfare fund, free school lunches, winter heating allowances, income maximisation and employment support schemes.

In recent years, support for community wealth building approaches has gained momentum at national, regional and local levels. The economic footprint of anchor organisations as employers, purchasers and owners of land and property undoubtedly affects the local and regional economy of places, and of the fortunes of people living and working in these places. Community wealth building has the potential, through economic development activity, to redirect wealth back into local economies and increase control and benefits for local people. The forthcoming Scottish Government legislation focusing on community wealth building will play a crucial role in providing guidance and support for anchor organisations to take community wealth building approaches that promote economic inclusion.

At a community level, GCPH has undertaken a range of evaluative work aimed at identifying preventative approaches in addressing health and social inequalities. A community focus can imply 'micro' and small scale, and that the described macroeconomic and policy levers which can influence the 'fundamental causes' of health inequalities are not being affected. However, we believe that some initiatives can illuminate a range of policy areas relating to some drivers of health inequality including public and third sector service delivery, education, additional support for vulnerable families, community identity and aspiration and addressing inequalities in opportunity. One such initiative is Sistema Scotland's Big Noise programme which GCPH has been evaluating since 2013.

Sistema Scotland is a charity *"on a mission to transform lives through music".* Through its Big Noise programme Sistema Scotland believes that children from disadvantaged backgrounds can gain significant social and life skills by playing in an accessible, long-term, intensive, immersive music education programme based on the symphony orchestra.

Sistema Scotland uses collective music-making to foster wellbeing, confidence, pride and ambition among the children and young people taking part. Big Noise also aims to be a positive and aspirational focal point for the community, a social intervention which supports other regeneration efforts, bringing families and wider community members together in regular local concerts and events. The GCPH evaluation has produced a range of reports and peer reviewed publications which makes clear the positive preventative impacts observed on participants. Sistema Scotland's approach also offers important learning as to the processes involved in the delivery of effective social regeneration and early-years interventions designed to address inequalities. A forthcoming publication makes clear that participation in Big Noise statistically enhances post-school destinations.

Questions 3, 6 and 7:12

- **Q3. What actions would you prioritise to transform the structural inequalities that are the underlying cause of health inequalities?**
- **Q6. How can action to tackle health inequalities be prioritised during COVID-19 recovery?**
- **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?**

We respond to these three questions together as there is overlap between them.

As stated above, effective policies to address inequalities are highlighted in the 2014 policy review report, we therefore again draw the Committee's attention to that piece of work[17].

We also direct the Committee to a set of detailed policy recommendations included within the forthcoming publication from Public Health Scotland (PHS), GCPH and the University of Glasgow on the causes of – and appropriate responses to – the recent austerity-driven changes to population health in Scotland and the rest of the UK[16.] These recommendations build on previous GCPH/PHS research and policy proposals[20], and also reflect relevant work from organisations such as the Joseph Rowntree Foundation, Oxfam Scotland, Child Poverty Action Group and others. They include relevant interventions at different levels of government and in relation to different topic areas: social security, employment, taxation, public services, material needs, and more.

A recent GCPH study of health trends and inequalities in Glasgow undertaken during the pandemic highlighted specific issues, many related to the wider impact of the pandemic on society which need to be addressed[21]. Examples include our reliance on digital technology which has increased during the pandemic but raises the danger of digital exclusion in education and for groups that may struggle to access or use digital technology. Government needs to ensure that there is comprehensive and affordable access to digital technology and that there are alternative ways of providing services and information for those people who face difficulties using digital media.

For issues, such as homelessness and drug policy, people with lived experiences have been involved in formulating policy, an inclusive approach which should be expanded. Additionally, in relation to designing new active travel infrastructure, the most vulnerable, including disabled people, should be

involved in the earliest stages of design to ensure that new paths and streetscapes are truly accessible to all and do not exacerbate existing inequalities in access. The period of the pandemic has also highlighted environmental inequalities. For example, there are inequalities in access and use of greenspace, which points to the need to ensure there is equitable access to good quality greenspace in every community.

Question 4. What has been the impact of the pandemic both on health inequalities themselves and on action to address health inequalities in Scotland? Please note, the Committee is interested in hearing about both positive and negative impacts.

Health inequalities in Scotland (as elsewhere in the UK) have widened consistently over time since the end of the 1970s/start of the 1980s, associated with a corresponding widening of socioeconomic inequalities over that period[20]. As stated, they have widened further in the past decade due to UK Government 'austerity' policies[16]. Even prior to the changes in the last decade, however, health inequalities in Scotland were wider than elsewhere in Western Europe[22-24]. This is important context to understand in relation to the scale of COVID-19 inequalities that have been observed. As has been pointed out by commentators, the pandemic has exacerbated pre-existing inequalities. Death rates from COVID-19 have been shown to be highly socially patterned[25], and all-cause death rates in the first year of the pandemic (2020) increased to a larger extent in areas with higher levels of socioeconomic deprivation (e.g. West Dunbartonshire, Glasgow, Inverclyde) compared to less deprived local authority areas[26]. We would expect similar findings for 2021, before death rates return to pre-pandemic levels. However, it is in fact those *pre-pandemic* levels of mortality that are of immense concern, given the recent changes – including increasing death rates in our poorer communities – that were occurring even before the pandemic occurred.

We also know that ethnic inequalities in COVID-19 infections, mortality and morbidity have been highlighted across the UK, including in Scotland. These disproportionate pandemic impacts on BME populations were observed even when considering individuals' socioeconomic position (SEP)[27 28]. The reasons for the undue burden of COVID-19 on BME groups are multifactorial, analysis within Scotland is hindered by the current inadequacy in ethnicity recording in health records alongside the shortcomings in measures of SEP[29]. Our recent micro briefing publication (see response to Question 5) co-authored with the Coalition for Racial Equalities and Rights (CRER)[30] makes clear how racism and discrimination are the key determinants of long-standing socioeconomic and health inequalities (including higher rates of chronic disease and COVID-19 risk factors such as cardiovascular disease, obesity and diabetes) experienced by some BME groups[31]. These pre-pandemic inequalities endured by some BME groups have driven the disproportionate COVID-19 infections, mortality and morbidity experienced by this group through a variety of mechanisms.

There is growing consensus that racism and discrimination can be regarded as the 'causes of the causes' behind the adverse impacts of COVID-19 on some BME populations. Dismantling racism is essential to achieving health equity. Racism is a fundamental determinant of health and a systemic problem which demands structural interventions and reforms. Failure to do so will hinder equitable pandemic recovery efforts and will exacerbate the health and social inequalities evidenced among some BME communities.

Differences in the economic impact of the pandemic are important to understand as they manifest themselves in health inequality impacts. A report published by the STUC (April 2021) detailed where the main economic impacts of COVID-19 had been felt – and which groups had been shielded from

them. The report stated that the impact was felt unevenly along social lines such as class, race, age, disability and gender, issues discussed further below. All of which will have an ongoing impact on inequality in Scotland[32].

Prior to the pandemic, it was known that disabled people across Scotland and the UK were more likely to face multiple disadvantage and less likely to have access to affordable, safe and secure housing than non-disabled people[33]. During the pandemic, disabled people were more vulnerable to COVID-19 and people with learning disabilities experienced worse health outcomes[34]. Disabled people were more likely to be socially isolated, digitally excluded and food insecure during the pandemic and face additional employment barriers before and during the pandemic[21].

The pandemic and related lockdowns have also adversely impacted on children and young people, with evidence making clear that families already experiencing poverty and disadvantage being disproportionately impacted [35;36;37]. Migrant families in Glasgow were particularly vulnerable to the economic impact of the pandemic given higher pre-existing levels of poverty, insecure employment, and a lack of access to social security and opportunities for social integration[38]. Rising financial and fuel poverty and food insecurity; digital exclusion from online learning; and statutory and third sector support service disruption have been the key mechanisms through which disadvantaged children and young people have been disproportionately impacted and inequalities further exacerbated. The physical and mental health of children and young people have also been significantly affected due to lack of social interactions, routine and support of school, closure of out of school activities, interruptions to learning and education and safe and accessible places to play and socialise within their communities[36;39;40].

It is well established that the health and wellbeing of children and young people is strongly influenced by their material circumstances, particularly the income level of their household. While official statistics do not yet provide estimates of child poverty after the onset of the pandemic, other indicators suggest that unemployment, the inadequacy of social security, and the rising cost of living, have all contributed to an increase in child poverty.[41;42] More families in Scotland are now reliant on social security in the form of Universal Credit (UC) than before the pandemic[43].

The extensive inequalities in the experience of mental ill health and mental health outcomes associated with gender, age, socioeconomic status, and ethnicity has also been further exacerbated by COVID-19. There are signs of a growing inequality between children and young people and the adult population in accessing an appropriate intervention at a sufficiently early stage. At the end of December 2020, in the NHS Greater Glasgow and Clyde area, on average compared to adults, children and young people waited seven times longer for mental health treatment and fewer young people were seen within the 18 weeks target timeframe. Similar patterning was found across Scotland[21]. Recent data (quarter ending September 2021) shows while there has been improvement and a decrease in waiting times, children and young people are still waiting twice as long to access mental health treatment compared to adults: despite there being considerably fewer children and young people referred for treatment[44;45].

Another key issue impacting on health and contributing to gender inequalities is women's safety. We know that prior to the pandemic the number of sexual offences against women had doubled in Scotland over the past decade and that women make up the overwhelming majority of victims of domestic abuse. During the pandemic, for those experiencing domestic abuse, the combined impact of isolation, lack of safe childcare options and managing the risk of the virus has had a negative impact on mental health[21].

Food insecurity (defined as “limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways”) is one of the key pathways through which income inequality is translated into inequalities in health outcomes. Growing trends in food insecurity were observed in Scotland prior to the COVID-19 pandemic, with emergency food aid provision increasing in response to need across the country[46]. However, food insecurity grew in both scale and intensity during the pandemic, with issues of access to and availability of food adding to the impact of economic hardship on household food insecurity[47;48]. Exposure to food insecurity was unequally distributed across the population during the pandemic, with households with families (particularly lone parents and low-income families), BME communities, and adults with disabilities experiencing particularly high levels of food insecurity. Food sector workers also reported much higher levels of food insecurity than the general population[48].

The third sector played a pivotal role throughout the pandemic demonstrating speed and agility in responding to the quickly unfolding crisis[49]. An online directory, Glasgow Helps Directory, was set up early in the pandemic, along with a helpline, so that people could search and connect to the services they needed. With hundreds of charities and community groups changing their service delivery in response to the pandemic and lockdowns, this allowed members of the public to find an appropriate service, whether for help with food, prescriptions delivery, mental health support or financial advice.

In terms of food, the most immediate need identified by both the third sector and the funding organisations was food provision. Having an established community food network (Glasgow Community Food Network[50]) in Glasgow aided the speed and coordination of the community food sector’s response to the pandemic. Further, it established the Food For Good Glasgow coalition with other partners to support community organisations to address the increased need for emergency food services to food-insecure residents. The Glasgow Community Food Network has also shared the experiences and lessons learned from the pandemic in relation to addressing food poverty, with a key recommendation that a ‘cash first’ approach to addressing food poverty is the most effective approach and should be the standard approach across Scotland[51]. Furthermore, in Glasgow, Farmfoods vouchers were given to all families with children eligible for free school meals for the first eight weeks of restrictions.

Question 5. 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?

The pandemic period has also shown some positive examples of what can be achieved when policy prioritises health and focusses on the most vulnerable in our communities, as evidenced in our response.

During the COVID-19 pandemic, governments across the UK pursued ‘*everyone in’* strategies – aiming to end rough sleeping and make sure everyone had COVID safe accommodation through partnership with third sector and lived experience experts. These strategies were successful in significantly reducing rough sleeping[21].The Scottish Government provided new funding and updated legislation on homelessness and renting and re-convened the Homelessness and Rough Sleeping Action Group to provide recommendations on tackling homelessness during the pandemic, drawing on the experiences of front-line staff and people with experience of homelessness[52].

Across Scotland and the UK, the pandemic resulted in a remarkable voluntary sector response. After the first national lockdown was announced, statutory services suspended or reduced most of their services and community and voluntary organisations took the lead in mobilising resources. Local authorities, in Glasgow and South Lanarkshire[36;37] and across Scotland, streamlined their grant funding application processes and allowed voluntary organisations to repurpose their grants to meet the urgent needs of families. The ability to use grant funding flexibly was a fundamental enabler of the COVID-19 third sector response. Learning from the faster temporary grant funding measures and the flexibility adopted under the COVID-19 emergency response should be used to inform the development of a long-term approach to third sector funding.

This sector played an essential role in the COVID-19 response during lockdowns and are engaged in supporting recovery despite many already stretched organisations struggling with a lack of sustainable funding. Sustainable, long-term funding of the third sector is vital to address the long-term impacts of the pandemic and future crises[53]. Local cross-sector networks enabled a targeted, place-based service response that could be adapted to the specific needs of different communities.

This crisis has implications for every aspect of policy that impacts on children and young people's lives, particularly in relation to poverty. Potential policy actions to support families recover include the re-establishment of the COVID-19 universal credit uplift, an increase to the living wage and the implementation of a universal basic income[54]. As noted previously, involving people with lived experience of an issue, be that poverty, homelessness, drug misuse, mental health or food insecurity can help provide a grounded, bottom-up approach to solving such problems. The National Standards for Community Engagement should inform and guide work with communities[i].

Finally, a lack of data on some key issues hinders research and understanding. This is the case in relation to racial discrimination which is a recognised social determinant of physical and mental health and a driver of ethnic inequalities in health at a structural and individual level. However, there remains limited information about experiences of racial discrimination in the United Kingdom. The absence of systematic data on racial discrimination in research serves to dismiss the lived experience of people from a non-White or minority population and inhibits further understanding of the drivers of health inequalities. Nevertheless, collection of better and good quality data is only one aspect and action is required across the system to dismantle systemic racism and drive the development of equitable policy and services. Minority ethnic people and communities should be closely involved in any initiatives for improving ethnicity and racial discrimination recording and in the re-design of services[21].

GCPH has been supporting Glasgow City Council's COVID-19 Social Recovery Task Force since its inception at the outset of the pandemic. A rapid review of evidence was published which summarised emerging evidence of the disproportionate impacts of COVID-19 and the ways in which the pandemic was likely to exacerbate existing inequalities[55]. Building upon this initial platform a suite of COVID-19 'micro briefings' aimed at responding to live discussion, debate and decision making within the City's pandemic recovery efforts have been produced.

The micro briefings summarise extensive evidence concerning the disproportionate impacts of the pandemic upon population sub-groups, such as disabled people; women; BME groups; and children and young people. The micro briefings were written in collaboration with expert equalities agencies, which enabled the evidence reviews to have a local focus and relevance and to be supplemented with the insights, experiences and wisdom of the equalities agencies and their service users.

[i] https://www.voicescotland.org.uk/national-standards

Support for community wealth building approaches has gained momentum at national, regional and local levels over the course of COVID-19 pandemic. A small number of pilot schemes have received desk-based support from Scottish Government with the involvement of the Centre for Local Economic Strategies (CLES) with this expert involvement having supported recommendations move into action. The economic footprint of anchor organisations as employers, purchasers and owners of land and property continues to affect the local and regional economy of places, and of the fortunes of people living and working in these places. Progress to date must be built upon with consideration given as to how Scottish Government continues to support community wealth building approaches. Building collaborative, inclusive, sustainable and democratically controlled local and regional economies sits alongside the wellbeing economy agenda, as well as climate change and sustainability goals, and can contribute to narrowing income inequalities (particularly through the 'fair work and just labour markets' pillar.) Again, the forthcoming Scottish Government legislation focusing on community wealth building must provide permission for anchor organisations to act to further promote economic inclusion.

Question 8. What role should the statutory sector, third, independent and private sectors have in tackling health inequalities in the future?

While all these sectors may have important roles to play, it is important to emphasise that *on their own*, actions from these sectors will not narrow inequalities in society. Only governmental action to address the fundamental socioeconomic drivers of health inequalities will achieve that aim.

Specifically in relation to the statutory sector, it should engage authentically with communities, including those with protected characteristics and those who are 'easy to ignore', enabling them to inform decisions that affect them, and to be involved in processes of change. For this to be adequate, resources (including time, staff and money) need to be invested in community engagement programmes and in training and developing staff in community engagement skills and approaches[56]. This involves engaging with community networks to understand (and address) their issues and the barriers that they face in trying to take positive action locally. The statutory sector should also ensure that statutory policies, strategies, and actions are aligned and complementary so that their implementation at local level can be optimised and that they adhere to widely accepted principles[18] in order to avoid exacerbating inequalities. Further, statutory sectors should facilitate networking and partnership opportunities that enable stakeholders (private, public and third sector) to collaborate to enable coherent and coordinated delivery of strategies and policies at local levels. In Glasgow, the Glasgow Food Policy Partnership is working to bring better alignment and coordination to the work to develop a more sustainable, fair, and healthy food system in Glasgow[57].

Sustainable, long-term funding of the third sector is vital to address the long-term impacts of the pandemic and tackle ongoing health and social inequalities. Streamlined and simplified grant funding application processes and flexibility adopted under the COVID-19 emergency response should be used to inform the development of a long-term approach to third sector funding.

Finally, all organisations that employ, purchase, and own buildings, land and/or property should consider their economic footprint and how their systems and policies promote economic inclusion and community wealth.

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