Glasgow Centre for Population Health

Mobilising People to Protect Health

Challenges in Population Health and Health Inequalities in Contemporary Scotland

February 2024

Preface

Glasgow Centre for Population Health is a partnership between NHS Greater Glasgow and Clyde, Glasgow City Council and the University of Glasgow, which is largely funded on an annual basis by the Scottish Government. The Centre, created in 2004, has worked with partners to improve understanding and awareness of the patterns and causes of the problematic population health outcomes in Glasgow and more widely in Scotland – including the unusually large health inequalities north of the border.

The Centre is particularly known for work in describing the phenomenon of 'excess mortality' in Glasgow and Scotland, and for explaining its causes. More recently, the Centre has led on important work in identifying the highly adverse population health trends caused, in large part, by the austerity policies of the UK government adopted in the aftermath of the 2008 banking collapse and the ensuing 'great recession'.

Less well known, though perhaps even more important, has been the Centre's work in translating improved knowledge and understanding into practical measures which our partners have taken to address population health challenges. Current examples include our work in supporting the Glasgow City Food Plan, on sustainable transport and travel, on an inclusive economy in the Glasgow City Region, on various dimensions of equalities, and on assets-based approaches to health.

Towards the end of 2023, as the Centre was approaching its 20th anniversary, Scottish Government officials asked the staff at the Centre to provide a 'reflections paper', focused on how Scottish Government might, in the very challenging financial circumstances it was facing, seek to make some better impact on population health. The request was that, drawing on the accumulated learning of the Centre, the paper should provide reflections and insights that took meaningful account of the prevailing financial constraints.

Drawing on the work and expertise of the GCPH team, the paper was finalised in mid-February 2024 and shared with government, where it was received positively. It is reproduced and shared here unaltered.

Of course, there have been significant changes in the period since February 2024. Michael Matheson is no longer the Cabinet Secretary for Health and Social Care, having been replaced by Neil Gray. There is now less focus in Scottish Government on the idea of a 'national mission' on population health – which was a major focus of the reflections offered in our paper, and, in the opinion of GCPH, an important element of a viable response. There has, though, been welcome discussion within Government of a ten-year plan for population health, and more recently the discussion has been about a 'framework' rather than a plan – which is currently expected to be produced in the later Autumn. GCPH is pleased to know that our reflections and insights are informing this framework. The wider political landscape has also changed, with the election of a Labour Government at Westminster, and a large increase in the number of Labour MPs in Scotland.

With the approval of Scottish Government colleagues, we are now publishing our reflections paper, which we believe can usefully inform the wider discussion with partners around the current, adverse trends we are seeing in health and health inequalities in Glasgow and more widely across Scotland. These trends are not only distressing in terms of the human suffering which underlies them, but also concerning from the point of view of the future social and economic development of Scotland.

As you will read, our reflections paper was largely focused on mitigating the worst of the harm which is arising from the current and projected adverse trends in access to positive social determinants of health for the Scottish population. Reversing the current trends in population ill health and inequality will require a significant reprioritisation of the resources of our (by any standards wealthy) society. Such reprioritisation was seen in the decades following World War Two, and so it can be made to happen again – if enough people, with access to the relevant levers of power, understand the trends and feel motivated to change them. GCPH will continue to make this case and to work to this end, while working in an increasingly focused way with our partners on the immediate priority of maximising the beneficial impact of existing resources on population health needs in Glasgow and more widely.

Professor Chik Collins,

Director, Glasgow Centre for Population Health,

Summer 2024

This ‘reflections paper’ is being provided following a visit to the Glasgow Centre for Population Health (GCPH, the Centre)[1] by the Scottish Government’s former Cabinet Secretary for NHS Recovery, Health and Social Care, Michael Matheson, on Tuesday 10th October 2023. During that visit, Mr Matheson was presented with the recent adverse trends in population health – mortality rates have increased, and both life expectancy and healthy life expectancy are in decline. The worst trends have been seen for the least advantaged populations – meaning that inequalities are widening. In response, Mr Matheson stressed the need to ‘amplify communication’ to raise awareness of these developments in population health. He expressed the wish to explore with GCPH ideas for a ‘national mission’ in response. He also stressed the financial constraints facing Scottish Government, and the desire to identify areas for disinvestment.

Our paper addresses three main questions subsequently posed by Scottish Government colleagues in looking to progress this dialogue. The questions are challenging – reflecting the context in which they are posed, including the financial constraints facing government. ***We are sharing our reflections on what might be done taking cognisance of these constraints.***

Much of the learning of the GCPH is based on work conducted, and questions posed, in a significantly different and much less difficult fiscal context. However, our evidence-based understanding of the underlying causes of health and health inequalities, notably their social determinants, is essential and adaptable to the new and changed context and points towards actions that can help in confronting the current challenges.

We have been asked for a ‘reflections’ paper, and that is what we seek to provide – a contribution to what is intended to be a continuing dialogue, rather than a summary of all of the relevant research and previous recommendations. A key theme of our response is that we see strong merit in the idea of a national mission on population health and health inequalities, which we believe would be important – arguably essential – in providing the unifying coherence likely to be necessary to make progress in both the shorter and longer term.

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[1] Glasgow Centre for Population Health (GCPH) was established as a partnership between NHS Greater Glasgow and Clyde, Glasgow City Council and the University of Glasgow, with core funding from Scottish Government, in 2004. The main focus of the Centre has been to identify the patterns and causes of the problematic health outcomes in the city and the wider region, to build knowledge and understanding amongst relevant organisations and agencies – as well as the wider public – and to influence and support actions to improve population health and to reduce health inequalities.

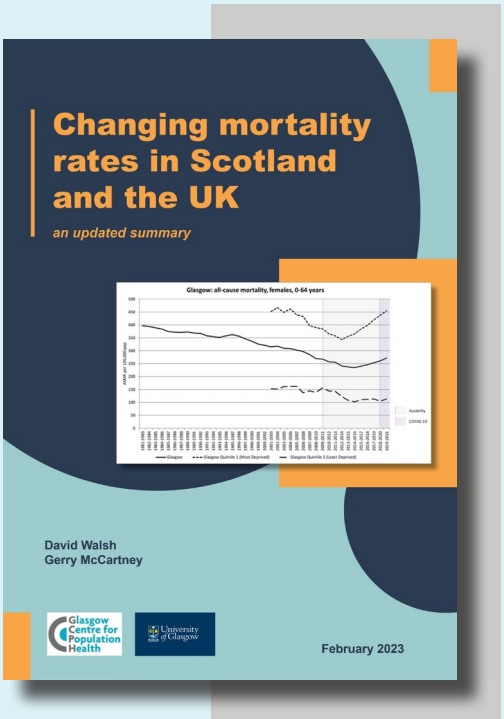
Question 1

Bearing in mind the evidence and insights GCPH has been gathering on health inequalities over the past 20 years, in the view of GCPH, how can such evidence be utilised to help inform what Scotland's priority (policy) areas of focus should be in future (i.e. in order to help us change the trajectory in life expectancy and poor health outcomes in Scotland)?

Generally improving population health reflects a wider pattern of economic and social development which supports the population to gain access to positive and improving 'social determinants of health' – in terms of income, assets (wealth), employment, housing, education, transport, food systems, environments, healthcare and so on, at various stages of the lifespan. Health inequalities reflect inequalities in access to these positive determinants for different social groups at different points in time (rather than behaviours, cultures, IQ or other factors which are still too often invoked as explanations and foci of action).

For roughly the first ten years of the Centre's existence, overall population health in Scotland and in Glasgow (as reflected in mortality rates) was continuing a decades-long trajectory of improvement, and absolute health inequalities were declining. The key concerns at that time were, firstly, that while there was continuing population health improvement, the rate of improvement was, with some few exceptions, slower than in other parts of the UK and Europe – even after accounting for the high deprivation in Glasgow and Scotland, and their experience of deindustrialisation. This was the challenge of 'excess mortality' seen in Glasgow and Scotland. The other main concern was that health inequalities here were higher than elsewhere, and that while absolute inequalities were declining, relative inequalities were widening[2].

As concerning as this picture was, by the time it was being satisfactorily understood – in 2016 – a changed health trajectory was being identified. This new trajectory, quite unprecedented in modern times, has seen the general population health improvement of previous decades slow and then move into reverse. This trend predates the Covid-19 pandemic by several years and, as GCPH research has shown, was set in motion by the overarching 'austerity' policy of the UK government post-2010. This policy led to very large cuts to local government spending, large changes to social security eligibility and declining benefit levels, and more general limitations on public spending – often involving real terms reductions. All of this led to an adverse and rapidly impactful shift in the pattern of economic and social development determining access to positive determinants of health for key groups in the population.



[2] Absolute inequalities refer to the size of the difference across the population, and relative inequalities refer to the ratio between the best and the worst in the population.

Indeed, only a response of that scale and at that macro level could have shifted the overall trajectory of population health in such a significant way.

That policy response has since been compounded by other factors – primarily Brexit, the Covid-19 pandemic, and the inflation-driven cost-of-living crisis. The cumulative outcome has been low economic growth/stagnation and highly constrained public spending in key areas, all impacting on access to positive social determinants of health, especially for vulnerable groups. This is broadly already recognised by Scottish Government – including in the Scottish Budget Statement in December 2023. Economic forecasts predict continuing slow growth, and the fiscal outlook – as also indicated in the recent Budget Statement – is arguably bleaker than for over a century. In other words, key macro-level factors adversely affecting access to positive social determinants of health will continue to impact the population – in particular, the least advantaged groups.

This sets the essential frame for thinking about responses to the current challenges.

Changing the current trajectory of population health and inequalities will require macro-level policies which change this adverse scenario. Currently, there seems little likelihood of the required policy measures at UK level being enacted in the short-medium term (say, 3-5 years) – regardless of the outcome of the 2024 general election. The issue then becomes what should be done with available powers and resources until such time as the wider economic and fiscal outlook will allow a return to an improving population health trajectory. It is also important to reflect on how what is done with these powers and resources can help to bring about that wider change in trajectory.

Firstly, the priority policy focus should be on maximising the protection of the population, and especially the most vulnerable groups and communities, from the continuing impacts of the adverse economic and fiscal context. This means seeking to prevent further deterioration, and supporting improvements, in access to key, positive social determinants of health – so that when 'recovery' can be supported, we will be seeking to recover from a better situation than would otherwise be the case.

Scottish Government deserves credit for some significant measures already implemented which are protecting the health of the population – the relative progressivity of the tax and social security system, including the Scottish Child Payment and the Scottish Welfare Fund, minimum unit pricing for alcohol, and other measures. All of these are making a difference. For example, child poverty in Glasgow is lower than in comparable English cities.

However, more needs to be done, and here there are various, interrelated, challenges. One is opposition to any further revenue raising through taxation, and another is the Scottish Government's own view that we are already "at the upper limit of the mitigation that can be provided" (Budget Statement, December 2023). There are also the difficulties likely to be faced when seeking to disinvest from some areas of spend in order to prioritise what is seen to be more important or impactful. How might these challenges be addressed?

First, we suggest that ***a major campaign of awareness-raising with all the relevant audiences, including the wider public, is required.*** The nature and significance of the current population health trends are still far from sufficiently widely understood. The relevant audiences are used to hearing that health in Scotland is generally behind other parts of the UK and Europe. This seems to be an impediment to the wider realisation of the stark and unprecedented current trend of declining population health, and the need for action to further mitigate it.

So, if the scope for the required action is to be increased, ***both the current trends and the key causes need to be made much more widely known and understood.*** It will be important to address the still too prominent view that poor health outcomes primarily reflect the lifestyle choices of disadvantaged groups, rather than the major disadvantages that they face. The case will need to be explicit and carefully made. This work of awareness-raising and consensus building aligns well with the idea of a meaningful national mission. ***We believe such a mission would be required to achieve sufficiently broad support for the kinds of measures needed to impact on the current adverse trajectory. It is doubtful that they can be achieved in a reasonable timescale without broad support and indeed a degree of mobilisation of the population.***

In what follows, we present our suggestions for action within the overarching approach of a national mission. This approach can also be a contributory factor towards a longer-term shift towards a pattern of economic and social development which can support the population to secure access to improving social determinants of health. It would necessarily focus national discussion and priority setting around the need to achieve that longer-term shift.

Question 2

Are there any examples of things/interventions, including any associated learning and robust evaluation, that have emerged from GCPH's recent or past research activities that have the potential to make meaningful impact in reducing health inequalities in the current context?

- ***How can we make use of such learning and evaluation, especially at national level, to help inform our policy priorities, in future?***
- ***Are there any examples of things which haven't worked well, or seen as much impact, as expected? How can we use this learning to inform areas where we can cut back investment?***
- ***What specific contribution, in addition to gathering insights and evidence, can GCPH provide to help us in this endeavour?***

The fundamental causes of health inequalities are inequalities in income, wealth and power. The prevailing trends in population health and health inequalities reflect the wider trends in the 'upward' redistribution of all three of these factors over an extended time period, and particularly over the period since 2010. These latter trends have been driven by austerity, as previously mentioned.

A longer-term strategy for population health which seeks to ***"make meaningful impact in reducing health inequalities"*** needs to address these trends in the distribution of income, wealth and power. This is well demonstrated by the experience of the decades following the second world war, when steadily declining inequalities in income, wealth and power were reflected in declining health inequalities.

Over the short-medium term, interventions that can have ***"meaningful impact"*** may be interventions that slow the rate at which health inequalities worsen. While such mitigatory interventions should not in any way be the limit of policy ambition, they need also to be seen as 'meaningful'.

Significant mitigatory impacts – and especially impacts which go beyond mitigation to actually reduce inequalities – are most likely to emerge from multiple interventions at different scales (from the national to the local) and across government portfolios. This reflects – and is needed to combat – the adverse impacts of the continuing economic and fiscal situation. This further supports the view that interventions will benefit from the unifying coherence provided by an explicit national mission.

a. Immediate priorities

Within the framework of a national mission, we highlight two immediate priorities.

- Intensified action on access to positive health determinants, especially for those facing the greatest poverty and discrimination.
- Supporting the development of a network of community-based organisations able to deliver support in a locally responsive manner.

Intensified action on access to positive health determinants, especially for those facing the greatest poverty and discrimination.

This points most clearly to ***income maximisation***, especially in relation to benefit uptake, but also in relation to wages. Income, as indicated, is a fundamental determinant of health and health inequalities (shaping access to most other positive determinants of health).

There remain very significant amounts of benefits unclaimed and greater prioritisation and efforts to render initiatives more effective are called for. GCPH work has highlighted the impact of NHS partnerships like Healthier, Wealthier Children and the Welfare Advice and Health Partnerships. These should continue to be scaled-up and further extended to reach at risk groups, including ethnic minorities and vulnerable groups accessing secondary services, such as mental health and community drug and alcohol services.

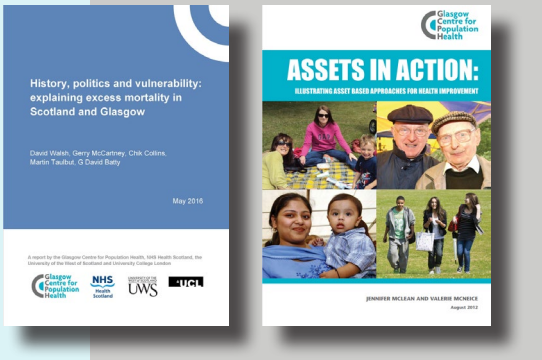
The further intensification of in-work poverty (a phenomenon which GCPH was highlighting over ten years ago) points to the need to increase wages for the low paid, for instance by increasing the numbers receiving the real Living Wage. Recent public sector wage settlements that have provided larger percentage increases for the lowest graded staff have been helping to reduce the income gap between lowest and highest paid and these should be continued in the coming rounds.

Also called for, especially for those for whom even maximised benefits remain seriously inadequate (and those who have issues with access to public funds), are further efforts to address food and fuel poverty, and to support those in – or entering – harmful debt. Key underlying issues here are usefully crystallised in a recent briefing from the Financial Fairness Trust. Benefits have declined from what were previously barely subsistence level – leaving many without the means to meet the most basic requirements (even food and home energy). Working age adults without children are particularly badly disadvantaged. Moreover, the majority of those on benefits receive even less than these inadequate levels (for example, due to paying back loans taken while awaiting their first payment, or because the rental payments are not fully covered).

Other candidates for further action include controlling rents (across the council, housing association and private rented sectors) and increasing access to affordable transport.

It is our view, based on our research and learning, and considering how we apply that in the current context, that much of this work can be effectively supported through community organisations, with strong roots in their localities – so long as they are adequately and reasonably securely resourced. For instance, in Glasgow and in areas across Scotland, important work is being done to improve local food systems, working with a range of third sector organisations, as demonstrated by the work of the Glasgow Food Policy Partnership. There is an opportunity here to make a short-term impact with relatively modest resourcing – for instance, building further on work that is currently being initiated in a range of places via the Scottish Government's Cash First programme.

A key insight from our work is that while poverty is the key cause of poor health outcomes in any population, the way in which poverty is ***experienced*** in any given place and at any given time can vary significantly – again pointing to the relevance of local interventions and the contexts in which they are implemented. Reflecting this, our past research indicated that Glasgow's substantial 'excess mortality', compared to Liverpool and Manchester, highlighted the particularly adverse way in which 'the same' poverty in Glasgow had been experienced – relative to those other cities. Thus, even where it is not possible 'to lift people out of poverty' in monetary terms, it is possible to reduce the harm arising from the way that poverty is experienced.



This can happen through a combination of 'material' and 'subjective' pathways. 'Material' pathways, in the current context, would involve widening access to various forms of assistance, including emergency support, access to affordable food, energy and clothing, and better insulation of homes, to reduce heating bills. 'Subjective' pathways would include support for community organisations to reduce social isolation, and to provide those dealing with adversity with more opportunities to experience a greater sense of agency/power in relation to their circumstances.

Supporting the development of a network of community-based organisations able to deliver support in a locally responsive manner.

In the preceding paragraphs, we have referred to the role that can be played by community organisations in addressing current challenges. This reflects GCPH learning on community dimensions of resilience conducted ten years ago, and which remains relevant. Moreover, the experience of the Covid-19 pandemic demonstrated further that when there is an understood need for action, then local communities and community organisations are willing and able to respond to local need – and indeed to do so with great energy and initiative, ahead of statutory bodies. The Children's Neighbourhoods Scotland research (in which GCPH was involved) which looked at *'The Impact of COVID-19 on Families, Children and Young People in Glasgow'* highlighted the speed and agility characterising the *"remarkable contribution of community and voluntary organisations"* in the early stages of the pandemic. However, more recently, many such organisations have been, and are being, adversely affected by ongoing budget cuts, especially at local authority level.

In creating and supporting a national mission around population health, government would invite and support local communities and community organisations to play a key role in developing local solutions and mitigating daily experiences of poverty and inequality.

The creation of such a network of community-led organisations has been proposed by Scottish Communities for Health & Wellbeing in their recent *Blueprint for a Healthier Scotland*. With relatively modest funding, this would provide increasing capacity and scope for responsiveness to deliver local solutions for locally identified priorities, and to rebalance power towards community organisations and grass roots health groups. This aligns well with GCPH work, indicating how communities that have control and influence over the decisions that affect them are likely to have more positive health and social outcomes than those whose voices are seldom heard.

A network of community organisations mobilised in this way could do work in relation to wider preventative action from within local communities – including in relation to the impacts of commercial determinants of health in the most disadvantaged communities. This could produce grassroots and community-led pressure to support some of the needed policy measures on commercial determinants – which we will go on to address further below.

b. Further priorities

GCPH's learning, applied to the challenges of the current context, suggests, beyond the immediate priorities indicated above, a further set of areas for action which can have a meaningful impact within the short-medium term. These are:

- Further and intensified action to address the damaging impacts of key commercial determinants of health contributing to poor and deteriorating health environments and outcomes.
- Seeking to accelerate initiatives to rebalance local and regional economies to prioritise health, wellbeing and equality, maximising the beneficial impacts of all forms of investment, particularly for the most disadvantaged groups.
- Further development of local social infrastructure – in the community and voluntary sector – to support community empowerment and participation more meaningfully.

Further and intensified action to address the damaging impacts of key commercial determinants of health contributing to poor and deteriorating health environments and outcomes.

To date, work to address the commercial determinants of health has required patience and persistence over extended time scales. However, with beneficial outcomes now clearly demonstrated (especially on alcohol and tobacco), there is arguably an increased mandate to work to shorter time scales and in relation to a wider range of determinants (gambling, vaping, ultra-processed food, sugar, air pollution, private sector housing rents, digital media).

There is abundant evidence of the harm being done by these commercial determinants. The challenge will be to effectively mobilise that evidence, as part of a national mission which can effectively counter the inevitable opposition from the commercial interests involved.

While the ensuing 'campaigns' are likely to be time consuming for policy makers, they need not be expensive in design and implementation terms, and their population health impacts – including in relation to inequalities – are likely to be significant. Clearly, the campaigns would need to be carefully planned (the national public health agency will be well placed to take a lead role) and the required legislation effectively implemented to achieve impacts within the envisaged timescales (3-5 years maximum).

In designing the campaigns, consideration should be given to opportunities to mobilise grassroots support and pressure for change – especially from within the local communities worst impacted by the harm done by commercial determinants of health. Our work focused on building knowledge and improving approaches to engage, enable and empower communities to be the focus of, and mechanism for, appropriate and relevant change could support action in ensuring community voice and lived experience are integral to the campaigns.

Seeking to accelerate initiatives to rebalance local and regional economies to prioritise health, wellbeing, and equality, maximising the beneficial impacts of all forms of investment, particularly for the most disadvantaged groups.

The National Strategy for Economic Transformation and associated National Performance Framework set out Scottish Government's commitment to creating a wellbeing economy – looking beyond traditional measures of prosperity to prioritise population wellbeing and environmental sustainability. Further, there is national support for mobilising 'anchor institutions' – public sector bodies, including Health Boards and local authorities, with assets and spending which have the potential to further the welfare of the people they employ and the communities they serve – through 'community wealth building' (CWB) approaches. Such approaches seek to support the development of local enterprises (co-operatives, social enterprises, charities and small businesses) which retain and build wealth in localities and are more responsive and accountable to local populations. Evidence from North-West England, where these approaches have been adopted in policy and embedded in practice, has indicated the potential to return significant health benefits.

The mutually reinforcing relationship between an inclusive economy and a population in better and more equal health is increasingly well understood. Investment that can be made in the creation of such an economy (for example through housing retrofit) can be viewed as having strong potential to generate cost saving in the medium to longer term. However, care must be taken to bring clarity to a somewhat 'busy' policy landscape that includes wellbeing economy, inclusive growth, community wealth building, and 'doughnut economics'.

In the short term, it is advisable that Scottish Government further seeks to create conditions that further motivate those who can drive these agendas – including public, private and third sector employers, trade unions, suppliers and developers able to deliver community benefit, and wider community-based organisations – to consider how their 'business-as-usual' activities affect local and regional economies and to implement changes. While much is currently in place in terms of fair employment, and progressive procurement, the other pillars of CWB[3] would provide a focus for future efforts. For example, the pillar concerned with plural (or shared) ownership of the economy

[3] The other pillars being plural ownership of the economy, making financial power work for local places, and socially productive use of land and property.

seeks to promote locally-owned and socially-minded enterprises. Encouraging more diverse models of enterprise ownership will enable wealth created by communities to be held by them, rather than flowing outwards into the pockets of distant shareholders.

Anchor organisations should also be supported to ensure that their practices mitigate against both worsening population health outcomes and widening inequalities. At their best, anchors can contribute to growing financially generative local and regional economies, that affect the income, wealth, and power of the most disadvantaged.

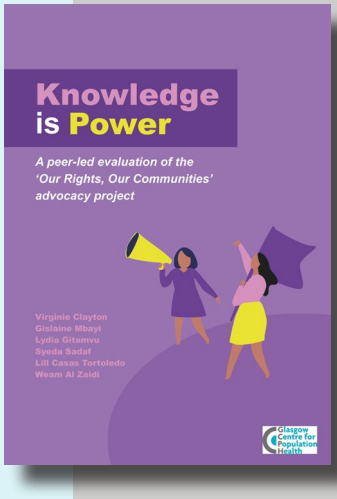
GCPH keenly awaits the Community Wealth Building (Scotland) Bill and anticipates that Scottish Government itself will be an exemplar for others in its own implementation of the CWB approach.

Can progress in Scotland through these developing economic models be accelerated without significant additional resourcing? ***Clearer framing of the role and significance of alternative economic approaches within an explicit national mission focused on addressing the current and projected population health (and related environmental) challenges would be likely to support motivation.*** Currently, there remains a risk of organisations 'satisficing' in relation to Scottish Government expectations – that is, being seen to do 'enough' to meet requirements in a context where organisations will already be dealing with other, competing, and often urgent, priorities and demands in a very challenging context. Thus, it would make good sense to strengthen collective purpose and also sense of agency, maximising the scope for creative implementation based on understanding local possibilities, and to give prominence to recognition and reward for those who actively embrace the approach and achieve desired outcomes.

Further development of local social infrastructure – in the community and voluntary sector – to support more meaningful community empowerment and participation.

Our learning suggests that prioritising support for the further development of social infrastructure in the community and voluntary sector should be maintained for purposes beyond the immediate delivery of mitigatory interventions (as described above). Such support will align with the rebalancing of the economy towards Community Wealth Building, but it would also link well to a strategy supporting grassroots pressure for action on the commercial determinants of health, which have the most significant impacts in our poorest communities, and for action on inequities in the healthcare system.

In terms of fundamental determinants of health, the key focus here is on supporting the opportunity for individuals and communities to have greater power and agency in relation to protecting and improving access to positive determinants of health, especially within the most disadvantaged parts of society. While there has been a great deal of discussion around 'empowerment' in recent decades, the prevailing health trends reflect the diminution in opportunities for individuals and groups to exercise power in our society. Action to address this would require investment in community development and community-led approaches. It would also require implementation of models of community development most likely to achieve the desired outcome – a greater reality of meaningful power and agency amongst disadvantaged groups.



The previously mentioned GCPH work on the phenomenon of 'excess mortality' in Glasgow, and our work on 'asset-based approaches', indicates that in places where local populations mobilise to exercise power in shaping their own lives, there are protective effects arising from the sense of agency and community which is produced. Here, consideration would be given to the balance in any model of community development between 'working in partnership' with statutory bodies and 'exercising voice' on behalf of the communities of place and of interest whose needs and interests need to be expressed publicly.

Equity in Healthcare and Climate Change

Before proceeding to the discussion of potential for disinvestment, we highlight two further considerations. Firstly, the well-recognised and enduring inequity in the healthcare system itself is an additional driver of health inequalities. This is not an area in which GCPH has sufficient current expertise to comment in detail and make specific suggestions, but it is apparent that in the current context of strained healthcare delivery it is increasingly vital to work to ensure that universal services meet individual and population needs more equitably.

Secondly, in the context of the immediate economic, fiscal, health and other challenges we are facing, we must not lose sight of the need to focus increasingly on climate change mitigation and adaptation. As we know climate change impacts health and the most disadvantaged are likely to be the most negatively affected. So, how we adapt and mitigate climate change, including changing our transport systems, housing and energy provision becomes increasingly important for health and health inequalities. There are opportunities if this is done well to have multiple co-benefits, including lower carbon emissions, reduced pollution, more liveable communities, reduced transport inequalities, greater physical activity, and more. This change needs to be managed in ways that do not increase inequalities and indeed reduces them.

c. Things that haven't worked so well and potential for disinvestment

The question about things that have not worked so well has been extensively considered by health inequalities researchers in the past and reported to government – including in the 2013 *Health Inequalities Policy review for the Scottish Ministerial Task Force on Health Inequalities* produced by NHS Health Scotland. That document, drawing on earlier work by Professor Sally McIntyre, provided a concise summary (p.42) of the characteristics of policies likely to be more and less effective in reducing health inequalities, as detailed below.

Characteristics of policies more likely to be effective in reducing inequalities in health:

- Structural changes in the environment: (e.g. area-wide traffic-calming schemes, separation of pedestrians and vehicles, child-resistant containers, installation of smoke alarms, installing affordable heating in damp, cold houses).
- Legislative and regulatory controls (e.g. drink-driving legislation, lower speed limits, seat belt legislation, child restraint loan schemes and legislation, house-building standards, vitamin and folate supplementation of foods).
- Fiscal policies (e.g. increase price of tobacco and alcohol products).
- Income support (e.g. tax and benefit systems, professional welfare rights advice in healthcare settings).
- Reducing price barriers (e.g. free prescriptions, school meals, fruit and milk, smoking cessation therapies, eye tests).
- Improving accessibility of services (e.g. location and accessibility of primary healthcare and other core services, improving transport links, affordable healthy food).
- Prioritising disadvantaged groups (e.g. multiply deprived families and communities, the unemployed, fuel poor, rough sleepers and the homeless).
- Offering intensive support (e.g. systematic, tailored and intensive approaches involving face-to-face or group work, home visiting, good quality preschool day care).
- Starting young (e.g. pre- and postnatal support and interventions, home visiting in infancy, preschool day care).

Characteristics of interventions less likely to be effective in reducing inequalities in health:

- Information-based campaigns (mass-media information campaigns).
- Written materials (pamphlets, food labelling).
- Campaigns reliant on people taking the initiative to opt in.
- Campaigns/messages designed for the whole population.
- Whole-school health education approaches (e.g. school-based anti-smoking and alcohol programmes).
- Approaches which involve significant price or other barriers.
- Housing or regeneration programmes that raise housing cost.

GCPH and others have for some years been presenting policy recommendations, and wider advocacy, formulated broadly along these lines. While this has clearly impacted on the policy understanding around population health, there has been limited success in getting recommendations and advocacy translated effectively into implementable policy, even in the rather better economic and fiscal circumstances prevailing 10 and 15 years ago. Research has identified a persistent tendency towards ‘lifestyle drift’ in health interventions, meaning that while policy rhetoric and broad ambition may be formulated in terms of acting on the underlying causes and determinants of health inequalities, delivery tends to gravitate towards more of a localised and

lifestyle orientation. All of this has in part reflected both the limited powers and resources of the Scottish Parliament, and also perceived constraints on the use of available powers.

An important point of clarification here is that we would not see the creation of a national mission on population health, and the awareness raising which would be part of that, as falling into the category of 'information-based campaigns' highlighted above – as being less likely to be effective in reducing health inequalities. Rather, we see the creation of a national mission as being an important step in creating the kind of support which will be required in both the shorter and longer-term for the range of actions that will need to be taken to mitigate the current adverse trends and ultimately to return to an improving trajectory of population health.

GCPH has not previously been specifically asked to conduct research or to present recommendations around potential areas for disinvestment. Work has been conducted specifically in the healthcare field to assess the relative value of different clinical interventions, but there has been less in the case of the wider, and arguably much more complex, field of social determinants of health. However, in looking for areas for disinvestment it makes sense to be guided by the broad characteristics of policies likely to be more or less effective – in line with the above recommendations.

For instance, as highlighted above, interventions which require individuals to opt-in to behaviours and positive lifestyle choices face formidable and entrenched obstacles in achieving reductions in health inequalities. Interventions which focus on regulation and which impact in terms of rebalancing systems and environments to make them more conducive to good health are more likely to be successful. Thus, interventions which seek to improve health literacy and cooking capabilities are more likely to be impactful in the context of co-ordinated, multi-partner local food plans which seek to increase access to healthy food for disadvantaged groups, and more widely to rebalance the local food system in favour of health, equality and sustainability. And as was indicated in the evaluation of Keep Well (which attempted to reduce health inequalities in Scotland by providing health checks to populations at risk of conditions such as heart disease): ***"Interventions which are most likely to be effective … are those which involve reductions in poverty and inequality, which regulate the environment (including tobacco, alcohol and food) and do not rely solely on individuals to act on advice or depend on their own resources (i.e. individual agency)".***

Work in Australia assessing cost effectiveness in preventative medicine similarly established the biggest impacts would come from taxation (tobacco, alcohol, unhealthy foods – key commercial determinants of health) and regulation (mandatory salt limits on processed food). A diet and exercise program for overweight people would, this research concluded, contribute only a tiny additional health gain to a package of obesity interventions which already included a 10% tax on unhealthy foods. The authors recommended the reallocation of funding to such best-practice prevention activities and away from those with poor cost-effectiveness, including inefficient practice in cardiovascular disease preventative treatment, prostate-specific antigen testing for prostate cancer, and aspirin for primary prevention of cardiovascular disease.

The Australian cost-effectiveness work reflects that the clearest advice from disinvestment research tends to come in relation to bio-medical treatments where 'what works' is focused on relatively simple causal pathways and treatments. However, the advice is less clear for disease conditions with more complex aetiologies that also take account of social and economic factors. Moreover, singular interventions that 'do not work', or are not as effective as desired, across the

population may in fact prove impactful either for some specific population groups (health education is efficacious for the higher socio-economic groups than for the lower ones) or when combined with other mitigative or preventative action focused on key determinants of health (dietary advice, for instance, when combined with higher income and improved local access to healthy ingredients). However, specific interventions are unlikely to be effective in the context of wider processes and forces which continue to generate the problem and are not being sufficiently dealt with (as is the case with the obesogenic environment).

The term ***superpolicies*** has been used to describe what is required to simultaneously address multiple dimensions of causality and so to be able to impact significantly on population health and health inequalities. Superpolicies are: *"policies that achieve positive outcomes across a wide range of areas beyond that which was the primary intention, and which do not have unintended negative outcomes."* An example of a superpolicy which would deliver a number of 'co-benefits' in relation to health, inequality and climate sustainability is free public transport – due to its potential to increase physical activity and improve respiratory health for the poorest in society, whilst addressing a structurally determined barrier to employment opportunity, as well as more generally reducing social isolation and exclusion. Of course, the investment required for such a superpolicy would be significant, however, it would eliminate the spending required to collect fares and manage ticketing, freeing up those resources for other things, and would be a key contributor to a Just Transition. In the longer term, these are the kinds of policies that will be required to return us to a trajectory of improvement in terms of population health and health inequalities.

Our reflections on the question of disinvestment clearly point to the need for more systematic work in this area. Health Improvement Scotland has, as part of its Evidence Directorate, the Scottish Intercollegiate Guidelines Network (SIGN), which develops and disseminates national clinical guidelines for effective practice based on current evidence. SIGN could potentially be deployed more extensively to identify ineffective spending in healthcare. Public Health Scotland, perhaps in partnership with the Improvement Service, could be asked to do similarly for broader social spending.

Implementation Gap?

Before concluding this section, we take an opportunity to comment on one prominent and recurring view as to why in general previous efforts to achieve ambitions in reducing health inequalities in Scotland have not delivered sufficiently. This view, stated in the report from the Health Foundation, Leave No-one Behind (January 2023), is that work in this area has been characterised by an 'implementation gap'.

Underlying this view is a set of assumptions:

- That what is required to reduce health inequalities has been sufficiently understood by policy makers.
- That the powers and resources required to address the challenges have been and continue to be available.
- That potentially efficacious policies have been adequately formulated such as to be ready for implementation.

Based on these assumptions, the argument is then that the relevant organisations and agencies should get on, in a more purposive way, with doing what they should already have been doing since the publication of the Christie Report in 2011. No new strategy, it is indicated, is required.

From the GCPH perspective, the above-mentioned assumptions are problematic, meaning that the implementation gap perspective is unlikely to be helpful – especially in the present circumstances – in guiding thought and action along the lines that are needed. The reasons for this are clear from the previous sections of this paper – not least when Scottish Government itself is indicating, in its recent budget statement, that it lacks the requisite powers and is not even able to mitigate every cut made by the UK government. We would instead endorse the view of the slightly earlier report of the Scottish Parliament's Health, Social Care and Sport Committee, Tackling Health Inequalities in Scotland (September 2022), which found that there was at that stage no coherent strategy, and we would argue that the elaboration of a national mission on population health would be a very good opportunity to produce one.

What specific contribution, in addition to gathering insights and evidence, can GCPH provide to help Scottish Government towards answering questions about disinvestment?

GCPH has over an extended period undertaken research and facilitated conversations around investment priorities under the heading of Participatory Budgeting (PB). These conversations deepened dialogue within and between organisations and communities, crystallising aspirations and priorities and providing useful direction as to the ways in which service delivery could be improved and potentially co-produced. Democratic processes were also enhanced. Building on this experience, an aim should be to ensure that when disinvestment decisions are made, they are informed by a combination of known research evidence and local knowledge of what is needed, works (or does not work), and takes account of knowledge, experience and values held locally.

The discussion of disinvestment will always be sensitive and difficult, and likely to generate defensive responses from within organisations and agencies which are likely to be affected. While such reactions are to a degree inevitable, ***the framing of the discussion of disinvestment within a clearly stated national mission is likely to increase the perceived legitimacy of the disinvestment discussion.*** Moreover, if the framing is effective, it should be possible not simply to reduce and better handle opposition to the discussion, but also to achieve a degree of active engagement with relevant organisations and agencies, and with the people working in them, who will often have significant insights to share regarding what works well and what does not, how things might be done differently and better, and so on.

Given that kind of framing, it is possible that GCPH, could play a further role, beyond that of gathering and presenting evidence. GCPH could, given its special position as a relatively autonomous partnership organisation, and the reputation and trust it has developed over 20 years, be supported to take the discussion of disinvestment into a dialogue with organisations and agencies – a dialogue which could prove to be more productive in getting good answers which could more readily be translated into practice.

Question 3

How can GCPH work more creatively/innovatively alongside other whole system partners to help us achieve our goal of improved population health?

As indicated previously, the goal of ***improved*** population health seems in all the prevailing circumstances to be at best a medium-long term aspiration – and one which will require some significant change in the wider trajectory of economic and social development which is shaping access to positive determinants of health.

In the meantime, it is vital that all partners have a clarity of understanding about where we are in population health terms and what we need broadly to be doing and prioritising in the short-medium and medium-longer terms. From the GCPH perspective, this kind of clarity is not always apparent in our dealings with key partners – including parts of Scottish Government itself, but also in dealing with other agencies. This is one important aspect of what we see as the creative and innovative work that GCPH is already doing with partners – including through our current seminar series, but also in senior level discussions with colleagues in Public Health Scotland, in Scottish Government and more locally (NHS GGC, Glasgow City Council, Glasgow City HSCP, higher education institutions and others). Yet, we are by no means 'there' with these discussions – and we hope this paper will support further progress.

This is one area where we believe we can build on current activity in working with partners. That is, in helping to achieve and sustain a clarity of understanding and perspective to frame and orientate collaborative efforts within what we hope will become a national mission. GCPH could play a key role in establishing and supporting a working group which would be charged with formulating the broad terms of a national mission. Such a group would be composed of 'whole system partners', but it could be broadened at the early stages to include a range of voices from different levels and scales of activity, including the voluntary and community sector. The work of the group would aim, amongst other things, to bring coherence and purpose to the work of the relevant organisations and agencies, and to formulate key themes and terminology (including how best to represent the challenges in ways which mobilise positive motivation and hope for future betterment).

GCPH would be able to play an important role in the communications and dissemination of the national mission, including to the wider public – using its well-established reputation and reach.

GCPH also has a great deal of experience in working with partners to implement and evaluate initiatives and interventions and could look to scale up capacity in order to be able to do this in support of the national mission – in 'responsive mode'.

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