Commission on Health Inequalities

Report for the Scottish Labour Party

October 2015

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Foreword

Inequalities in the distribution of income, wealth, and power manifest most obviously in how long people live and how healthy and well their lives are lived. Health inequalities are not just about health services, and not just about lifestyles or behaviours – but they are about justice.

Health inequalities are a manifestation of socioeconomic inequalities. Health inequalities are political inequalities. How we organise society creates inequalities. Therefore, how we organise society in the future can eliminate them. To do so means tackling injustice, unfairness and inequality. This report is an appeal to the Scottish Labour Party and other policy makers to take this challenge head on. Here we propose a transformative agenda for the Scottish Labour Party and for Scotland – where we shift from health inequalities to health equity.

In 2013 Neil Findlay MSP launched this policy review commission to consider the issue of health inequalities. Not with a remit of producing another description of the nature of the problem, but rather to help wider understanding of health inequalities while also contributing to, and helping shape the debate and discourse. Critically, Neil Findlay was clear from the outset that this review should make firm policy recommendations and not simply be another 'talking shop'.

During the course of this review we heard from a wide array of voices. We received evidence from professional's working in communities bearing the brunt of health inequality, from experts and organisations who sat on our Steering Group (Appendix 1) and from nearly 40 individuals and organisations who responded to our consultation process (Appendix 2). We also gathered evidence through the application of Freedom of Information (FOI) legislation, where we asked each Scottish Health Board and Local Authority to provide information outlining their activities to tackle health inequalities.

However all this evidence from the health service, local government, trade unions, and the third sector has been bolstered by the evidence we heard in community engagement consultation events. The testimonies we heard from people working tirelessly and heroically in their communities (both geographic communities and communities of common interest) powerfully painted a graphic picture of the day to day miserable reality of poverty and inequality and the causes and effects of the (often inadequate) policy and resource response to health inequalities.

The following five sections attempt to capture the views that we heard during this policy review. Taking a holistic approach the four sections make clear that tackling health inequality can only happen if a cross-portfolio and coordinated approach is taken.

Dr David Conway, Chair of Commission on Health Inequalities

Declaration

We believe that health inequalities are an infringement on our human rights.

Long established human rights principles are pertinent to policies in this area (Balakrishnan and Heintz, 2010), particularly:

- Obligation for governments to progressively realise social and economic and health rights
- Principle of non-discrimination and equality, including obligation for governments to take targeted measures to secure substantive equality
- Principle that governments, even in the face of public revenue limitation, must use the maximum available resources to fulfil economic and social rights

Executive Summary

This report proposes a breadth of priority areas for policy development necessary to tackle health inequalities in Scotland. We have purposely not attempted to fully cost these proposals due to the wide range and diverse nature of the policy proposals. Nevertheless, we are clear that solving and mitigating against unequal health outcomes means asking difficult questions over how we raise funds and how thereafter we allocate services. We believe that tackling health inequality necessitates the political priorities and choices taken by the Scottish Parliament having to change and become more focused on tackling this national shame.

Here we briefly set out as bullet points our proposed recommendations for action to tackle health inequalities in Scotland. In focusing on action we debunk the myth that there are no devolved powers or levers available to take on this huge challenge that we face in Scotland, albeit there are some recommendations particularly around welfare that we acknowledge require change from Westminster. Additional detail and explanation behind the recommendations can be found within the body of our report.

1 Health Inequality in Scotland

- Ensure genuine community participation in health inequalities discourse and policy development at all levels.
- Create and harness "the political and institutional will" to tackle health inequalities.

2 Increase and Stabilise Earnings, Employment and Social Security

- Full employment should become a political priority.
- Ensure that agency workers are given parity with full-time employees.
- Ensure that the Government, and no other public authority, uses the so-called "Swedish Derogation" opt-out, which enables employers not to pay agency workers the same rate as full time employees.
- Using procurement we should ban the use of umbrella companies on Public construction projects to ensure pay and conditions protection for workers.
- Use the buying power of all Scottish public authorities, through procurement (est. £10-£11billion per annum) to ensure that every contractor paid by the public purse pays their workforce at least the living wage. This should be a new 'Scottish Real Living Wage', which would ensure the real value of the living wage is retained in Scotland by calculating how much more should be paid to incorporate the value of lost tax credits. We should also take on any European Union challenge to the introduction of a living wage for all (including contracts).
- Ensure the 'Scottish Real Living Wage' is paid in the Social Care sector. This will directly improve the health of care workers, and ultimately the recipients of care services.
- Use procurement to ensure no company contracted to provide public works, goods or services employ their workers on zero-hour contracts.

- Use procurement to prevent any company found to have blacklisted workers/ trade unionists from getting public contracts.
- Encourage all public authorities to employ people on full-time permanent contracts and discourage them from employing people on temporary, insecure contracts and hiring from agencies and bank and locum lists.
- Encourage Collective Bargaining Processes.
- Ensure all Fair Work Convention recommendations are implemented.
- Establish a Scottish Health & Safety Executive.
- We welcome and support the Scottish Government decision to scrap fees for employee tribunals
- Prioritise help to young people neither in employment, education or training.
- Upgrade the skills of those out of work but in a way that ensures a genuine increase in skills, which match the skills deficit in Scotland.
- Redesign the work programme, coming to Scotland via the new powers as recommended by the Smith Commission, in a way that is humane and reflects local needs and circumstance – based on evidence and which seeks to achieve a genuine increase in skills. A review of providers should be undertaken – considering whether the private sector is most appropriate and cost-effective.
- Have an employment strategy that focuses on job creation and seek to develop an evidence based industrial strategy for Scotland.
- Increase the number of active advice shops, which offers an income maximisation service, in each local authority area.
- Raise the levels of Social Security payments to a level conducive to the minimum income for healthy living.
- Abolish the cruel sanctions regime.
- Review all employment and welfare policies devolved in the Scotland Bill and ensure that they are used to maximum potential to reduce health inequalities.

3 Strengthen Local Government and Communities

- Fully realise the potential of local government and communities to tackle health inequalities
- Reform the regressive Council Tax and consider options for fairer local taxation.
- Lift the council tax freeze.
- Strengthen local democracy and devolve power to local authorities and communities.
- Apply a proportionate universalism approach by allocating resources to where they are needed most.
- Create a network of Community Hubs that provide services under one roof creating a coordinated community resource.
- Increase active community engagement and participation
- Enhance the physical environment through more community control and influence.

- Support sustained active and affordable transport infrastructure
- Make best use of sports and recreational facilities by making them affordable and accessible for all – including widening sport/recreation access to those from the most deprived communities.
- Transform the quality and quantity of social housing across Scotland.
- Redefine what we mean by Social Housing and ensure that social housing is not merely seen as being for people on low incomes or with additional needs.
- Build a minimum of 10,000 new social houses each year.
- Introduce better regulation of private rented sector including effective rent controls and consider extending the Housing Quality Standards to the Private Sector.
- Design early years education that is fully cognisant of its essential role in tackle health inequalities.
- Free childcare at the point of use
- Support for schools to help pupils from disadvantaged backgrounds, for example enabling all pupils from all socio-economic backgrounds can go on school trips.
- Extend breakfast clubs and free healthy meals to nursery schools.
- Ensure schools strive to develop social, emotional, health and wellbeing agendas as a foundation for learning.
- Reverse Cuts and boost spending at Further Education colleges.
- Develop national and local plans to help tackle fuel poverty
- Better utilise the role of Councils as employers – as the gold standard for pay and conditions.

4 Health Services and Public Health

- Provide better access to equitable high quality holistic care for those from disadvantaged communities.
- NHS to influence socioeconomic determinants of health inequalities as an employer (the largest in Scotland) and through procurement.
- Democratise the NHS and join up health, social and other public services. Fundamentally review health board and public service structures.
- Tackle the Mental Health Crisis in Scotland - We strongly recommend that mental health services are prioritised and invested in as a matter of urgency.
- Rethink how we support people with problem drug use.
- Create an advocacy service focused on supporting people from the poorest backgrounds to help navigate the complex landscape of health and social care.
- Take on the public health challenges through a socioeconomic health inequalities priority focus.

5 National level Recommendations: Action to Prioritise Health Inequalities – A Call for Leadership

- Tackling health inequalities must become an explicit Scottish Government priority.
- Create national targets for reducing health inequalities.
- Create a Cross-portfolio Cabinet Secretary for Health Equity.
- Create statutory Guidance that ensures better and more effective Coordination of activity between government, local authorities, health boards and communities.
- Undertake health inequalities impact assessment on all policy proposals by every public authority.
- Review and improve resource allocation to meet needs based on socioeconomic circumstances of communities. Charge Scotland's special health board (National Services Scotland, Health Scotland) to provide evidence, data, evaluation and implementation support for equity measures that will help identify where allocation of resources. Ensure that these "health boards" take a greater role in wider public service support – particularly local authorities.

Section 1:

Health Inequality in Scotland

"People with higher socioeconomic position in society have a greater array of life chances and more opportunities to lead a flourishing life. They also have better health. The two are linked: the more favoured people are, socially and economically, the better their health. This link between social conditions and health is not a footnote to the 'real' concerns with health – health care and unhealthy behaviours – it should become the main focus." (Marmot, 2010)

Persistent health inequalities in Scotland are a disgrace and the national scandal in contemporary Scotland. It is our foremost national shame. Allowing so many people to die or become ill earlier than their neighbours and fellow Scots because of a simple accident of birth underpins our national ignominy in this area. But, perhaps the greatest shame is our collective sanctioning of health inequalities. We know both what causes and what will solve health inequality. As a society we comment and frown about how terrible unequal health outcomes are but we don't devise, and then put in place, the bold polices that we know could go some way towards tackling the biggest policy failure of our times.

Gerry McCartney from NHS Health Scotland encapsulated the stark reality of health inequalities in Scotland using a map of the Glasgow Subway. He showed how life expectancy is reduced by 2 years for males and 1.2 years for females for each station on the line between Jordanhill and Bridgeton (McCartney, 2012). McCartney illustrates how life expectancy starts at 61.9 years in Bridgeton and increases to 75.8 by the time it reaches Jordanhill. However, differentials of life expectancy can increase much more than that between different council wards in Glasgow and indeed elsewhere in other areas of Scotland. The recent Scottish Parliament Health Committee (SPHC) for example reported that:

"A boy born in Lenzie, East Dunbartonshire, can expect to live until he is 82. yet for a boy born only 8 miles away in Calton in the East End of Glasgow life expectancy may be as low as 54 years, a difference of 28 years or almost half as long again as his whole life." (SPHC, 2015)

Healthy life expectancy differentials also highlight the obvious unequal health outcomes between Scots. A Government paper in 2013 showed how In the most deprived areas, males spend 22.7 years 'not in good health', compared to 11.9 years in the least deprived areas. While females in the most deprived areas spend 26.1 years not in good health compared with 12.0 years in the least deprived areas.

Life-expectancy – depends on where you are born and live...

Boy born in Lenzie can expect to live to .....

84

Boy born in Calton can expect to live to .....

64

"League Tables" of highest and lowest life-expectancy in women and men in Scotland (2003-2007). How long children born in these areas can expect to live:

Female Life-Expectancy

	Area	Years
Highest 10	Fairmilehead	92
	Barnton and Cammo	90
	Monifieth West	90
	Dalkeith Rd	90
	Cramond	89
	Clashindarroch	89
	Ettrick, Yarrow and Yair	89
	Newmachar and Fintray	88
	Blackford	88
	Balmullo and Gauldry	88
Lowest 10	Ashgrove	72
	Drumry East	72
	Laurieston and Tradeston	72
	Craigneuk Wishaw	72
	Ibrox	72
	Govan and Linthouse	72
	Parkhead West and Barrowfield	72
	Raploch	72
	Pollok North and East	71
	Paisley Ferguslie	70

	Area	Years
Highest 10	Lhanbryde, Urquhart, Pitgavney and seaward	89
	Banchory-Devenick and Findon	89
	Fairmilehead	87
	Barnton and Cammo	86
	Baberton and Juniper Green	84
	St Andrews South West	84
	Braeside, Mannofield, Broomhill and Seafield North	84
	Braids	84
	Currie East	83
	Nairn Rural	83
Lowest 10	Gorbals and Hutchesontown	65
	Roystonhill, Blochairn, and Provanmill	64
	Blackhill and Barmulloch East	64
	Possil Park	64
	Calton, Gallowgate and Bridgeton	64
	North Barlanark and Easterhouse South	64
	Ibrox	64
	Gallowgate North and Bellgrove	64
	Greendykes and Niddrie Mains	61

Life Expectancy Data (2003-2007) – Intermediate Geography area. Scottish Neighbourhood Statistics http://www.sns.gov.uk/

Nelson Mandela told a rally in London in 2005 how, "Massive poverty and inequality are such terrible scourges of our times…that they have to rank alongside slavery and apartheid as social evils". Like slavery and apartheid inequality is man-made and hence can also, with the necessary political motivation, be unmade. We recognise that health inequalities are intimately associated with wider problems of poverty and wealth inequality and that an eradication of wealth inequality is necessary to fully deal with health inequalities. That should not mean that we stand idle in the meantime, there are many policies that we can introduce that would, at the very least mitigate, if not solve the wide health inequality that exists in Scotland today.

Developing, legislating and implementing policy, or a set of policies, that place health inequality at the forefront of the policy agenda is vital for the individual's effected but also for the wider community. Fairer and more equal countries are more content, happier and are more economically successful and productive. A point increasingly reiterated by a wide array of economists currently arguing against austerity. They recognise that health and wealth inequality is bad for the wider economy as well as for individuals. Tackling health inequalities makes social and economic sense and should be

prioritised with a coordinated, cross portfolio and focused approach. This is not just about helping the poor and disadvantaged. It's in everyone's interest and we need to make the political case for change.

Inequalities in health can manifest across many different communities and groups, however the most persistent, insidious and damaging inequalities are defined by the unfair and unequal distribution of socioeconomic factors – whether that is income, wealth, power, occupation, education, housing, or the collective level of deprivation within neighbourhoods. Inequalities manifest across society as a gradient – with the greatest burden falling on the poorest. But let us be clear they affect everyone, they hold all of society back, and they cost us dear: socially, economically and morally.

One point we wish to make clear is how tackling health inequalities is not simply a matter of focusing on health services. We contend throughout this review that to reduce the differentials in health outcomes necessitates a coordinated and cross-portfolio approach. Too often solutions are focused solely around the health service. If we are to confront and deal with health inequalities then an integrated approach across portfolio areas is required. Education, housing, employment, welfare and local government, as well as health, are some, but not all, of the policy areas that must respond to and be part of the complex answer we require to deal with unequal health outcomes. The Child Poverty Action Group (CPAG) illustrate in a submission to this review how different policy areas impact on health outcomes:

"No strategy to improve universal health outcomes can be successful in the long term while there are still children in Scotland living in families which struggle to heat their homes, provide nutritious food or ensure their child has access to safe recreational activities." (CPAG, 2014)

A point reiterated by South Lanarkshire Council who reminded us that health inequalities are caused by, amongst other things:

"A lack of affordable childcare and continuing high levels of family poverty impact on health, as do deteriorating employment and working conditions (low pay, job insecurity etc.), the increase of in-work poverty, the rise of food banks and fuel poverty, the shortage of affordable housing, and historically high levels of unemployment – especially youth unemployment – and of long term unemployment" (South Lanarkshire Council, 2014).

The British Medical Association (BMA) repeated this message telling us how:

"Policy levers for responding to health inequalities are out-with the realm of health policy and include employment, education, fiscal, housing and other welfare-related policies." (BMA, 2014)

Yet, health inequalities have been too often written off as a problem of individual behaviour. This is not to say that this does not contribute poor health. But behaviours are impacts, not causes, of wider inequalities. Therefore, we are clear that issues of alcohol and problem drug use and addiction, smoking and obesity are not the determinants but the manifestations of health inequality. It is the "causes of the causes" that we intend to focus on in our review and recommendations for action.

A broad consensus largely agrees that health inequality is not caused by individual behaviour. As Mandela alluded, inequality in any form is caused by wider structural forces, albeit developed and introduced by the active agency of those individuals involved in developing these structures and who create social structures in the first place. Deliberate policies over the past 25 years have led to worsening social and economic outcomes and rising inequality. An obvious example is the declining share of wages as the proportion of GDP at the same as there has been exponential wealth increases for the rich and super rich. As the economist Stewart Lansley told the Scottish Parliament in 2012:

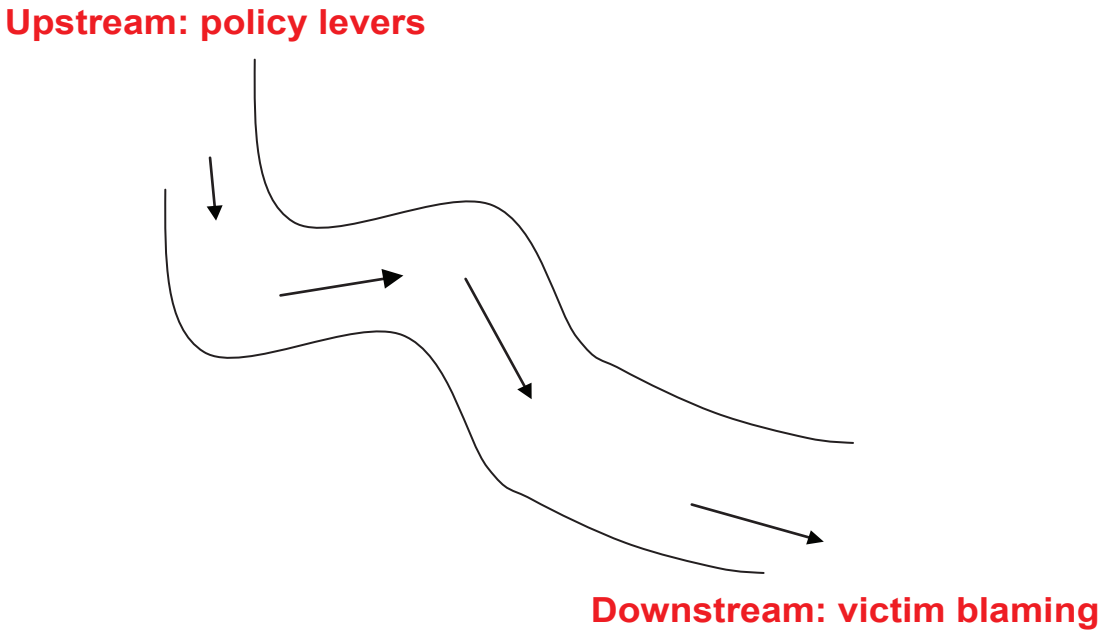
"In the 1950s and 1960s, the Share of output going to wages in the UK economy held relatively constant at 58 to 60 per cent. However, in the mid-1970s, it jumped to just over 64 per cent and since then it has been on a permanently downward slide and now stands at around 53 per cent….. Over the past 30 years, the wages of those in the 90th percentile, on the edge of the top 10 per cent, have been rising at roughly twice the rate of those in the middle of the wage distribution, whose own wages have been rising at roughly the double the rate of those at the bottom. Essentially, the bottom 60 per cent has been receiving a declining share of a smaller pool; in other words, the bulk of the fall in wages has fallen on them." (Lansley, 2012).

"If we always do what we've always done, we'll always get what we've always got." (Community Activist, 2015)

Failure of Public Policy

Recently in Scotland, analysis of health inequalities has been undertaken, reports written and task forces set up. Despite this apparent appearance of engaged activity there has been no difference made to reducing stubbornly persistent health inequalities. Moreover, public policy is too often guided by the 'solutions' that we know don't work i.e. a focus on individual behaviour is what all too often still directs the public policy direction.

This failure to reduce health inequalities raises several concerns. Prominent amongst them is how, despite the appearance of working towards reducing health inequalities, the issue has still not been sufficiently prioritised in political and governmental circles.



"We need to seriously move upstream to address the more fundamental causes and not focus on victim lifestyle focused victim blaming – to tackle the causes of the causes". (Community Activist, 2015)

Lacking at the moment is a cohesive and integrated approach applied across the Scottish Government, local authorities, health boards and, critically, with communities themselves as key partners in developing services at grass roots / community levels that respond to local needs. Therefore we recognise that tackling health inequality necessitates having the wherewithal to:

Currently, responding to local needs in a one size fits all basis is common practice. Evidence of current policy and spending responses reveal that communities and local areas often do not receive an allocation of resources appropriate to local need. Too often the principle of proportionate universalism is absent when allocating resource.

1.1 Create and harness "the political and institutional will" to tackle health inequalities and apply that 'will' in a much more effective and coordinated fashion

Our evidence has also found that people feel disconnected and not part of the decisions that impact on their lives and communities.

At a meeting we attended in North Ayrshire we heard stark evidence of what health

inequality meant for the people living and working there. They described a community with multiple issues that contribute to health inequality but identified "poverty as the root cause". They outlined how community workers observe the tangible humiliation and shame felt by the growing numbers of people compelled to source their food from food banks; where the gaunt and malnourished faces of mothers is common, particularly those who feed their children before feeding themselves; where too often people face continual barriers to accessing (diminishing) local services; where it's the community themselves setting up much needed services; where poor un-insulated housing is common and where the 'ghettoization' of once thriving social housing schemes is routine.

The impact on our young people is nothing short of tragic. The contributors to our meeting spoke of the difficulties facing them. How young people are ostracised and moved on by the police but with nowhere, and no recreational services, to go to; the minimal employment opportunities available to young people, where the work that is available is characterised by low pay, zero hours and insecurity; where welfare cuts have sapped the confidence of young people so affected by constant rejection from jobs (that don't exist) such that they give up looking and are sanctioned as a result; where stress and mental health issues "are going through the roof" yet mental health service provision for young people is abysmal (sometimes waiting 2 years for a psychiatric appointment) and suicide is increasing. The consequence is that people have a "greyness about them", "a deflated-ness", "a hopelessness" and "a helplessness".

A major failure in policy development thus far is the extraordinary lack of involvement in decision making with those from communities (both geographic and common interest communities) which bear the greatest burden of health inequalities. Somewhere along the line we have forgotten the necessity to do things with our communities. There is a well-meaning middle-class industry across Scotland, which perpetually analyses and discusses the issue in a vacuum. Conferences, events, discussion groups, committees rarely involve people from these real and suffering communities. Our experience in undertaking this commission, where we engaged with such communities in a relatively small scale, demonstrated the wealth of knowledge, experience, and insight which these communities hold, but all to often they do not get the opportunity to share their experience and knowledge. Our second recommendation is therefore to:

1.2 Ensure genuine community participation in the dialogue and policy development over health inequalities

Section 2

Earnings, Employment and Social Protection

Health inequality mirrors wealth inequality. Economic circumstances shape and impact the health and well-being and ultimately the life chances, life expectancy and healthy life expectancy of people. As NHS Health Scotland said in a consultation response to us:

"Inequalities are caused by a fundamental inequity in the distribution of money, power and resources. This has an impact on the opportunities for good quality work, education and housing etc. And in turn, these determinants shape individual experiences and health throughout life." (NHS Health Scotland, 2014)

Conversely, if countries actively intervene in the economic sphere to redistribute wealth and resources and use those additional funds to help create employment, invest in public services and in other areas such as good quality housing we know that health inequalities decrease. This was evidenced from the 1940's to 1970's when during a period of a more social democratic and interventionist government inequalities in health and income reduced. However, since the early 1980's, when there was a greater emphasis on the market, minimal government and reducing taxation levels (benefiting the wealthy the most) – we have seen wages, in proportion to GDP, reduce and exponential increases in wealth for the richest in society. This wealth and income inequality has corresponded with greater health inequalities (NHS, Health Scotland, 2015)

Therefore we would argue that we must:

2.1 Tackle health inequalities through aspiring for full employment that is secure, with fair pay terms and conditions

Good secure work that pays sufficiently is necessary for the well-being of individuals, families, and for a well-functioning society. Indeed, ensuring individuals enjoy adequate, earnings, have secure and satisfactory employment and social protection (if without work) are fundamental prerequisites to tackling health inequality. As the World Health Organisation (WHO) note:

"Employment and good-quality work are critically important to population health and health equity in several interrelated ways. Participation in, or exclusion from, the labour market determines a wide range of life chances, mainly through regular wages and salaries, social status and psychosocial well-being. Material deprivation from unemployment or low-paid work and feelings of unfair pay in organizations with high levels of wage disparity contribute to physical and mental ill health." (WHO, 2012)

The direct physical and mental health consequences of unemployment on individuals and families as well as at the community and at the macro-country level are well recognised (Dorling, 2009). On that basis we contend that striving for full employment with work that is good, productive, well-paid and secure is something we must aspire towards. The transformative Atlee Labour Government, in response to the social and economic catastrophe of the 1930's wrote in their 1945 election manifesto that:

"Full employment in any case, and if we need to keep firm public hands on industry in order to get jobs for all, very well. No more dole queues, in order to let the Czars of Big Business remain kings in their own castles. The price of so-called 'economic freedom' for the few is too high if it is bought at the cost of idleness and misery for millions". (Labour Party, 1945)

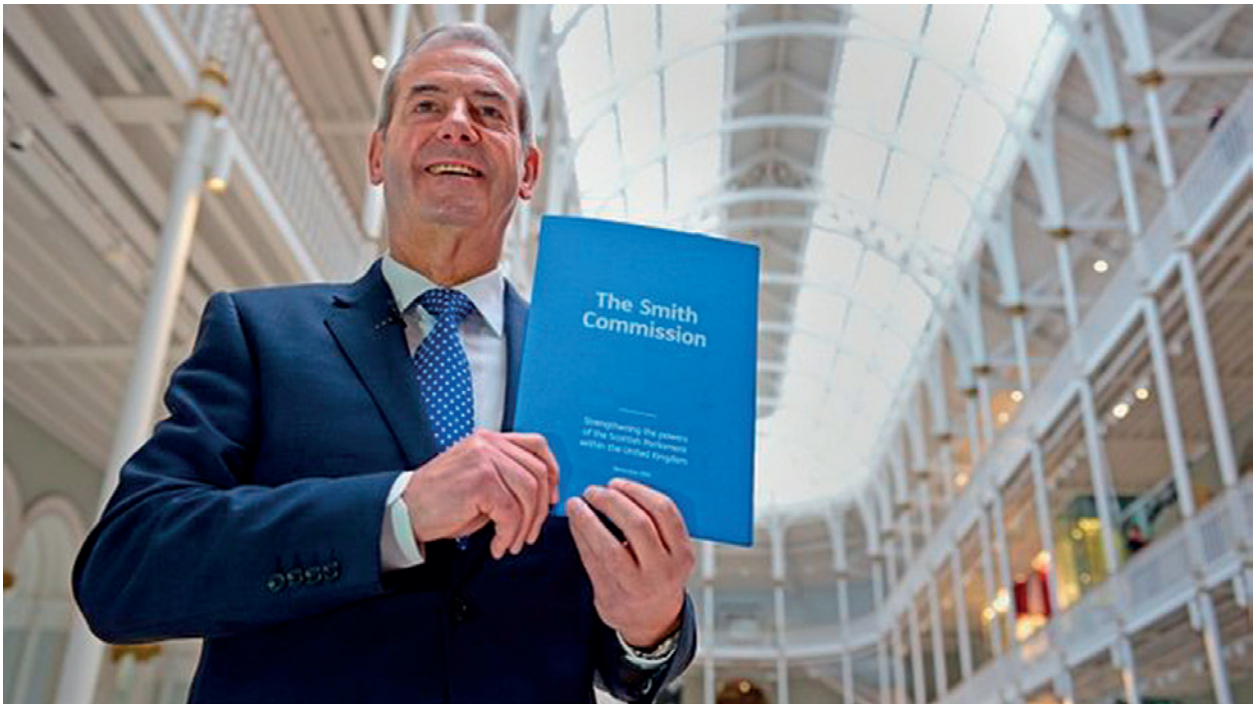
Achieving full employment today is an objective that too many contemporary policy-makers have neglected. Aspiring for full employment requires more active intervention in the economy, but such thinking has been frowned upon since the advancement of neo-liberal policy making and is often painted as unnecessary (as the markets are seen as ultimately best for progress) and inefficient (as markets are believed to be most efficient). Yet, we contend more active intervention in job creation is vital and agree with Professor Peter Donnelly from St Andrews University who responded to our consultation and stated:

"In terms of health inequalities and social exclusion having a job is hugely important. Research we did with young men involved in Glasgow gangs suggested that getting a job is disproportionately important in helping them change their lives." (Donnelly, 2014)

Greater intervention in the economy to achieve full and better employment is required in order to end the misery of millions across the UK, who are currently experiencing poverty and poor health outcomes as a result of unemployment. Therefore, there should be much greater focus on job creation as unemployment is driven by a lack of available work rather than a lack of skills. We argue that it is fair, just and beneficial to wider society and the individuals concerned if we have a society where all people who can be are in work. However, we also suggest that those in work must

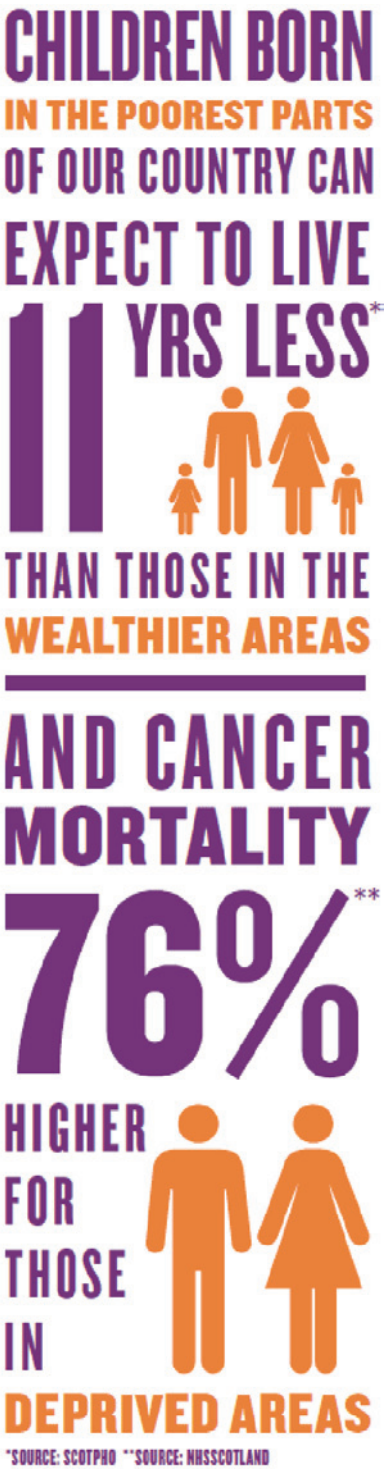
have better and fairer pay as we know a fairer and more equal society is a healthier and more content society.

Currently in-work poverty is far too common. In Scotland nearly 430,000 people earn less than the living wage. Addressing this necessitates people in Scotland being paid at least the 'Scottish Real Living Wage'. The Conservative plans for an increased minimum wage will correspond with a cut to tax credits, thus reducing the real value of the living wage. There should be a 'Scottish Real Living Wage' that is recalculated to ensure its real value is maintained, despite the cuts to tax credits, and ensure that there is a minimum income for healthy living.



At present employment law is not devolved. We recognise that there is debate currently taking place on whether employment law should be devolved with good reasons being given on both sides of that discussion. There are however actions that can still be done with the powers that we do have. For example any current and future Scottish Government could and should with the appropriate level of political will, use the buying power of all Scottish public authorities, through procurement (estimated at around £10-£11billion per annum in Scotland) to ensure that every contractor paid by the public purse pays their workforce at least the living wage. This would benefit approximately 39,000 people in Scotland each year (SPICE, 2015). The Scottish Government should resist any challenge to this policy by the European Union on the basis that introducing the living wage would benefit our people and wider society.

Work in Scotland is also characterised by underemployment and insecurity, instability, zero-hours as well as low pay. Swathes of graduates are unable to find employment appropriate to their educational qualifications and unable to work as many hours as they would like with temporary and part-time contracts normal (sometimes people are only on contracts of 4 hours a week and are dependent on 'over-time'). This insecurity at work is epitomised by nearly 80,000 Scots (Scottish Affairs Select Committee, 2014) working on zero hours contracts where no work at all is guaranteed with people expected to work at very short notice, more often than not a rate of pay that is lower than the living wage. When people do not know how much they will earn from one week to the next and whether they will have enough to pay their rent, feed themselves and/or their families and pay the rest of their bills, it is inevitable their health will be affected.



In West Lothian we were told of workers made redundant by Vion and how they were re-employed elsewhere. The group we met told us how this has been deemed a success story but on closer inspection those redundant workers have had to take part-time, low income and zero hour work while other people have had to relocate in pursuit of employment. In short they described how many people in West Lothian, those who worked at Vion and others who worked elsewhere, are in work but still in poverty.
Work has to me made better, fairer and more secure. This requires laws to be passed by Westminster as well as at Holyrood, if employment law is eventually devolved.

However, again, in Scotland, we can use present guidance on procurement to drive change and improve working conditions, certainly at least in the public sector. This would ensure companies contracted by the Scottish Government treat their workers fairly. The Scottish Government asserts itself as being the Government of 'Fair Work'. If so it should use all its might, and every avenue open to it to apply this ambition in practice. This must mean encouraging and incentivising public authorities, including the Scottish Government itself, to employ people on secure contracts and significantly reduce the numbers of working people employed on zero-hours contracts and/or through agencies or bank lists.

For those that are employed through an agency the Scottish Government should ensure that agency workers are given parity with full time employees. The Government itself only recently stopped using the so-called "Swedish Derogation" opt-out, which enables

them and other employers not to pay agency workers the equivalent rate as full time employees when they have worked in the same employment for 12 weeks or more, as directed by European legislation. They must ensure that no other worker in any other Scottish public authority uses this opt-out.

Moreover, those companies who blacklist selfless workers who have raised health and safety concerns and bad employment practices should not get public contracts. Working people should be protected in the workplace and so must those fellow workers who speak out on their behalf. Procurement, again, should be used to prevent blacklisting companies from getting public contracts.

The Scottish Government must also make similar plans to the Welsh Government who are planning to outlaw the use of umbrella companies on its public projects (UCATT, 2015). This will stop exploitative and opportunist employers setting up new (umbrella) companies in order to pay workers less, whilst simultaneously costing the exchequer in reduced tax yields. These are the type of proactive policies that the Scottish Government has to pursue in order to make work more secure, fairer, better paid and ultimately healthier for working people.

Procurement is not the only instrument for accomplishing better terms and conditions in the workplace. The Scottish Government should also actively seek to organise and 'encourage' collective bargaining. In colleges and social care for example the Scottish Government could collectively drive up wages and conditions by bringing together employers, trade unions, local authorities and other relevant bodies to ensure staff and service users get a fair deal and to make work better, less stressful and healthier. In the Social Care sector particularly, using a collective bargaining approach could end the race to the bottom in standards, pay and working conditions; which would help improve the health of both care workers and indeed the recipients of care services who would undoubtedly receive a better service as a result. The Fair Work Convention could play a meaningful role in developing such good and best practice by encouraging a different model of industrial relations in Scotland. It must not be allowed to become simply a talking shop.

Work could also be made better and healthier by protecting workers from rogue employers and unsafe working conditions that are bad for the health of workers. The Tory Government has recklessly cut the resources to the Health and Safety Executive (HSE), indeed David Cameron infamously referred to health and safety as a "monster and albatross" round the necks of business and that his New Year resolution in 2012 "was to kill off the health and safety culture for good" (Independent 2012). We must challenge this thinking and enhance the protection of health and safety for people at

work. With that in mind we recommend establishing a Scottish HSE to set enforcement priorities, goals and objectives in Scotland and tackle the scandal that sees workers more likely to die at work in Scotland than anywhere else in the UK.

We welcome the decision by the Scottish Government to abolish fees for employment tribunals that was introduced by the Tory/Liberal Government. Charging fees for workers who want to take unscrupulous employers to Employment tribunals has saw the number of workers taking employers to tribunals hugely reduced, with single claims down by 67% and multiple claims by 64% since fees were introduced. The result is that in recent times thousands of Scot's have not taken bad employers to tribunals, meaning that many Scots have suffered at the hands of bad employers who know that it's unlikely their employees will be able to afford the fees to access employment tribunals. This is bad for working conditions and ultimately for the health of employees. Now that fees are to be scrapped we should also explore how to use these administrative powers to strengthen employee dispute resolution processes.

Despite the Modern Apprenticeship scheme that is in place youth unemployment and economic inactivity amongst our young people is persistently high. This is illustrated by Scottish Government figures which show that currently there are 93,000 young people - between the ages of 16 and 24 - neither in education, employment or training (NEET) (Scottish Government, 2015). Helping these young people to progress their lives is, or at least should be, a national priority. There may be valid reasons for their lack of activity, for example illness, disability and addiction, but there will be other young people classified as NEET who need help to move on. Moreover, the Scottish Government should ensure apprenticeship pay for Modern Apprenticeships should receive the same minimum wage as all other workers, as the current rates of apprentice pay are quite frankly disgraceful.

The work programme, coming to Scotland via the new powers as recommended by the Smith Commission, could be one such vehicle for helping young people find work or training. It could be designed in a way that that reflect local needs and circumstance. Agencies involved in this could include Skills Development Scotland (SDS), local government, voluntary organisations and training agencies. However, devolving the Work Programme without the corresponding devolution of the sanctions regime reduces the possibilities and opportunities of creating a system that reflects a more humane welfare system. There is therefore an argument for the devolution of Job Centre Plus, which could help provide the Scottish Parliament with the ability to set much fairer rules and abolish the cruel sanctions regime, which inevitably results in further health inequalities.

Helping people find work and improving pay and terms and conditions in the work place is vital if we are to reduce health inequalities. Work and earnings have a direct association with health outcomes. We should, indeed we must, address these issues if we are to fundamentally tackle health inequality in Scotland.

"Income in general and poverty in particular, are clearly linked with a range of health outcomes through material, social and psychological factors. Policies that reduce risks of poverty or, more generally, contribute to better family incomes are therefore likely to contribute to better public health. A key aim of welfare (and other) policy should be the development and maintenance of minimum standards needed for healthy living." (WHO, 2012).

2.2 Review and improve Social Security Protection and Welfare

Despite a broad awareness of this reality the welfare state has come under unprecedented attack in recent years. The view of our welfare system as social insurance, let alone ensuring minimum standards for healthy living, when people fall on difficult times, has been replaced by a vicious assault and negative characterisation of welfare recipients with little concern for how cuts to welfare impact on people's health and the health of their families. Since the Conservative and Liberal Coalition formed in 2010 the impact on the poorest people has been profound. However, it is important to note that the impact has/is being felt by the local economy as well as the individuals and families of those made unemployed or who have suffered cuts to benefits. For example, in our consultation South Lanarkshire reported:

"It has been estimated that welfare reform will take £104mn per annum out of South Lanarkshire. Claimant unemployment has now been above the Scottish average since the recession began and is 84% higher (3,248) than before the recession. Long term unemployment is now 4 times its pre-recession level. Youth unemployment is up 114% from its pre-recession levels –twice the rise in Scotland. Around 20% of workers in South Lanarkshire earn less than the Living Wage. And in 2013-14, 1,187 attended Trussell Trust Foodbanks including 415 children." (South Lanarkshire Council, 2014)

In our community engagement events, we heard from people who said that those finding themselves unemployed and/or unable to work, including some of our most vulnerable people, the disabled and sick, have suffered the humiliation and indignity of callous assessments, the loss of benefits and/or delays to payments and cruel and punitive sanctions, where benefits are withdrawn and people left with no money at all; often for the most minor and trivial of reasons.

Unsurprisingly people experiencing cuts to benefits and sanctions have felt compelled to turn to food banks. Across Scotland and the rest of the UK food banks have seen an unprecedented increase in people seeking their help to feed them and their families and prevent them going hungry. At a meeting in Glasgow we heard about the dependence on charitable organisations to feed people and how they saved many peo-

ple, punished by way of sanctions from the DWP, from going hungry. They described how people who suffer sanctions go without any money at all and have to source food from food banks or modern day soup kitchens to survive. Without this charitable help they said that they knew people would quite simply have starved instead.

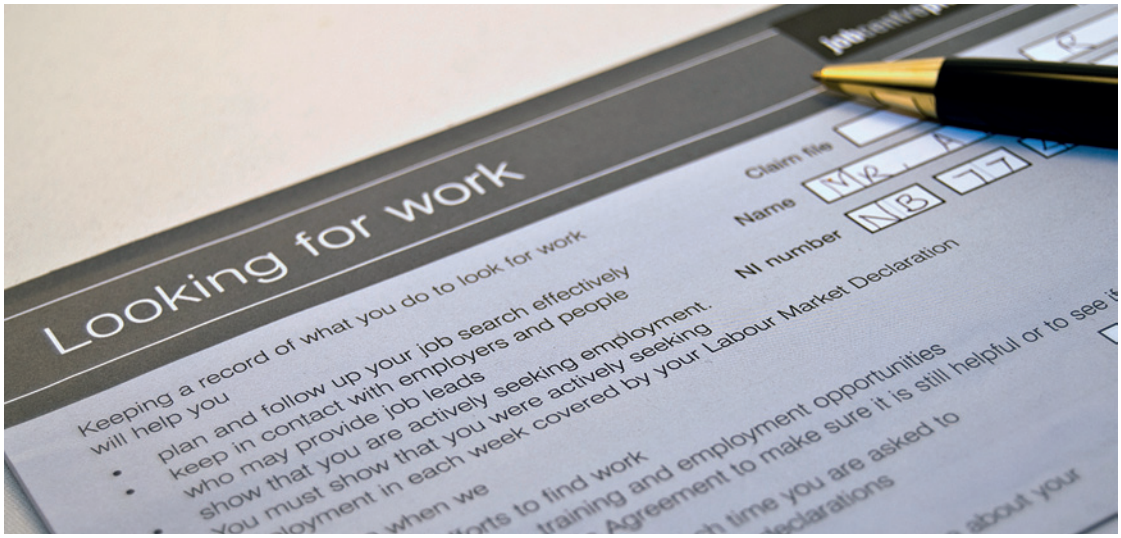
At another of our meetings in North Ayrshire the desperation of people visiting their local food-banks was discussed. Participants described "an old lady having to walk a mile from her house to get food at a food bank for her and her housebound husband". They described how she was "shame faced, could hardly look anyone in the eye because of what she saw as her humiliation at having to get food from a food bank". They also described how "the food that they gave her was almost as heavy as her and she was unable to carry the food back to her home, yet she had no transport to do so. And it was only the kindness of a neighbour who offered her a lift home that enabled this old woman to get back to her house with the food she had just got from the food-bank". This type of situation is a daily occurrence for far too many of our people and is intolerable for Scotland in 2015 and will only exacerbate the health inequality that still scars our country.

We must ensure that the welfare system is sufficiently resourced to prevent people having to use food banks at all. Likewise we must assist people when seeking employment and end the punitive and cruel sanctioning regime. Too often people on welfare feel that obstacles are put in their way to accessing benefits, that information is sparse over what benefits are available and that too often they face delays in receiving the benefits that they are entitled too. We would therefore recommend that each area across Scotland has an active advice shop which offers an income maximisation service ensuring all people are aware of their entitlements and which can, and does, act as advocates for those facing problems with benefits being paid at all and/or in time.

Having a functioning and humane welfare state that provides assistance for people is a vital component for the well-being of any society. If we are serious about tackling health inequalities then it seems clear this necessitates a base income for all our citizens. Welfare is predominately reserved to Westminster; nevertheless, there are significant swathes of welfare that are going to be devolved to Scotland. The Scottish Parliament, if it chooses to do so, can also raise the levels of welfare payments. We would recommend that this is introduced in Scotland. Therefore we can, with the right level of political willingness, improve the welfare system for people in Scotland.

Employment and income are fundamentally associated in attaining either good or bad health outcomes. Good conditions and fairness in the workplace and a sufficient

income providing the means to live a fulfilling life improves life chances and the health and well-being of individuals and society as a whole. Conversely, poor and unfair workplace circumstances and low pay will reduce life chances and exacerbate negative health outcomes. Similarly, the nature of the welfare system we have; how much people are paid in welfare and whether they are treated fairly when claiming benefit impacts upon people's health.



How such policies are designed, what they consist of and who designs them is currently in a state of flux. The Conservatives have just won an overall majority at Westminster, the SNP are have a majority at Holyrood and debates are taking place on both sides of the border over the nature of further powers coming to Scotland. There are obvious concerns that the Conservative Government is going to intensify attacks on welfare, trade unions, workplace rights and pay, terms and conditions. The Scotland Bill, which will determine the the new powers coming to Scotland is passing through Westminster with the nature of new powers still to be fully clarified.

Whatever new powers are devolved to Scotland it is our view that that they must be used purposefully. In welfare and in taxation the Scottish Parliament and the current and any future Scottish Government must use new powers to create a humane welfare system that sees it not as a way to punish the poor but as a social insurance system that gives people a helping hand. They must also use taxation to raise the necessary levels of tax to help create employment through investment in our people and communities.

It is also important to pay close attention to policies emerging from Westminster. Perhaps conscious, of the importance of childhood experiences and of a child's material circumstances the CPAG and UNISON published a paper prior to the May 2015 election which argued for any incoming government to introduce policies that made

work fairer, more secure and better paid for parents with access to good affordable childcare. Informed by the knowledge that helping parents in the workplace will in turn improve the childhood experiences of tens of thousands of children the recommendations in this joint report are policies that we concur with. However, we fear (and expect) that the election of the Conservative Government will not advance this agenda. On the contrary the Tory Government will jeopardise hard won gains, exacerbate wider inequality and intensify and worsen health inequalities throughout the UK. Hence, we would contend that whatever new powers are coming to the Scottish Parliament are used to promote, as far as it can within whatever powers it has, a fair work agenda that will help both parents and children and therefore help in the long term to address health inequality in Scotland.

East Refrewshire Council signing a community care charter

Section 3

Public Services, Local Government and Communities

In this section we look at how public services, outwith the NHS, can contribute to eradicating health inequalities. The value of public services, paid for through a greater emphasis on progressive taxation, is often underestimated in tackling inequality. The OECD and World Bank (2014) have put a virtual income value on public services:

"Public services mitigate the impact of skewed income distribution, and redistribute by putting 'virtual income' into everyone's pockets. For the poorest, those on meagre salaries, though, this 'virtual income' can be as much as – or even more than – their actual income. On average, in OECD countries, public services are worth the equivalent of a huge 76 per cent of the post-tax income of the poorest group, and just 14 per cent of the richest. It is in the context of huge disparities of income that we see the true equalizing power of public services."

(OECD and World Bank, 2014)

Investment in public services is vital, but we also recognise that the way we deliver public services can contribute to reducing health inequalities. In this section we argue for a more local delivery focus, built around communities and for people in communities to be at the centre of community planning. Currently, to the chagrin of the community activists we heard from in North Ayrshire, community planning has not substantively or seriously included the community there. People with a significant level of local expertise, such as those we encountered in Kilwinning must be heard. Not to do so ignores a rich level of understanding within communities which would help inform strategies being devised to improve the well-being in their communities. As NHS Scotland stated in their consultation response,

"While action will be taken at a national level, a significant contribution needs to take place locally, connecting with communities and building the hopes of people that face the biggest challenges." (NHS Scotland, 2014)

Or, as Alliance Scotland stated:

"Locality planning, in particular, must make sure the voices of those

most in need of support to tackle health inequalities are heard. More of a central role for communities in contributing to Health and Social Care Partnership action in making decisions about service development and resource allocation." (Alliance Scotland, 2014)

Maximising the benefit of public services to ensure they deliver for communities that need them most requires a coordinated approach; incorporating councils, health boards and the Scottish Government. An approach that allocates funding where it is needed most and which includes a cross portfolio approach and goes beyond a focus on individual behaviour is vital. Information we received from FOI requests demonstrates that there is still an over emphasis on individual behaviours and insufficient cooperation between different public agencies. The importance of joint working was articulated to us by Stirling Council, who said:

"All local authorities must work with their health colleagues and other community planning partners, in partnership with their communities and the third sector, to plan and deliver services that focus on the fundamental socio economic causes of health inequalities." (Stirling Council, 2014)

What is also clear is that insufficient attention is paid to allocating resources where they are needed most. As Children in Scotland said in their response to our consultation:

"If Scottish public bodies wish to give serious attention to addressing health inequalities in the current financial environment, more consideration should be given to diverting financial and human resources to those families and communities where health and other inequalities have become embedded across generations." (Children in Scotland, 2014)

3.1 It is our contention that councils, health boards and the Scottish Government must take a proportionate universalism approach to developing and delivering public services

In other words that in addition to the base resource allocation for service provision that additional funds are found for those areas and individuals in most need of them. As noted by the RCN who said:

"We can only really begin to tackle health inequalities effectively when we get the appropriate services close to the local communities that need them most." (RCN, 2014)

3.2 Current and any future Scottish Governments must place tackling health and inequalities front and centre of its agenda

3.3 This would start by having 'health inequality impact assessment' attached to every policy that they and every other public body in Scotland ever devise

The Scottish Government has a critical role in facilitating this and directing spending towards those policy and geographical areas that need them most.

3.4 This and future Scottish Governments must take a cross portfolio approach to health inequalities and appoint a Minister whose exclusive role is to tackle health inequalities

In other words anything that the Government and every other body do must always take cognisance of its impact on health inequalities.

This could also incorporate a regular assessment of whether their policies are helping or hindering the reduction of health inequalities. As the RCN said:

"Providing the public and services with a clear and understandable assessment of whether Scottish Government decisions have addressed poverty and inequality will help focus and prioritise the tackling of such issues." (RCN, 2014)

3.5 Fully realise the potential of local government and communities to tackle health inequalities

At a local level tackling health inequalities requires joined up action at the level of Community Planning Partnerships and in locality planning. As David Ross, leader of Fife Council, said to us in our consultation:

"A joined up community planning approach at local level is essential for dealing with health and other inequalities in a comprehensive and integrated way." (Ross, 2014)

While NHS Health Scotland suggested:

"Community Planning Partnerships (CPPs) are one of the main vehicles

for the cross-sectoral work that is necessary at local level to address inequalities and ensure, for example, the delivery of linked services that support those in greatest need and offer intensive tailored support." (NHS Health Scotland, 2014)

Critically, NHS Health Scotland are also clear that:

"Services should be co-designed with citizens to ensure they meet the needs and aspirations of the population rather than being imposed." (NHS Health Scotland, 2014)

Community Planning Partnerships must have an understanding that health inequalities are about social inequality rather than purely a concern of the NHS. The Christie Commission and the Equally Well test sites highlighted this in 2008. Key messages included the strengthening of democratic accountability, joined up public sector leadership, working with communities and giving public service staff the autonomy to develop approaches in accordance with local circumstances.

There needs to be investment in community development to build local capacity to respond to local needs. Single Outcome Agreements should include clear outcome measures for reducing inequality and health inequalities, together with the commensurate resources targeted on greatest need. This should lead to the development of greater resilience enabling individuals and communities to withstand challenges such as poverty, inequality, worklessness and other factors that endanger health and wellbeing.

We agree with the Commission on Strengthening Local Democracy (2014) that fifty years of centralisation hasn't solved Scotland's biggest challenges, so let's try strengthening local democracy. They also identify a link between the absence of strong local democracy and the prevalence of inequalities. It is communities that empower governments at all levels, not governments that empower people. Scotland has the smallest number of councils and councilors per head of population in Europe.

How we fund and raise money for local government must also be looked at. Local Government is a vital provider of front line services and therefore a vital instrument in helping to reduce health inequalities. Local Government must be funded adequately from central government and moreover must be able to raise more funds locally. We recommend therefore that the council tax freeze is lifted and longer term we recommend a full assessment of local taxation that ensures local government can raise revenue in a fair and sustainable way.

Given the size of most of our councils we need to put a new focus on real com-

munities. Starting with the most disadvantaged communities, we recommend the building of community hubs/partnership centres that would include various public services based under the same roof, for example social work, housing, health, libraries and leisure and recreation services such as community cafes, gyms, children soft plays and swimming pools. We would also recommend that these hubs should also host advice shops that offer amongst other things debt, welfare and income maximisation advice. These local hubs containing multidisciplinary teams that join up services in real localities would also serve as community meeting places, where communities are free to set their own agenda. These are the type of services envisaged by Christie, who recommended services designed from the bottom up with citizens are at their heart and a high degree of professional autonomy exists from front line teams rather than managers. This would build and extend on community centres.

3.6 Create a network of Community Hubs

This is not about market led models of localism or fragmentation. We recommend the development of a national 'localism framework' that would allow these community hubs to focus on service delivery, with essential back office services provided elsewhere. All too often localism has led to the creation of organisations with inadequate and often unnecessary administrative responsibilities. A key element of the framework would be a common workforce deal that provides for fair pay and conditions, pensions and staff governance standards in return for joined up working with colleagues across the current public service silos.

3.7 Increased active Community Engagement and Participation

Current approaches to community engagement, such as participant requests and asset transfer, are likely to provide opportunities for 'sharp elbowed' middle class interests rather than those who suffer most from health inequality. Community hubs will play a key role in building genuine community engagement and capacity to participate, developing asset based approaches and co-production in partnership with public services. But crucially community hubs need backed up with asset-based approaches and sustained investment in communities and third sector organisations. As the Scottish Centre for Health and Well Being (SCHW) said to us:

"Public services can recognise, in policies and budgets, the critical importance of community led health improvement in bringing about the interventions which have a major impact on the lifestyles, attitudes to health and wellbeing and overall quality of life of individuals and their communities." (SCHW, 2014)

We need to develop capacity of communities to actively participate in local decision making and in developing local policies – shifting us up Arnstein's Ladder of Citizen Participation. There is a growing body of evidence suggesting that greater levels of

community control and support leads to better health, while low levels of control are linked to poor physical and mental health and wellbeing. Communities empowered to take decisions and work to achieve common goals can also result in improved social support, reduce isolation, and foster a sense of community cohesion that produces positive social outcomes including access to education, training and employment alongside improved health and wellbeing outcomes (Due North Report, 2014).

Studies looking at Glasgow's relatively poor health has shown different outcomes can be related to empathy and connectedness. Citizens living in disadvantaged areas are far less likely to trust their neighbors, far less likely to be members of clubs, to volunteer, to go to church or to be part of a definable community. The challenge is to create a sense of community and of compassion for people. However, we recognize that the main barrier to this change is poverty and income inequality and the stresses and struggles that accompany this.

The Community hubs will also provide communities with physical space to meet and use for their own self defined needs and purposes and is so doing help facilitate and enable a sense of community and connectedness.

3.8 Enhance the Physical Environment through more community control

The places that we live in have a fundamental impact on our wellbeing. Improving the physical environment is important in tackling health inequality. People living near parks, playgrounds and good-quality walking and cycling links have higher levels of physical activity and better mental health. As the recent Carnegie Trust report (2012) shows, the most successful public spaces are those that people play a role in designing and shaping and that offer continued opportunities for involvement.

Councils should ensure that the existing greenspaces are maintained and take opportunities for further improvement in consultation with local people. Taking action over derelict buildings, fly tipping and dog excrement should be a priority. Street lighting should be maintained to ensure communities can a safely move about and use community facilities. Environmental Health teams in Community Hubs should focus on poor housing estate conditions; environmental factors such as neglected gardens, noise and air pollution.

In West Lothian we were told by the group there that the open space in some communities was suffering from a lack of investment with many derelict buildings in some high streets. Abandoned or burnt out buildings characterized one particular high street in the county, which was said to be crying out for investment, failing to do so had had an impact on the look of the high street and in turn the mood and atmosphere of the town in question. We were also told that too often high streets in

disadvantaged communities consisted of off-licenses or shops with a focus on selling alcohol, bookmakers, pubs and fast food outlets. Proactive local authorities must use space more productively to improve individual and collective well-being.

Community hubs could also be a base for community initiatives that aim to improve the physical environment. For example community organisations, perhaps working alongside third sector and local authority partners, could provide a grass cutting service and gardening advice to tenants. They can also help create and maintain community gardens in green spaces located in the community. Deriving the maximum benefit from the space that is available can assist in developing a community connectedness and help improve a collective sense of well-being.

Another group in West Lothian described to us the positive outcomes for them and their community through their active citizenry which was intent on improving green space and the natural environment within, what is, an urban area. Dedridge Environment Ecology Group (DEEP) is a community-led organisation in Dedridge, Livingston created by local residents in 2007 to improve the local woodland, ponds and burn which at that time were suffering from environmental degradation. Since 2007, they have raised funds to implement projects that have improved the look of local woodlands, ponds and the burn as well as creating a successful flood prevention scheme. In so doing they have consulted with their community getting cross-generational involvement in the project. Since the work was completed the woodlands, burn and ponds have been well used by local people and have played a significant role in improved morale, healthy activities and overall happiness within the local community.

Every council should have an active travel plan including action to reduce transport related pollution by requesting drivers to switch off their engines, in particular when parking outside schools and lower speed limits in residential areas. Walking and cy-

cling infrastructure should be protected and prioritised for investment. This is likely to bring benefits for both public health and for the local economy. Connectivity should be improved giving priority to active travel modes and public transport.

3.9 Support sustained active transport infrastructure

Public transport should be made more accessible and affordable to enable young and unemployed people to take advantage of services across communities. Young people and those seeking employment are currently penalised from travel through prohibitively expensive fares.

Evidence suggests that free or reduced fares are beneficial, at the very least bus and rail tokens that enable people most in need to get affordable travel could be made available for young people and the unemployed. We heard accounts at meetings we held in Glasgow and Kilwinning of people having to walk miles to get food from food banks. In Scotland 2015 we must do better than this and assist those financially struggling to be able to travel for food and indeed for employment.

Problems with rural transport provision were also highlighted to us during our data gathering. Maureen McMillan said that in the Highlands a central concern was a 'lack of adequate accessible transport' which she said was 'always the number one concern for service users and carers, particularly relating to care of elderly'.

The positive, direct effects of engaging in regular physical activity are particularly apparent in the prevention of several chronic diseases, including: cardiovascular disease, diabetes, cancer, hypertension, obesity, depression and osteoporosis. A number of studies have also shown that exercise may play a therapeutic role in addressing a number of psychological disorders. Small scale recreational facilities should also be available in Community Hubs and access improved to more specialist facilities through lower and more affordable prices and better transport access.

3.10 Make best use of sports and recreational facilities by making them affordable and accessible for all – including widening free sport/ recreation access to those from the most deprived communities

Sports clubs and facilities, community centres etc should be made more affordable and accessible; indeed they could be made free to some users including as part of a wider roll out of gym memberships prescribed by Doctors. Local government leisure and sport facilities, and those that are outsourced, should have a pricing structure that takes account of socio-economic circumstances. Meaning in practice that the unemployed, disabled, students and other people classified as economically inactive are not excluded from sporting and fitness activity due to cost. Similarly, sporting facilities should be accessible seven days a week. It is often the case that presently, com-

munity centres, schools with sporting facilities etc are closed at the weekend. These should be open and accessible at times to allow full participation in sporting activity. Moreover, we should exploit green areas to make them into play areas to ensure sufficient play parks and play areas are in place for children and that encourage play and outdoor activity. The removal of no-ball signs would also help encourage, rather than discourage, outdoor play and activity.

Poor housing can impact on occupants' health through damp, poor thermal efficiency and fuel poverty, poor home safety and accidents, and indoor air quality. Neighbourhoods, with concentrated disadvantage, where services are overburdened, basic amenities in short supply and issues such as high crime, challenging schools and poor transport limit the life chances of many.

3.11 Transform quality and quantity of housing across Scotland

Poor quality private renting is a major problem, but so is concentrated poverty in social housing. Overcrowding affects only a small proportion of households, often large families or multiple adult households, but it creates high pressures on those families. Well designed and well laid out housing is also important. There are also serious health impacts for homeless people living in temporary accommodation
Build at least 10,000 new social houses each year.

3.12 Redefine what we mean by Social Housing and ensure that social housing is not merely seen as being for people on low incomes or with additional needs.

Introduce better regulation of private rented sector including effective rent controls and consider extending the Housing Quality Standards to the Private Sector.
There needs to be a step change in social housing investment with at least 10,000 new units of social housing each year. The perception of social housing must change. It should never be seen as a second class option and the definition of social housing must change so that social housing is seen as an option for all, provided in mixed communities, and that social housing is not only for people on low incomes. The growth of the private rented sector also needs to be better regulated including effective rent controls and prevent profiteering and the abuse of the housing benefit system.

Housing policy must also be amended to ensure community cohesion is retained. In many areas across Scotland social housing has been treated as the second class option with current housing policy reducing the local character of those communities that consist mainly of social housing. Local character is important not in a nimby type

way but is vital for ensuring the social fabric of communities is protected. For example ensuring that local organisations, like residents association, football teams, community council's, parent teacher associations etc are resourced with sufficient manpower and a succession of volunteers. New people settling into these communities can be immersed into that social fabric, if however there is a high turnover then local character is lost resulting in community cohesion also being lost resulting in a cost to the wider collective health and well-being of the community.

Regeneration of neighbourhoods and communities can create generally mixed-communities. Studies have shown health benefits, encouraged attachment and engagement with communities, created role models for aspiration, supporting co-production and community action (Go Well, 2015).

Improve education opportunities for those in the most deprived communities / circumstances

3.13 Design early years education that is fully cognisant of its essential role in tackle health inequalities

Early years education was cited by nearly all of those individuals and organisations that we spoke to and who responded to our consultation. All of them said early years education was a fundamental component of tackling health inequalities. Stimulating learning in very young children and preparing them for primary school is seen as necessary to help break the cycle of health inequality. Professor John Frank unambiguous offered us his view of the importance of early years, stating:

"That high-quality, universal, early childhood education and care (ECEC) is the most cost-effective investment for improving lifelong health and economic productivity. This is especially the case for children from socio-economically deprived backgrounds, in that ECEC can substantially "level the playing field of life."

Indeed, some experts have convincingly argued that universal early childhood education and care is an essential investment if any society is to successfully reduce lifelong health and functional inequalities by social class – of which Scotland has some of the steepest in Western Europe The key reason this is so is that the first few years of life are the time when the human brain is most malleable, as its sophisticated circuitry is recurrently sculpted by daily experience. Thus stimulating, loving and healthy environments in infancy and toddler-hood lead to much more brain capacity than deprived, neglected and unhealthy environments (both social and physical)." (Frank, 2014)

Professor Susan Deacon's report "Joining Up the Dots" (2011) also highlights the

importance of early years and draws on best European practice. She argued:

"Where children and family centres work well, and offer a range of childcare, activities, services and support - as well as valuable opportunities for parents to volunteer and to support one another – they can have a major beneficial impact on the wellbeing and development of young children, the family and the wider community. When coupled with effective outreach work they can often engage with parents and children who might otherwise not seek - or be offered - support from which they could greatly benefit." (Susan Deacon, 2011)

How we provide early years education, who provides it (nursery nurses or teachers), the hours young children spend in a learning environment, the age that they begin, the role of parents etc are all in need of debate and clarification. However, what we are certain off is that there is an almost universal consensus of the importance of providing early years education to help address health inequalities. Henceforth, all parliamentary and government discussions over early years educational provision should have as its starting point how whatever changes are made will help contribute to reducing health inequalities.

In addition to stimulating early learning environments it is also important for families to have access to childcare. Well-supported early childhood services, led by qualified staff, will also lead to improvements in educational and health outcomes. We envision family centres, with childcare provision, being an important element of the Community Hub. This will also enable parents to work who otherwise are unable to do so due to exorbitant childcare fees.

The current system is patchy, complex and expensive. Parents in Scotland pay 27% of their household income on childcare, compared to the OECD average of 12%. We need a radical overhaul of childcare provision to ensure that it provides what families actually want: a safe nurturing environment for their children that doesn't cost the earth (UNISON, 2015).

3.14 We now need to adopt a radical and comprehensive approach to this issue by providing childcare free at the point of use – prioritised for those with the least based on those with the greatest need

Education enriching activities are crucial as children in disadvantaged families gain most from activities like school trips and are often excluded due to cost.

Free school meals have proven to be a successful policy and have important health benefits as do breakfast clubs. NHS Health Scotland suggest, that providing free school

meals, free fruit and free milk in schools have been identified as having potential to reduce health inequalities (NHS Health Scotland, 2014).

3.15 Schools should also be supported to ensure children from disadvantaged families have access to school trips and activities

3.16 Extending breakfast clubs and free schools meals – particularly to nursery schools is another policy option that we would recommend

The Child Poverty Action Group (CPAG) also recommended that local authorities should be encouraged to provide school clothing grants for disadvantaged children (CPAG, 2014). The current variation in allocating clothing grants amongst local authorities must be addressed.

Ensuring schools strive to develop the social, emotional, health and wellbeing agendas as a foundation for cognitive development and learning. Schools that work on their whole-school ethos and culture have been demonstrated to reduce health-risk behaviours (Henderson et al 2008). In parallel, schools should be encouraged to develop student parliaments/student councils, promoting learning about how to engage in politics, change and community activism.

3.17 Ensure schools strive to develop social, emotional, health and wellbeing agendas as a foundation for learning

While the abolition of tuition fees rightly embodies the principle of free education, it has done little to improve access to university for disadvantaged young people. They require greater financial support as well as reviewing university admission policies. Support for university education should not be at the expense of further education colleges, which have borne the brunt of education cuts. Nor should it be at the expense of grants for college students, which have been cut and which are in addition to the fact there is no guaranteed income for students who want to enrol at college. Colleges and college students who proportionally, come from communities at the lower end of the socio-economic spectrum, should be given a guaranteed income and we would recommend this to happen

Workplace lifelong learning has been a real success story and this could be extended by learning opportunities, including non-vocational courses for adults, based in accessible community hubs.

3.18 Boost Spending to Further Education

Colleges in Scotland have suffered from funding cuts in recent times. The consequence is staff reductions, diminishing teaching time and decreasing student numbers and

courses available as well as cuts to student grants and bursaries. We contend that colleges are a vital educational lifeline for young people wishing to gain vocational qualifications and for people who wish to retrain and up-skill after redundancy and/or gain the qualifications to move on to Higher Education. Further Education disproportionately benefits people from disadvantaged communities. We must boost spending and prioritise further education for example by guaranteeing an income for all who need it, which will reduce drop-out rates and ensure people in need of educational support get it and are not hindered by a lack of financial support. Increased investing in further education is undoubtedly a means and a way to reduce health inequalities.

3.19 Develop national and local plans to help tackle fuel poverty

At least 40% of Scottish households are living in fuel poverty. The latest figures show that in 2013 in Scotland there were 940,000 households in fuel poverty, compared with 647,000 households in 2012. These figures indicate that current measures will not meet the statutory duty under the Housing Act 2001 to eradicate fuel poverty by November 2016.

Financially disadvantaged families cannot make substantial contributions to have energy saving measures fitted to their homes. There needs to be a transparent action plan of properly funded effective measures to address energy efficiency in every locality.

Councils and government can only do so much. The big energy firms who never seem to pass on savings to customers have ripped off millions of people. We need measures that have a real impact on the cost of domestic energy along with powers for a new energy regulator to force firms to cut gas and electricity bills. This should be just the first step towards a more radical restructuring of the energy industry including a key role for local authority energy generation and community heating schemes and community ownership of renewable schemes.

3.20 Better utilise the role of Councils as employers – as the gold standard for pay and conditions

Local authorities are often one of the largest employers in disadvantaged areas. They should set the benchmark for good employment practice including occupational health, healthy workplaces, no nominal or zero-hours contracts and paying the Scottish Living Wage to all, incorporating contractors as well as directly employed workers. This can be extended into the private sector through procurement.

Section 4

Health Services and Public Health

Repeated throughout this paper is the understanding that tackling health inequalities requires much more than solutions within the health service. That said we are also clear that a well-funded, universal and free at the point of use health service has a vital role in helping to reduce health inequalities.

The health inequalities we observe across Scotland are not caused by different levels of access to or quality of NHS care. However, there remain issues around access to health services and care depending on the level of deprivation – with the poorest areas having the poorest access (Audit Scotland, 2012).

This situation, known as the so-called inverse care law needs turned on its head. As noted above we contend that resources should be allocated to where they are needed most. As noted by UNISON, who referring to the Deep End group of GP's working in areas of high deprivation, said how it was important to, 'Challenge the flat distribution of GP and other health services as highlighted in the Deep End Project report. The NHS must be at its best where it is needed most' (UNISON, 2014) NHS care does, to some degree, help to mitigate the worst damage in terms of illness caused by the wider socioeconomic determinants. NHS services including: primary care (GP services), screening (e.g. cancer screening), prevention (e.g. smoking cessation), as well as hospital services do have a role in tackling health inequalities in several key areas.

4.1 Providing equitable high quality holistic care

There is a welcome quality improvement agenda in the NHS in Scotland. However, while equity of access is an accepted dimension of healthcare quality, it is not the priority driver. Equitable access to care also includes ensuring health services are more flexible in terms of providing a holistic range of services, but also in their opening times and in the length of appointments given to the neediest patients. As Professor Peter Donnelly told this review:

"Health care access, too, is crucial. The elderly, inarticulate and vulnerable, for example, need longer appointments." (Donnelly, 2014)

However, we must be careful to balance the resources of health allocation towards those areas that are needed most at a socioeconomic level. Concerns were ex-

pressed that people from more deprived areas were not getting the level of service required in key areas. It was said to us during our evidence gathering that there were:

"Problems with the service some GPs are delivering in deprived areas - National Survey of NHS patients' attitudes to General Practice showed that a significantly higher proportion of people living in deprived areas reported putting off a visit to see the GP because of inconvenient hours. Similarly, a significantly higher proportion of people living in deprived areas felt like making a complaint about staff - but had not actually done so….Also, rates of immunisation, and screening for cervical and breast cancer, are significantly lower in people from more deprived areas - areas where cancer mortality rates are highest…..The quality of treatment in general practice for people with chronic diseases such as asthma has been shown to be inadequate, with significantly higher admission rates to hospital for these conditions from deprived areas" (Scottish Communities for Health and Well-Being, 2014).

We were impressed by the evidence of the General Practitioners at the Deep End (2015), who work in the 100 general practices serving the most socioeconomically deprived populations in Scotland. Amongst various proposals they recommended proposals for:

- "Increased time – additional clinical capacity, on a pro rata basis, providing one extra GP session per week per 1000 patients living in the most deprived areas.
- Embedding joint working with general practices and area-based workers including named attached workers from social work, mental health, addictions, and child health services.
- Developing "lay link worker" role to link practices and patients with community-based services and resources."

The Deep End GP's are also committed to ensuring that NHS resources are allocated to where they are needed most. They argue,

"NHS Scotland should be seen at its best in areas of greatest need, or inequalities in health will widen".

There is some concern that NHS Scotland and NHS Boards are not sufficiently prioritising health inequalities. Professor Peter Donnelly encapsulated these concerns stating:

"***Chief executives need to worry about health inequality issues, the way they do about waiting lists. They have tough jobs and survive by focussing on the must do targets. And health inequalities do not appear mean-***

ingfully on their priority list…Not that this is easy. They have only partial control over the outcome due to underlying inequalities in social determinants of health. However, we should hold boards to account over how they respond to these inequalities. I do not think we have yet found a way to do this." (Donnelly, 2014)

We recommend that the method used by NHS boards to allocate resources is recalibrated to ensure that those communities in most need are provided with the appropriate level of resource.

We also propose that services are further holistically developed within primary care (and in hospital settings) to reduce poverty among people with chronic illness, including: income maximisation, welfare benefit support, debt advice, housing advice, food poverty, and fuel poverty.

Doctors should also provide letters, free of charge, to patients who for example need proof of illness to give to the DWP. We heard from professionals, in our West Lothian focus group, of instances where GP's were charging people who were without the means to pay. As a consequence their claims were held up and they went without benefits. While we acknowledge the extra layer of bureaucracy that the changes to the welfare system involves for GP's it is clearly unacceptable to introduce fees which results in people in dire need of benefits having their claims delayed as a result of GPs charging fees.

To ensure primary care services can be re-orientated to tackle the inverse care law, and to meet the current GP recruitment / access challenges, consideration should be given to a more fully integrating salaried GP / primary care services.

4.2 NHS to influence socioeconomic determinants of health inequalities as an employer (the largest in Scotland) and through procurement

As proposed for Councils, the NHS in Scotland should continue to lead the way in occupational health, healthy workplaces, no nominal or zero-hours contracts and paying the 'Scottish Real Living Wage'. Bank contracts should only be on offer for those who specifically want a bank contract. As far as possible people seeking full time work should not be on bank contracts.

But it should also go further in a number of ways: introducing a pay ratio in the NHS and across the public sector. This proposal links the pay of the top NHS and public-sector executives to their lowest paid employers. This is currently approximately 14:1 in the NHS, we propose reducing the limit to a maximum of 10:1. Moreover, doctors' enhanced pay via the merit award and discretionary points system needs reviewed as this increases their pay substantially and inequitably above other healthcare workers. The NHS in Scotland has potential via its employment and procurement processes to make a positive impact on the health and local economies.

4.3 Democratising the NHS and joining-up health with social and other public services

There is a growing body of evidence that increasing democracy and community control can reduce health inequalities (Whitehead, 2014)

The experiment to have direct elections onto Health Boards undertaken in 2011/12, despite a relatively positive evaluation, was not rolled out. There remains a local democratic deficit in the NHS in Scotland. This issue runs in parallel with the NHS struggling to fully and meaningfully integrate with social services. The Scottish Government's developing model is a further local quango made up of Health Board and Council representatives with limited democratic accountability.

Major reorganisation of structures should not be taken lightly. Moreover, serious consideration and a fundamental review of Health Board structures should be undertaken. Having NHS primary care and public health services fully linked into local authorities should be considered within such a review. This model would ensure democratic accountability, the integration of health and care services, and access to the levers of local government to tackle health inequalities through improving the wider socioeconomic determinants. Not least given that, as Stirling Council told us:

"Control over most of the services that concern the wider determinants of health – education, employability, early years, built and natural environment, lies not with health but with local authorities." (Stirling Council, 2014)

Another possibility for an increasing role for the NHS in communities was suggested by the Scottish Communities for Health and Wellbeing (SCHW) in their report titled 'NHS Community' they argue that:

"Establishing 'NHS – Community' would take up less than 1% of the current NHS budget or around 4% of the current NHS health improvement budget. 'NHS Community' would initially involve an active network of over 100 community–led health improvement anchor organisations with over 500 staff and over 4000 volunteers, This is truly a community asset based approach to health generation." (SCHW, 2014)

4.4 Re-invigorate community development in health improvement activities

In 2006, the then Labour-Liberal Scottish Executive established a Ministerial Task Group to support the development of community-led health improvement in Scotland. They established a strong evidence base, and identified sustainable investment in terms of finance and commitment. This leadership needs kick-started once again.

Consensus is also emerging on the need to refocus health improvement action away from 'downstream' behavioural lifestyle change interventions, which have had limited success and (according to the recent Audit Scotland report) cost no small fortune, to more 'upstream' and 'asset-based' approaches to improving health outcomes. This recently proposed 'asset-based' approach emphasises positive aspects of communities instead of deficits, and support communities and individuals to have more control over their own circumstances. This work, not dissimilar to community development approaches, has largely been lost from and was never fully adopted by NHS-led public health activities.

However, unlike community development, asset-based approaches fall short of explicitly focusing on the investment in disadvantaged communities, which would enable local people to participate in building and developing community resources. Examples of community development work which needs such support and which develops local solutions for local issues – include: fresh food cooperatives, credit unions, local energy saving initiatives, and environmental enhancing schemes. We recommend that these type of schemes, where they exist, are supported and resourced.

4.4 Tackle the Mental Health Crisis

We were told that 'Scotland has a mental health crisis' (SCWH, 2014). The Royal College of Psychiatrists made clear that,

> ***"Mental health plays a central role in Scotland's overall health. The contribution of suicide, drug misuse and alcohol (including the rapidly rising rates of alcoholic liver disease) to premature mortality and other health inequalities in Scotland is now well recognised…It is widely recognised that life expectancy is reduced by 15-20 years in people with serious mental health problems."*** (Royal College of Psychiatrists, 2014)

The impact of poor parental mental health, including substance misuse, has an enduring effect on the development of children (Royal College of Psychiatrists). Male suicide rates in Scotland are still 50% higher than in 1968 and the rates for men and women are above the European average. A clear focus on enhanced well- being and the promotion of good mental health within schools, workplaces and general hospitals is needed to reduce the economic and social burden of mental ill health

In Kilwinning we heard from the community there that they were facing a mental health crisis, manifesting mostly in young men in the area. Yet, they told us that often young men were waiting up to 18 months before getting a psychiatric appointment.

Things were getting so bad that a local community anchor organisation hired a CBT counsellor treat some of the young people waiting for an appointment. This prompted

the local NHS to call the local organisation asking why they were providing CBT. The local community worker in question reacted by turning that question around by saying to them "Actually the most important question is why aren't you providing counselling?" for the very many young people in need in the area. In the meantime we heard from people in Kilwinning that several young men in the local area had taken their own lives. We strongly recommend that mental health services are prioritised and invested in as a matter of urgency.

4.5 Rethink how we support people with problem drug use

Scotland has one of the highest rates of problem drug use in Europe. This is a significant social problem strongly associated with poverty and deprivation and largely rooted in the lack of employment, hopelessness and helplessness of the 1980s. We must deal with the underlying conditions which drive the problem and limit the ability of people to recover and live meaningful and fulfilling lives. It is crucial that drug policy is not seen in isolation and that in order to deal effectively with the drug problem we deal also with wider social and economic injustice.

Sadly people with a drug problem are among the most marginalised and stigmatised in society. This compounds the fact that they are often from the most marginalised communities in Scotland and so are doubly disadvantaged.

The focus of the 'drugs debate' has been around drug use as a lifestyle choice – which it is not. In most cases it is a means of coping with underlying problems and it must be recognised that these individuals are in many respects victims of their circumstances. The rate of mental health problems, often the result of childhood trauma and poor family experiences, being in care, school and other state services, among problem drug users is very high.

The discourse around help and support has tended to focus on medical or criminal justice responses rather than recognising the wider support necessary to respond holistically to individuals. In terms of treatment, methadone is historically and internationally evidenced in helping to preserve life and stabilise people in terms of their drug use and their criminal activity. However, for those who want to move one methadone should be seen as the foundation for building further recovery with its prescription bolstered with other support.

The current drug strategy highlights the importance of an individualised person-centred approach. However, we met several recovering drug users in Glasgow who are now training to become drug counsellors. These inspirational people described to us the context that many young people find themselves in and the reasons behind drug use. While they recognised the role of methadone in stabilising their lives they also warned of the dangers of people being parked on methadone and how sometimes it is prescribed without being supplemented with other support services.

With nearly 60,000 people with a drug problem Scotland faces a huge challenge to provide individualised care but this needs to happen if we are to adequately respond to the needs of this group and ensure that they, their families and communities can make progress. This requires a re-design of how services are delivered so that they are not 'factory services' which require the individual to fit the service. Drug services should be integrated with a range of other support, both psychological and social (housing, debt, employment etc). We heard of very large services offering care to 1000s of individuals. Given the nature of the problems people face tailored services need to be created to build a therapeutic relationship that all the evidence shows is key to successful outcomes.

4.6 Create an advocacy service focused on supporting people from the poorest backgrounds to help navigate the complex landscape of health and social care

Inequalities in access to care can also be related to inequalities in patients' ability to navigate the system, including: (i) confidence to challenge and question the quality and options of their care, and (ii) knowledge regarding their rights or in relation to the best services and care available. We propose introducing an advocacy service, focused on supporting those from the poorest backgrounds, to navigate the system. For this to be effective, this would work differently to current advocacy provision that often relies on patients seeking support in the first instance. It would need to take a pro-active approach working with front-line staff.

4.7 Take on the public health challenges via socioeconomic health inequalities priority

Interventions that are information-based or that require individuals to "opt-in" are ineffective at reducing inequalities.

Public health legislation can be somewhat effective at improving public health inequalities – such as banning smoking in public spaces, minimum unit pricing for alcohol. Their full impact in terms of reducing health inequalities is yet to be fully assessed.

Going forward, we need to build on these bold policies and expand into other areas including reforming alcohol licensing to reduce the near ubiquitous availability, and examining how alcohol minimum pricing can also be implemented as a tax.

We would also be complacent to think we had cracked the issue of smoking in Scotland. We haven't – a quarter of us still smoke and there remains substantial inequalities with those from the most deprived communities and backgrounds far more likely to smoke. Smoking cessation services need to be far more tailored to those from the poorest areas.

Obesity is a major health inequalities issue affecting children and adults across Scotland. While sugar/fat taxation can be considered regressive, it has been introduced across Europe and evidence would suggest it could have an impact on health outcomes and possibly inequalities, therefore we should consider specific policy on the food industry which we know results in an obesity inequality with the poorest suffering most. Further extension of free-school meals policy and regulation of the "toxic external food environment around schools" should also be explored. In addition to food taxation measures are needed to alleviate food poverty.

Financial incentives Evidence from robust studies undertaken in Tayside and Glasgow, has shown effectiveness for financial incentives (via vouchers) to reduce smoking rates among pregnant women. As smoking, and particularly in pregnancy is driven by poverty and socioeconomic deprivation, then it is not surprising that providing financial incentives (over and above the savings from not purchasing cigarettes) reduce smoking. While this has been shown to be effective over the duration of pregnancy, the ongoing sustainability of these interventions needs to considered. Further development and assessment of financial incentive interventions focused on improving health among the poorest groups should be encouraged.

Early years Ensure early years focus of public health is sustained and evaluated – with learning and practice maintained. Already established and groundbreaking initiatives and research programmes include: the Early Years Collaborative, Childsmile (the national oral health improvement programme), Family Nurse Partnerships (the Thrive trial).

Section 5

National Level Recommendations: Action to prioritise health inequalities - leadership

In addition to action on, earnings, employment and social protection; local government and communities and health services and public health we believe that health inequalities requires national level leadership, priority setting, and decision-making.

We recognise that there is a lot said on health inequalities – not least by the Scottish Government. However, it is clear that it is not given sufficient priority and that policy responses are not bold or cohesive enough and fail to get to the roots of the problem. In short there is a lot of rhetoric but limited action.
The ethical and economic case for tackling health inequalities is clear. Health inequalities are unfair and unjust, they affect everyone, they are avoidable and the means are available to us to seriously tackle this national scandal.

The first challenge is to create "the will" to change. This change is needed at all levels – national and local government, across the public sector, and all communities.

We propose the following national actions

5.1 Tackling health inequalities is an explicit Scottish Government priority. Health inequalities do not explicitly feature in the government's strategic objectives

We propose to ensure that reducing health inequalities is a strategic objective of government.

5.2 Create national targets for reducing health inequalities

The current Scottish Government's purpose is defined through five Strategic Objectives, sixteen National Outcomes, and fifty National Indicators. [http://www.gov.scot/About/Performance/purposestratobjs], yet health inequalities do not explicitly feature at any level.

There are also rafts of targets, covering many areas and activities, yet there are no health inequalities targets – not even in relation to health services. While health inequalities are heavily monitored [http://www.gov.scot/Publications/2014/10/7902] these indicators are not currently used to create stretch targets or goals to work towards. Setting targets are accepted as aspirational and can focus attention on what should and could be done.

We propose to develop a range of health inequalities targets including a target to narrow the inequality gap in life-expectancy across Scotland's communities and reducing infant mortality inequalities. Furthermore a range of current health targets and indicators will be re-orientated to focus on reducing the inequalities associated with socio-economic factors.

5.3 Create a Cross-portfolio Cabinet Secretary for Health Equity

It is well recognised that the solutions to health inequalities lie beyond the NHS. Health inequalities should not be the sole remit of the Cabinet Secretary or Directorate of Health and Wellbeing. This role would ensure that appropriate action was taken across other and all government directorates.

While there is currently a health inequalities taskforce this is a somewhat sidelined with a limited workstream. The priority, ambition and reach of policy to reduce health inequality must be at the heart of government.

5.4 Undertake health inequalities impact assessment on all policy proposals

We propose that health (socioeconomic) inequalities impact assessments of all policies be undertaken. The current model of health impact assessment in Scotland are inadequate and need to be improved to give a far greater focus on health inequalities associated with socioeconomic factors. These impact assessments should be applied to all policies not just "health sector" policies. The Cabinet Secretary will be responsible for ensuring these impact assessments are undertaken.

There is also a case that major policies should also be tested and evaluated more fully to ensure that they remain focused on their aim, but also could be tested to ensure there was no adverse impact on health inequalities. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/62529/TLA-1906126.pdf.

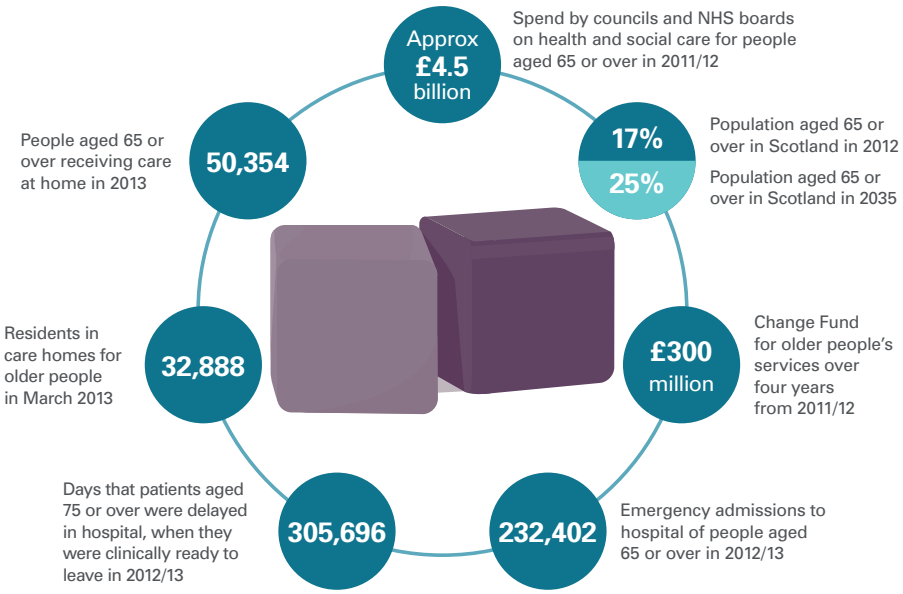
5.5 Review and improve resource allocation to meet needs based on socioeconomic circumstances of communities

Currently resource allocation to local authorities and health boards is largely on a population basis. While there are resource allocation formulae in place there is not

sufficient weighting to ensure that the poorest areas and communities with the greatest need receive a sufficiently higher proportion of funds. Similarly, allocation of resources from health boards and local government to communities and neighbourhoods could also be better targeted to the poorest areas and communities. This will take political will and leadership as it will involve difficult political decisions and choices. The first step will be to undertake a fundamental review of resource allocation formulae to ensure socioeconomic deprivation factors are the principle driver.

The Marmot Review in England developed the principle of "proportionate universalism". It makes the case for the importance of basic universal services, but also ensures that targeted services are proportionally developed to complement universal services. This is a principle we propose is fully adopted and embraced when developing policies to tackle health inequalities in Scotland.

We also support the principle based on Sally Macintyre's (2007) review of evidence of what works to reduce health inequality, which identified that removing price barriers, where practicable by providing "free" services directly associated with health is effective at tackling health inequalities (e.g. free school meals, free prescriptions)



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Appendix 1 Reference Group Membership*

Richard Bourne	Socialist Health Association (UK)
Andrew Briggs	Professor of Health Economics, University of Glasgow
Gordon Casey	UNITE
David Conway (chair)	Socialist Health Association Scotland
Neil Findlay MSP	Scottish Labour Party Shadow Cabinet member for Health and Wellbeing
Emma Gillan	Glasgow City Council
Tommy Kane	Scottish Parliamentary Officer to Neil Findlay MSP
David Liddell	Scottish Drugs Forum
Jennifer McCarey	Community Activist
Janet McKay	UNISON
Danny Phillips	Child Poverty Action Group
Peter Taylor	Independent consultant and researcher involved in community regeneration
Dave Watson	UNISON

*** Note - participation does not imply agreement with all recommendations in the Review**

Appendix 2 List of responders to consultation

1. Alliance Scotland
2. British Dental Association
3. British Medical Association
4. Colwyn Jones
5. Child Poverty Action Group
6. Children in Scotland
7. Constructing Better Health
8. Deep End GP's
9. Dr Brian Chaplin
10. Fife Council
11. Midlothian Council
12. Professor John Frank / Scottish Centre Public Health Research and Policy
13. Peter Taylor
14. RCN Scotland
15. Hepatitis C Trust
16. Voluntary Health Scotland
17. West Dunbartonshire Council
18. West Lothian Council
19. NHS Health Scotland
20. NSPCC Scotland
21. Maureen Macmillan
22. Royal College of Physicians
23. Royal Pharmaceutical Society
24. Royal College of Psychiatrists
25. Scottish Communities for Health and Well Being
26. Scottish Council for Voluntary Organisations (SCVO)
27. Senscot
28. Socialist Health Association Scotland
29. Professor Peter Donnelly
30. Stirling Council
31. UNISON