Report of the Ministerial Task Force on Health Inequalities
2013

Foreword

Health inequalities are a blight on our society. It is unfair that many individuals, particularly in our most disadvantaged communities, suffer the effects of chronic ill-health and die prematurely.

So far, and despite our best efforts and significant resource, we have not delivered the improvements we had hoped for in reducing the inequalities gap between the wealthiest and poorest in our society. But we are determine to reverse these trends.

Scotland has not always been in this position. It is only in the last few decades that we have seen the health gap widen. Only by better understanding how Scotland has changed over that period – including the impact of deindustrialisation - will we make the required improvements. Health inequalities are a consequence of fundamental inequalities in the distribution of power, wealth and resources and therefore our approach has to address these drivers as we create a fairer Scotland.

Our national policy on health inequalities - Equally Well – offers us a strong foundation on which to build; but we also recognise that the public service landscape has changed since 2008. Our commitment to the renewal of community planning offers a vehicle to better coordinate resources at a local level, to ensure that these can be targeted at the most disadvantaged communities. Or again, the wider process of public service reform and the prospectus laid out by the Christie Commission brings with it a commitment to coproduction, inclusion and the empowerment of citizens in exercising greater control over public services. So while we are not complacent and understand the size of the challenge in front of us, we are confident that we have the building blocks of reform in place, which if built upon, will gradually turn our record on inequalities around.

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Minister for Public Health

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1. Executive Summary

The Task Force was reconvened to consider the latest evidence on health inequalities in Scotland. The Task Force identified key priorities that would support delivery of Equally Well in the next few years. The Task Force were asked to:

- reflect on changes in the way that people and communities were being engaged in decisions that affect them;
- consider the implications of the Christie Commission report for how health inequalities might be tackled; and
- look at how characteristics of "place" had an impact on health inequalities in Scotland.

There was a general understanding that the fundamental principles set out in Equally Well remained extant and that tackling health inequalities should sit at the heart of government policy alongside the other key social policy frameworks.

The Task Force was presented with the latest science behind health inequalities, and heard from stakeholders about their experiences and learning and learned of developments in the public sector since the last review.

A significant development since 2010 has been the report of the Christie Commission and the publication of a Statement of Ambition agreed by both local and national government. The Christie Commission was absolutely clear that a radical change in the design and delivery of public services and the way in which public services work with each other and with communities was required. The Scottish Government has agreed this requires that:

- public services are built around people and communities, their needs, aspirations, capacities and skills, and work to build up their autonomy and resilience;
- public service organisations work together effectively to achieve outcomes;
- public service organisations prioritise prevention, reducing inequalities and promoting equality; and
- all public services constantly seek to improve performance and reduce costs, and are open, transparent and accountable.

The Task Force heard evidence that while the health of Scotland was improving it was doing so more slowly than other European countries. It heard that mortality rates have improved in deprived and affluent areas at broadly the same rate, leading to an increase in relative inequalities and that in order to reduce health inequalities there needs to be a faster improvement in the most deprived. It heard evidence that conventional approaches to the problem that involve attempts to modify the health related behaviours of poorer people have failed and that a new approach has to be widely adopted and that this must go alongside actions to address the wider inequalities in society.

The Task Force heard evidence that the level of deaths the 15-44 age group were experiencing was contributing significantly to the relatively poor position of Scotland health in a European context. The Task Force also heard evidence that despite many

similarities Glasgow and the West of Scotland were experiencing many more deaths than comparable cities and regions in the UK and that one potential contributing factor was the difference in social capital between these areas. The Task Force also heard evidence of the importance that the immediate environment plays on health and wellbeing through the work of Good Places, Better Health.

Rather than make new specific recommendations the Task Force agreed to identify priority areas for action. The priorities support new existing area areas of work that have been developed since the last review.

The Task Force identified the following areas as priorities:

- Support for CPPs and the community planning process

Equally Well has always placed Community Planning Partnerships at the centre of achieving the ambition set out in the strategy. The Task Force is convinced that Community Planning Partnerships remain the best vehicle for making progress in delivering Equally Well. Community Planning partnerships have the potential to demonstrate the leadership and partnership working that is required if we are to realise our ambitions and realign available resources towards prevention and engage all partners including the Third Sector is a priority in line with the Christie Commission.

- Development of Social Capital

The Task Force believe that a key function of CPPs will be how they engage with their local communities. The Task Force supported the objective set out by the Christie Commission of 'building personal and community capacity, resilience and autonomy' or "social capital" and that this should be a priority in any on-going work with communities.

- Focus on 15-44 age group

In addition, the Task Force recognised that in taking a life course approach there was scope to examine and potentially enhance what we do that impacts on the 15-44 age group. The evidence suggested that it was in this age group in particular that Scotland experiences many more excess deaths compared with other European countries and regions. The Scottish Government will review with our partners current activities that impact on this age group to identify potential new actions that would impact positively on this age group's health outcomes.

- Support the implementation of a Place Standard

The Task Force noted that the development of a Place Standard was a welcome addition to the fight to tackle health inequalities and that the development and implementation should be monitored.

Finally the Task Force also considered its own input into the work to tackle health inequalities. It was clear to members that a regular two yearly review may not be the best way to monitor progress nor influence the current way of working and that

alternative arrangements for coordination of work to tackle health inequalities, to monitor progress and to influence progress should be considered. Members agreed that this would be the last report of the Ministerial Task Force on Health Inequalities. In addition all members of the Task Force were clear that the focus of all our efforts should be on tackling inequalities and as part of that we should maximise participation from all parts of Government and the wider public sector.

2. Background to Equally Well

Equally Well, the report of the Ministerial Task Force on Health Inequalities, was published in 2008. At the time the strategy was considered ground breaking in that it focussed on the mechanisms through which the wider determinants of inequalities impact on individuals' life chances, and emphasised the need for action from all sections of Government. Equally Well was also the first of a set of three linked social policy frameworks for tackling inequality, and sat beside the *Early Years Framework* and *Achieving our Potential* (both launched later in 2008).

Equally Well identified four primary areas for action

- children's very early years;
- mental health and wellbeing;
- the harms associated with violence, drug and alcohol abuse;
- and the big killer diseases (heart disease and cancer), together with their risk factors, such as smoking.

The Ministerial Task Force was reconvened in 2010 to review progress. The aims of the 2010 Review were to:

- gauge how well key agencies including Scottish Government had been able to respond to the principles of the recommendations in Equally Well;
- make additional recommendations or statements to give impetus to the vision for tackling inequalities set out in the three linked social policy frameworks. This was particularly pertinent in the tight public financial climate and, emerging trends in the key social inequalities;
- consider how to replicate progress made by the *Equally Well* test sites
- set out arrangements for future monitoring and governance.

The main conclusion of the 2010 review was the need for a greater focus on prevention and preventative spend and reinforcement of the general principle that poor health was not simply due to life style choices but that there were links to people's aspirations, sense of control and other cultural factors. This was described then as a 'sense of coherence', in which the external environment is perceived by individuals as comprehensible, meaningful and manageable. The 2010 review also re-emphasised that a more collaborative approach across different public services was required and that Community Planning Partnerships (CPPs) working effectively together would be key. The Task Force agreed to reconvene in 2012 to assess progress.

2.1 Remit of the Task Force in 2012

When the Task Force reconvened in November 2012 it was clear from the health inequality data that, for most indicators, the health gap between Scotland's most and least affluent groups had not reduced[1]. It was also clear that the impact of the current economic situation had yet to be fully realised and would apply further pressure; and that anticipated changes to the welfare system were likely to

[1] Long-Term Monitoring of Health Inequalities: Headline Indicators, Scottish Government 2012

exacerbate health inequalities and that this was a public health issue. In addition the Report on the Future Delivery of Public Services[2] (Christie Commission) had reset the expectations on the public sector and Community Planning Partnerships in particular.

The Task Force was asked to consider the latest evidence on health inequalities in Scotland within this context. Members were provided with summaries of the latest evidence, opinion and analysis from key stakeholders, and representations from a range of organisations. Over the course of 4 meetings, the Task Force sought to identify key priorities that would support delivery of Equally Well in the next few years. Specifically, members were asked to:

- reflect on changes in the way that people and communities were being engaged in decisions that affect them;
- consider the implications of the Christie Commission report for how health inequalities might be tackled; and
- look at how characteristics of "place" had an impact on health inequalities in Scotland.

There was a general understanding that the fundamental principles set out in Equally Well (Annex A) remained extant and that tackling health inequalities should sit at the heart of government policy alongside the other key social policy frameworks.

All the papers and presentations that the Task Force received are available from the Scottish Government website[3]. The current report does not seek to replicate that material, and should be read alongside the key background documents – in particular the Scottish Government's report on long-term monitoring of health inequalities and NHS Health Scotland's Health Inequalities Policy Review[4].

2.2 Membership of the Task Force

- Michael Matheson MSP, Minister for Public Health (Chair)
- Margaret Burgess MSP, Minister for Housing and Welfare
- Aileen Campbell MSP, Minister for Children and Young People
- Roseanna Cunningham MSP, Minister for Community Safety and Legal Affairs
- Derek MacKay MSP, Minister for Local Government and Planning
- Paul Wheelhouse MSP, Minister for Environment and Climate Change
- Sir Harry Burns OBE, Chief Medical Officer
- Sandy Watson (replaced Dr Charles Winstanley), Chair of NHS Chairs
- Margaret Burns, Chair NHS Health Scotland
- Professor Carol Tannahill, Director, Glasgow Centre for Population Health
- Andrew Muirhouse, Chief Executive, Inspiring Scotland
- Councillor Peter Johnston, Health and Well-being spokesperson, COSLA

[2] http://www.scotland.gov.uk/Publications/2011/06/27154527/0
[3] www.scotland.gov.uk/Topics/Health/Healthy-Living/Health-Inequalities/Equally-Well
[4] Health Scotland's Policy review

3. Health inequalities in Scotland

This chapter briefly describes the evidence presented to the Task Force about Scotland's current position with regards to health inequalities and what we can learn from how our health inequalities compare with similar parts of Europe and the UK. It draws from presentations to the Task Force which can be found on the government website[5].

Key Points

- **Scotland's health is improving**
- **Scotland's health is improving more slowly than other European countries**
- **Mortality rates have improved in deprived and affluent areas at broadly the same rate, leading to an increase in relative inequalities. In order to reduce health inequalities there needs to be a faster improvement in the most deprived**
- **Scotland has not always been an unhealthy society compared to the rest of Europe**
- **The origins of health inequalities are the inequalities in power, money and resources between deprived and affluent groups which impacts through complex interactions between social economic, educational and environmental determinants of health**
- **Conventional approaches to the problem that involve attempts to modify the health related behaviours of poorer people have failed.**
- **We must address wider inequalities in society, unless and until we do that health inequalities will persist.**

3.1 The continuing problem of health inequalities

The Scottish Government published its health inequalities indicators in October 2012 (Annex B). What the report showed was that there is evidence of improvement but only in one or two of the indicators. For example, there is a narrowing of the gap in low birth weight babies although having a baby with a low birth weight was still twice as common in poorer than in the more affluent homes. In addition there has been a 40% reduction in first admission to hospital for heart attack between 1997 and 2009 in those under the age of 75. Not only had there been a significant fall in admission rate but there also had been a narrowing of the gap between rich and poor both in absolute and relative terms. However, these trends are small and fragile and are minor exceptions when compared with other indicators. Since the Task Force last met (in June 2013) the latest position on these national health inequality indicators has been published[6]. Again there has been no significant narrowing of the gap..

The Task Force noted that mortality among younger working age aldults (aged 15-44 years) in Scotland is a particular cause for concern. While mortality in this age group fell from the 1950s to the mid-1980s, there has been no net improvement for men or women in this age group since then. These trends are unusual in a European

[5] http://www.scotland.gov.uk/Topics/Health/Healthy-Living/Health-Inequalities/Equally-Well/Equally-Well
[6] http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/TrendHealthOutcome

context and Scotland's relative ranking compared to other European countries has become progressively worse for both sexes in this age group over the last 55 years. This is different from what's happening in older working age or older age populations. There are also some worrying trends of some specific causes of death, for example of lung cancer mortality of women and male suicides which are contributing significantly to early death in the young working age population.

3.2 Comparing Scotland to Europe

Until about 1950 Scotland was in the middle of the European countries, neither exceptionally good nor bad, in terms of life expectancy. However, from the second half of last century Scotland's position has become worse so that as we approached the turn of the millennium Scotland's health was at the bottom of the Western European league table.

This differential growth in life expectancy has puzzled many who believe that there is something inherently unhealthy about Scotland or the Scots. The evidence suggests that Scotland has not always been an unhealthy society.

Figure 1. Male life expectancy: Scotland & other Western European Countries, 1851 -2005
Source: Human Mortality Database

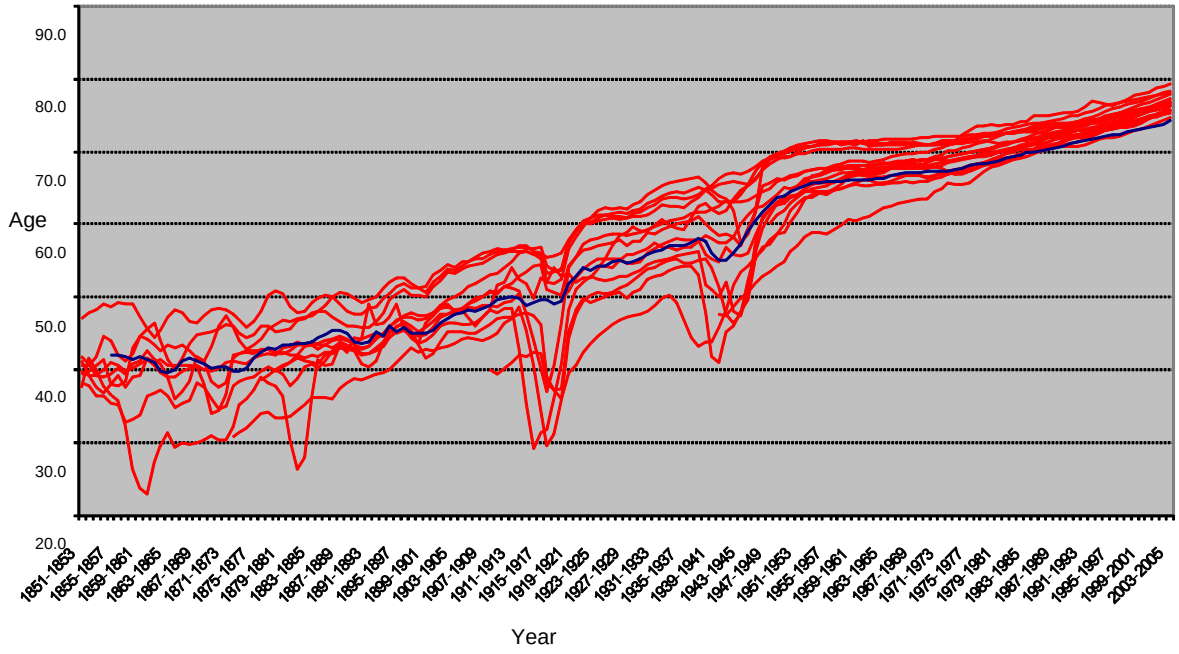


Figure 1 – Scotland in Blue shows that a relative slowing in the rate of improvement in life expectancy, compared to countries of Western Europe, took place in Scotland's health around 40-50 years ago. Scotland's life expectancy only began to fall behind our Western European neighbours after the 1950s.

3.3 Understanding health inequalities in post-industrial Scotland

Social capital describes the pattern and intensity of networks among people and the shared values which arise from those networks. Greater interaction between people generates a greater sense of community spirit. The definition used by Office for National Statistics, taken from the Office for Economic Co-operation and Development (OECD), is 'networks together with shared norms, values and understandings that facilitate co-operation within or among groups'.

Higher levels of social capital are associated with better health, higher educational achievement, better employment outcomes, and lower crime rates. There are a number of different aspects to social capital:

- *levels of trust - for example, whether individuals trust their neighbours*
- *membership - for example, to how many clubs, societies or social groups individuals belong*
- *networks and social contacts - for example, how often individuals see family and friends*

Formal and informal networks are central to the concept of social capital.

- *bonding social capital – describes closer connections between people and is characterised by strong bonds, for example, among family members or among members of the same ethnic group; it is good for 'getting by' in life*
- *bridging social capital – describes more distant connections between people and is characterised by weaker, but more cross-cutting ties, for example, friends from different ethnic groups, friends of friends, etc; it is good for 'getting ahead' in life*
- *linking social capital – describes connections with people in positions of power and is characterised by relations between those within a hierarchy where there are differing levels of power; it is good for accessing support from formal institutions.*

Shared norms, values and understandings relate to shared attitudes towards behaviour that are accepted by most individuals/groups as a 'good thing'. These norms of behaviour are understood by most members of society.

Groups in this context are very broadly defined and can refer to:

- *geographical groups - such as people living in a specific neighbourhood*
- *professional groups - such as members of a local association or voluntary organisation*
- *social groups - such as families, church-based groups, groups of friends*
- *virtual groups - such as the networks generated through common interest groups*

Social Capital is just one psycho-social explanation for inequality of outcome in life. There are many other theories that could be classified as supporting the concept of "salutogenesis" or the creation of health. These include ideas such as emotional intelligence, learned optimism, and social connectedness. All are theories which help to explain why some people are more successful at creating good lives regardless of their circumstance. All point to the importance of inner psychological capacity as critical to sustaining wellbeing.

Some council areas and communities across Scotland have health outcomes that are as good as the best in Europe. However, when Scotland is broken down into its constituent local authorities it is those in post-industrial West Central Scotland, together with Dundee and the Western Isles, that have the greatest burden of poor health and early death. Higher levels of poverty and disadvantage are the root causes; and continued efforts to reduce poverty and income inequality within Scotland[7] form an essential foundation for action to reduce health inequality.

[7] The Scottish Government's Solidarity Target is to increase overall income and the proportion of income earned by the three lowest income deciles as a group by 2017

In addition, more detailed analyses of the West of Scotland's position relative to comparable regions in Europe and of Glasgow relative to other UK cities have highlighted the presence of a significant 'excess mortality', which is not explained by the levels of income deprivation, income inequality or deindustrialisation in this part of Scotland. Explanations for this excess are currently being explored, and it is clear that there will be no single factor that accounts for the difference. That said, plausible causes include lower levels of some aspects of social capital (trust and reciprocity, and social participation)[8]. There are significant associations between higher social capital and lower mortality: a recent review concluded that 'both individual social capital and area/workplace social capital had positive effects on health outcomes, regardless of study design, setting, follow-up period, or type of health outcome'

That social capital is one important factor in meeting the Scottish Government's key strategic objectives is clear. For example, the strategic objective to 'Help local communities to flourish, becoming stronger, safer places to live, offering improved opportunities and a better quality of life' (Safer and Stronger) reflects assumptions from social capital theory that if individuals and communities are supported to build their own capacities and networks this will lead to improvements in wellbeing.

3.4 Summary

In summary Scotland's health is improving but it is improving more slowly than other European countries and our health has dropped below that of comparable European countries from the middle of the last century. As a general pattern the rate of improvement in health in the poorer areas of Scotland is significantly slower that in the more affluent areas. The age group of 15 - 44 year olds appears to be the group for whom Scotland compares most poorly with our European peers in terms of excess deaths. There are also concerning trends for older working age women.

The origins of health inequalities are complex and they are to be found in the many interactions between social, economic, educational and environmental determinants. During its most recent discussions, the Ministerial Task Force on Health Inequalities recognised the continued need for concerted action across this range of determinants. It noted that the government's performance framework provides a structure for monitoring progress and identifying priorities for enhanced attention within this wide range of factors. The specific focus of the Task Force on this occasion was to consider how better health might be supported within Scotland's communities through considering the role of Community Planning Partnerships, the recommendations of the Christie Commission on the Future Delivery of Public services , and how aspects of 'place' impact on health. The Task Force noted that in trying to understand the similarities and differences between communities the level of - "social capital" - was a potential contributing factor in determining positive outcomes. This had also been identified by the Christie Commission and was a feature of the Equally Well test sites.

[8] Exploring potential reasons for Glasgow's "excess" mortality. Glasgow, Glasgow Centre for Population Health, NHS Health Scotland, University of Aberdeen, 2013.

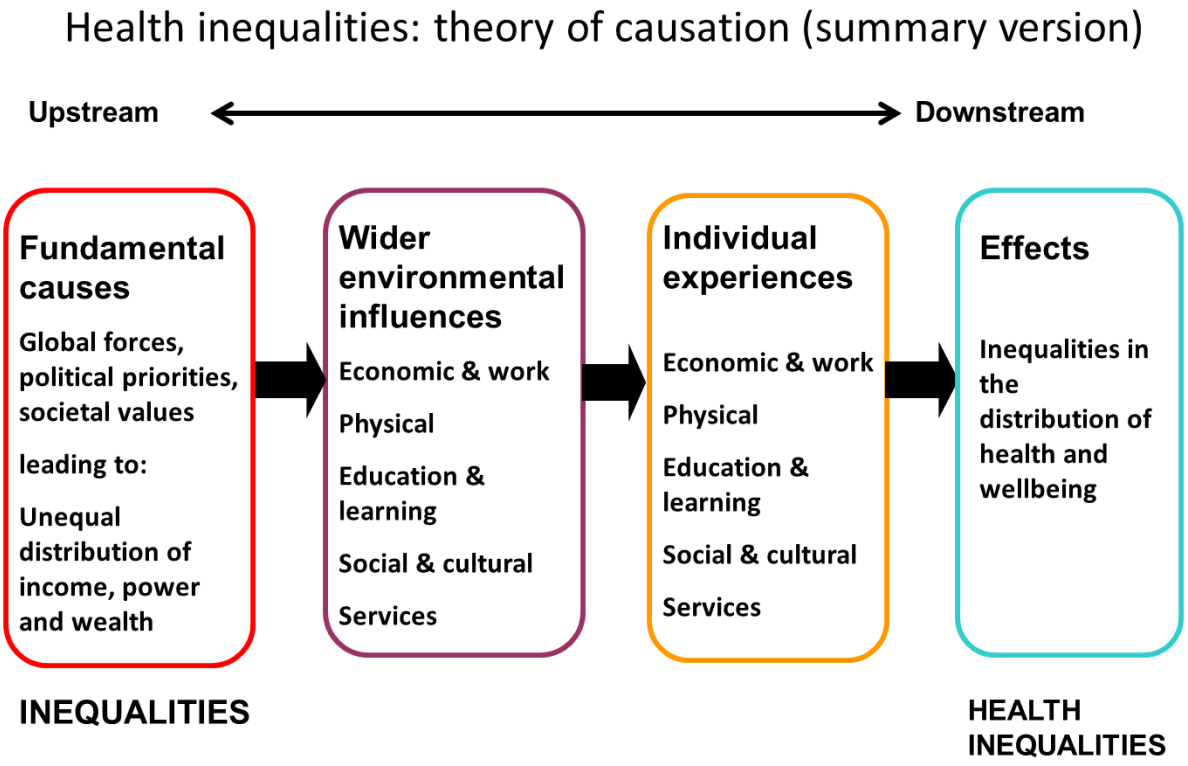
4. Priorities for tackling health inequalities

This section highlights some of the key points from the policy review[9] undertaken by NHS Health Scotland and also discusses the role of CPPs

Key Points

- **NHS Health Scotland's policy review suggested that there is evidence of "lifestyle drift" in tackling health inequalities with actions focussing on mitigation of poor lifestyle choices rather than efforts to tackle the underlying causes**
- **Equally Well has the potential to bring together a range of Government Strategies but that monitoring of actions could be managed better**
- **There needs to be a greater focus on the fundamental causes of health inequalities**
- **Priority must be given to those areas that contribute most to the burden on early death if health inequalities in Scotland are to be addressed.**
- **Community Planning Partnerships remain key to tackling health inequalities and must be fully supported to achieve transformational change**
- **Third Sector organisations are important to the success of CPPs tackling health inequalities**

4.1 What works to address health inequalities?



It is clear that any strategy to address health inequalities requires actions operating across all three levels of determinants: fundamental, wider environmental and

[9] Health Inequalities Policy Review for the Scottish Ministerial Task Force on Health Inequalities, NHS health Scotland 2013

individual. Action to address the wider environmental causes, such as the availability of quality work, housing and education; and individual experiences, risks and lifestyles are important, but will alone not solve the problem. The fundamental causes (upstream) of health inequalities such as lack of power and money also need to be addressed. For example, fiscal and employment policies such as paying a living wage to all employees covered by the Public Sector Pay Policy; power redistribution through engaging people and communities in co-production to help to design and shape the services they receive through assets based approaches. A significant problem has been where attention has been focussed and how that has been monitored.

4.2 Where to focus activity and how to maintain that focus?

NHS Health Scotland's Policy Review concluded that Equally Well was bold, grounded in good evidence and had made progress in some areas. It noted that Equally Well recognised the influences of both 'upstream' economic, social and physical environments as well as the influences of 'downstream' individual factors such as the accessibility of services, behaviours/lifestyles, and personal strengths, vulnerabilities and social networks. But there were several key factors that require attention if the strategy was to be fulfilled.

The Policy Review highlighted that actions in support of Equally Well had in many instances become focused on mitigating the effects of social inequalities, for example smoking and alcohol misuse, rather than on addressing the long term underlying causes, such as poverty and income and that despite its ambitions, Equally Well has primarily been delivered as a health and wellbeing initiative with limited spread into other policy areas other than early years. This is sometimes termed "lifestyle drift" and is a common feature of strategies like Equally Well. These actions are usually put in place to improve health generally but become the focus for efforts to tackle inequalities and can deflect attention from tackling the underlying causes. Whilst these activities are important they must not be seen as a proxy for action to deliver Equally Well. There is therefore a challenge for action to remain focussed on the fundamental causes and wider environmental influences. Without action to address the unequal distribution of power, money and resources and to deliver an equitable distribution of health-enhancing environments, health inequalities will remain.

The Policy Review noted that many other strategies and actions undertaken by the Scottish Government and its partners impacted on inequalities but were not explicitly linked to Equally Well for example the introduction of the Scottish Housing Quality Standard, the smoking ban and proposed pricing controls for alcohol. This poses a challenge when trying to monitor and reflect on all the activity that is underway to tackle inequalities and the Task Force agreed that this should be addressed.

4.3 Supporting CPPs to deliver transformational change

The review of progress to date on Equally Well highlighted a number of delivery challenges which in the main are in the hands of CPPs. From the outset Equally Well has emphasised the role that CPPs can make to delivering change but they have not yet lived up to expectation. Achieving better joint working across agencies

and services as well as involving local communities and target groups were seen as cornerstones for successful delivery on health inequalities. Equally Well highlighted the need for a significant improvement in partnership working in CPPs.

The Christie Commission was absolutely clear that a radical change in the design and delivery of public services and the way in which public services work with each other and with communities was required. The Scottish Government has agreed that this requires that:

- public services are built around people and communities, their needs, aspirations, capacities and skills, and work to build up their autonomy and resilience;
- public service organisations work together effectively to achieve outcomes;
- public service organisations prioritise prevention, reducing inequalities and promoting equality; and
- all public services constantly seek to improve performance and reduce costs, and are open, transparent and accountable.

CPPs remain critical in tackling health inequalities because much of what needs to be done is not specifically health related but about the wider determinants as highlighted previously, and which are under the control of local authorities.

The Task Force noted that while progress has been made in some localities, it is also true that this has neither been consistent nor game-changing. Audit Scotland recently argued that CPPs have not taken full ownership of the health inequalities agenda across Scotland, that there has not been effective partnership working and that partnerships have struggled to put in place appropriate interventions[10]. It is clear that tackling health inequalities should be at the core of what CPPs do.

The Task Force heard from both CoSLA and the Improvement Service on how CPPs can best respond to the recommendations from the Audit Scotland report and also the ambition of all partners and stakeholders. It noted that measures already planned include strengthening duties on individual partners through a new statutory duty on all relevant partners (whether acting nationally, regionally or locally) to work together to improve outcomes for local communities through participation in CPPs.

4.4 The Third Sector and CPPs

The Task Force also heard from representatives of the Third Sector to discuss the issues that they faced and to reflect on their relationship with CPPs. A key long standing issue faced by many Third Sector organisations is their ability to obtain sustained funding for small scale work over long periods. Even when the work is recognised by the CPP as the best and preferable course of action that is no guarantee of security and there is a need for CPPs to provide such at an earlier point in the planning process to ensure delivery. The Task Force noted that engagement of the third sector remains inconsistent across CPPs and it was acknowledged that they needed to be more closely involved. This would be a priority to rectify in good economic times but the current climate heightens that need, given the key

[10] Improving community planning in Scotland, Audit Scotland 2013

Lessons from the Equally Well Test Sites

A series of test sites were established under Equally Well in 2008 to employ innovative ways to redesign and re-focus local public services working with communities to address health inequalities. The work in the test sites has been mainstreamed.

Key Learning From the Test Sites

- *A requirement for a commitment at senior level from across the participating organisations – and for this to be visible and active and highly permissive to give encouragement to the use of novel approaches and to be willing to accept emergent and unanticipated solutions.*
- *A requirement for blurring of boundaries between partners, usually facilitated by someone who could span organisational boundaries, who could work horizontally and vertically with ease to bring ideas, people, communities together.*
- *A requirement to understand each other and the challenge, by losing the barriers placed by language and perceptions of roles and responsibilities. (e.g. health inequalities, not being about NHS, but about social inequality).*
- *That the more communities were involved in co-creating and co-delivering the more success was seen in the journey to outcomes.*
- *That the lived experience in communities may be very different to the professional perception and that assets can be found in the community from the residents, the families and individuals but also from the range of services and groups in the community .*

contribution the third sector can make to prevention and assets based approaches. The Third Sector representatives also raised their capacity issues regarding their ability to tender for contracts and meet the demands with regard reporting requirements. It was noted that there was scope for that to be managed better both at the interface with the CPP but also to help third sector organisations work more effectively together.

4.5 Giving back control – unleashing the assets in our communities

To explore and support new ways of working a series of test sites were established under Equally Well to employ innovative ways to redesign and re-focus local public services working with communities to address health inequalities. The key learning from the test sites included:

- a requirement for commitment at senior level from across the participating organisations,
- visible efforts at co-ordination and joint working across agencies,
- working with communities
- use of novel approaches and a willingness to accept emergent, unanticipated solutions.

It was noted that the key learning points were replicated by other pilots which focussed on different health issues and that the learning overlapped the aspirations set out by the Christie Commission.

A key element of the test sites was the development of assets based approaches as there had been growing interest in understanding how such an approach might help address some of Scotland's long-standing health problems and inequalities. The Chief Medical Officer's annual report (2011)[11] describes the assets-based approach as involving 'helping people to be in control of their lives by developing the capacities and capabilities of individuals and communities'. It highlights the 'recognition of social capital (the connections within and between social networks) and its importance as an asset' in discussing Area Based Community Development as an approach that could be applied to improve health and wellbeing.

[11] Transforming Scotland's Health. Chief Medical Officer Annual Report 2011

Link Up – Harnessing assets & improving wellbeing

Link Up (a partnership between Inspiring Scotland and 10 charities) began operating in January 2012 and is funded by the Scottish Government's CashBack for Communities Programme until July 2014. The programme operates across ten vulnerable communities. In each, a Link Up worker is employed to harness community assets to establish activities (e.g. cooking, gardening, sports, cinema) where residents are actively participating in running the activity and are helping it become a sustainable part of community life.

Impact - By September 2013, 6,300 people (often 'hard to reach') had participated in Link Up activities with 400 volunteering. This engagement is helping to establish social networks and build social capital, important precursors to realising the potential of a community's assets.

Link Up is also starting to evidence that enabling individuals to use their strengths and/or new skills for the benefit of others can lead to transformative change. For some, this can begin to redefine their world view and that they hold of their community and place in it, as contributors not recipients. This in turn has led to higher-order outcomes: re-engagement with work; healthier life-styles including reduced drug & alcohol misuse; reduced isolation; increased confidence; better feelings about where they live; belief in self-efficacy; and community activism.

Approach - Link Up is creating conditions where positive change is possible and for some people, is improving wellbeing by making a relatively bigger part of their life "comprehensible, manageable and meaningful". In this respect, the key features are:

- starts by asking ***what's good*** in a community and what locals can contribute rather than focus on deficit.
- ***not about enforcing external agendas***, local people determine activities and how groups develop
- workers have significant ***autonomy to develop and flex approach within local context*** and aims of locals.
- flexible funding enables participant ***ideas to be rapidly turned into action.***
- workers treat local people with real ***respect and value,*** recognising them as valuable contributors, not victims/issues to be saved/resolved.

The Christie Commission also argued that 'building personal and community capacity, resilience and autonomy' should be a key objective of future public service reform. Engaging individuals and communities in decisions about services is seen in the Scottish Government's response to that report - *Renewing Scotland's Public Services*[12] - as key if public services are to become both more efficient and more effective at meeting people's needs. And arguably such this can only be achieved if individuals and communities engage both with each other and with service providers – in other words, it relies on social capital.

The Task Force is supportive of the development of asset based approaches and noted that they serve as a means by which social capital can be developed which can have a beneficial health effect and that programmes like Link Up reflect that approach.

4.6 Creating quality neighbourhoods

The Task Force also heard about the experience of Good Places, Better Health (GPBH). GPBH was launched in 2008 as the Scottish Government's strategy on health and the environment[13]. Traditionally the focus within environmental health has been on toxic, infectious, allergic and physical threats. While these still demand attention, there is now a growing recognition of an additional need to shape places which are nurturing of positive health, wellbeing and resilience.

A key recommendation flowing from the GPBH experience was the proposal to develop a Scottish Neighbourhood Quality Standard. The SOA guidance

[12] Renewing Scotland's Public Services. The Government's response to the Christie Commission 2011.
[13] Good Places, Better Health: A New approach to the Environment and Health in Scotland: Implementation Plan 2008

published in 2012[14] highlighted the importance of tackling place as a key determinant of health and this has recently been followed up by the new Architecture and Place policy statement, "Creating Places" published in June this year[15]. It recognised that the quality of the built environment affects everyone, and that it is the purpose of architecture and urban design not only to meet our practical needs but also to improve the quality of life for the people of Scotland. To that end it has committed to developing a Place Standard. The Task Force is supportive of that and sees it as an important step in providing a framework that will help reshape local environments to help promote better health. The Task Force noted that the development and implementation of the place standard should be monitored.

4.7 The life course approach – young people

One of the highest priorities for any country is to ensure the best possible start to life for every child. This was recognised and reflected in the original Equally Well report which sat alongside the *Early Years Framework* and *Achieving our Potential*. The Task Force continues to support the life course approach and noted that the age group 15-44 had been identified as a source of early deaths. There is a need to reflect on what we are doing for this age group to reassure ourselves that our approach is balanced between treatment and prevention and it may be that we need to consider a framework approach that builds on the early years framework but is focussed on those key points in a young persons' life where there may be significant transition such as primary to secondary school or secondary school to work with a focus on prevention.

4.8 Impact of Welfare Reform

The UK Government has introduced a major overhaul of the welfare benefits system. The overarching aim of this is to reduce the cost of welfare benefits. This could lead to a cut of £4.5 billion over the 5 years to 2015, around £1 billion of which relates directly to children. The Task Force heard that the consequences of welfare reforms will manifest in the short and longer term[16]. In the short term the NHS is seeing an increase in demand on primary care from those losing benefits as claimants seek advice and evidence for appeals. This demand can be expected to continue until the bulk of the changes have worked through the system by 2017. Claimants are also turning to other parts of the NHS for help when Primary Care cannot help them.

In the longer term consequential demand for healthcare arising from the impact of welfare reform and ongoing austerity will be as a consequence of the health impact of increased poverty:

- poorer mental health, increased cardiovascular and respiratory illness

(associated with low income, income inequalities);

- increases in obesity-related illnesses such as diabetes, arthritis and cancer

[14] Single Outcome Agreements: Guidance to Community Planning Partnerships Scottish Government and COSLA 2012.
[15] Creating Places - A policy statement on architecture and place for Scotland 2013
[16] http://www.scotland.gov.uk/Resource/0042/00426052.pdf

arising from poorer nutrition (associated with low income, income inequalities);

- poorer mental health and general wellbeing, reductions in/disruption to health care access (associated with housing difficulties/housing insecurity); and
- potential increases in avoidable winter mortality (associated with fuel poverty).

As welfare benefits are reserved to the UK Government, mitigating the impact of the reforms is challenging. The Scottish Government is focussed on tackling child poverty and published its Child Poverty Strategy for Scotland in March 2011. The *Strategy* expresses the Government's commitment to tackle the long term drivers of poverty through early intervention and prevention. Guidance has also been developed for NHS Boards on mitigating activities. The focus is on maximising household resources and improving children's wellbeing and life chances over the longer term. This long term approach has three underpinning principles: early intervention and prevention to break the cycle of poor outcomes; building on the assets of individuals and communities, moving away from a focus on deficits; and ensuring that children and families' needs are at the centre of service design and delivery. This is very much in line with the approach outlined originally in Equally Well and reinforced here. Collaborative action across the public and third sector is required to ensure that those with greatest need can access the appropriate support to address the impacts that benefit changes may have on public health.

5. Summary

Health inequalities are caused at three different levels – fundamental causes, wider environmental influences and individual experiences. Action to address the wider environmental causes and individual experiences are important, but will alone not solve the problem. The fundamental causes of health inequalities such as lack of power and money need to be addressed. This can partly be achieved by engaging people and communities in helping to design and shape the services they receive through assets based approaches, and similar. Such approaches can redistribute power within communities, share information and intelligence, build connections, and produce better outcomes.

NHS Health Scotland's policy review suggested that there is evidence of "lifestyle drift" in tackling health inequalities with actions focussing on mitigation of poor lifestyle choices rather than efforts to tackle the underlying causes. Part of the challenge to minimise such drift is better coordination of national and local government strategies. Whilst part of the focus should be on tackling the fundamental causes of inequalities, such as through the Child Poverty Strategy there should be continued effort on coordinating approaches to tackle the wider environmental causes. Community Planning Partnerships are key to tackling health inequalities and must be fully supported to achieve the transformational change required.

The Task Force heard evidence from the Good Places, Better Health team and noted their recommendation that a Scottish Neighbourhood Quality Standard should be adopted. The Task Force were made aware that the Scottish Government had agreed to develop a place standard through its Architecture and Place policy *Creating Places*

- *A policy statement on architecture and place for Scotland*[17] (June 2013) and were supportive of this.

The number of deaths in the age group 15 to 44 years was highlighted in the latest evidence presented to the Task Force. It was agreed that in line with the Life Course approach that this the government and other agencies should reflect on actions that are currently underway that impact on this age group to ensure that this work is coordinated and as effective as possible in changing young people's health which will have an impact on their health in later life.

[17] http://www.scotland.gov.uk/Publications/2013/06/9811

6. Conclusion

The Task Force agreed that the fundamental principles of Equally Well still hold true and also that Equally Well remains at the heart of inequalities policy in Scotland. Members also agreed that the life course approach should remain central to that policy and that giving children the best start to life was essential.

Through this review the Task Force heard from a number of contributors about learning and experience since the last review in 2010 and also received an update on the latest evidence. The Task Force noted that despite a lot of commitment and resource the scale of health inequalities, as measured by the national indicators had not reduced. If the strategy is fundamentally sound and the actions and themes robust then the focus has to be on delivery and how we go about implementation. The Task Force were asked to consider the latest evidence and to reflect on changes in the way that people and communities were being engaged in decisions that affected them and the impact of the Christie Commission on how health inequalities is being tackled.

The Policy Review noted that whilst the publication of Equally Well in 2008 marked the desire to shift focus to the social determinants of health, linking beyond the NHS and engaging local authorities, there had been a tendency towards focussing on "downstream" activities that is dealing with people after they had acquired problems rather than dealing with issues "upstream" preventing problems arising in the first place and often these issues were tackled individually and there was limited joining up of activity.

The Policy Review also noted that there was a significant amount of work that contributes to tackling inequalities undertaken across Government but which is not explicitly linked to Equally Well. A similar conclusion has been reached by the Health and Sport Committee of the Scottish Parliament who had planned a review of health inequalities but have recently decided against such as review seeking instead to widen the debate on health inequalities by inviting other relevant subject committees to consider the question within their remits.

The Task Force was asked to reflect on changes in the way that people and communities were being engaged in decisions that affected them and the impact of the Christie Commission on how health inequalities are being tackled. In addition the Task Force looked at how "place" had an impact on health inequalities.

Finally the Task Force noted that welfare reform was a public health issue and that impact was already being felt by the NHS. The Task Force noted that there were limits to what the Scottish Government and Local Government could do to mitigate the impacts of the UK wide changes to the system.

The Task Force identified the following areas as priorities:

- Support for CPPs

Equally Well has always placed Community Planning Partnerships at the centre of achieving the ambition set out in the strategy. This was reinforced in the 2010 review and has been reflected in the recent list of six priorities given to CPPs which

includes tackling health inequalities. The Task Force recognised that recently CPPs have received greater attention through the Christie Commission report and the response of national and local government to the challenge. The Task Force is convinced that CPPs remain the best vehicle for making progress in delivering on Equally Well's priorities at sub-national level and in responding to the Christie Commission Report. In particular, the need for Community Planning Partnerships to realign available resources toward shared priority outcomes in new Single Outcome Agreements – including to reduce health inequalities - and engage all parties including the Third Sector is a priority for the Equally Well agenda. The Task Force considers that community planning partners need to act on this, in fulfilment of the Agreement on Joint Working on Community Planning and Resourcing[18] which was published in September 2013.

- Development of Social Capital

The Task Force believe that a key function of CPPs will be how they engage with their local communities. The Christie Commission argued that 'building personal and community capacity, resilience and autonomy' should be a key objective of future public service reform. The Task Force supported that objective and noted that this would play a role in generating and maintaining social capital which had been identified as a key difference between communities that are healthy and those that are unhealthy.

- Focus on 15-44 age group

In addition, the Task Force recognised that in taking a life course approach there was scope to examine and potentially enhance what we do that impacts on the 15-44 age group. The evidence suggested that it was in this age group in particular that Scotland experiences many more excess deaths compared with other European countries and regions. The Scottish Government will review with our partners current activities that impact on this age group to identify potential new actions that would impact positively on this age group's health outcomes.

- Support the implementation of a Place Standard

The Task Force noted that the development of a Place Standard was a welcome addition to the fight to tackle health inequalities. However, members noted that the processes of implementation of the standard would be critical and that this should be monitored.

- Coordination and monitoring of progress

Finally, it was clear to members that a regular two yearly review by the Task Force may not be the best way to monitor progress nor influence the current way of working. Alternative arrangements should be considered. As well as reflecting on progress, these arrangements might enable a more frequent exploration of how to respond to evidence about causes of, and responses to, health inequalities; how to best support Community Planning Partnerships in reducing health inequalities within

[18] http://www.scotland.gov.uk/Resource/0043/00433714.pdf

Scotland; and how best to coordinate local and national government activity and the wider public sector.

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7. Annex A – Principles of Equally Well

Equally Well was informed by the shared features of the social policy frameworks, and set out some key defining principles that would be its focus:

- Improving the whole range of circumstances and environments that offer opportunities to improve people's life circumstances and hence their health and other beneficial outcomes.
- Reducing people's exposure to factors in the physical and social environment that cause stress, are damaging to health and wellbeing, and lead to health and other inequalities.
- Recognising the particular importance of children's very early life experiences in shaping future health, social, learning and lifestyle outcomes
- Prioritising early intervention - to break into recurring cycles, including poverty, unemployment, low skills, and poor health, and to prevent crises and problems requiring extensive responses from public services
- Engaging individuals, families and communities most at risk of poor health in services and decisions relevant to their health, and promoting clear ownership of the issues by all involved.
- Building the capacity of individuals, families and communities to manage better in the longer term, moving from welfare to wellbeing and dependency to self-determination
- Providing effective routes for individuals out of poverty and other life circumstances and lifestyles likely to get in the way of positive wellbeing, health and other good outcomes
- Using government policy when it is helpful to set universal regulation or national services in place to reduce inequalities
- Developing a "shared outcomes" approach to local delivery of the relevant public services, in which action likely to work in achieving longer term outcomes is shared between partner agencies, supported by sound internal performance management, public reporting and a cycle of continuous improvement
- Promoting an investment approach to the best use of public sector resources, based on the business case for shifting resources over time to prevention and underlying causes of social problems, rather than dealing with the consequences of those problems
- Improving alignment of the relevant resources across public services managed by different agencies
- Shifting priorities, towards the use of mainstream public sector budgets to address inequalities and underlying causes and away from discrete project funding
- Delivering health and other services that are both universal and appropriately prioritised to meet the needs of those most at risk of poor health and other outcomes, and that seek to prevent problems arising, as well as addressing them if they do.
- Transforming and redesigning the spectrum of local public services, so that they respond well collectively to people who need multiple forms of support, and who may not currently be getting a productive response from these services, because of the complexity of their needs

- Ensuring we have a flexible workforce with the right skills, able to work effectively together across organisational boundaries and adapt their approach depending on the individual needs of service users
- Basing current and future action on the available evidence and adding to that evidence for the future, through introducing new policies and interventions in ways which allow for evaluating progress and success.
- Ensuring that the range of actions we take now will achieve both short and long-term impact and will address foreseeable future challenges.

8. Annex B – Long term monitoring of health inequalities

Headline Indicators - Summary of Trends as at 2012[19]

- Healthy life expectancy at birth: A new methodology means change over time cannot be measured, but there continues to be inequalities in both relative and absolute terms.
- Premature Mortality (all causes, under 75 years): since 2006, inequalities have been stable in relative terms, and have fallen in absolute terms.
- Mental Wellbeing (WEMWBS): inequalities are increasing in absolute terms but remain stable in relative terms.
- Low birth weight: inequalities are narrowing in both absolute and relative terms.
- Hospital admissions for heart attack (under 75 years): over time inequalities have fluctuated in both absolute and relative terms, but with no clear long-term trend
- Coronary Heart Disease (CHD) deaths (45-74 years): inequalities are narrowing in absolute terms and, following a long-term increase, have begun to stabilise in relative terms.
- Cancer incidence (under 75 years): over the long term, inequalities are stable in both absolute and relative terms.
- Cancer deaths (45-74 years): over the long term there has been a slight increase in relative inequality, although this has been more stable since 2004. Absolute inequalities have fluctuated over time with no clear trend.
- Alcohol - first hospital admission (under 75 years): the level of absolute inequality has fallen since 2007, while relative inequality has remained stable over the same period.
- Alcohol - deaths (45-74 years): inequalities have reduced since a peak in 2006 in both relative and absolute terms, but remain higher than in 1998.
- All-cause mortality (15-44 years): inequalities have grown in relative terms over the long term, but have stabilised in recent years. Absolute inequality shows no clear trend over the time.

Relative Index of Inequality (RII): How steep is the inequalities gradient? This measure describes the gradient of health observed across the deprivation scale, relative to the mean health of the whole population.

Absolute gap: How big is the gap? This measure describes the absolute difference between the extremes of deprivation - the rate in the most deprived minus the rate in the least deprived group.

[19] Note that the latest indicators were published in October 2013 and can be found here http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/TrendHealthOutcome