Background

NHS Health Scotland is a national Health Board working with public, private and third sector organisations to reduce health inequalities and improve health. Our 2012–17 corporate strategy A Fairer Healthier Scotland\(^1\) sets out our vision of a Scotland in which all of our people and communities have a fairer share of the opportunities, resources and confidence to live longer, healthier lives. Our primary role is to work with others to produce, share and implement knowledge of what works to improve the health of the people in an equitable way, thereby reducing health inequalities.

Our work spans the wider social determinants of health, shown below. We can provide the Committee with further evidence in any area relating to equitable health improvement on request.

In this submission we are focussing specifically on obesity and mental health, in line with the Committee’s work programme.

Figure 1: Social Determinants of Health

What are Health Inequalities?

The overall health of the Scottish population is continuing to improve, along with a decline in the death rate. However, the gaps between those with the best and worst health and wellbeing still persist and there are thousands of unnecessary premature deaths every year in Scotland.
As set out in our Inequality Briefing Health Inequalities: What are they? How do we reduce them? health inequalities are the unfair and avoidable differences in people’s health across social groups and between different population groups. Health inequalities are unfair because they do not occur randomly or by chance, but are influenced by the wider social determinants detailed above. They are avoidable because they are rooted in political and social decisions and priorities that result in an unequal distribution of income, power and wealth across the population and between groups.

The stark reality of health inequality is illustrated by the Glasgow train line map below. Life expectancy in men goes down by two years for every station on the trainline travelling from Jordanhill (in the west end) to Bridgeton (in the east end). On average, a man born in Bridgeton can expect to live 14.3 years less than his counterpart in Jordanhill, and a woman 11.7 years less.

**Figure 2: Health Inequalities in Glasgow**

Health inequalities are described and measured by comparing the health outcomes of different groups. Health outcomes such as life expectancy (mortality), healthy life expectancy and rate of disease (morbidity) are compared using groupings such as social class, area deprivation, educational attainment, employment status, gender and ethnicity.

The simplest measure of health inequalities is to compare the health of those in the lowest socio-economic group with those in the highest group. The evidence shows that, in general, the lower a person’s position is in society, the worse their health will be.

However it is not only those in the lower socioeconomic deciles who experience health inequalities. Simple comparisons of the lowest and highest groups do not account for the social gradient in health across the whole population. As highlighted by the Scottish Government, health inequality affects almost everyone:
“All the way, from top to bottom of society, the lower you are, the worse your health. The gradient includes all of us below the topmost 1 per cent.”

What Causes Health Inequalities?
There is widespread agreement that the fundamental cause of health inequality is the unequal distribution of:

- **Income**: money received by individuals or groups over a specific time period.
- **Power**: This is a complex concept which includes the ability or capacity to do (or not to do) something and control, force or influence through a variety of means. Power can also arise from additional resources such as knowledge, prestige, beneficial connections and other necessary social resources that protect health, no matter what mechanisms are relevant at any time.6,7
- **Wealth**: Accumulated material and capital assets which provides a reserve of financial resources and often provides an income stream (e.g. from interest, rents and share dividends).

These fundamental causes also influence the distribution of wider environmental influences on health, such as the availability of good quality housing, work, education and learning opportunities, as well as access to services and social and cultural opportunities in an area and in society.

The wider environment in which people live and work then shapes their individual experiences of, for example, low income, poor housing, discrimination and access to health services. This all results in the unequal and unfair distribution of health, ill health (morbidity) and death (mortality). This is shown in the figure overleaf.
Figure 3: Theory of Causation

What works to reduce health inequalities?
Tackling health inequalities requires a blend of action to undo the fundamental causes, prevent the harmful wider environmental influences and mitigate (make less harmful) the negative impact on individuals. Action must be based on evidence of need, understanding of barriers to social opportunities and what is most likely to work.  

- **Action to undo the fundamental causes of health inequalities**
  Action is needed to address the fundamental causes of social inequality which determine inequalities in income, employment, education and daily living conditions. Resources and actions need to be reallocated from interventions that are not effective to those focused on reducing health and social inequalities with the prioritisation of social equity and justice. For example:
  - Introducing a minimum income for healthy living.
  - Ensuring the welfare system provides sufficient income for healthy living and reduces stigma for recipients through universal provision in proportion to need.
  - Developing more progressive individual and corporate taxation.
  - The creation of a vibrant democracy, greater and more equitable participation in elections and local public service decision-making.
  - Active labour market policies and holistic support to create good jobs and help people get and sustain work.

- **Action to prevent harmful environmental influences on health inequalities**
  Action is needed to ensure equity in the distribution of, for example, good work, high quality and accessible education and public services in line with proportionate universalism. The most effective means of reducing health inequalities in relation to health behaviours are those which involve taxation and regulation to tackle causes of poor health (e.g. alcohol duty or sales restrictions). These interventions are also amongst the most cost-effective because they require fewer resources to deliver them and they have wide reach. For example:
  - Ensuring local service availability and high quality green and open spaces, including space for play.
  - Drink-driving regulations; lower speed limits.
  - Raising the price of harmful commodities like tobacco and alcohol through taxation and further restrict unhealthy food and alcohol advertising.
- Protection from adverse work conditions (greater job flexibility, enhanced job control, support for those returning to work and to enhance job retention).
- Provision of high quality early childhood education and adult learning.

- **Action to mitigate the effects of health inequalities on individuals**
  Action is required to tackle the unfair differences in people's experiences of environmental factors such as work, education and health. These differences are largely beyond an individual's control but can limit their chances of living longer, healthier lives. Action should, therefore, be taken to ensure equal access to public services, targeting high risk individuals with intensive, tailored individual support with a focus on young children and the early years. For example:
  - Training to ensure that the public sector workforce is sensitive to all social and cultural groups, to build on the personal assets of service users.
  - Link services for vulnerable or high risk individuals (e.g. income maximisation welfare advice for low income families linked to healthcare).
  - Provide specialist outreach and targeted services for particularly high risk individuals (e.g. looked after children and homeless).
  - Ensure that services are provided in locations and ways which are likely to reduce inequalities in access (e.g. avoiding discrimination by language).
  - Maintain a culture of service that is collaborative and seeks to co-produce benefits, including health and wellbeing, through work with service users.

**The importance of a preventative approach**
Inequalities account for a significant element of the increasing demands on our public services because of a persisting cycle of deprivation: children and young people brought up in deprived circumstances are more likely to be deprived in later life, which affects the life chances of their children. The Christie Commission report suggested that around 40% of our spending is currently accounted for by interventions that could have been avoided by prioritising a preventative approach. The focus needs to shift (from meeting the cost of dealing with health or social problems after they have developed) to prevention and early intervention.

Understanding the likely impacts of interventions on health and health inequalities can help Scottish Government, Health Boards and local government make challenging decisions about where best to invest resources. Modelling work undertaken by ScotPHO shows that interventions focusing on individual behaviours (such as alcohol brief interventions, smoking cessation and anti-obesity interventions) have modest impacts on inequalities and overall health compared to interventions which redistribute income (such as increasing benefits, creating jobs and increasing the minimum wage).

**Policy Context**

At a UK level, the Black Report of 1980 and the Whitehead Report of 1987 both found that health inequality is caused by wider socio-economic factors and that action was required on redistribution, increased public expenditure and taxation. Similarly, in 1998 the Acheson Inquiry into Inequalities in Health found that the root cause of health inequality is poverty and income inequality.

The World Health Organization established the Commission on Social Determinants of Health in March 2005 to support global action to address the social factors leading
to ill health and health inequities. This resulted in the report Closing the gap in a generation: Health equity through action on the social determinants of health.\textsuperscript{6}

In 2008, Professor Sir Michael Marmot was asked by the Westminster Government to chair an independent review into health inequalities in England. The report, Fair Society Healthy Lives\textsuperscript{13}, the “Marmot Review”, concluded that reducing health inequalities would require action across early years, good work, standard of living, places and communities and ill-health prevention.

In Scotland, the Ministerial Task Force on Health Inequalities reported in June 2008. The report, Equally Well\textsuperscript{14}, outlines the actions required by national and local government, NHSScotland and the third sector to tackle health inequalities and the underlying causes of health inequalities. It also links reducing health inequalities with sustainable economic growth.

Since the publication of Equally Well the Scottish Government has published the Equally Well Implementation Plan\textsuperscript{15} and the Equally Well Review\textsuperscript{16}.

In 2012, the Ministerial Task Force was reconvened in order to review new evidence, look at lessons learned to date and highlight new areas for attention. NHS Health Scotland produced a Health Inequalities Policy Review\textsuperscript{17} to provide evidence to the task force about what works to reduce inequalities and to make recommendations for future strategy. The review concluded that in order to make a real impact on health inequalities, the following key issues would have to be addressed:

- The case for tackling health inequalities will have to be widely understood and be given the highest priority across government.
- A shift of emphasis toward suitable use of regulatory and fiscal measures – which do not rely on individual take up – and away from addressing individual lifestyle issues and the targeting of specific areas.
- Effective coordinated and focused action at both a national and local level.

Most recently, the Health and Sport Committee’s report on health inequalities\textsuperscript{18} published in January 2015 emphasised the need to tackle the structural causes of health inequalities and recognised that the responsibility to reduce health inequalities extends far beyond the health service.
Mental Health

Approximately 1 in 4 people experience a mental health problem (such as depression or anxiety) at some point in their life. Mental health problems are one of the major contributors to disability in the UK.

Good mental health is not only the absence of mental health problems. The World Health Organization defines good mental health as:

“a state of [mental] well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community”

The cost of mental ill health

The most recent data suggest that the economic costs of mental health to Scotland are substantial. In 2009/10 this was approximately £10.8 billion, a 25% increase from 2004/5 (£8.6 billion). This is made up of estimates of:

- Almost £2 billion spent on health and social care for those with mental health problems. However, English data suggests that only around a quarter of people with mental ill health are in receipt of treatment.
- £3.2 billion of losses as a result of mental ill health in the workforce during 2009/10. This is the result of worklessness, loss of unpaid work, sickness absence and premature mortality.
- £5.6 billion in human cost. This is a monetised estimate of the adverse effects of mental health problems at a population level, in terms of morbidity, quality of life and, premature mortality resulting from suicides due to mental health problems.

Mental health inequalities

Mental health problems are not equally distributed across the population. Those who are socially disadvantaged are at increased risk. For example adults living in the most deprived areas in Scotland are approximately twice as likely to have common mental health problems as those in the least deprived areas (22% versus 11%). In 2010/2011 there were twice as many GP consultations for anxiety in areas of deprivation than in more affluent areas in Scotland (62 versus 28 consultations per 1,000 patients).

The prevalence and type of mental health problems also varies by gender and age.

What drives inequalities in mental health?

Current thinking suggests that the link between social status and mental health problems is the level, frequency and duration of stressful experiences and the extent to which these are buffered by social and individual resources and sources of support. These stressful experiences (including poverty, family conflict, poor parenting, childhood adversity, unemployment, chronic health problems and poor housing) occur across the life course and contribute to a greater risk of mental health problems if they are multiple in nature and if there are no protective factors to mitigate against the negative impact. The stress-vulnerability model suggests that stressful life circumstances and events trigger and exacerbate mental health problems amongst those who are vulnerable.
Where should we intervene?
Actions across the life course and in all policy areas have the potential to impact on mental health and mental health inequalities. Key areas where there is strong evidence of an association with mental health problems include:

- adversity and disadvantage in early years
- low and insecure income and problem debt
- unemployment and access to good work
- poor housing
- violence and physical abuse
- the physical environment

Childhood adversity
Half of all lifetime mental disorders start by the mid-teens and three-quarters by the mid-twenties. Mental health problems are influenced from an early age by the social environment. Adversity and multiple disadvantage in childhood, as well as abuse and neglect, poor parenting and parental mental health problems are some of the factors associated with an increased risk of mental health problems in both childhood and adulthood.

Action to reduce adversity and multiple disadvantage in childhood and promote emotionally and physically secure, safe and supportive relationships and environments will contribute to reduced levels of psychological distress in both childhood and adulthood.

Key actions to tackle childhood adversity:
- Addressing the inequalities and adversities in childhood through actions to reduce child poverty and actions to prevent child abuse and neglect including those outlined in Equally Safe
- Targeting high risk individuals with intensive tailored interventions focusing in particular on pregnant women and early years
- Actions to promote early childhood development
- Early identification and management of childhood mental health problems

Low income and debt
Low and insecure income and problem debt are associated with an increase in the risk of mental health problems. Data from the Psychiatric Morbidity Survey in 2007 found that men in the lowest income group (less than £10,575 per annum) were three times more likely to have a common mental health problem than those in the highest income households (>£40,384 per annum). Similarly, estimates suggest that adults in debt were three times more likely to have a common mental health problem than those not in debt. The relationship between problem debt and mental health problems is likely to be two way. Around a quarter of those with mental health problems report being in serious debt. Having a mental health problem can effect ability to manage financial commitments and trigger problem debt as well as affect ability to regain financial control, thus contributing to a cycle of deprivation.

Key actions to tackle low income and debt:
- Introduce a minimum income for healthy living and ensure the social security system provides sufficient income for health living.
• Tighten regulation and enforcement of the Office of Fair Trade guidelines about responsible lending and address premium rates for essential services for those on low income. \(^{ibid}\)
• Maximise income through provision of welfare benefits advice in or via health care settings or social services and money advice. \(^{ibid}\)

**Unemployment/poor quality employment**

Unemployment has consistently been associated with an increased risk in common mental health problems.\(^{35,36}\) This is of particular concern in relation to young people with few qualifications who find it difficult to enter the labour market and those with mental health problems who are often excluded from the workforce.

Supporting people to move into sustainable paid employment that lifts them out of poverty and protects their mental health is important. But poor quality employment which does not protect against poverty and offers limited control is associated with an increased risk to mental health.\(^{37}\) The Marmot Review\(^1\) argued that to reduce health inequalities:

> “Jobs need to be sustainable and offer a minimum level of quality…. Getting people off benefits and into low paid, insecure and health-damaging work is not a desirable action”.

The NHS Health Scotland Inequality Briefing on Good Work for All\(^ {38}\) highlights actions that can be taken to ensure good work for all including supporting good mental health and ensuring people with mental health problem have the opportunities to get and keep good work.

**Violence and abuse**

There is a strong link between experiencing violence and increased risk of mental health problems. In a large English survey half of those who had experienced extensive physical and sexual violence (many of whom experienced childhood sexual abuse) had a common mental health problem and were five times more likely than those with little experience of violence to have a common mental health problem and more likely to have attempted suicide or self-harmed.\(^ {39}\) Similarly there is a strong relationship between experiencing domestic violence, for both men and women, and mental health problems.\(^ {ibid,40}\) Women and girls are often at increased risk of violence and women living in poverty are disproportionately affected by violence and abuse. Whilst the reasons for this are unclear it may reflect increased economic pressure and reduced access to resources to leave abusive relationships. The impact of intimate partner violence and abuse can be far reaching, affecting the next generation and having a negative impact on a broad range of infant and child health and wellbeing outcomes.\(^ {41}\)

Key actions to tackle violence and abuse include:
• Implement interventions that promote gender inequality, including fiscal policies to improve the economic status of women.
• Interventions should aim to have a broad impact on violence, rather than focusing on individual behaviour, and challenge the norms which give rise to and sustain such abuse.
Proven interventions include collaboration between agencies to provide a co-ordinated response with a focus on increased identification, e.g. routine enquiry, and provision of tailored advocacy, support and outreach to enhance protection and reduce re-victimisation.

School-based programmes and early years’ interventions support longer-term prevention of abuse.

**Poor physical and social environments**

The environment we live, work and play in, including our homes, neighbourhoods and access to green space can influence mental health and contribute to inequalities in mental health.

Poor quality housing is one example of the physical environment that has a negative effect on mental health. Fuel poverty in particular is associated with poor mental health both in childhood and adulthood. Warmth and energy efficiency interventions have been found to result in improvements in mental health as well as other health outcomes. Whilst the mechanism linking aspects of poor housing to mental health is unclear it is possible that either poor quality housing acts as a direct source of stress or that poor quality housing is risk factor that is related to poverty and is therefore associated with other physical and social risk factors.

The availability of and access to green space is associated with low levels of mental distress. Current thinking suggests that green space might offer psychological restorative effects for those experiencing stress. However green space is unevenly distributed in urban areas, those living in areas of the greatest socioeconomic deprivation are less likely to live within walking distance of greenspace and are less likely to be satisfied with that greenspace. Improving access and quality of greenspace in proportion to need therefore has the potential to reduce health inequalities.

The NHS Health Scotland Inequality Briefing on Place and Communities highlights the role that good quality places can play in improving health and wellbeing and reducing health inequalities and actions that can contribute to reducing health (including mental health) inequalities.

**Social and health inequalities experienced by people with mental ill health**

Evidence shows that people experiencing mental health problems experience significant stigma and social exclusion, have higher rates of morbidity and mortality and are at increased risk of poor social outcomes such as unemployment, financial hardship and poverty, homelessness and loss of human rights. This is particularly stark for those experiencing long term mental health problems. These health and social inequalities cannot be accounted for by the illness alone and are not an inevitable outcome.

**Unequal access to healthcare services**

Estimates suggest that only 1 in 4 people with significant symptoms of mental health problems are receiving treatment (either medication or psychological interventions). Poor access to mental health services is associated with:

- lower social class
- geographic location
• ethnicity
• presence of sensory or other impairments
• presence of learning difficulties
• other demographic factors such as age and gender

Stigma and fear, lack of knowledge about mental health services, language/communication problems amongst the general population as well as the knowledge and behaviour of practitioners (including adequacy of assessment and communication style) and systemic and resource issues (such as provision and capacity in mental health services) also influence access to services.\textsuperscript{ibid}

Rates of physical ill health amongst those with long term mental health problems are much higher than the general population. Life expectancy for men with a diagnosis of schizophrenia is 20 years less than the general population and for women this difference is 15 years.\textsuperscript{51} Approximately a fifth of premature deaths are due to suicide and accidental death, however a large proportion are due to physical illness.\textsuperscript{52}

The current healthcare system is not designed to support an integrated approach to meeting the mental and physical health needs of the population. In addition the continued stigmatisation of mental health and diagnostic overshadowing (the process by which physical symptoms are misattributed to mental illness) means that those with mental health problems, particularly long term mental health problems, do not always receive the same quality of care for physical health problems. For example, despite higher rates of cardiovascular disease and related health issues amongst people with a diagnosis of schizophrenia, there is evidence of under-recognition and treatment of these conditions.\textsuperscript{ibid}

Key actions to improve equal access to health care and other public services:
• Provide training to ensure that the public sector workforce is sensitive to all social and cultural groups, to build on the personal assets of service users
• Develop a more integrated physical and mental health service and ensure equal access to health and other services
• Implement NICE Guidance on increasing access to primary care mental health services\textsuperscript{82}
• Implement NICE Guidance on promoting better access to health for those with long term mental health problems.\textsuperscript{83,53}

**Unequal access to work**
Many people with long term mental health problems actively want to and can engage with work, training or education and this is important for recovery. Lack of work has significant implications in terms of income, daily routines and choices as well as contributing to social isolation and exclusion.\textsuperscript{84}

Rates of employment are much lower amongst people with mental ill health. Whilst rates vary with diagnosis, a large English survey found the employment rate for those with severe mental ill health was 40% compared with 64% for those with common mental health problems and 76% for those with no mental health problems.\textsuperscript{54}

Action to support people with mental health problems access and remain in work, training or education involves a commitment to workplace adjustment and specialised
support. In many cases individuals are not given sufficient support or are discriminated against by employers. Individuals themselves are often fearful of losing benefits and employers lack the experience to put support in place.

Key actions to support people with mental health problems to access and remain in work, training and education:
- Make necessary adjustments to job, workplaces and educational institutions that help people with mental health problems get and keep work, training and education and implement of guidance such as offered by NICE.
- Implement NICE guidance on workplace policies and practices that can help improve the health and wellbeing of employees.

Stigma and discrimination
Whilst mental health problems and side effects of some medications can contribute to poor health and social outcomes; stigma, injustice and discrimination are significant barriers to achieving parity of access, health and citizenship. Good mental health for all means reducing stigma and discrimination and ensuring equal access for everyone to all public services including mental and physical health services and good work.

Key actions to address stigma and social exclusions include:
- Implement the Equality Act 2010 with respect to mental illness in all areas of life and supporting employers and public services to implement the Act
- Tackle stigma and discrimination and implement a human rights based approach to mental health including empowering service users to respond to stigma
- Develop evidence based programmes to reduce stigma and discrimination amongst target groups prioritised by mental health service users and including social contact with people with mental health problems

Conclusion
Given the social, economic and human cost of mental health and the current financial constraints on service provisions, there is a clear case for investment in prevention of mental ill health and promotion of mental wellbeing. Comprehensive, evidence based strategies at a population level to address the determinants of mental ill health are likely to prevent mental health problems and in the long term contribute to a reduction in mental ill health and inequalities in mental health. This is consistent with the recommendations of the Christie Commission report.

Achieving good mental health for all means that actions to improve mental health across the population must also reduce inequalities in mental health and not make them worse. This can be achieved through:
- addressing the fundamental cause of inequalities
- reducing the harmful environmental influences by improving life circumstances and ensuring equity in the distribution of, for example, good work, high quality and public services proportionate to need
- ensuring equal access to public services including mental health services.

Taking actions to improve life circumstance means addressing factors that increase the risk of mental health problems at each stage of life from pre-natal to later life as well as building opportunities and sources of support which we know can help buffer against difficult life circumstances.
Achieving good mental health for all is not the responsibility of one agency or policy area. Actions across health, social, economic and environmental policy areas are likely to have an impact on mental health and collaboration across all policy areas as well as integrating mental health into health and health inequality outcomes is necessary. In parallel, any potential unintended negative consequences of policies on mental health and inequalities in mental health should be considered and addressed.
Highlighted interventions were assessed for potential scaled impact and cost-effectiveness. Those not assessed either did not have sufficient quality data or were not relevant in the context of the United Kingdom (our pilot geography for this analysis).

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<td>Government authorities redesign urban planning to facilitate and encourage cycling</td>
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| Parental education: schoolchildren | Government authorities provide educational program (e.g., 12-week course) to parents of schoolchildren covering nutrition and parental feeding styles, and providing opportunities for physical activity |</p>
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<td>8. Portion control</td>
<td>Reduced portion size</td>
<td>Food producers reduce average portion sizes</td>
</tr>
<tr>
<td></td>
<td>Reduced portion size: restaurants</td>
<td>Restaurants reduce average portion size of meals and snacks</td>
</tr>
<tr>
<td></td>
<td>Reduced portion size: workplace</td>
<td>Employers reduce average portion size of foods in workplace canteens</td>
</tr>
<tr>
<td></td>
<td>Reduced portion size: reduce portions of high-calorie beverages</td>
<td>Beverage producers reduce average portion sizes of high-calorie beverages</td>
</tr>
<tr>
<td></td>
<td>Eliminate “supersize” items from menus and product ranges</td>
<td>Remove extra-large single-serve portions from packaged food ranges and restaurant menus</td>
</tr>
<tr>
<td>9. Price Promotions</td>
<td>Price promotion reconfiguration: regulated</td>
<td>Retailers and producers restrict promotional activity (e.g., two-for-one) of high-calorie food and Beverages</td>
</tr>
<tr>
<td></td>
<td>Price promotion reconfiguration: voluntary</td>
<td>Food producers/retailers voluntarily increase price of high-calorie food and beverages</td>
</tr>
<tr>
<td>10. Public Health campaign</td>
<td>Comprehensive public-health campaign</td>
<td>Government launches public-health campaign promoting healthy habits across various media (e.g., TV, radio, out-of-home advertising)</td>
</tr>
<tr>
<td>11. Reformulation</td>
<td>New “better for you” products</td>
<td>Introducing new product ranges with improved nutritional profile, and advertised as such</td>
</tr>
<tr>
<td></td>
<td>Stealth product reformulation: food</td>
<td>Food producers deliver small, incremental changes to formulation of food products (e.g., reduction in sugar) that consumers do not notice</td>
</tr>
<tr>
<td></td>
<td>Stealth product reformulation: beverages</td>
<td>Beverage producers deliver small, incremental reduction in the caloric content of beverages that consumers do not notice</td>
</tr>
<tr>
<td></td>
<td>Stealth product reformulation: restaurants</td>
<td>Fast-food retailers deliver small, incremental changes in the formulation of food products that consumers do not notice</td>
</tr>
<tr>
<td>12. School Curriculum</td>
<td>School temporary diet and exercise programs</td>
<td>Schools provide short-term intensive nutritional education or exercise programs</td>
</tr>
<tr>
<td><strong>School curriculum mandates physical activity: regulated</strong></td>
<td>Schools mandate or increase the amount of physical activity in the curriculum</td>
<td></td>
</tr>
<tr>
<td><strong>School curriculum includes nutritional-health education: regulated</strong></td>
<td>Schools include or increase the amount of nutritional-health education</td>
<td></td>
</tr>
<tr>
<td><strong>13. Subsidies, taxes and prices</strong></td>
<td><strong>Government introduces a tax in order to drive price increases on certain types of food or nutrient</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Relative price increase: regulated</strong></td>
<td><strong>Government reduces subsidies on certain food commodities that drive prices (e.g., processed foods such as corn, sugar, and palm oil)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Relative price decrease on fresh produce and staple foods: increased agricultural subsidy</strong></td>
<td><strong>Government subsidizes fresh food such as fruit and vegetables</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Relative price decrease on fresh produce and staple foods: personal subsidies</strong></td>
<td><strong>Government provides personal subsidies (e.g., food stamps for low-income individuals for sole use on certain healthy food types)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>14. Surgery</strong></td>
<td><strong>Provision of gastric-banding surgery</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Bariatric surgery: gastric banding</strong></td>
<td><strong>Provision of gastric-bypass surgery</strong></td>
<td></td>
</tr>
<tr>
<td><strong>15. Urban Environment</strong></td>
<td><strong>Government authorities/schools invest in higher-quality physical exercise facilities</strong></td>
<td></td>
</tr>
<tr>
<td><strong>School physical exercise facilities</strong></td>
<td><strong>Government authorities increase access to community sports facilities and programs</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Improved community sports facilities and programs</strong></td>
<td><strong>Retailers increase presence in areas with poor access to grocery stores</strong></td>
<td></td>
</tr>
<tr>
<td><strong>16. Weight management programmes</strong></td>
<td><strong>Health systems/employers provide personal technology platforms and wearable technology to support goal setting, tracking, and measuring of key behaviour and health outcomes</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Personal technology and wearables to support healthy eating and physical activity: cross-platform</strong></td>
<td><strong>Health system provides a short-term (e.g., 12-week) one-to-one counselling program on nutrition and how to change dietary and physical activity behaviour</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Health-system individual counselling</strong></td>
<td><strong>Health system provides a short-term (e.g., 12-week) group counselling program on nutrition</strong></td>
<td></td>
</tr>
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<td><strong>Health-system group counselling</strong></td>
<td><strong>Health system provides a short-term (e.g., 12-week) group counselling program on nutrition</strong></td>
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<tr>
<td><strong>17. Workplace wellness</strong></td>
<td><strong>Workplace team challenge incentive schemes</strong></td>
<td>Employers provide team challenge activities to encourage physical activity and improved key health indicators</td>
</tr>
<tr>
<td></td>
<td><strong>Workplace individual challenge incentive schemes</strong></td>
<td>Employers provide individual challenge activities to encourage physical activity and improved key health indicators</td>
</tr>
<tr>
<td></td>
<td><strong>Employer material (financial) incentive</strong></td>
<td>Employers provide material incentives for improved key health indicators (e.g., discounts on insurance premiums, gym membership, prizes)</td>
</tr>
</tbody>
</table>
These data have been updated using the ScotPHO profiles published in June 2015 comparing the intermediate zones – Broomhill in Glasgow’s west end (close to Jordanhill Station) and Parkhead & Barrowfield in the east end (close to Bridgeton Station).
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