OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 24 May 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
19th Meeting 2022, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP)

DEPUTY CONVENER

*Paul O'Kane (West Scotland) (Lab)

COMMITTEE MEMBERS

*Stephanie Callaghan (Uddingston and Bellshill) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Evelyn Tweed (Stirling) (SNP)
*Sue Webber (Lothian) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

David Finch (The Health Foundation)
Professor Gerry McCartney (University of Glasgow)
Claire Stevens (Voluntary Health Scotland)
Dr David Walsh (Glasgow Centre for Population Health)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 24 May 2022

[The Convener opened the meeting at 10:41]

Decision on Taking Business in Private

The Convener (Gillian Martin): Welcome to the Health, Social Care and Sport Committee's 19th meeting in 2022. I have received no apologies from members.

Item 1 is for the committee to decide whether to take items 3 and 4 in private. Do members agree to take those items in private?

Members *indicated agreement.*

Health Inequalities

10:42

The Convener: Item 2 is the first formal evidence session of our inquiry into health inequalities. This session will focus on progress in addressing and tackling health inequalities in Scotland since 2015, when our predecessor committee published a report on that topic.

I thank everyone who took part in our informal evidence sessions last Friday and yesterday. The evidence that we heard at those sessions will feed into a formal evidence session, which will take place on 14 June, but do not be surprised if it comes up throughout all our evidence sessions, because it was very powerful testimony from people with lived experience. I thank Claire Stevens for organising the attendance of a lot of the people whom we spoke to, because their voices really need to be heard. Regardless of the formal session on 14 June, I imagine that people will make reference—albeit with names redacted—to some of the things that we heard, particularly from the people who feel that they lack access to healthcare.

I welcome to the committee David Finch, who is assistant director of the healthy lives directorate of the Health Foundation. David is attending online; I believe that he has had a little difficulty with the connection, so I hope that that connection is being made as I speak.

I also welcome Gerry McCartney, who is professor of wellbeing economy at the University of Glasgow, and is attending in person; Claire Stevens, who is the chief executive of Voluntary Health Scotland, who helped us to organise our informal sessions and is attending in person; and David Walsh, who is public health programme manager at the Glasgow Centre for Population Health, and joins us online.

I was going to ask all the witnesses about the progress that has been made since 2015 and I do want that to be in the back of your minds. I know that you all have an opening statement to make, but I will say up front that health inequalities is a massive subject and it would be remiss of the committee if all we did was talk about the problems. I want our inquiry to look at how and where we can find solutions, actions and recommendations in areas of devolved competence.

With that in mind, I will start with the opening statements. David Finch is not online yet, so we will go first to Gerry McCartney.

10:45

Professor Gerry McCartney (University of Glasgow): Thank you, convener, for inviting me. To build on the point that you made, health inequalities are arguably one of the biggest challenges that Scotland faces. Health inequalities are wider here than anywhere else in western or central Europe and they have been growing during the past 10 years.

That widening in health inequalities has been particularly stark since around 2012, with mortality rates in the poorest 30 or 40 per cent of areas worsening in real terms in the run up to the pandemic. Of course, they were subsequently exacerbated by the pandemic. We should be under no illusions about the lack of progress towards narrowing health inequalities and the challenge that we face in Scotland.

You asked us, rightly, to think of some of the things that have been helpful during that time and I want to highlight three things that I think have mitigated the stark problem that I have outlined. The first is the introduction of the Scottish child payment. We know that health inequalities are a result of inequalities in income, wealth and power in society and it is because those inequalities have continued to widen that health inequalities have continued to widen. The Scottish child payment, however, starts to mitigate some of the rises in child poverty that we have seen and makes it less bad than it would otherwise have been. That is important because mitigation can make a difference.

It is also worth mentioning the furlough scheme. Had it not been for that, people would have been without incomes for a prolonged period during the pandemic, so it is important to recognise that the furlough scheme was a saviour.

Finally, at a time when costs are rising, we know that some things have reduced people's costs, such as free bus travel for some groups, free prescriptions and free school meals. They reduce the costs that families face, so they are also important in reducing the real effect of poverty on people's lives.

However, a wide range of unhelpful policies, particularly on the macroeconomic scale, have driven inequalities in income, wealth and power. Not many of those are within devolved competence, if we are honest about it. We continue to have an economic design that drives widening economic inequalities and that, in consequence, causes health inequalities to widen.

Arguably, at times during the past 10 or 20 years, we have been a bit distracted, introducing specific policies such as the keep well programme to address health inequalities, which have not been found to be effective at reducing those inequalities. We have relied on improvement science approaches and the collaboratives to reduce health inequalities, but those approaches have not addressed the fundamental causes and, again, have not been proved to make a difference.

There is also a sort of vogue at the moment for place-based approaches. I do not hold out much hope for them because they do not address the gradient, even if they are focused on the most deprived areas. Health inequalities are seen across the entire population, not just in deprived areas. Most deprived individuals do not live in deprived areas, so such an approach will not target those groups. Also, that approach ignores the economic relationship between social groups and instead almost pretends that people's deprivation status is independent of those relationships. Therefore, we need to think about how to address the economic design of the country, which leads to widening income, wealth and power inequalities.

However, from the big review that NHS Health Scotland did a number of years ago, we also know about other policies that work to reduce health inequalities. They are invariably the kinds of policies that do not rely on individual agency but involve taxation, regulation and legislation. We have seen good examples of that in Scotland with minimum unit pricing, the ban on discount buys for alcohol, and the ban on smoking in public places. Those are good examples, but there are other areas that we need to think about, including the food system, for example, and what that does to drive an obesogenic environment and a rise in obesity in Scotland.

Claire Stevens (Voluntary Health Scotland): Good morning, everybody. Thank you for the opportunity to contribute to the inquiry and to be involved in helping to shape the informal events that took place on Friday and Monday.

My organisation, Voluntary Health Scotland, is a national intermediary and network for health charities and other voluntary organisations that are involved in health in the widest sense—a lot of community development organisations, for example.

Our core purpose is to work with member organisations and other stakeholders to address health inequalities, and to create better health and wellbeing for all people and communities. For the past seven years, we have also been the secretariat for the cross-party group on health inequalities here in the Scottish Parliament. It is a well-supported CPG, with more than 90 external member organisations, five members of the Scottish Parliament, and a mailing list of more than 300 additional people.

If I reflect back to 2015, which is the time of your predecessor committee's inquiry, that is the year that my organisation first started to look at health inequalities. We conducted research, which we published in our report, "Living in the gap: a voluntary health sector perspective on health inequalities in scotland". The report describes the widening health inequalities gap from our sector's standpoint, giving an insight into people's real lived experience. It also sets out the wide range of positive approaches and interventions that voluntary organisations undertake, which in large part is to mitigate inequalities but also to prevent and reduce inequalities.

We followed that up with a second report in 2018: "The Zubairi report: the lived experience of loneliness and social isolation in Scotland". It was mindful of Glasgow Centre for Population Health's findings that lower levels of social capital and community connectedness are associated with higher levels of health inequalities.

I mention those reports because the findings are as valid today as they were when we published them seven years ago. However, as Gerry McCartney has said, the gap is widening, not narrowing, and any green shoots are in danger of being cut down by the pandemic and the growing poverty crisis.

When I was reading some of the written responses to your inquiry, I was struck by Diabetes Scotland pointing out that people in Scotland's most deprived areas spend half their lives in poor health, and 24 more years in poor health than people in the most affluent areas.

Throughout the past seven years, the third sector has continued to mitigate the impacts by providing targeted services and support; tackling social isolation, loneliness and stigma—we have heard a lot about the stigma over the past two days; building social capital through community development and place-based work; and homing in on those who have simply been left behind or overlooked by public policy and services.

Voluntary organisations also work upstream, carrying out research, campaigns and education to improve law, policy and practice. They also play key roles in local and national partnerships, and in relation to community empowerment.

Voluntary organisations do all that without reliable or sustainable funding for a great deal of the time, and in the face of growing demands and needs, not least through this continuing phase of the pandemic.

The upstream strategies that our sector wants to see include investment in wellbeing communities to build, sustain and protect durable community assets; compassionate, non-stigmatising and humane public services; high-quality, secure and affordable housing; improved access and support to use green and communal spaces for those facing the greatest barriers; easy access to healthy, affordable food; improved digital connectivity and affordability for those least able to access it; much more accessible and affordable public transport; measures that are focused on food, tobacco and alcohol to help to prevent unnecessary deaths from non-communicable diseases; proportionate universalism and active outreach to ensure that services are reaching those missing from services or who are furthest away; and, above all, a cross-Government strategy that is centred on ending poverty.

Dr David Walsh (Glasgow Centre for Population Health): The danger of going last—or almost last—which is a hazard of having a surname that begins with W, is that you sometimes end up repeating what has already been said. I highlight that I might repeat some of Gerry McCartney's points.

I will try to make four quick points. They all relate to the important issue—it is important to be clear about this—of there being no mystery about the causes of and the solutions to health inequalities. At the risk of sounding Rumsfeldesque, there are more knowns than unknowns.

I will give you four knowns. The first is that the horrific scale of and the adverse trends in health inequalities are well known, which Gerry has mentioned. Even before the changes of the past 10 years, which I will say a bit more about, and before the pandemic, we had the widest health inequalities in western Europe. As Gerry alluded to, those inequalities have been exacerbated massively since about 2012.

The second known, which is very important, is that we know clearly why we have wide health inequalities in general and why those have widened so much in the past 10 years. Health inequalities are an extension of wider societal socioeconomic inequalities. A country with a wide wealth gap will have a wide health gap. Since 1979, Scotland, like the rest of the UK has seen a massive widening of socioeconomic inequalities and, as a clear consequence of that, a massive widening of health inequalities. The two go hand in glove.

In the past 10 years, because of the UK Government's implementation of the austerity programme, which has slashed tens of billions of pounds from the income of the poorest and most vulnerable people in society, we have—scandalously in my opinion—seen increasing death rates in the poorest communities up and down the UK as a consequence of widening inequalities.

We now have a new form of inequality. Previously, health inequalities widened because the health of the better-off improved faster than the health of the less well-off although, importantly, the health of the less well-off was still improving. The impact of austerity means that the health of the less well-off is actually getting worse, so we have a new form of widening inequality.

The third known is as important as knowing why we have wide health inequalities. We also know what we need to do about those. Gerry McCartney alluded to a lot of international evidence about the correct policies. A few years ago, the Scottish Government commissioned Health Scotland, which is now Public Health Scotland, to undertake a review of the international evidence of what does and does not work to narrow health inequalities. The information is all published in black and white for people to look at.

That review talked about the need to address inequalities at three levels. The first need is to address fundamental socioeconomic inequalities and the wealth gap in society. The second is one that Gerry alluded to, and which the review referred to as wider environmental influences. That includes housing, pollution, alcohol pricing and all those things, as well as individual experiences of inequality.

The most important part of the report was the part that said that if we do not do the first thing, and if we do not narrow socioeconomic inequalities in society, we will not succeed in narrowing health inequalities.

My fourth and final point is that it is important to understand that. It is also really problematic for Scotland, because, in order to narrow those socioeconomic inequalities, we need to have the relevant powers. Scotland has some powers. We can change income tax rates and bands and we have a very small number of social security powers. However, it remains the case that, as Gerry McCartney said, the vast majority of taxation, social security and other relevant legislative areas such as employment law remain reserved to Westminster.

There are some really great things that we can do in Scotland, as the other two witnesses have said. There are also things that we have done and should be very proud of, but there is an issue of balance. If we do all those great things but the UK Government then comes along and takes tens of billions of pounds from the income of the poorest and most vulnerable people in society, what happens? The bad outweighs the good.

There is a need to be honest about the situation and to understand the constraints that we face. Realistically, Scotland is not going to narrow health inequalities unless we have additional powers in those socioeconomic areas or there is a change of policy direction at Westminster. When recommendations are formed, whether they come from this committee or from the review that David Finch's Health Foundation is working on at the moment, it is important to understand the reality of what we are able to do.

The Convener: David Finch has been able to join us. David, people are giving opening statements, so I ask for yours.

We cannot hear David, so we might have to ask him to join us on audio only. I am speaking through the ether to our broadcasting colleagues. Can we have David join us on audio only so that we have a fighting chance of hearing him?

David Finch (The Health Foundation): Can you hear me now?

The Convener: Yes, we can hear you now. On you go.

David Finch: Thank you. I think that I was using the wrong microphone. Thank you for inviting me to speak today. For those who do not know, the Health Foundation is an independent charity that aims to improve health and reduce health inequalities. We undertake a range of activities, from giving grants to working on the front line to funding and conducting policy analysis.

11:00

We are carrying out an independent review of health inequalities in Scotland. Through that review we are aiming to provide a detailed analysis of health trends and socioeconomic factors that influence health—[*Inaudible*.] We are really trying to understand why, because we recognise that there is significant historical work in that area and there are significant policies. We want to understand why, despite that, health inequalities persist.

Our past research, which includes a 10-years-on update to the Marmot review, and our Covid impact inquiry, have often highlighted the way in which people's health is influenced by the conditions in which they are born, live and grow, as well as their experiences in their day-to-day lives. Those influences will be key themes in the review that we are supporting. However, we want to ensure that the review considers issues that are specific to Scotland.

Also, we want to focus on—[*Inaudible*.]—and capturing the experiences of people who work on the front line and people in policy and delivery roles as well as doing some public engagement so that we get a really rounded picture of what is happening.

We have come to that work with open minds. We have no preconceived ideas about where the review will end or the findings that will come out of it. We want to be driven or led by the findings from the different strands of research and our advisory group. We have tried hard to ensure that the work is grounded in Scotland. We have four key strands of research for which we have funding. One is looking at public health themes, which is being led by Anna Pearce at the University of Glasgow. A second strand is looking at social and economic factors that impact on health. That is being led by David Eiser at the Fraser of Allander Institute.

There are two further strands: one is trying to engage with stakeholders in the policy and delivery sphere, which is being led by Adam Lang at Nesta; the other is a strand of deliberative public engagement, which is being led by Mark Diffley at the Diffley Partnership. We hope that those strands come together to inform each other throughout the process. We are planning for publication of the research from those strands to start in the autumn, with a final report of our own set to follow that to give an overview of the findings. We hope that it will also give some indications of the key priority areas for policy.

I will finish by saying that we are keen that the review will help to inform the work of the committee, whether that is by sharing our emerging findings or by helping to inform some of your policy recommendations, particularly where the committee's work on the inquiry highlights areas of interest that we should consider as greater priorities as the review develops.

The Convener: Thank you, David. You will notice that we switched you to audio only, which improved your signal quite a bit. We might not be able to see you, but we can certainly now hear you fine.

I will deal with a bit of housekeeping. To those of you joining us online—specifically, the two Davids, David Finch and David Walsh—if you want to come in on anything, please type R in the chat box and my clerk will let me know.

I want to pick up on a couple of things that were said in witnesses' opening remarks. Gerry McCartney mentioned the place-based approach. I want to delve a bit deeper into your thoughts on that. You said that, to your mind, a place-based approach might not have the effect that people think that it will. We hear an awful lot about the issue from Government ministers and commentators generally. Can you expand on your point?

Professor McCartney: Yes. If we are honest, it is a bit of an ill-defined approach, but if it means focusing on the areas that are the most deprived and which have the worst health outcomes—that is what I take it to mean, on most occasions—that would not address the gradient in health inequalities. Even if you had a set of effective interventions that could be carried out at a small community level, notwithstanding what we have already discussed about the biggest drivers of health inequalities, that in itself is unlikely to be effective.

Furthermore, even if that were to be effective and improve the health of people who live in the most deprived areas, it would not address the gradient in health inequalities that occurs across all of Scotland, all of society and all of the UK.

As Claire Stevens said, we need a proportional universal approach, whereby effective interventions are introduced that impact most in deprived areas, but have an impact across the gradient in proportion to need. For that reason, a place-based approach is unlikely to be effective, but there are also more technical reasons around the fact that most deprived individuals do not live in the most deprived areas. If you look at income deprivation and employment deprivation, for example, only a very small proportion of the Scottish population who are individually income or employment deprived live in the 20 per cent most deprived areas, so if you simply target those areas with interventions, you will miss the vast majority of people who need them.

That refers back to the fundamental causes of health inequalities—the social and economic relationships between social groups—but a place-based approach does not consider those in any way, shape or form. I worry that a lot of energy and attention goes into the place-based approach and that, ultimately, we will look back in 10 years' time and it will be another keep well programme—that is, another failed specific health inequalities approach. We need an inequalities approach for Scotland that addresses inequalities in the round as well as health inequalities. An effective general inequalities approach would generate a narrowing in health inequalities.

The Convener: Claire Stevens earlier talked about those who have simply been left behind or overlooked by public policy and services. We heard from a lot of people in those marginalised groups in our two evidence sessions, a lot of whom had no recourse to public funds. Could you expand on your point? Who did you have in mind when you said that policies and services are not getting to those people or taking those people into account? Which policies and services did you have in mind?

Claire Stevens: There is a wide range of groups. We saw a cross-section of those groups over the past two days, including people from black and ethnic minority communities, people living in deep poverty, Gypsy Travellers and some

disabled people. Those sorts of groups were represented at the two sessions yesterday and are represented across our network.

Dr Andrea Williamson, who is a colleague of Dr McCartney at the University of Glasgow and a deep-end general practitioner, has done interesting work looking at who she calls "the missing" in health. Those are the people who should be patients of primary care who do not turn up to appointments or take advantage of screening and so on. Why do they not come forward? It is because the NHS is a universal service that expects people to turn up and take advantage of it, but without the sort of targeted outreach or proportionate universalism that reaches out to people, some people face such barriers that it is difficult for them to do that. If there is time later on, I would like to talk about our work in helping to make the Covid vaccine programme more inclusive, because that is a good example of that outreach.

I will comment briefly on what Dr McCartney said about place-based approaches, because I agree with him entirely at one level but, on the other hand, in my sector, the vast majority of the 40,000 voluntary organisations across Scotland work in a single community, not even across a whole local authority, so they are getting in at the deep end and at the grass roots. They are reaching the marginalised communities that are often the furthest away from public services for whatever reason, and they are gaining the trust and confidence of those people and working with them. That work is very place based, but there is not enough investment in it.

The other element that has so far been missing from our very important discussion about the economy and wealth is where people with lived experience sit in all this. Involving people in the co-design and the co-development of services and empowering people often has to be done at a place-based community level. Again, I have examples from our own work. For example, we sit on the Scottish Government's primary care health inequalities development group, which reported earlier this year. Its work was about looking at the recovery of primary care and what GPs and other primary care practitioners have to do to overcome the health inequalities in their communities and reach the people who are missing from their practices at the moment. The process that the group went through involved a group of people with lived experience being involved and things being checked with them every step of the way. That was through Dr Peter Cawston, who is a deep-end GP in Glasgow.

As we have heard very powerfully this morning, we need top-down measures. However, something also has to come from the grass roots—something that works with people where they are and does things not to people but with people.

The Convener: In informal sessions, we certainly heard very strongly: "Don't just consult us—involve us in the decision making". Your point about almost road testing things with focus groups of people that the decisions will affect is absolutely important.

I will pick up on a few things with David Walsh before I open the discussion up to my colleagues.

David Walsh talked about mitigation measures and the issues that are faced when things outwith your control—in particular, austerity measures—have an impact. Obviously, austerity measures were put in place by those who thought they were a good idea, or to save money. However, what is the long-term cost of austerity measures when we look at what you said about the impact on people's health? Where does the Scottish Government sit in relation to mitigation with a fixed budget?

Dr Walsh: That is a great question. The Scottish Government has done good things. For example, at the start of austerity, when the bedroom tax came in, the Scottish Government helped by basically making up for it through discretionary housing payments. As Gerry McCartney mentioned, it has also brought in a new social security payment—the Scottish child payment—for those on low incomes.

However, the issue comes back to what I said about a balance. Although there are things that Scotland can do and has done, the sheer scale of austerity means that those good things are dwarfed by the negatives. Next week, we will publish a report with Gerry McCartney and the University of Glasgow about all the evidence of what austerity has done in relation to overall health and health inequalities. The evidence is all there in black and white in relation to the scale of it: the cuts to people's incomes and the loss of services and how that has affected people through lots of different pathways and in increasing levels of poverty. There is evidence not only in relation to poverty rates but also the relationship between austerity and food bank provision and homelessness, and how austerity has impacted on increased levels of mental health issues. There are also clear links—which are evidenced—between mental and physical health and so on. You can therefore trace the effects of austerity through well-understood pathways to—ultimately and tragically—early death.

The answer to your question about the cost of austerity is therefore that the costs are horrendous. Some studies have tried to quantify that in terms of the numbers of deaths, and we are

also doing a bit of work around that. However, it is horrific.

Coming back to the issue of the cost of life and the financial cost, if we think about the amount of money that was invested—correctly—in response to the pandemic, that came about because of modelling that showed that, if the UK Government did nothing about Covid, we would have half a million deaths in the country, which is a terrifying figure. Research that we have published with colleagues—again, at the University of Glasgow—shows that half a million deaths is more or less what we get from inequalities in the UK every couple of years. If people understand that scale, they will see that, if we can find lots and lots of money to deal with one crisis, we need to find the money to deal with a much longer-lasting crisis that is having a bigger effect.

The obvious final point to make is that the UK and Scotland are wealthy countries. We need to distribute that wealth across the country and think about the extent to which doing that helps the poorest and those who need the most help.

11:15

Sandesh Gulhane (Glasgow) (Con): Professor McCartney, you said "employment deprived". I do not understand that term. Could you clarify it for me, please?

Professor McCartney: Of course. The Scottish index of multiple deprivation has several domains, two of which are about income deprivation and employment deprivation. The index is about the number of people within each local area who claim unemployment-related benefits. It underestimates the true deprivation of employment opportunity within areas, because it only covers the people who claim those benefits, but it is what is used to rank small areas in terms of deprivation and monitor inequalities in a whole range of outcomes for Scotland.

Sue Webber (Lothian) (Con): Claire Stevens, we spoke yesterday in the informal evidence session and I was interested in your comments on proportionate universalism and about Gerry McCartney's colleague, who is a GP in a deep-end practice, in relation to how we can do some more targeted approaches, and how you think that it might help us to really drill down and take those targeted approaches rather than having a universal approach. I think that one of the comments yesterday was that those who are best able to advocate for themselves get an unfair share of resources. I am interested in your thoughts on that.

Claire Stevens: I am not an expert on proportionate universalism; I suspect that Gerry McCartney and David Walsh know more and will be able to explain it far better than I can.

My understanding is that, with a service such as the NHS—or, indeed, education—which is free at the point of delivery and is ostensibly open to all to take up, the issue is that, for some people who face greater barriers to taking up those services, the universal offer is not as accessible.

If we look at screening, for example, there is some work going on in North Lanarkshire and West Lothian on bowel cancer screening and how and why that is less taken up by people in more deprived communities. Ostensibly, bowel screening is open for everyone to take up but some people do not, so we need to ask why they do not and what might help them to take it up.

If we take the example of what happened with the Covid vaccine, a year ago, when all the blue envelopes were coming through people's letter boxes—in December and January, really, as the vaccine programme was just starting—the third sector got quite concerned that there would be all sorts of people who might not have a letter box for a blue envelope to come through in the first place. They might be homeless or living in temporary accommodation; they might not have good levels of literacy; English might not be their first language; or they might have serious mental health problems or learning disabilities, so what would be done to support people to take up this universal offer that was going to protect not just them but the whole of the community?

Indeed, we were concerned that the groups who might be least able or least likely to take up the vaccine, or hesitant about it, would be those at highest risk of Covid. We did some research across the sector and we got involved with Public Health Scotland and the Scottish Government in what then became the inclusion vaccine programme.

In Lothian, the third sector worked with the Edinburgh and Lothians Health Foundation, which is the endowment fund part of NHS Lothian, with NHS Lothian itself and with the four third sector interfaces for the Lothians to look at what the third sector could do through grass-roots organisations to support people to understand the benefits of the vaccine, to help them to understand the communications that were coming out from NHS Inform, because they were not always easy to understand, and then to actually get to the vaccine.

NHS Lothian set up a microgrants scheme, which funded grass-roots organisations to hold events in people's own languages and in some cases to get health experts along to debunk myths about the vaccine, because there were a lot of myths and misinformation. The organisations also

helped people physically get to vaccination centres and then, in some cases, to have outreach to where people were, whether that was in homeless shelters or other situations. In a modest sort of way, from a third sector perspective, that is an example of where we think a targeted approach to a public health intervention was successful.

That has all sorts of wider implications—the third sector could be involved in that way with screening, for example. The third sector is not routinely involved in planning vaccination programmes, but what a difference it might make if it were. With such involvement, perhaps we could more successfully reach the people in West Lothian and North Lanarkshire who are not taking up bowel screening, for example.

Sue Webber: That is great—thank you. We have heard today about inequality in life expectancy, which Gerry McCartney spoke about at length. Scotland has the lowest life expectancy of the four UK nations, despite its higher public spending. Scotland and the US are the only countries at the bottom of the life expectancy table that are not eastern European. After comparison with the other UK nations, the assumption could be made that the situation is not because of Covid. What might be creating the perfect storm of issues in Scotland?

Professor McCartney: That is a big question. There is layer upon layer of history to consider. Back in the 1950s, Scotland was among the average for rates of life expectancy across Europe and in other higher-income countries. Scotland then slowly drifted apart as its rate of improvement was a bit slower, but that became really apparent from the 1980s onwards—that is when the departure from the European means happened.

David Walsh led a huge programme of work that looked at excess mortality—the higher rate of mortality after accounting for the socioeconomic circumstances that pertain in Scotland, which some people have termed the Scottish effect or the Glasgow effect. We have tried to get rid of that, because all that research made it clear that the effect was political—it was about the decisions that were made in the run-up to the 1980s about urban policy, new towns policy and deindustrialisation. That was all exacerbated by the change in economic policy that we have rehearsed, which led to the widening of income inequalities and to privatisation.

That was the initial phase. From 2010 onwards, austerity has further widened health inequalities—David Walsh has rehearsed those points, too. Covid has then impacted on that. We have had three important waves of negative impacts on health.

Sue Webber: I was trying to say that the other parts of the United Kingdom have faced the same political policies, such as austerity, but they are not seeing the same regression. We are trying to drill down to tackle inequalities. We heard yesterday that we have wonderful policies, but I do not get the sense that those are getting under the skin of the issue, getting down to the ground for implementation and making the differences that we need.

Professor McCartney: I am sorry—I misunderstood your question.

Sue Webber: That is okay—it was a long question.

Professor McCartney: Scotland has become more vulnerable to such economic policies. If investment is turned away from council housing in a country that has a higher proportion of council houses, that country will be more badly affected. Scotland had that in the 1980s, so it was more badly affected than the rest of the UK. If a country has a particular industrial structure to employment and that structure is systematically undermined, it will lose more jobs and have a worse health impact.

That is why Scotland deviated from the rest of the UK in the earlier period. We see the scarring effects of that on people's health now—for example, drug-related deaths are in part because of the scarring effects of what happened 20 and 30 years ago in the population. All that leaves the population more vulnerable to such policies.

I would not be too down on some of the policies that we have introduced, such as the ban on smoking in public places and minimum unit pricing, which have made huge differences to outcomes in Scotland. Claire Stevens talked about services. We have resisted a lot of the marketisation that has happened in other parts of the UK, which gives us a better shouting chance of mitigating the effect of health inequalities.

Julian Tudor Hart's inverse care law is much quoted, but the bit that is less well known is that services are not taken up in proportion to need—especially when market forces operate and when a number of barriers exist. The most equitable uptake of services—when services are taken up in proportion to need, so people who are in more deprived circumstances access services more because their need is more—occurs in places where the fewest barriers exist, such as accident and emergency departments.

Primary care is somewhere in between: there are some barriers to people accessing it, as Claire Stevens has mentioned. Where we have more marketisation of services, even in Scotland—I am thinking of dentistry, optometry and physiotherapy—and there is limited supply in the

NHS, such services are much less likely to be taken up in proportion to need. Middle-class people are more likely to get what they need from those additional services because of the barriers—monetary and otherwise—that Claire Stevens talked through.

There is a complicated history as to why Scotland does worse, but I do not think that we should be too down on the mitigations that we have in place.

Dr Walsh: I just want to make a quick clarification. Gerry McCartney answered the question correctly about the historical reasons for Scotland lagging behind other UK nations, but the question was also about austerity. I want to make it clear that the effects of austerity have not just been seen in Scotland. The same issues in relation to increasing death rates among more deprived populations have been shown in research for England, Wales and Northern Ireland. The same broad, horrific effects of austerity have been seen across the whole of the UK. It is important that we are clear about that.

The Convener: Given the point about deindustrialisation, I imagine that parts of England and Wales have been similarly affected, but that may not show up in national data in the same way as it does in Scotland.

Dr Walsh: Several years ago, we did a huge study of deindustrialised regions in the UK and across Europe. The general rule is that, for many historical reasons, all post-industrial regions tend to be poorer and therefore the people living in them tend to have poorer health. Again, it comes down to politics. There are several areas on the continent where the national and local responses to deindustrialisation have been a lot better than those in the UK and have therefore protected the population's health. It comes down to different political responses in the different layers.

Emma Harper (South Scotland) (SNP): I have a quick question about upstream causes of health inequalities, the balance between downstream and upstream interventions and how we address that.

I have a paper from the National Institute for Health and Care Research that uses the river metaphor to talk about public health: downstream interventions focus on things such as behaviour change and treatments for illnesses, and upstream interventions focus on social factors that contribute to health and prevent illness, such as housing, employment and education. What is the balance between upstream and downstream interventions in that regard? I think that Claire Stevens mentioned something in relation to that in her opening comments.

Claire Stevens: I do not know whether there is an easy answer to where the balance lies. The most important means to tackle health inequalities are upstream, but the challenge is that that is a long-term project. Getting the political change and change in the economy—the sort of measures that Gerry McCartney and David Walsh are talking about—is a long-term project. We are talking about preventing health inequalities in generations to come. For the voluntary sector, our interest is always in the here and now and in people who are suffering or who we might be able to help right now. That is why the third sector is in part fishing people out of the stream further down.

The balance is difficult. The third sector has a keen sense of the need for measures such as better housing, employment that is secure, pays well and does not cause stress, and much more affordable and accessible public transport. Those are all political decisions that make a difference. If someone cannot afford to get on a bus to get to their GP appointment, that will have an impact. Such policies should be in the gift of policy makers and decision makers today. Changing the economy is a longer-term, harder thing to do.

However, I agree that the focus needs to be upstream. Your predecessor committee held an inquiry seven years ago, there was a ministerial task force on health inequalities and there was the equally well strategy. There have been big programmes designed to address health inequalities, but if they last only for the lifetime of a session of Parliament, they will not have the necessary traction to make the difference that we know needs to be made.

Emma Harper: Is the introduction of the living wage one of the policies that is working? As of April 2022, it is £9.50 an hour. Is that giving people enough money to manage their families and homes? Is that part of something that works?

11:30

Claire Stevens: I will come back briefly on that. There was a very interesting contribution at one of the events that I attended; I think that it was last Friday. Somebody from the health improvement side at NHS Highland said that, although NHS Highland is a living wage employer, she felt that, as an anchor institution in the community and—along with the local authority—as one of the biggest employers in Highland, it could do much more to promote the living wage to other employers. I thought that that was a really interesting take.

In those sessions, we heard that the living wage alone might not be enough for people who are unpaid carers, are disabled, have other health conditions or other things going on in their lives, or have extra costs. We heard a great deal about the UK Westminster benefits system and very positive

things about the Scottish social security system. The living wage is hugely important, but it is not the only thing.

Professor McCartney: There is some confusing terminology in that area, so I will briefly rehearse some of it. The living wage in Scotland is a voluntary sign-up scheme that most public sector agencies have engaged with or are working towards. The minimum wage, which regulates all wages in the economy, is set by the UK Parliament and has recently been rebadged as the living wage, but it is at a slightly lower level than the Scottish living wage. I say that to be clear about which living wage we are talking about in different circumstances.

The living wage is very much needed; it also needs to be higher, because the majority of people in poverty at the moment are in in-work poverty. That is because wages are not high enough, people are not getting enough hours, or their work is precarious, so they are in and out of work or they are not getting the hours that they need every week. Claire Stevens also alluded to the fact that the living wage does not impact on people who are out of work, but that is certainly a very important part of the mix to reduce income inequalities in the country.

Evelyn Tweed (Stirling) (SNP): I am really interested in what David Walsh had to say in his opening statement about how we deal with health inequalities. Given that we do not have overall powers for social security, taxation or employment, do you think that it would make any difference if we had an overall national strategy to reduce health inequalities?

Dr Walsh: At the risk of repeating myself, I think that a strategy would be great in the sense that it would focus minds on the importance of the issue and on what we can do about it. However, fundamentally, if the aim is to narrow health inequalities across society, as I said before, you need the relevant powers. It is difficult.

That also goes back to the previous question about the levels at which we do those things. I refer people to the NHS Health Scotland report from a few years ago, because that was really helpful in laying out the three levels at which policies are needed: the fundamental socioeconomic causes, all the wider environmental issues and the individual experiences of inequalities, such as the things that Claire Stevens referred to.

As I have said, a strategy would be great to focus minds, but it comes down to the balance of what we can do versus what is not in our control. As I said at the beginning, there is a need for honesty about what we can do under the current circumstances. That is just a repeat of what I said before—it was basically the same question and answer.

Evelyn Tweed: Thank you, David. Even if we had an overall strategy, if we did not have those devolved powers and Westminster does not look at austerity at an overall UK level, would we still struggle to get on top of inequalities?

Dr Walsh: I would again emphasise that this is not my personal opinion; this is me pointing to the published evidence. As I have said before, if you want to narrow health inequalities, you have to address the fundamental socioeconomic causes of health inequalities. Therefore, you must look at what powers we have to address those fundamental causes. There are things that we can do and things that we have done. Again, it is a balance because what can you do if you do not have power in certain areas?

Employment legislation is a decent example of that. Even prior to the current cost of living crisis, some of the biggest increases in the level of poverty were among the employed. In-work poverty relates to all sorts of issues that we know about, such as zero-hours contracts and the gig economy. However, we cannot do very much about that because employment legislation is entirely reserved. That is one important area.

Social security is a massive area. It should be a safety net to help people when they are in difficulty, not something with which we punish people, which is basically what the UK Government has done with aspects of austerity, such as the conditionality of benefits.

This is about getting big amounts of taxation and distributing income a bit more not just through income tax but through corporate taxation, and taxing wealth and assets. It is about protecting the poorest through a proper, helpful and protective social security system. It is about employment legislation. As I have said, that is where we get into difficulty in Scotland, because there are only small parts of that that we can affect.

Carol Mochan (South Scotland) (Lab): I thank David Walsh for his contribution. I whole-heartedly agree about austerity, but I want to be clear that it is the current Westminster Government's position on austerity that has had those effects. We have very different powers in Scotland and we can use them in very different ways, depending on which policies come to us from the UK. If policies across the UK were different from those in Scotland, could that be helpful for us in Scotland, because we could make alternative arrangements?

Dr Walsh: Yes, 100 per cent. As I said at the end of my opening statement, we will not narrow health inequalities without additional powers in those economic areas or a change of policy direction at UK level. If austerity had not happened

at the UK level, I do not think that we would be having these conversations about the horrific scale of the increasing death rate in poorer communities. We would not have aspects such as food banks and homelessness, which have been put in published research. That is the reality. That is where the economic powers around those fundamental socioeconomic causes lie. If Westminster took a different direction, it would have an effect on Scotland.

Gillian Mackay (Central Scotland) (Green): On the whole-systems approach that we have been talking about, should we be embedding work to tackle health inequalities across all statutory services, and not just in health? To what extent is that happening?

The Convener: That really goes to the heart of the matter, in our inquiry.

Professor McCartney: The short answer to your question is yes. All public services, and indeed services from other providers—whether that is police services, housing or health services—contribute to the things that make populations healthy or unhealthy. Those providers all matter—they all contribute and they all need to provide services in accordance with people's needs.

There is a great cartoon that I will try to describe. There are three people of different heights trying to look over a wall. If you have an equal approach to systems, that does not help everyone to see over the wall, but with an equitable approach, with the biggest box for the shortest person, everybody can see over the wall. That is a visual representation of the proportionate universalism that Claire Stevens talked about.

To a degree, all services need to be sensitive to that, but that is difficult at a time when services face overwhelming needs. For example, following the pandemic, health services have a massive backlog of unmet need in the system. That is difficult to deal with when people are stressed and tired, and when staff are still working in difficult circumstances because people are still off sick and so on. In such circumstances, it would be extremely challenging to add an equity duty that would mean that people would be sensitive to that in how they manage waiting lists, demand and need.

As Claire Stevens said, if someone does not turn up to an appointment, in some ways that is great, because there will be one person fewer on the list, but those are the people who need the system most. We must resist the temptation to reduce waiting lists, or to reduce the seen demand in the system, in that way. I have given a health service example, but that applies equally to almost every other system that we have. We need to resist such temptations. It is the people who do not turn up, who decline appointments and who do not respond who have the greatest needs. It is the unseen people whom we need to show most sensitivity to and make the biggest efforts to encompass.

I used to be a doctor—a "proper" doctor, if you like. I will tell a short story from my six months in psychiatry. It is a horrific story that embarrasses me, but it illustrates some of the problems. When I was on call for a horrifically long shift over a weekend, we saw people who were, perhaps, intoxicated but who also needed some sort of psychiatric assessment. Our way of managing that demand was to give them an appointment for 9 am on Monday morning, knowing full well that they would not turn up. I am so ashamed that I was part of that system. I do not think that that would happen now, but it is an example of the kind of thing that we need to eradicate from all our public services, in order to ensure that the people who need the system most have best access to it.

The Convener: Claire, would you like to comment?

Claire Stevens: Yes. It is an important question. At events over the past two days, we heard a lot about stigma and discrimination in services. I found that shocking. I hear a lot of that sort of thing from our member organisations, but I still found it shocking. Somebody said that, from the point of view of resources, there is nothing that would prevent our public services from being more compassionate.

We know that services are under huge stress and that workforces have been through the pandemic and everything else, so it is a difficult situation. However, at one level this is about the art of the doable. It is important that it is taken as read that we must have services that focus on people's right to health, and which are non-discriminatory and non-stigmatising.

As far as progress on the opportunities that exist in relation to policy and legislation is concerned, we are, with the Good Food Nation (Scotland) Bill that is going through Parliament at the moment, in danger of missing opportunities to enable people to access healthy food, and to address the food environment and the obesogenic environment that some people live in.

Things such as the forthcoming public health bill and the national planning framework 4 will be scrutinised by committees other than the Health, Social Care and Sport Committee. If this committee can influence the outcomes at those committees, that would be very welcome.

The Convener: The issue comes back to our general ethos as a health committee, which is that we think that every portfolio should have a health

aspect to it, because quite a number of the drivers of health inequalities do not fall within the health portfolio. An example of that is transport. Quite a lot of the people to whom we spoke on Friday and Monday talked about the cost of transport and the cost of food, which they said were having an impact on their health and their ability to access services.

David, would you like to come in on Gillian Mackay's question?

Dr Walsh: I have nothing specific to add. As researchers, we are forever coming out with recommendations. A previous large report that we produced included a lot of recommendations about using the World Health Organization's approach to health in all policies. We would sign up to that but, as Gerry McCartney alluded to, rhetoric is one thing when it comes to pressed services in that kind of environment; doing it is another.

There are also issues associated with the economic duty on councils always to look at what impact their policies have on poverty. Those are all really good things, but the practical aspect of embedding them in the everyday managing of policy and services is the issue.

11:45

Gillian Mackay: We have been talking a lot about income. To what extent would panel members support a universal basic income, a minimum income guarantee or something like that as a way of tackling income inequality, and therefore the health inequalities that result from it?

Professor McCartney: I need to declare a couple of interests first. I chaired the Scottish citizens basic income feasibility study, and I am on the minimum income guarantee steering group. With those hats on and off, I think that UBI is a really promising intervention, because it could move more people out of poverty, reduce precarity in people's income streams and allow people the income security to thrive. However, there are a number of risks with the policy and a number of considerations about how it would be financed. We recommended that it be piloted, but we do not yet have the co-operation of the necessary UK agencies to allow piloting to take place.

On that basis, we are looking at minimum income guarantees, using the existing powers in Scotland to shore up the holes—[*Interruption*.]—in the benefits system to ensure that people do not fall through the cracks and experience poverty. I think that it is a really promising approach that could, I hope, reduce the number of people who experience poverty and all its consequences.

The Convener: [*Inaudible*.]—to have a gremlin in the room. Someone is speaking to us from the beyond. We heard everything that Gerry said. Emma Harper has a quick question, before I go to a question from Sandesh Gulhane.

Emma Harper: This is a quick supplementary that relates to what Evelyn Tweed and Gillian Mackay were saying. Rishi Sunak could make changes in policy that would address the cost of living crisis, which will probably exacerbate health inequalities. National insurance contributions have gone up, people are in fuel poverty, and people are having to choose between heating and eating. Luckily, summer weather might be coming now. Universal credit has been removed—or, at least, a portion of the uplift was taken away. What is the barrier to the Chancellor of the Exchequer setting a windfall tax or to addressing some of those things? Is it a political issue? What are the constraints?

Professor McCartney: These are all political choices, if we are honest. Inflation is not unique to the UK or to Scotland. It is happening across many countries, sparked by higher prices for oil, gas and food, and countries are taking different approaches. I gather that in Germany, for example, the costs of public transport have been slashed, partly to reduce demand for oil for cars, and partly because it will have spin-off benefits for people's incomes and positive environmental consequences by reducing car travel. That is just one very specific example of the variety of approaches that are being taken across the world. Each country and each Administration will make its own choices.

It is ultimately a question about priorities. If the inflation in the cost of living that people are facing is not addressed by policy, it will have massive consequences for the real experience of poverty and, as a result, it will have real consequences for people's health. The trends that David Walsh has described in such detail around rising mortality for our poorest communities will get worse, and they will get worse faster, if those challenges are not addressed properly.

The Convener: David Finch would like to come in.

David Finch: I was initially going to comment on UBI, but I will talk about the cost of living crisis. As Gerry McCartney said, it comes down to choices. As we saw through the pandemic, it is possible to put in place quite significant support at relatively short notice. The remaining resilience of families would be a concern of ours: those families have already gone through the pandemic, when lower-income households were more likely to build up debt. Those families will now be coming into the cost of living crisis, when lower-income households are likely to face higher inflation rates. The knock-on health impacts of that are a significant concern. The point is that that can be

tackled through extra and increased Government support to help families to cope. The benefits system would be the quickest route to get support to lower-income households.

Sandesh Gulhane: I want to talk a bit about evidence, data and our successes.

Audit Scotland has said that we need far more robust data, which seems to be a theme that runs throughout healthcare; we need far more robust data on long-standing health inequalities. When I was training in medical school back in 2000, Glasgow was used as an example of a place that had great inequality. What data gaps do we have, and how can the Scottish Government step up to try to fill in that information, so that we can get more robust data?

Professor McCartney: There are different types of data. Claire Stevens has articulated very vividly the importance of lived experience in qualitative data, and there is much more that we can, and should, do to gather that type of data and feed it into policy making.

However, Scotland has the best system in the world, bar none, for gathering quantitative data and monitoring trends in health inequalities. Every year, the Scottish Government publishes a long-term monitoring report on health inequalities; this year, that report was published in March. Those reports are simply outstanding in respect of the detail that they go into about overall mortality trends in different groups, the different trends for specific causes of death, wellbeing measures and a wide range of other things. The reports are a thoroughly good and clear read, and they include a series of statistical analyses, including on gradients, gap measures and absolute trends. We need to keep in place the high-quality data systems that we have.

I would not say that the problems that we have in Scotland are related in any way to gaps in data. However, as a researcher and someone from a university, I will always want more. For example, there are gaps in understanding of the health of ethnic minorities, Gypsy Travellers and other equalities groups. There are means by which we could get such data—for example, through linkages with the census and its health records, which has been done previously. The Scottish health and ethnicity linkage—SHELS—study by Raj Bhopal did that in the past, and it uncovered a lot of interesting statistics about the different experiences of various groups in Scotland. For example, we learned from that study that white Scots had a lower life expectancy than all the ethnic minorities, but that hospitalisation rates for some specific conditions were higher for some ethnic minority groups.

We could gather more of that evidence routinely, and we could also do more to gather evidence on individual measures of socioeconomic positions; for example, occupational social class, educational attainment and income. In the past, we have tried to encourage parliamentarians to include income questions in the census, which has always been seen as being too controversial. However, that would fill a massive gap in what we currently know about the experience of inequalities of all kinds in Scotland.

It would also be ideal if we could get linkages to Department for Work and Pensions and Her Majesty's Revenue and Customs data, which we have been asking for for more than a decade. We still do not have those linkages, which means that we cannot do individual level studies of the whole population on the impact of sanctions policies on benefits, for example. We have to rely on some our panel surveys, such as the understanding society survey, which takes a sample of the population and allows us to look at those impacts.

We could look at that at a much more local level if we had full data linkage. The UK Digital Economy Act 2017 should facilitate some of that, but we are still finding that there are a number of administrative barriers to accessing the data and doing the studies.

Dr Walsh: Not for the first time, Gerry McCartney has said what I was about to say. I had three points to make when I indicated that I wanted to come in, but Gerry has addressed all of them.

To echo what Gerry said in response to the question, I say that it is important to realise that the issue is not to do with the data, but with the horrific things that the data are showing.

Sandesh Gulhane: Gerry McCartney talked about minimum unit pricing as a marker of success, but there is a bit of controversy around how successful the measure has been and whether increasing the minimum price per unit would make a difference. I would be interested to hear a bit more about that from him.

Professor McCartney: In my previous job, I was heavily involved in minimum unit pricing studies. Those studies are still under way. We have really strong theoretical evidence that MUP has a positive and equalising effect in terms of mortality and hospitalisations, and that is what the early studies show. The legislation has a sunset clause, so the definitive studies will be reported to Parliament before that expires. That will be the definitive point at which to make a judgment.

I think that you are alluding to the level of MUP. The level that was set in the legislation has been eroded by inflation over time, so the number of

products that would have been affected has decreased. Therefore, the effectiveness of the policy might have been impacted by the rise in prices. Arguably, MUP could or should be index linked, or at least increased, to remove cheap sources of high-strength alcohol, because that is the most damaging to people's health.

The Convener: Does anyone else want to come in on that issue?

Claire Stevens: Can I come in on the previous question about data?

The Convener: Of course.

Claire Stevens: In large part, I entirely agree with Gerry McCartney. I just want to add that, although the third sector is a source of rich qualitative data, that is not taken up and used to the extent that it could be by any means.

Another point is about who gets access to data and how that is used. If our sector had better access to data, we would be better able to develop responses, approaches and services.

There are perhaps more data gaps in relation to the health inequalities that relate to service provision. For example, for a number of years, Voluntary Health Scotland has been working with mental health charities, the Mental Welfare Commission for Scotland, Audit Scotland and the Care Inspectorate to look at the inequalities that face people with serious mental health conditions, such as schizophrenia and bipolar disorder, when they reach 65. At that age, some people are moved into geriatric mental health services and they lose services such as access to a community psychiatric nurse. Those people are overlooked; they are missing in terms of the services that are available.

We have been frustrated in our ability to get policy makers to take that issue seriously, because there is no data on it. When NHS Health Scotland existed, its knowledge services helped us to do literature reviews and look at the issue. The data on older people's mental health simply is not gathered.

That is just one example. Across the third sector, a lot of charities work on a single issue or with a population group or groups with particular conditions. From our sector's point of view, the data is not necessarily always available that would help to back up what organisations and services experience in practice on the ground, and to make the case to advocate for policy change.

Dr Walsh: I want to go back to the question about minimum unit pricing, which referred to the controversial aspect of the policy. I think that the questioner was alluding to output from a right-wing think tank, which received coverage in the *Daily Mail*, about MUP not being an effective policy.

It is important to say that that was not really evidence based at all. All the robust evidence from modelling and the work that NHS Health Scotland has done since shows that it is an effective policy. However, as Gerry McCartney alluded to, the important issue is the price level and whether it needs to go up. On the basis of all the robust evidence that has been produced, I do not think that it is a controversial policy.

12:00

David Finch: I will jump back to the point about data. I am sorry that we have moved between points.

I agree with what other people said about data, particularly about administrative data. Research that we have been funding with the University of Glasgow has been waiting for three years to get a data linkage between DWP data and data on drug and alcohol deaths, which is frustrating.

A strand of the research in our review is looking at the kind of data that is available and potential gaps in that, although I admit, as I think David Walsh said, that a comprehensive report has already been published on the health trends. In particular, the research involves speaking to people who use the data, including practitioners, about its presentation, how they interpret it and whether it suits their needs, which links to the point that has been made about the voluntary sector. We will be very happy to share that information when that element of the work is finished.

The Convener: Sandesh Gulhane wants to make a comment before we move on to questions from Emma Harper.

Sandesh Gulhane: It is very important that people do not put words into the mouths of the questioners. I was asking a question; I was certainly not referring to a right-wing think tank, and I do not think that that comment was very appropriate.

The Convener: Witnesses can, of course, make points that they want to make.

I am going to ask about human rights issues, but I will leave that until the end because my colleagues want to come in on some substantive issues. We move on to health inequalities impact assessments, with questions from Emma Harper.

Emma Harper: I will be pretty quick. In our private sessions, one person who gave us information said that inequalities impact assessments are not being made routinely in planning, for instance, and that wider engagement is needed in thinking about how people access services. Do the witnesses have any thoughts on

how inequalities impact assessments could be done better in order to tackle health inequalities?

Claire Stevens: I meant to mention health inequalities impact assessments in my opening statement and forgot to. I would be interested to know the extent to which health inequalities impact assessments are used already and I have not been able to find that out, so if the committee was able to find that out, it would be interesting and important.

Ostensibly, it would be easy for health inequalities impact assessments to be used routinely across the board in decision making and planning, whether that is through the national planning framework structure, for example, or in any other decision making across public services or public policy. We would certainly say that that could at least be done. The danger, of course, is that it becomes a tick-box exercise.

However, I have no evidence about the extent to which impact assessments are used, how they are used and whether that has been successful, so other colleagues on the panel might have better answers than I do on that. In principle, we support greater use of them.

The Convener: Does anyone else want to come in on impact assessments? I will not press you, if you do not want to.

Professor McCartney: My recommendation is that, if you are really interested in that, you should speak to Margaret Douglas at the University of Edinburgh, who is kind of Scotland's lead expert on all things to do with impact assessments. She would be a source of more knowledge.

The Convener: Thank you for that recommendation. Claire Stevens's question is one that we have as well. It strikes me that doing an inequalities impact assessment can save problems further down the line when projects are launched and policies are put into action.

Emma Harper: Down the line in our inquiry, we might have more clarity on how health inequalities impact assessments are used. Claire Stevens said that she would support further use of those assessments. I am interested in hearing whether you think that it should be a requirement for public sector organisations to conduct health inequalities impact assessments so that health is considered in every portfolio.

Claire Stevens: In principle, we would support that. Indeed, in our response to the consultation on the national planning framework, that was the main thing that we called for. We are not experts in planning, so it was a very difficult consultation for us to get to grips with, but that seemed like a very clear ask that we could make. In principle, I agree that it should be a requirement, but with the caveat that, if it is made a duty, it has to be a meaningful duty. It needs to be backed up with training and understanding on the part of the decision makers in services as to what the duty actually means, so that it is a meaningful exercise and not just a tick-box exercise.

David Finch: We have a programme of work that we call economies for healthier lives, which is thinking about how economic development can be used to help improve health. One of those projects is with Glasgow city region and is led by Jane Thompson of Glasgow City Council. In effect, that is looking at developing a capital investment health inequalities impact assessment tool. It is exploring the design of the tool as well as how it can be embedded at the different stages of capital investment projects. We might be able to give you more information about the challenges of doing that, as well as the effectiveness of doing it.

The Convener: Since no health committee meeting would be the same without this line of questioning, we move to questions from Paul O'Kane on the impact of Covid-19.

Paul O'Kane (West Scotland) (Lab): Good morning. We cannot escape Covid, because we have lived through two years of the pandemic. A lot of the submissions in response to our call for evidence reflected the Covid experience. In our informal evidence sessions over the past few days, a lot of the conversation has been dominated by the impact of Covid and the barriers that it has created to people improving their health.

What has been the biggest impact? We have obviously seen an impact on people's physical health, such as their ability to get out and about and access healthcare and exercise. However, in addition, a number of policy initiatives that were designed to tackle health inequalities have been paused or deprioritised. Is it too early to say what the impact of those things have been? What has been the most serious impact?

Professor McCartney: If I understand the question correctly, it is about thinking in the round about the impacts of the pandemic. I refer the committee to a paper that Margaret Douglas—whom I referred to earlier—led on and that was published in *The BMJ* early on in the pandemic. In the paper, we did a health impact assessment of the unintended consequences of physical distancing measures. Clearly, there are the direct impacts of Covid, such as mortality and the morbidity of long Covid that people have experienced. There is also the plethora of indirect impacts, some of which are healthcare related, such as the postponement of healthcare services or people not coming forward to express their needs for healthcare services.

There is a range of other impacts, such as changes to people's jobs and to their experience of education, childcare and transport, as well as people being stuck in the house, potentially with abusers. There was a massive decline in road travel, which, for a time, had really positive impacts on air pollution. For a time, there was a reallocation of road space towards active travel in some areas. Some places have retained that and other places have removed it. People's finances changed, so some people—largely the middle classes—were able to save. Other people, who were perhaps already in precarious employment or could not access the furlough scheme, had their incomes reduced.

That is a complicated set of pathways, and the net impact has been a rise in mortality and in mortality inequalities. That has peaked—things have improved since the worst aspects of the pandemic. Although a lot of that was direct Covid mortality, we also saw a rise in indirect mortality from other causes, and we are not as clear about what is behind that. Some of it might be coding issues, where Covid is a contributing factor but is not recorded as part of people's journey. It might be other factors, such as stress or job loss. It could now be the cost of living crisis or the cumulative effects of austerity. It is difficult to disentangle that and attribute the impact that the Covid experience in the round has had on specific health experiences.

My worry is that, if we return to the economic policies that we had prior to the pandemic, we cannot expect the improvements to continue—we will go back to the flatlining that we saw from 2012 onwards. We have talked a lot about mortality, but healthy life expectancy has been declining for that period. If we combine mortality experience with people's self-reported health, that has been getting worse since 2012. The worry is that that will continue on that trajectory.

Claire Stevens: It is hard to add to what Gerry McCartney has said and I do not want to repeat it. On top of all that, the worry in our sector now, as expressed over the past six months or so, as things get back to a bit more normality, is that people are still on very long waiting lists for healthcare and are still having difficulty accessing healthcare. In addition, other services in communities have still not opened up fully. Some third sector organisations cannot reopen lunch clubs and day care and so on because, in some cases, public sector community centres are still not open. On "Good Morning Scotland" this morning, they were saying that swimming pools for children in Glasgow are still not open. Those wider issues impact on people's health.

Just yesterday, Voluntary Health Scotland, along with the charity Versus Arthritis, wrote a letter to the Cabinet Secretary for Health and Social Care about hospital waiting lists. The letter was specifically about elective care, but I think that it goes wider than that. Things are not back to normal, and people have all sorts of health needs that are not being met through the NHS, for all sorts of reasons. We have been thinking about what our sector—third sector organisations such as Versus Arthritis and the British Red Cross—can do to support people to self manage and manage the mental distress about that. We use the phrase "to wait well", and we have been thinking about what we can do to support people to wait well.

Paul O'Kane: Those were helpful points on the broader context. An important part of any Covid inquiry should be to look with laser focus at a lot of those issues and try to understand their impact.

Claire Stevens alluded to this already, but some unintended positives came out of the pandemic. That was probably about communities coming together in a way that they had not done before, and voluntary health organisations in particular stepping up. How do we measure that and protect it in the future? I think that we would want to see investment in the sorts of softer services that have made the difference for people.

Claire Stevens: That is an interesting point. The community sector and the voluntary sector stepped up and aimed to fill the gap when there were lockdowns and other services were not necessarily available.

One interesting positive outcome is that the voluntary sector has had to change a lot of what it does. For example, services have been made available via telephone or the internet, which did not happen previously to anything like the extent to which it does now. A lot of organisations are now doing both because, for some clients and service users, the new approach works better or as well. A positive outcome has been that there is more choice for some people in relation to third sector services.

12:15

Funders, not least the Scottish Government as well as a lot of independent funders, made funds available quickly to the voluntary sector, so that the sector could pivot—that is the word that was used—from its normal services to doing whatever was needed to reach out to people and support them. That funding was very welcome. Funders also flexed existing requirements on funding that had already been allocated, so there was a lot of flexibility. Now we hear from our members that a lot of the old bureaucracy is creeping back into those relationships. We want that spirit of partnership with and trust in the voluntary sector. We were trusted to get on with it and deliver in

times of deep lockdown, so can we not be trusted now to carry on with that?

Paul O'Kane alluded to the need for sustainable funding. Emergency short-term funding has been very welcome, but in the longer term our sector still faces enormous difficulties with regard to sustainable funding and not lurching from one short-term funding package to another. Therefore, changes on funding would be very welcome, but flexibility when it comes to bureaucracy also goes a long way.

The Convener: I said that I would leave human rights to the very end, because it has run through a lot of what we have been talking about. The human right to live your life well is fundamental.

It is difficult to talk about conversations from our informal evidence sessions when three out of four of the witnesses who are here today were not party to those, so I will not use specifics. However, I was struck by people we spoke to who are seeking asylum and people who are advocating for family members and friends who are in prison, and we also heard about Gypsy Travellers and people with no recourse to public funds. The thread going through a lot of our conversations was that people do not feel that they are getting access to their basic human rights.

What would a human rights approach to tackling the structural inequalities look like? What specific interventions could be made to make human rights the thread that runs through the delivery of absolutely all our services, regardless of whether people have recourse to public funds and whoever they are in society in Scotland? What would that look like? It is a huge question, so you can see why I left it till the end.

I was particularly struck by what people told me about our prison population not getting access to healthcare, including medication, even if they have clinical health conditions when they go into or come out of prison. That will stay with me for a long time—frankly, it blew my mind. Other people from marginalised communities also feel that they do not have access to healthcare. Could there be interventions to ensure that they get that access?

Claire Stevens: It is a really enormous question. One thing that came through from those informal sessions was that people did not know that they had a right to health. Perhaps that needs to be one of the starting points. Why do people not know that they have a right to health? In the work that we published for the inclusion health partnership earlier this year, which looked at the experience of Covid among marginalised populations, the strong message that came through was that people did not know that they had a right to health; for example, they did not know that they had a right to a GP.

Maybe it is again about having a targeted approach. There have been targeted approaches in relation to Gypsy Traveller populations to help them to understand, for example, that they have a right to register with a GP. On the flipside of a targeted approach to helping people understand their rights is education and training on that for the service providers and decision makers, not just in the public sector but in the third and private sectors—for everybody, wherever they are, out there in the real world. There needs to be education and training for anybody who is providing a public service of any kind, on what people's rights are. Those are the two things that I would focus on.

I am sure that Gerry McCartney will know more about this, but there are different frameworks and toolkits. There are things such as the PANEL—participation, accountability, non-discrimination and equality, empowerment and legality—principles and the triple A framework, which I think would help workforces in public services to understand how to embed a more human rights-based approach. The starting point is people understanding that they have a right to health, as well as other rights, such as human rights. That has to be a step forward.

Dr Walsh: There were people in NHS Health Scotland, as it was before it became Public Health Scotland, who looked at a human rights approach to inequalities, so it might be worth speaking to them about how that work developed.

More generally, to return to the evidence on how to address broader health inequalities, I have talked before about the three levels that have been identified as being important. The third of those is about individual experiences of inequalities. In that regard, there is a need to target people at high risk, such as children in care and the homeless. I would add to those groups the ones that the convener mentioned—the prisoner population and asylum seekers. That brings us back to the politics and the way in which asylum seekers and people who seek refuge in this country are being treated and discussed. I do not need to say much more about that.

We also come back to an issue that I have talked about quite a lot, which is that of social security as a human right. Social security should be a system to protect people in their time of need, rather than one that has been attacked in the way that it has in recent times.

It is a huge question, but it ties in with many of the themes that have emerged in this discussion.

The Convener: Professor McCartney, do you have anything to add?

Professor McCartney: I will be brief. The groups that you mentioned all have very high

needs. We need to provide services that are built around those needs and which are built in deep collaboration with those groups. Such services do not lend themselves to place-based approaches, which is why we need to find the groups with high needs or different needs. They might not find it easy to access services that have not been designed around them. We need to think about how we meet those needs differently. Every public service, as well as other services that are not provided by the public sector, needs to think about that.

The issue also speaks to the power inequalities that I mentioned at the start. Those groups are all groups that, in one way or another, have been made powerless, either by dint of being relatively small compared with majority populations or because they are silenced in one way or another. The prison population is a classic example of that. The reaction in some arms of the media when consideration is given to giving prisoners the vote is such that, even at the very basic level of hearing the voices of such groups and hearing about their needs, we are not able to do that.

I would like to give a shout-out for the need to think about different models of democracy. More participatory methods have been used to discuss trickier issues that particular groups are more affected by, and perhaps that approach could be considered when we design services for such high-risk groups. I probably should not refer to them as “high-risk groups”; “groups with greater needs” is a better way of framing it.

The Convener: That rounds off our session. I thank the four of you for the time that you have spent with us. It has been very interesting and a very good start to what we hope will be an important and interesting inquiry, at the end of which—we should always remember this—we will make some recommendations.

At our next meeting, which will be on 31 May, we will continue to take evidence as part of our health inequalities inquiry. We will focus on the impact of the pandemic on health inequalities and the work to tackle those.

That concludes the public part of our meeting.

12:24

Meeting continued in private until 12:32.

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