# Leave no one behind

## The state of health and health inequalities in Scotland

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The Health Foundation

Health inequalities in Scotland: An independent review

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# Foreword

How has Scotland fared on health inequalities since devolution? At one level the answer is simple. It begins as a story of steady improvement, then stalling and, most recently, of shockwaves.

Inequity in health outcomes is, of course, affected by access to health care and treatment. But it is wider socioeconomic factors – the determinants of health – that do the heavy lifting. So the answer is also complex.

Despite undoubted policy ambition, effective implementation in Scotland has fallen short and inequalities persist. Worse still, they are growing. The effects of the pandemic and the current crisis in living standards, following a decade of stagnation, compound the risks to health ahead.

This review is the most comprehensive of its kind since devolution began. Its evidence suggests that progress in building a healthier and fairer nation is possible. But it also raises a stark question – for all our good intentions, have we taken our eye off the ball?

The most glaring predicament revealed by the review is that the fortunes of those living in our most deprived communities are becoming detached from the rest. Among a plethora of challenges for Scotland it points to are the health prospects of infants and young children, and the plight of young and middle-aged men experiencing multiple disadvantage.

The recent report of the Scottish Parliament's Health, Social Care and Sport Committee rightly acknowledges that a more coordinated whole-government approach is urgently needed. Joined-up policy design and delivery matters. As does the right balance between universal and targeted intervention. But this is not simply a public policy problem. Employers, for example, must do more too. Government cannot act alone.

The causes of inequalities in health outcomes are deep rooted and structural – exposed and exacerbated by short-term crises. And they can only be resolved by a sustained, long-term response across society. This is a problem for every one of us.

It is heartening therefore that the review suggests a well-informed and engaged public will back bold action to tackle the causes of health inequalities, rather than merely the symptoms. There are those who argue that to respond effectively, Scotland needs more powers – in turn leveraging greater investment. Of course, this could make a difference, but there is already significant scope to act. Either way the actions of the UK government matter too – the damage to health created by austerity over the past decade is unarguable.

But with or without additional powers, and whatever path Westminster chooses, the cost of inaction in Scotland is simply too great to contemplate. We cannot give in to intractability or fatalism and allow the most disadvantaged in our communities to be set adrift.

This is a report not only for government, but for all of Scotland – its institutions, businesses and citizens. We do not need another grand strategy. We need practical collaboration, up and downstream, to sweat the considerable assets we already have – public, third and private sectors, collaborating with communities. Each of us has our part to play.

It is not for the Health Foundation or any expert group to prescribe what that collaboration should look like. Our task now is to act – together – to call time on health inequalities.

**Chris Creegan**
Chair of the expert advisory group

# Executive summary

The two decades since devolution in Scotland have seen major external shocks change the underlying social and economic context, create new challenges and shift the relationship between Scotland and Westminster. These shocks include the 2008 financial crisis and prolonged period of real wage growth stagnation that has followed and, more recently, the COVID-19 pandemic and alarming rises in the cost of living. These events have drawn attention to the inextricable link between health and wealth, bringing society's underlying poor health and existing inequalities to the fore.

Good health has a significant influence on overall wellbeing and allows people to participate in family life and in their community. There is a bidirectional relationship between health and social and economic outcomes. Social and economic factors – like income – affect our health, and our health affects social and economic outcomes. Failing to maintain and support good health can also reduce people's ability to work, or their productivity at work, limiting economic potential.

Since the 1950s, Scotland has had the lowest life expectancy of UK nations and in recent decades its position has deteriorated relative to other western European countries. Inequalities in life expectancy between people living in the most and least deprived areas widened in the years prior to the pandemic – with the gap growing to 13.3 years for men, and to 9.8 years for women by 2017–19. Projections of how long people will live have been falling. A person born in 2012 is now expected to live to 86 years, 4.4 fewer years than expected in 2013.

The COVID-19 pandemic has been a shock to health, while the current cost-of-living crisis risks eroding the population's health even further. These crises, though distinct in nature, share an impact that has largely reflected existing societal fault lines – with the most disadvantaged tending to experience the worst outcomes.

No single institution or sector can turn the tide of declining health and widening inequalities on its own. Despite existing policy plans for action across sectors to tackle health inequalities, intent is not reflected in practice. Progress will require central and local government, business, the third sector, local communities and the public to apply a shared and sustained focus on multiple factors that influence health.

## What is driving health trends and inequalities in Scotland?

Almost every aspect of our lives shapes our health and how long we will live – our jobs and homes, access to education and the quality of our surroundings. These are called the wider determinants of health. Income is particularly important because it enables other advantages such as higher levels of educational attainment or high-quality, secure housing.

People living in the poorest two-fifths of households are almost eight times as likely to report poor health as the richest fifth. The association between income and health has potentially grown stronger in Scotland over the past decade.

Health inequalities are a consequence of unfair differences in people's living conditions and life experiences. In 2019, there was a 24-year gap in the time spent in good health between people living in the most and least socioeconomically deprived 10% of local areas in Scotland. This gap has been widening since 2016. There are also wide income and wealth inequalities. Income inequality grew significantly during the 1980s and early-1990s and has remained high since. The 10% of households with most wealth in Scotland had median wealth of £1.65m compared with £7,600 in the 10% of households with the least wealth – this is over a 200-fold difference.

'The 10% of households with most wealth in Scotland had median wealth of £1.65m compared with £7,600 in the 10% of households with the least.'

Health inequalities in Scotland are concentrated in particular areas, having been sustained over a long period of time. Scotland's health inequalities are a consequence of historical socioeconomic inequalities and deindustrialisation. Although these factors underly differences in health in other parts of the UK (and other countries), the greater health inequality in Scotland suggests the population is more vulnerable to the health consequences of disadvantage.

The persistence of health inequalities in Scotland over the past decade is related to three underlying factors:

1. **The accumulation of severe multiple disadvantage:** Living in more deprived areas, living in a lower income household, or living in poor-quality housing are just some of the forms of disadvantage that lead to worse health outcomes and are associated with much higher rates of mortality. Experiencing two or more of these factors creates a greater risk to people's health. Severe forms of disadvantage present even greater risks of higher mortality and include homelessness, opioid dependence, imprisonment and psychosis. A study from 2019 has estimated that 5,700 people in Scotland had experience of homelessness, substance dependency and offending; 28,800 people had experience of two out of the three, and 156,700 had experience of one.

2. **A lack of improvement in living standards:** Better living conditions, greater access to opportunities, and help and support with negotiating systems such as higher education or finding a higher paid job, can all contribute to living a healthier life. But more than a decade of stagnation in pay and a lack of growth in living standards is acting as a brake on health improvement. In 2019/20 median

household income in Scotland was £70 per week lower than if pre-2010/11 growth trends had continued. Median household income in Scotland was no higher in 2015 than it was in 2007.

This is compounded for people starting off in life with fewer resources and lower income because, as in the rest of the UK, occupations of workers in Scotland are strongly associated with those of their parents. People with parents who worked in higher paid managerial or professional occupations are twice as likely to work in similar occupations as people whose parents did not.

3. **Austerity has left public services in a fragile state and reduced provision for supporting healthier lives:** Public services play an important role in building and maintaining good health across areas including education, housing and employment as well as health and social care services. In the decade prior to devolution there were sustained real-terms increases in public spending, but through the 2010s the policy of austerity led to a much tighter settlement for public services. By 2016/17, the Scottish government's resource block grant was 6% lower in real terms than in 2010/11, and had only just returned to 2010/11 levels by 2019/20.

Across a range of aspects of health there is a widening health gap between people living in the most deprived fifth of areas and the rest of the population. Trends in the socioeconomic factors that influence health provide little indication that health inequalities will improve in future, underlined by increasing rates of extreme poverty.

### Three particular areas of concern

Our report highlights three specific areas that must be prioritised given the actual or potential scale of harm:

- **Prevalence of drug-related deaths in Scotland:** The overall rate of drug deaths increased from 6.2 per 100,000 in 2001 to 25.1 per 100,000 in 2020. This has been driven by the increase in deaths in the most deprived areas to 68.2 deaths per 100,000 people in 2020 – 18 times as high as in the least deprived areas. In 2020, deaths from drugs were 3.6 times higher in Scotland than the UK average and 2.6 times higher than Northern Ireland and the Northeast of England (which had the next highest rates).
- **Health and experiences of infants and children in their early years:** Relative and absolute inequalities have widened for infant immunisation uptake and risk of obesity at the start of primary school. Absolute inequalities widened in low birth weight, relative inequalities have widened in infant mortality and development concerns at age 27–30 months. Meanwhile there has been no significant improvement in the poverty-related attainment gap for primary school and secondary age pupils.
- **Health and socioeconomic outcomes of young and middle-aged men:** Suicide, alcohol and drugs are leading causes of death for men aged 15–44 years old, accounting for two-thirds of absolute inequalities in total mortality at that age. Socioeconomic trends also point to younger men being at greater risk of poor future

health through reduced earnings potential. The gender gap in higher education participation is wide and has been growing – in 2020/21, male participation rates in higher education were 16 percentage points lower than for women. Employment rates for men aged 16–24 years in Scotland have fallen by 7.7 percentage points, from 65.1% to 57.4% between 2004 and 2019.

Failing to act early to maintain good health and prevent deterioration will create future costs for the health care system, the economy and society. It will also mean greater harm to people living with poor health day to day. Understanding how various factors combine to create a greater risk to people's health can direct policy attention to where it is needed most.

## What is holding back progress?

With a tight fiscal settlement for public services, identifying the barriers to successful policy delivery and enacting reform will be critical to improving future health. We argue that resources exist but must be used more effectively. Doing so will require action and collaboration across all parts of the delivery system: central and local government, the third sector, delivery agencies, health services, business and from the public.

Discussions with stakeholders and a survey undertaken as part of this review identified a series of perceived tensions and challenges. These included policy short-termism, over centralisation and a failure to scale up success. Overcoming these challenges is an opportunity to reform fragile public services and bring about the necessary focus on implementation by:

- **Adopting a longer term planning approach:** Budgets are stretched and often relate to specific interventions used in specific areas, but there is an opportunity to use them more effectively and achieve more with a joined-up, long-term approach to planning the best use of resources.
- **Creating greater coherence across policy streams:** Policy design can in isolation be good, yet fail to recognise the context in which it is then applied – either in relation to other existing policy strands, the wider economic and political context or local conditions. Developing structures that enable policy design and delivery across government, sectors and local areas can facilitate greater coherence.
- **Restoring trust and empowering communities:** A lack of trust can exist between institutions involved in delivery – across national government, local government, agencies and the voluntary sector. This appeared to be caused in particular by a lack of empowerment among actors in the system or in engagement between sectors. Provisions in the Community Empowerment Act 2015 to promote and facilitate public participation in local decision making can be brought to the fore so that community involvement enables successful change locally.
- **Learning from evaluation and scrutiny:** The need for growing the maturity of the policy system was shown in several ways, including the need for greater evaluation of what has worked, what has not and why. People perceived a lack of an independent voice, scrutiny and challenge, with a fear of failure throughout

the system preventing innovative approaches to delivery. Policymaking can be enhanced by effective use of data and evidence in decision making and policy design and an openness to the challenge brought by independent scrutiny.

- **Scaling up success and innovation:** There has been little sign of change in the policy system to support the greater take-up of successful approaches. Instances of policy success were not being adopted at scale. Examples of best practice and successful delivery exist and should be used to scale up to have greater impact in a larger number of geographical or policy areas.

The National Performance Framework provides a means by which a cross-societal approach can be implemented. But stakeholders felt there was a disconnect between the high-level aims to achieve greater wellbeing in Scotland, and the specific indicators that underly them and are targeted by policies, reducing its effectiveness.

Some barriers can be overcome within the current parameters, while others will require longer term reform. Short-term political cycles mean that effective policy development and delivery is difficult when in fact long-term gradual change is necessary for success. Many of the elements identified as lacking in current policy are those set out over a decade ago by the Christie Commission (see Box 3). The tight fiscal position places greater urgency on the need for reform of public service delivery if policy ambitions are to be successfully met.

Workshops with the public highlighted considerable concern at the scale of health inequalities in Scotland, a strong sense that these disparities are unfair, and a clear appetite for greater action to reduce inequalities. They suggest that the public is receptive to longer term preventative interventions aimed at the fundamental causes of health inequalities, rather than a shorter term focus on health care or individual behaviours.

## A radical shift but not another strategy

There is a difference between the policy intent and the reality on the ground for people experiencing services – a persistent and growing 'implementation gap'. It is apparent at different points through the continuum of policymaking – between intent, design, delivery and experience – and ultimately results in a lack of progress in reducing health inequalities.

Many of the elements underlying the implementation gap relate to a lack of progress in delivering on longstanding policy ambitions of the Scottish government. Recognition of this inertia and

'There is a difference between the policy intent and the reality on the ground for people experiencing services – a persistent and growing 'implementation gap'.'

taking action to reinvigorate progress in delivering in a radically different way to now is necessary or risks failing to deliver on the long-term policy needed for a healthier and more equal Scotland.

The pandemic led to considerable changes in policy and local practice. This raises the question of how that pace of change can be applied to addressing both the immediate cost-of-living crisis and a longer term reduction in inequalities. Kickstarting delivery means setting clear, focused and achievable short-term goals – ensuring these are part of a longer term preventative approach to policy design and resourcing.

It is our hope that this review will help to galvanise change. Yet for that change to have lasting impact it must be developed and owned by Scotland. Taking action and making progress is possible and can be achieved within existing powers, and by maximising their use. The human and economic cost of inaction for Scotland is simply too high, particularly for the poorest and most vulnerable groups. The time to create a sustainable approach to closing the gap in health outcomes is now.

‘Taking action and making progress is possible and can be achieved within existing powers, and by maximising their use.’

# Key findings

## Life expectancy projections have been revised

A person born in 2012 is now projected to live to 86.

**4.4 fewer years**

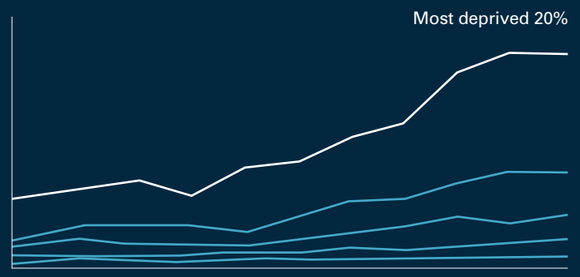
than they were expected to live in 2013.

## The gap in healthy life expectancy has been widening

In 2019, there was a

**24-year gap**

in healthy life expectancy between people living in the most and least socioeconomically deprived 10% of local areas in Scotland.



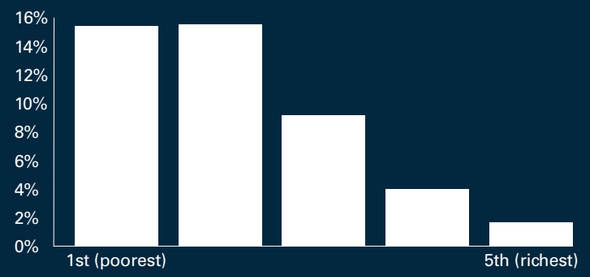

## Growing inequality in drug deaths

The overall rate of drug deaths increased from 6.2 per 100,000 in 2001 to 25.1 per 100,000 in 2019.

Deaths in the most deprived areas were 68.2 deaths per 100,000 people in 2019 –

**18 times**

as high in the least deprived areas.

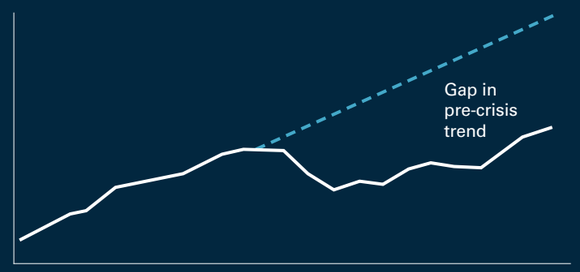



## The association between income and health

People living in the poorest two-fifths of households are almost

**8 times**

as likely to report poor health as the richest fifth.

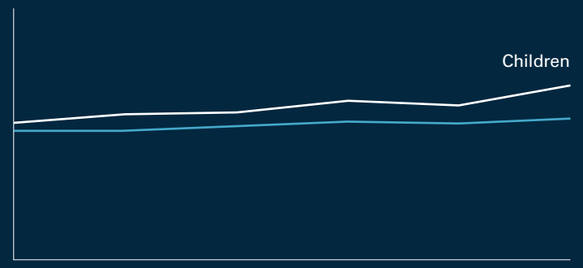



## Wage stagnation

Median weekly earnings were around

**£80 per week**

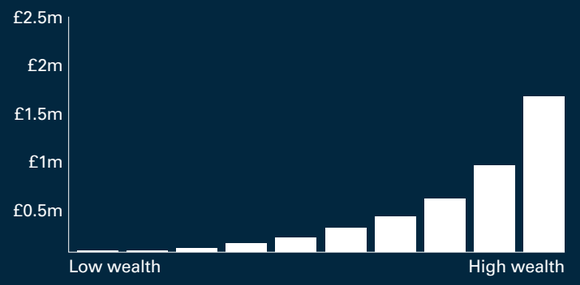
lower in 2021 than they would have been had earnings growth followed its long-run trend after 2010.




## Rising poverty

Since the mid-2010s the proportion of the population in both relative poverty and extreme poverty has been on a slow but persistent upward trend, which is particularly marked for

**child poverty**




## Median wealth inequality

**£1.65m**

The 10% of households with most wealth in Scotland.

**£7,600**

The 10% of households with the least wealth.

**Over a 200-fold difference**

# Health inequalities in Scotland: an independent review

## About this review

Rooted in Scotland and informed by Scottish experts, this review brings together evidence of trends in health inequalities and wider determinants of health over the past two decades since devolution.

It explores public perceptions of what affects people's health and what future action they support to tackle health inequalities. It also draws on perceptions of barriers to progress from people working in the voluntary and community sector, public bodies and health services. This material is drawn on extensively in this report and is the source of evidence unless otherwise referenced.

The review aims to support improvements in health and health inequalities in Scotland, providing a picture of past and present health and inequalities to inform future efforts to improve both.

## Our research partners

The Health Foundation has worked with four research organisations in Scotland as part of the review:

- **The MRC/CSO Social and Public Health Sciences Unit, University of Glasgow** synthesised a wide range of existing data and new analysis including trends in social inequalities in health, health-related behaviours, and health and social care services in Scotland.
- **The Fraser of Allander Institute** analysed trends in the wider determinants of health such as work, education and housing, and how these are experienced differently across the population.
- **Nesta in Scotland** conducted in-depth workshops with health-related stakeholders to help understand implementation challenges for policy and delivery services that support better health.
- **The Diffley Partnership** undertook a series of deliberative workshops with members of the public, exploring public perceptions of the reasons behind health inequalities, informed by the evidence from the other strands of research. A survey of stakeholders supported Nesta in Scotland's qualitative work.

The public engagement project was complemented by a review of existing research on lay perspectives of health inequalities and determinants of health in Scotland, conducted by the School of Social Work and Social Policy at University of Strathclyde.

A further research project delivered by IPPR Scotland set out the extent of devolved powers in Scotland and produced a set of case studies to draw insights about policy implementation.

These projects, the interpretation of the evidence and the conclusions drawn in this report have been guided by our advisory group, bringing together experts from across academia, civil society, delivery and policy.

## Box 1: Advisory group

The advisory group members are:

- Chris Creegan, Chair and review Strategic Adviser
- David Bell, Emeritus Professor of Economics, University of Stirling
- Jo Bibby, Director of Health, the Health Foundation
- Sarah Davidson, CEO, Carnegie UK
- Cam Donaldson, Yunus Chair & Distinguished Professor, Health Economics, Glasgow Caledonian
- Anna Fowlie, Chief Executive, Scottish Council for Voluntary Organisations
- Mubin Haq, Chief Executive, abrdn Financial Fairness Trust
- Katie Kelly, Depute Chief Executive, East Ayrshire Council
- Michael Marmot, Professor of Epidemiology, University College London
- Jim McCormick, Chief Executive, The Robertson Trust
- Dona Milne, Director of Public Health and Health Policy, NHS Lothian
- Shantini Paranjothy, Clinical Chair in Public Health, University of Aberdeen
- Carol Tannahill, formerly GCPH Director and Scottish government Chief Social Policy Adviser.

## Scope and structure of this report

This report sets out the key findings and conclusions of the review, drawing on and synthesising evidence from each of the funded research projects. It concludes by considering how Scotland can build on strong policy intent to reduce stubbornly high inequalities in the socioeconomic determinants of health and create a sustainable approach to closing the gap in health outcomes.

- Section 1 provides the background and context in which the review and associated research projects are situated.
- Section 2 sets out key trends and inequalities in health and social and economic determinants of health over the past two decades.
- Section 3 explores core reasons underlying current health trends and inequalities.
- Section 4 considers key risks to future health and inequalities in Scotland.
- Section 5 discusses public perceptions of health inequalities and the views of policy and delivery stakeholders on the barriers to implementation.
- Section 6 concludes by setting a direction of travel for making progress in tackling health inequalities.

# Health and wealth in Scotland

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The health of the population is one of any nation's greatest assets. Good health is a prerequisite for prosperity and a flourishing society – allowing people to play an active role in their communities and the economy. A failure to maintain and support good health can reduce people's ability to work, or reduce their productivity at work, limiting economic potential.

A person's health is largely determined by their day-to-day experiences and the places in which they live, work and grow. Almost every aspect of life shapes health and longevity – our jobs and homes, access to education, the quality of our surroundings and whether we experience poverty. These are called the wider determinants of health.

The inextricable link between health and wealth has been evident through the COVID-19 pandemic and the current cost-of-living crisis. Both have brought underlying poor health and structural inequalities to the fore. COVID-19 mortality rates were over twice as high in the most deprived areas,[1] driven by poorer underlying health and increased risk of exposure to the virus.[2] As the cost-of-living crisis bears down, the poorest families are least able to cope with higher costs of food and fuel. These crises are exacerbating long-established health inequalities, placing greater urgency on the need for comprehensive and sustained action across society.

Increased wellbeing and sustainable development are part of the core purpose of Scotland's National Performance Framework, which includes health as one of 11 national outcomes.[3] This encompasses several national indicators including healthy life expectancy and premature mortality. The other 10 national outcomes include fair work and business, education, children, the economy and poverty. Each of these in turn encompasses indicators that relate to the wider determinants of health, such as secure work, educational attainment, child social and physical development, income inequalities and wealth inequalities.

Working to achieve such goals means that Scottish government policy is implicitly and explicitly focused on improving health and reducing inequalities.

## From devolution to 2020

In the 22 years since devolution the powers available to the Scottish government have gradually increased. Alongside devolved power for the NHS, social care and public health, many of the policy levers that shape the determinants of health, and decisions over where resources are focused, are now held by the Scottish government.

There are potential limitations in the efficacy of these powers given the significant policy levers still held by the UK government, and other influences that sit outside the direct scope of government. For instance business has a significant influence on health through procuring employment opportunities, and the quality of that work, as well as the goods and services produced.

Over this period, the Scottish government's approach to developing and implementing policy has evolved. So too have its relationships with local government, the voluntary and community sector, public bodies and the public.

Devolution followed a half century of significant economic change. Deindustrialisation led to a large move away from employment in sectors including mining, quarrying and manufacturing, shifting instead towards retail and services. The service sector orientated economy brings with it increased risk of job insecurity and low pay. The longer term consequences of deindustrialisation play out in the pattern of inequalities in Scotland with earnings inequality widening as a result of economic structural change. Areas once dominated by heavy industry are now more likely to have higher levels of deprivation.[4] This shift underlies differences in health in other parts of the UK (and other countries), but the greater health inequality in Scotland suggests the population is more vulnerable to the health consequences of disadvantage.[5] Research suggests that while there have been similar industrial declines in other parts of the UK, in Scotland the population has been left behind.

Recent decades have also seen a shift in risk bearing, and with it higher insecurity for individuals. This is evident in forms of employment contract and reduced ability to acquire assets for the younger generation, including home ownership and final salary pension arrangements. The aftermath of the 2008 financial crisis reinforced a pre-existing trend of stagnating productivity growth, which led to little improvement in living standards over the past decade. After a decade of little progress, the economic situation has been weakened further by the COVID-19 pandemic followed quickly by the cost-of-living crisis.

Significant political events and developments – such as the independence referendum in 2014, followed by Brexit and the shifting make-up of governments at Holyrood and Westminster – mean that the ongoing debate about Scotland's constitution has remained high on the agenda. This has contributed to a consistent divergence of policy direction between the Scottish and UK governments.

## Life expectancy

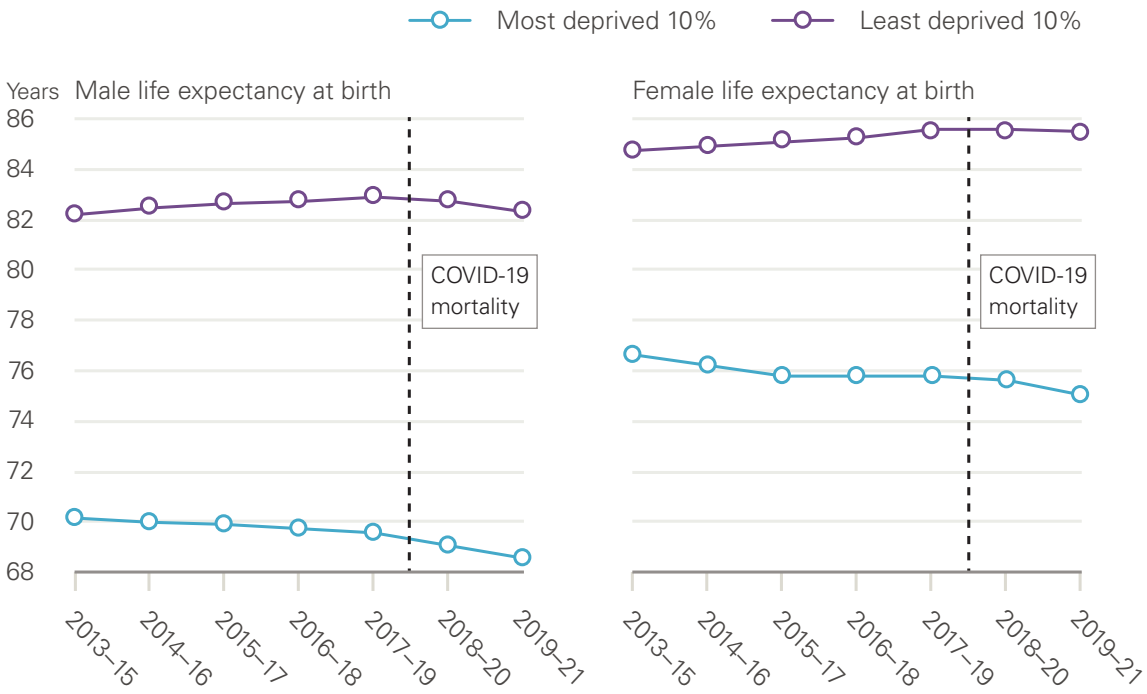
Against this backdrop, the story of Scotland's health has been mixed. In 1998–2000, period life expectancy at birth (a measure of current health)* was 75.6 years in Scotland. By 2017–19 it had reached 79.1 years, but there was no improvement after 2011–13. Largely reflecting deaths related to COVID-19, life expectancy fell to 78.7 years in 2019–21. Scotland has had the lowest life expectancy of UK nations since the 1950s[6] and its ranking compared with other western European countries has fallen.[7]

'Scotland has had the lowest life expectancy of UK nations since the 1950s and its ranking compared with other western European countries has fallen.'

* Period life expectancy is an estimate of the number of years that someone is expected to live based on mortality rates that apply at different ages at a given point in time. It reflects a population at a moment in time, rather than a cohort of people over their lifetime.

Inequalities in life expectancy were widening in the years before the pandemic, as shown in Figure 1. Between 2013–15 and 2017–19 the gap in period life expectancy at birth between people living in the least and most deprived tenth of local areas widened by 1 year to 13.3 years for men, and by 1.7 years to 9.8 years for women.[8]

**Figure 1: The deprivation gap in life expectancy was gradually widening before the pandemic**
Period life expectancy at birth by deprivation: Scotland, 2013–15 to 2019–21

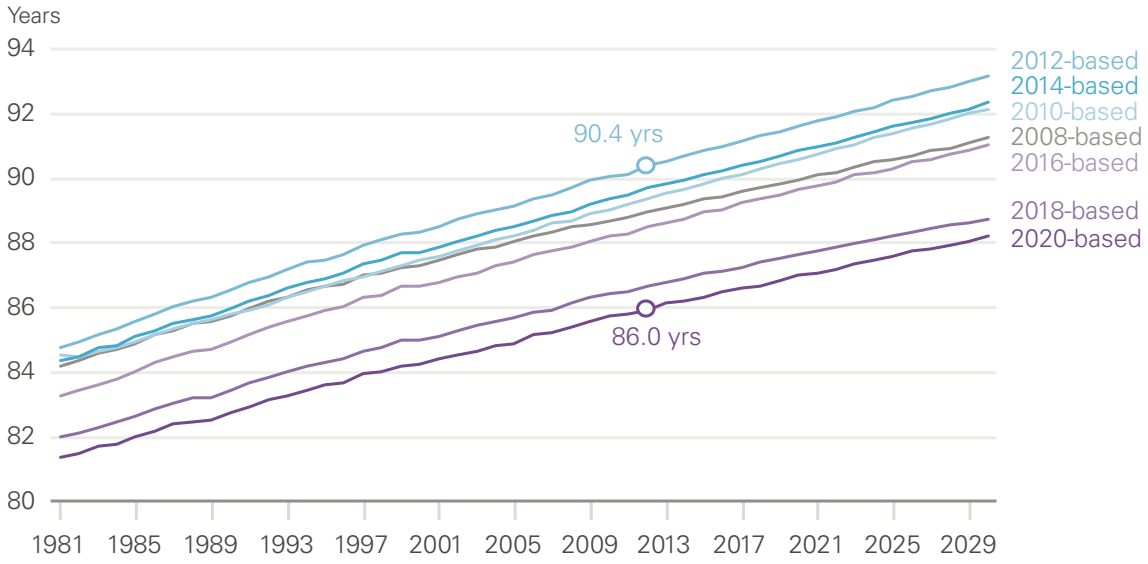



Source: Scottish government, *Long-term monitoring of health inequalities*, March 2022 report; NRS, *Life expectancy in Scotland 2019–2021*

Cohort life expectancy better captures how long people are expected to live[9] by reflecting the expected mortality rates at each age of their future lifetime. Using this measure, the expected lifespan of people born in Scotland in 2012 has fallen by 4.4 years over the past decade.

Figure 2 shows that projected cohort life expectancy at birth has been revised down from 90.4 years for the 2012 birth cohort (under 2012-based assumptions) to 86 years under 2020-based assumptions. In cohort projections the impact of the COVID-19 pandemic is minimal because mortality rates at older ages relate to future years rather than pandemic years.

**Figure 2: Changing expectations of longevity**
Cohort life expectancy at birth by birth cohort and year of projection: Scotland, 1981–2030




Source: ONS, cohort life expectancy projections, various

The stalled progress in health improvements over the past decade is mirrored by stalled progress in living standards. For example, typical household incomes are no higher than they were before the financial crisis. Given long-term health outcomes are a consequence of experiences over the lifetime, the past decade of little improvement in incomes is likely to act as a drag on future improvement in health.

The overall lack of progress on health and widening inequalities comes despite continued policy focus and detailed surveillance and data collection. There remains a gap between policy intent, delivery and the extent to which this has led to meaningful change in people's lives. Recognition of the scale of existing inequalities, and the need for greater collaboration between areas of government policy and delivery, were among the core conclusions of the Health, Social Care and Sport Committee health inequalities inquiry in 2022.[10]

## Crises have exposed existing societal fault lines

The COVID-19 pandemic was an unprecedented shock to health: directly through increased mortality and infections; indirectly through the restrictions put in place to reduce the spread of the virus. The full consequences for health inequalities are yet to be fully understood. The cost-of-living crisis, which is set to leave household finances in a worse position than the pandemic,[11] presents a further risk to health.

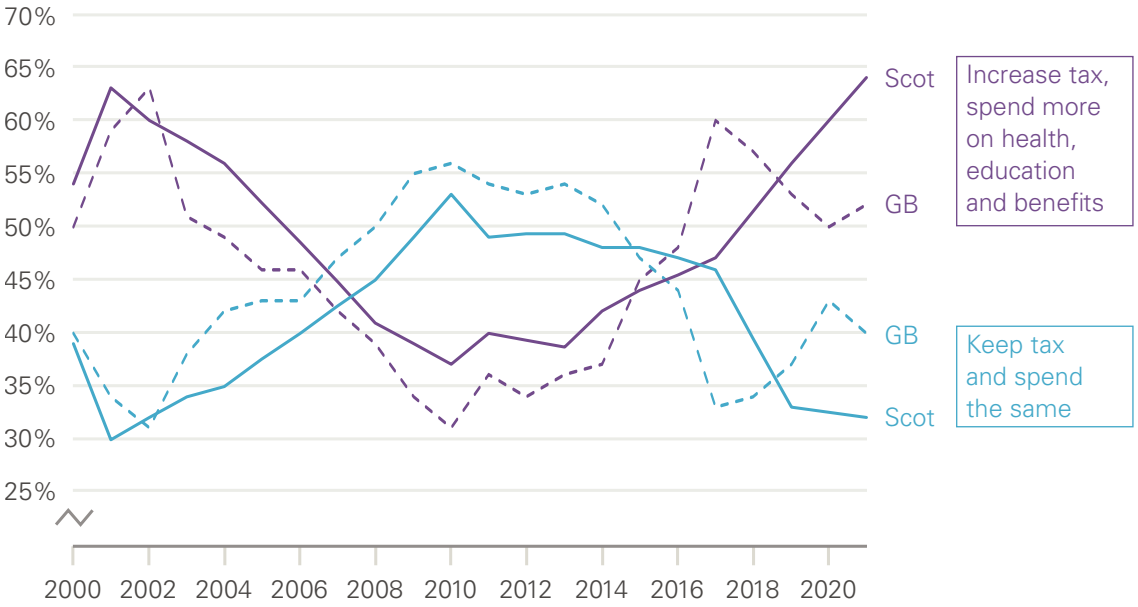
Recent crises have added greater pressure to already strained public services and follow a period of austerity, as part of efforts to reduce UK borrowing in the wake of the financial crisis. This had left services in a fragile state by 2020. Audit Scotland has highlighted the need to reform public services so that they are 'delivered to people in a way that more effectively meets both their needs and the government's policy aspirations'.[12]

These crises have affected the population largely along existing societal fault lines – with the most disadvantaged tending to experience the worst outcomes. Action to remedy the structural inequalities that cause such disadvantage would increase resilience to future shocks.[13] The scale of the challenge in doing so, however, and of sticking to the long-term action required, cannot be underestimated. But there is public support for doing more to invest in health and activities that support good health.

Recent attitudinal data show the British public increasingly favour raising taxes to spend on health, education and social benefits. Figure 3 shows that there has tended to be a greater level of support for this in Scotland. When the same question was asked of the Scottish public in 2021, 64% were in support compared with 52% in Great Britain.[14]

‘These crises have affected the population largely along existing societal fault lines – with the most disadvantaged tending to experience the worst outcomes.’

**Figure 3: Shifting attitudes towards taxation and spending on health, education and social benefits**
Share of population: Great Britain and Scotland, 2000–2021



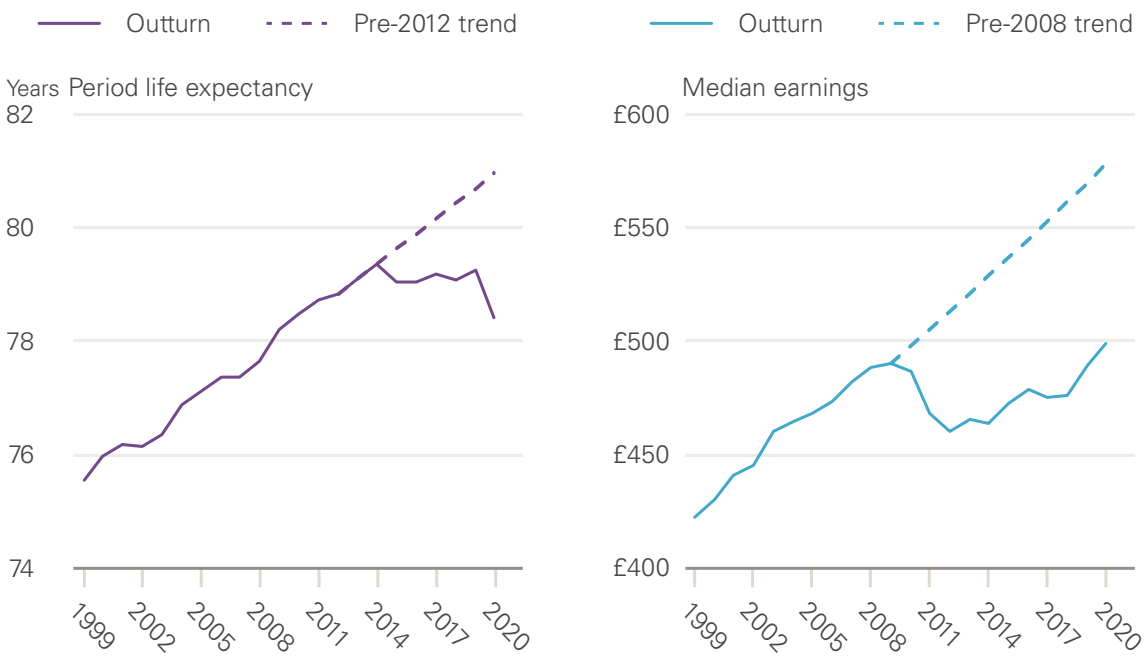

Source: Natcen, British Social Attitudes Survey, 2022; Scotcen, Scottish Social Attitudes Survey, 2021–2022
Note: Values for Scotland are interpolated in years where the survey was not run. Years without data for Scotland are 2005,

The next section details the key trends and inequalities in Scotland’s health over the past two decades, as well as the social and economic determinants of health.

# Health, health inequalities and their determinants in Scotland

The past two decades can be characterised as having two distinct periods in changes to health and living standards. Through the 2000s there were robust improvements in period life expectancy (an indicator of health) and real earnings (an indicator of living standards). But this is followed by a period of stagnation and departure from historical growth trends through the 2010s (see Figure 4). The large fall in life expectancy in 2020 mainly reflects COVID-19 mortality.

**Figure 4: A decade of improving health and living standards followed by stagnation**
Period life expectancy and real typical pay growth: Scotland, 1999–2020




Source: Fraser of Allander analysis

These parallels between life expectancy and pay growth cannot be taken to indicate a direct causality in either direction, but the ways in which changes in standards of living affect health suggest, at the least, an association. Some negative changes in socioeconomic factors may have an immediate impact on health, such as stress and anxiety when struggling to budget on a limited income, or respiratory diseases due to living in damp and mouldy housing. However, such factors may not always immediately feed through to higher mortality rates in the short term. Rather, they exert a growing influence on health over the lifetime. This begins with deterioration in people's physical and mental health, leading to more years spent in poor health and, ultimately, shorter lifespans.

It has been argued that reductions to the value of working-age social security since 2010 have contributed to an increase in mortality rates,[15] with an effect on aspects of mortality such as drug deaths or infant mortality (which in large part reflect maternal health).[16] Near-term changes in mortality are likely to relate to:

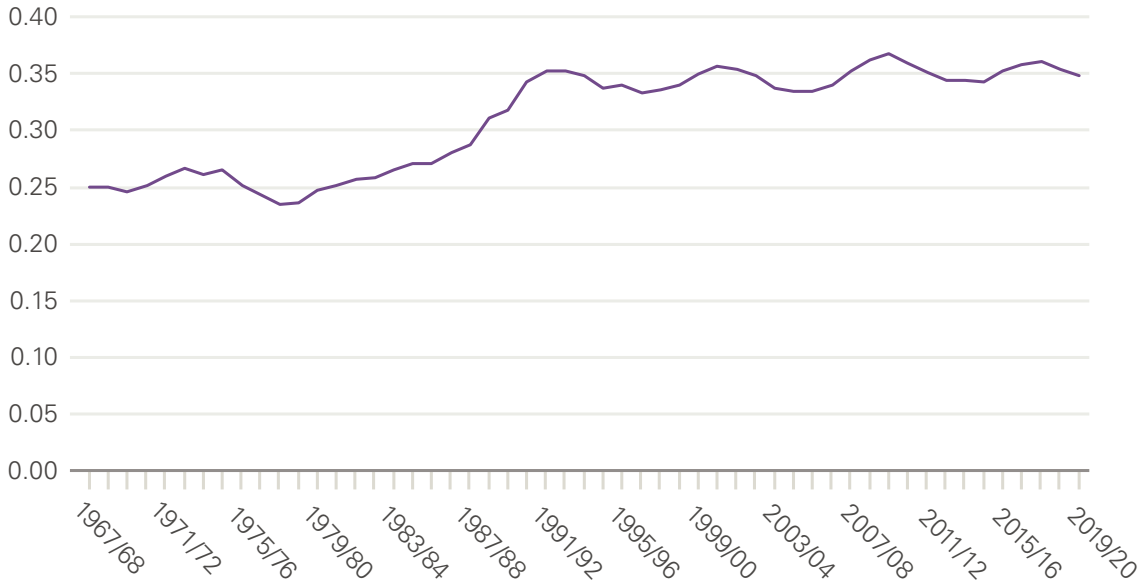
- a sudden shock or disaster such as the COVID-19 pandemic – the impact of which will likely relate to the existing vulnerability of certain groups

- deterioration or improvement in health services providing treatments that may extend life or diagnose otherwise terminal diseases early enough to treat, and
- historical population-wide changes to health, such as immunisation or reduction in smoking rates.

While inequality in life expectancy has widened in the past decade, after improving in the decades before, income inequality widened in the 1980s and 1990s and has remained high since, with little change in the extent of inequality over the past two decades. Inequality in socioeconomic conditions interacts with other factors – such as the lack of availability of affordable healthy food – widening inequalities in health, as observed through increased mental ill health, obesity rates and non-communicable diseases.

**Figure 5: Income inequality rose significantly during the 1980s and has remained high**

Gini coefficient, net equivalised household income (after housing costs): Scotland, 1967–2019




Source: Fraser of Allander analysis using HBAI, 1967–2019
Note: Data are presented on 3-year rolling average basis for the 3 years up to the date shown on the x axis

## Key trends in health outcomes

In the past two decades health outcomes have broadly followed a similar trend to life expectancy, although with some noticeable differences. This section shows the main trends by drawing on a set of metrics that track headline measures of health and then outcomes at different life stages.

We are concerned with both the overall change in health for the population and how different parts of the population fare. To enable consistent comparison across metrics we use a segmentation of the population by levels of deprivation, as measured by the SIMD. However, where data allow a similar pattern tends to exist across other measures such as occupation or income. There are also wide geographic inequalities which tend to align with where neighbourhoods with higher levels of deprivation are concentrated.

These are arranged from those where there has been steady improvement overall and a narrowing of inequalities through to others where outcomes have deteriorated, and inequalities widened. These are illustrated in Figure 6. It is important to note that inequalities in health measured on a relative or absolute basis may not always move in the same direction but a deterioration in either can be considered a worsening of inequality. We highlight the specific type of change in inequalities.[†]

## Sustained overall improvements and narrowing of absolute inequalities

### Alcohol-related deaths

Deaths from alcohol are more common among men than women. The overall rate of alcohol deaths has fallen in the past two decades and both absolute and relative inequalities have fallen, driven by a reduction in mortality rates of around a third in the most deprived fifth of areas. Rates of alcohol-specific deaths are still higher in Scotland than the rest of the UK, at 21.5 deaths per 100,000 people in 2020 compared with 19.6 in Northern Ireland, 13.9 in Wales and 13.0 in England. Even with this improvement, people living in the most deprived fifth of areas are five times as likely to die due to alcohol than those living in the least deprived fifth of areas.

‘Rates of alcohol-specific deaths are still higher in Scotland than the rest of the UK, at 21.5 deaths per 100,000 people.’

### Smoking in pregnancy

Smoking in pregnancy increases the risk of babies being born small for their gestational age, post-natal mortality, and being hospitalised for respiratory illnesses in the early years. The proportion of women who report smoking at the time of their first antenatal booking has halved over the past two decades, falling from 29% in 2000 to 14% in 2020. This reduction occurred across all levels of area deprivation and the absolute difference between the most and least deprived fifths has fallen. However, the relative inequality has increased, with the prevalence of smoking during pregnancy now 11 times higher in the most deprived fifth compared with the least in 2020.

† Where data are an average of multiple years, we refer to the final year of the period, and in the case of financial years the year starting in April.

## Earlier overall improvement followed by an overall stalling or deterioration and widening of inequalities

### Healthy life expectancy

Healthy life expectancy provides a broader measure of health than life expectancy by reflecting how many people in the population report they are in good health. Healthy life expectancy increased between 1995 and 2009 by around 9 years, but then decreased by approximately 2 years between 2011 and 2019. Relative inequalities in healthy life expectancy remained broadly similar between 2013–15 and 2017–19, with people in the least deprived 10% of local areas expected to live 1.5 times longer in good health than people in the most deprived 10% of local areas. Absolute inequalities for men widened by 2.6 years to a gap of 25.1 years by 2017–19 (due to declining healthy life expectancy in the most deprived 10% of local areas). For women the gap narrowed slightly to 21.5 years over the same period.

### Avoidable mortality

In 2020, 27% of deaths in Scotland were avoidable – higher than the overall UK share of 23%.[17] The leading causes of avoidable deaths in Scotland were cancers, diseases of the circulatory system and alcohol and drug-related disorders. Avoidable mortality among men was falling up until 2013, but the trend has since been flat.

Absolute inequalities declined across the first decade or so of the 21st century, but then increased again slightly. Relative inequalities increased across the entire period, with the rate of avoidable mortality for men in the most deprived fifth of areas four times that of those in the least deprived fifth of areas in 2019.

### Birthweight

Birthweight is an indicator of foetal health, the mother's health and is also a predictor of health throughout the life course. In Scotland, the relative difference in low birthweight (excluding multiple births such as twins) between the least and most deprived 20% of local areas decreased between the early 2000s and 2014 but has since widened.

Absolute inequalities have increased since 2014. In 2020, those in the most deprived areas were twice as likely to have low birthweights than in the least. The causes of low birthweight may be driven by an increase in premature births (which may partly be down to improved survival rates) and declining maternal health.

## Little change or gradually increasing prevalence and sustained inequalities

### Infant mortality

The infant mortality rate is the number of infant deaths (before first birthday) for every 1,000 live births. This measure is an indicator of societal health and can act as an early indicator of future health trends. Since 2000 infant mortality has declined overall and in Scotland rates are lower than many other high-income countries. However, since around 2014 infant mortality rose in the most deprived fifth of areas and fell in the least deprived 60% of areas. By 2016–18 infant mortality rates in the most deprived areas were 2.6 times the rate in the least deprived areas.

### Childhood obesity

At the population level, the proportion of childhood obesity has remained stable over the past 20 years in Scotland, with around 1 in 10 children at the start of school at risk of obesity. Risk of childhood obesity has fallen slightly in the least deprived areas, whereas it has increased slightly in the most deprived areas, leading to a widening of absolute and relative inequalities. By 2018/19 children living in the most deprived fifth of areas were twice as likely to be at risk of obesity, with an absolute gap of 7.2 percentage points.

### Asthma hospitalisations

Asthma prevalence in Scotland is high, affecting around 17% of adults, a prevalence that has remained broadly stable over time. For severe instances of asthma (indicated by asthma-related hospitalisations), people in the most deprived fifth of areas were three times as likely to be hospitalised than those in the least deprived fifth in 2018–21, widening from 2.4 times as likely in 2002–05. Hospitalisations reflect uncontrolled or exacerbated asthma, likely occurring from air pollution, occupational exposures or damp housing – all of which are more common or worse in more deprived areas.

### Mental health

Adult mental health, using a measure of psychological distress, has slightly increased in prevalence from 16% to 18% between 2012/13 and 2018/19. In 2018/19 people living in the most deprived fifth of areas were almost twice as likely to experience psychological distress as those in the least deprived fifth. This has remained broadly similar over time.

## Overall deterioration and widening of inequalities

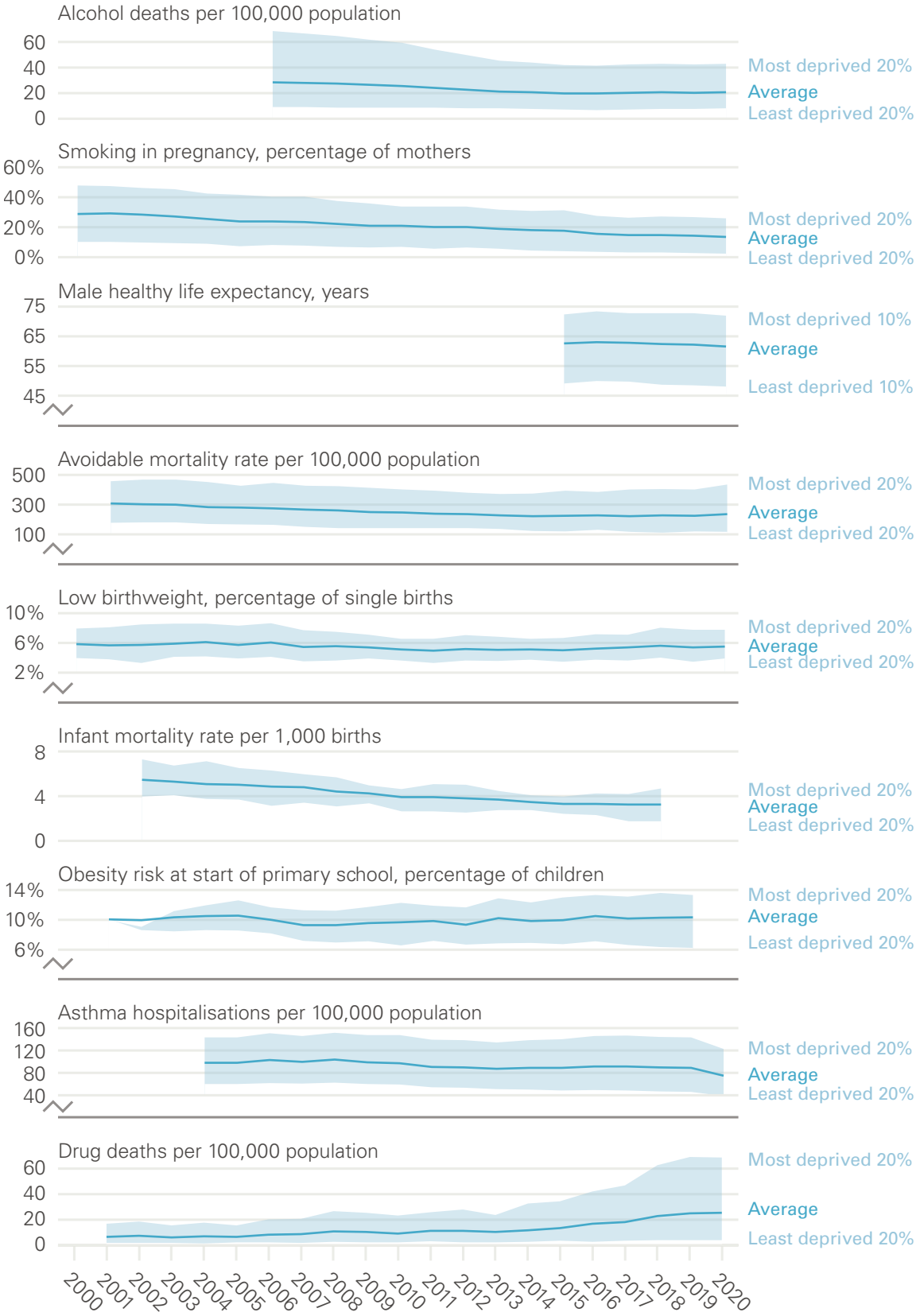
### Drug deaths

While drug deaths are increasing for all socioeconomic groups, people in the most deprived areas face a far greater burden of the total drug deaths and have experienced a far faster rise in the problem. By 2019, those living in the most deprived fifth of Scottish areas were 20 times as likely to die from a drug-related death as those living in the least deprived fifth of areas (after accounting for age). This corresponds to an additional 65 per 100,000 deaths in the most compared with the least deprived areas.

The age and cohort patterns of drug-related deaths are similar in England and Wales, but overall rates are far higher in Scotland. In 2020, deaths from drugs were 3.6 times higher in Scotland than the UK average and 2.6 times higher than those in Northern Ireland and the Northeast of England (which had the next highest rates).[18]

‘By 2019, those living in the most deprived fifth of Scottish areas were 20 times as likely to die from a drug-related death as those living in the least deprived fifth.’

**Figure 6: Changes in key indicators of health: Scotland, 2000–2021**




Source: University of Glasgow, *Health Inequalities in Scotland: Trends in death, health and wellbeing, health behaviours and health services since 2000*
Notes: Some axes are truncated. Alcohol deaths are rolling 5-year averages ending in 2016–20; Asthma hospitalisations are rolling 3-year financial year averages ending in 2018/19–2020/21; smoking in pregnancy is a financial year; healthy life expectancy is a 3-year average; infant mortality rate is a 3-year average

## Socioeconomic influences on health

Beneath the overarching trend of much weaker growth in living standards over the past decade there are different trends across the individual socioeconomic factors that support good health. This section explores key aspects of living conditions and how they have changed over the past two decades.

The weak real-terms earnings growth over the past decade – now expected to fall in 2022 and 2023 due to high inflation – is a key driver of weakened income growth (which accounts for other forms of income, such as benefits) over the same time period.

The depth and duration of this wage stagnation is unprecedented and this has implications for current and future standards of living and health. Limited overall growth, however, does not mean progress cannot be made in closing inequalities because these are influenced by how existing resources are shared.

## Income

Having sufficient money and resources is important for health. It allows people to maintain an adequate standard of living, affording essentials such as food and a home, and to participate in society. Insufficient income, or problem debt, can have an additional impact on health through the stress and anxiety of trying to make ends meet. Stress itself can lead to physical health problems.[19]

Income is perhaps the most key determinant of health because it also enables people to access other determinants of health, such as higher levels of educational achievement or high quality and secure housing. There is a strong association between income and health, which has potentially grown stronger in Scotland in the past decade as highlighted by Figure 7.

**Figure 7: There is a strong association between poorer health and lower income**
Proportion of respondents saying their health is 'bad' or 'very bad' by income, women: Scotland, 2009 and 2019


Source: Fraser of Allander analysis using Scottish Household Survey, 2009 and 2019

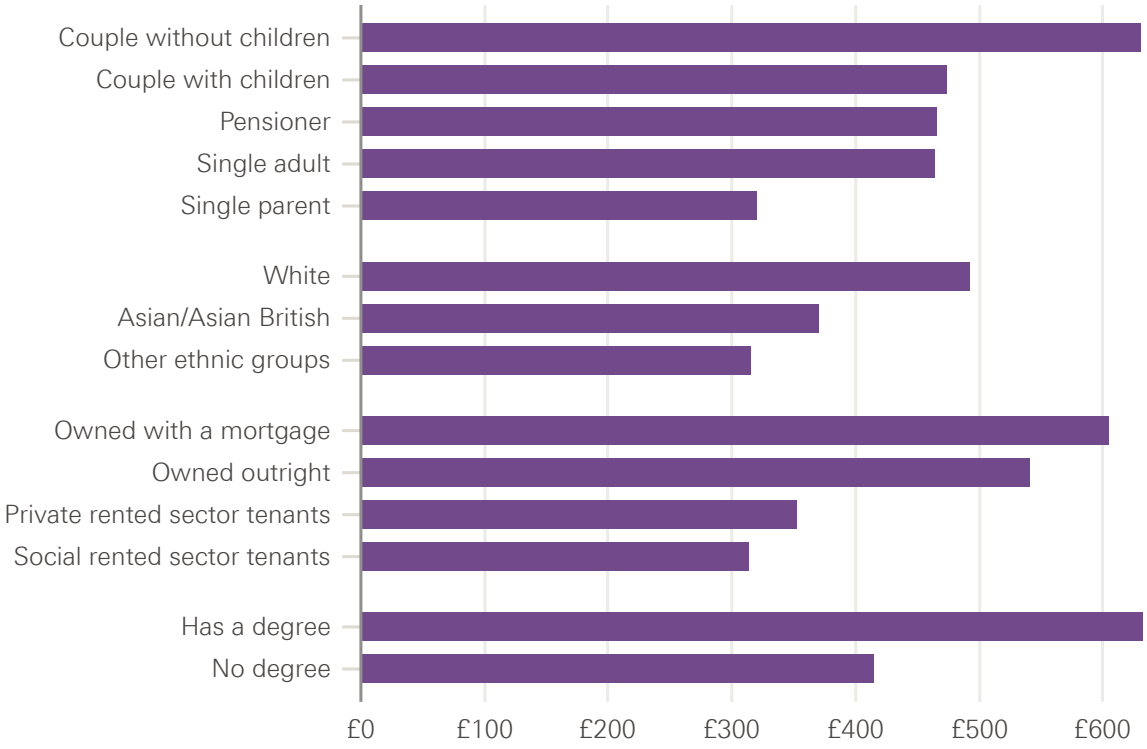
## Income inequality

Driven by trends in earnings growth, income growth was relatively robust through the 2000s but weakened in the decade prior to the pandemic. Over the same period, inequalities in income have remained high compared with most western European countries. There have been some fluctuations in income inequality over the past two decades, but the most significant increase in inequality occurred through the 1980s and early 1990s. Although overall household income inequality did not widen during the 2000s, the growth for the very highest income households was faster than the rest, while the lowest tenth of incomes grew more slowly than the rest.

Sustained income inequality will be a factor in differential health outcomes. This will either be directly through day-to-day consumption, or through wider experiences, such as education, social, and cultural activities, to which a relatively higher income enables greater access. Through similar mechanisms, even wider inequalities in wealth will play a part in the scale of health inequalities: the 10% of households with most wealth in Scotland had median wealth of £1.65m compared with £7,600 in the 10% of households with the least wealth – this is over a 200-fold difference.

Figure 8 shows that there are income inequalities between family structure, education level, ethnicity, disability and housing tenure. Not having a degree, renting, having children and being from an ethnic minority background are all characteristics typically associated with a lower income. The relative differences within these groups have remained largely unchanged over the past two decades.

**Figure 8: There is a wide variation in income between different groups of people**
Median net equivalised household income (after housing costs) by population groups: Scotland, 2017/18–2019/20




Source: Fraser of Allander analysis using Households Below Average Income datasets
Note: Income measured at household level, weighted by individual

### Poverty

Compared with the rest of the UK Scotland has a slightly lower rate of relative poverty, largely because of lower housing costs – ie the cost of housing represents a smaller proportion of lower income household budgets. The proportion of the population living in relative poverty fell significantly from around 23% in 1999 to around 18% in 2012.

Since around 2015, however, the proportion of the population in both relative poverty and extreme poverty has been on a slow but persistent upward trend. This is particularly marked for child poverty. The share of children in relative poverty has gradually increased by two percentage points to reach 24% in 2017–20. The share of children in extreme poverty has increased from 13% in 2009–11 to 17% in 2017–20. These upward trends largely reflect changes to working-age social security benefits that have had a downward effect on working-age incomes.

### Social security

Some changes to social security for working-age families by the UK government since 2010 have had a direct impact on income, and therefore indirectly on health, with lowest income families most negatively affected. Taken in their entirety, and once the policies are

fully in place,[‡] reductions in the value of support are estimated to reduce the incomes of the poorest 10% of UK households by 10%, compared with a reduction of 2% for all families. These measures include the 1% cap on increases in most working-age benefits between April 2013 and 2015 and limiting support to two children.

The Scottish government has provided some mitigation of social security cuts through offsetting the 'bedroom tax' and cuts to council tax support that both started in 2013. For affected families this is likely to have had a significant impact. However, the estimated £50m a year spent on these measures is only a fraction of the estimated £3.7bn a year total UK government welfare cuts in Scotland. More recently, the introduction of the Scottish Child Payment is providing an important top-up for low-income families with children. That said, the size of the effect on poverty is not fully known, particularly given the cost-of-living crisis.[20]

'The Scottish government has provided some mitigation of social security cuts […] For affected families this is likely to have had a significant impact.'

Compounding these income effects is the growing body of evidence that shows welfare reforms have increased the prevalence of mental health problems. This has been shown through higher prevalence of depression or anxiety among those at risk of having their benefits capped compared with those who have not; an increase in psychological distress from the introduction of Universal Credit (UC) in local areas; and evidence that becoming unemployed under UC is worse for mental health than becoming unemployed under the legacy system for lone parents and single adults (but not couples). Stress and anxiety can also eventually lead to deteriorating physical health.[21]

## Employment

Employment is the main route by which people can secure income and is also important for health by providing day-to-day routine, societal participation, and a sense of status and purpose. Employment rates have overall been high in Scotland over the past two decades, aside from the 2009 recession following the financial crisis. There has been a steady increase in female employment since 1999, especially at older ages. Growing levels of employment through the 2010s provided an income boost to lower income households.[22]

Figure 9 shows a concerning reduction in employment for those younger than 24 years, particularly for men, where employment rates for 16–24 year olds have fallen from 65.1% to 57.4% between 2004 and 2019. This mirrors a broader trend in the UK of worsening labour market outcomes for young men.[23]

‡ The two-child limit will take up to 19 years from implementation in April 2017 to have full effect because it applies to children born after 5 April 2017.

**Figure 9: Employment rates increased at older ages but fell for younger people**
Employment rate: Scotland, 2004 and 2019


Source: Fraser of Allander Institute analysis of ONS, Labour Force Survey, 2022

### Work quality and security

The quality of work people do – including whether it provides a lasting and stable income, the autonomy and flexibility it provides, or the extent to which it takes a physical toll or increases stress for employees – is also important for health. Working in a low-quality job can be more detrimental to health than remaining unemployed.[24]

Part of the employment growth that followed the financial crisis was an increase in less secure zero-hour contracts and low-paid self-employed work. On subjective measures of job insecurity – such as whether workers feel they will lose their job in the next year, or negative emotions they associate with their job – there is little evidence of a sustained increase over the past decade. But there is evidence of a persistent level of insecurity.

A further measure to consider is underemployment – the extent to which there are workers who want to work longer hours. Underemployment rates in Scotland increased from 7% to 11% immediately after the financial crisis but had gradually reduced to 8% by 2021.

Insecure work and underemployment are much more likely to be experienced by younger people, particularly men, and workers in lower-paid occupations. Zero-hour contracts are also increasingly concentrated among migrants and workers from ethnic minority backgrounds.

### Economic activity and health

There is a two-way relationship between health and employment, with good-quality employment supporting good health but poor health reducing chances of employment.

In Scotland, the working-age economic inactivity rate due to long-term health problems reduced from 7.5% in the mid-2000s to 5% in the mid-2010s, reflecting a fall in the prevalence of musculoskeletal and cardiovascular problems. Since the mid-2010s, the economic inactivity rate has increased, driven by a rise in the prevalence of depression and mental health problems. Both trends broadly follow the experience of the rest of the UK, where economic inactivity due to poor health has been gradually increasing and has become more apparent since the start of the pandemic.[25]

Compared with the rest of the UK, the proportion of working-age people living in Scotland who are economically inactive for health reasons has consistently been around 1–2 percentage points higher. Scots appear to be more likely to cite health as the main reason for inactivity than other factors, such as caring responsibilities.

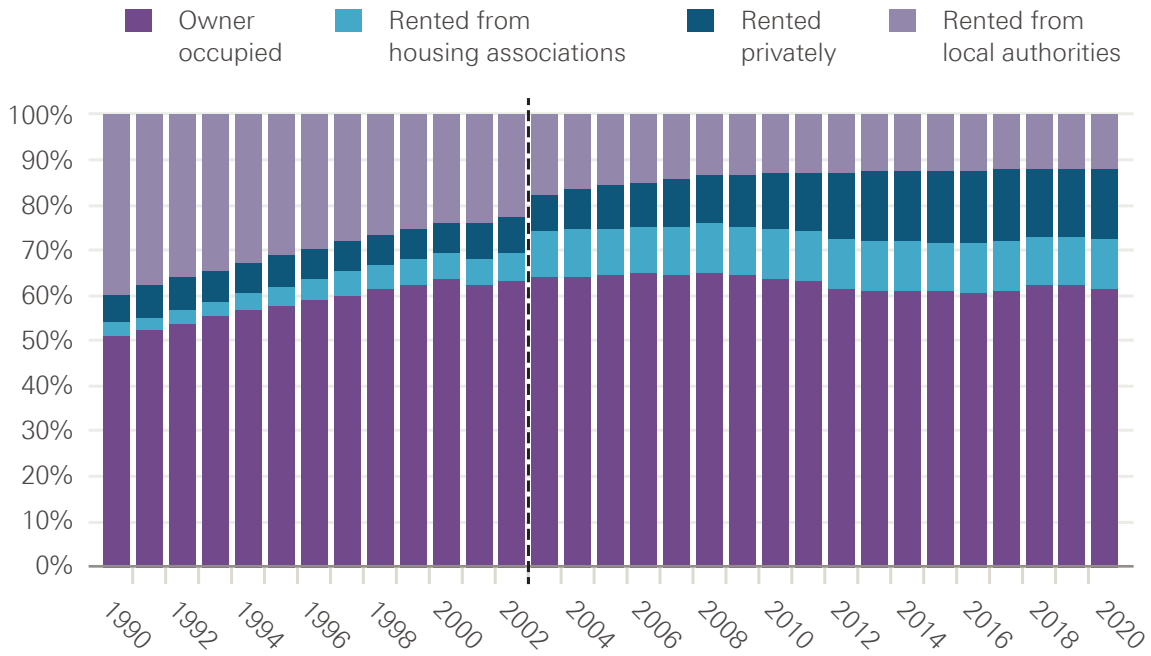
## Housing

Housing has a significant influence on health, including the quality of housing and its affordability. Housing quality relates to the actual physical state of a property and how suitable it is for residents. This can encompass a wide range of potential flaws, such as lacking sufficient insulation, being damp or mouldy, or containing risks such as trip hazards.

Housing affordability is the extent to which a household can meet the direct and indirect costs of housing, including rent and mortgage repayments, council tax and utilities. Housing affordability is associated with housing security but can also contribute directly to poorer mental health through stress and anxiety. Affordability can also create pressure on other elements of household expenditure associated with health, such as food or social participation.

Over the past two decades, the private rented sector has become a larger part of the housing mix in Scotland, as shown in Figure 10. This has direct implications for health via its impact on housing quality and affordability.

**Figure 10: The share of homes in the private rented sector has grown over the past two decades**
Proportion of dwellings by tenure: Scotland, 1990 to 2020




Source: Fraser of Allander analysis using DCMS and Scottish government
Notes: Breaks in the series show a data continuity due to differently timed data collection and change in source

The increase in private renting also has implications for household finances. Housing costs have increased for social and private renters in absolute terms and as a share of income since devolution. Overall housing costs have fallen as a proportion of income in Scotland, but they have increased for families with the lowest fifth of incomes. Relative to the rest of the UK, housing costs in Scotland tend to be lower, which has helped to keep poverty rates lower.

Inequalities in housing costs exist between other groups of the population. Younger people and people from minority ethnic backgrounds are more likely to have higher housing costs. Disabled people are more likely to live in owner occupied or social housing and therefore have housing costs that are slightly below average.

Housing quality is generally worse in the private rented sector, although in the case of damp and condensation, local authority owned social housing performs poorly. These differences between groups and tenures will contribute to health inequalities either directly (in the case of conditions such as damp) or indirectly (in the case of financial pressures on household finances from housing costs).

## Two decades of change

Scotland's health trends over the past two decades present cause for both optimism and alarm. There are clearly concerning trends that indicate a lack of improvement in the decade before the pandemic and, in many cases, widening inequalities, with signs that the most disadvantaged are being left behind. This is underlined by increasing rates of extreme poverty.

Trends in the socioeconomic factors that influence health outcomes provide little indication that health inequalities will improve in future. Large-scale income and wealth inequalities have not changed and levels of job insecurity persist, deepening for some workers in less secure forms of employment.

But the 2000s show that progress in health, inequalities and advances in wider living standards are possible. That some aspects of health inequalities continued to improve rather than deteriorate in the past decade shows that, even in a more difficult context, stagnation and decline are not inevitable and progress can be made on these complex issues.

# Drivers and trends of health inequalities in Scotland

3

Health inequalities are largely a consequence of differences in people's living conditions and experiences through life. Inequalities in power, money and resources at a local and national level can make people's daily lives more challenging. In turn, this can make people more vulnerable to poor health.

In 2018–20, there was a 24-year gap in healthy life expectancy between people living in the least and most deprived 10% of local areas in Scotland. This inequality has been widening since 2015–17, due to worsening trends among more disadvantaged groups.

Poorer health in Scotland is concentrated in areas with higher levels of deprivation, with little improvement in the past decade. This is related to three underlying factors:

- The accumulation of severe **multiple disadvantage** is associated with much higher rates of mortality, with people experiencing this tending to live in the most deprived areas.
- The limited extent to which people can improve their **living standards** due to a long period of wage stagnation and in comparison to their parents.
- The past decade has been typified by a period of austerity, which has left **public services** and social security in a fragile state and reduced the extent to which these elements of provision have been able to support healthier lives.

## Multiple disadvantage

Living in more deprived areas, living in a lower income household, having low or no earnings and insecure work, or living in poor-quality housing leads to worse health outcomes. Experiencing two or more of these factors creates an even greater risk to people's health. This is likely because there are strong associations between the factors and how they interact. For instance, having low income may lead to living in poor-quality housing and both have negative effects on health, compounding disadvantage.

Severe forms of disadvantage include (but are not limited to) homelessness, opioid dependence, imprisonment and psychosis. A data linkage study considering adults living in Glasgow between 2010 and 2014 found that 1 in 20 adults experienced at least one of these severe forms of disadvantage. Experience of one or more of these is linked to significantly higher mortality rates, while the impact on mortality of experiencing two or more is greater still.[26]

A further study from 2019 estimated that 5,700 people in Scotland had experience of homelessness, substance dependency and offending; 28,800 people had experience of two out of the three, and 156,700 had experience of one. Greater numbers were estimated to have these experiences over the life course (21,000 all three, 226,000 two and 876,000 one) with homelessness the most common of these experiences. The highest risks of multiple disadvantage were associated with being younger than 40 years, single, white and male. People experiencing multiple disadvantage are also more likely to be concentrated in more deprived areas.[27]

Qualitative evidence also suggests that people with multiple disadvantage are more likely to have adverse experiences throughout their lives, from childhood through to young adulthood. There is also evidence of greater exposure to violence for people who experience severe multiple disadvantage in a range of settings – home, school and local communities.[27] Violence is a factor that can be difficult to capture through surveys or crime data because both will to some extent rely on self-reporting. But violence is consistently reported as a factor driving health inequalities in qualitative studies.[28]

Even where health-related behaviours are distributed more evenly between people living in areas with different levels of deprivation, related health outcomes are worse in more deprived areas, suggesting that other exposures leave people in those areas less protected from worse health outcomes. This is the case when comparing alcohol consumption to the pattern of alcohol-related deaths and comparing physical activity rates to the pattern of obesity rates in children.

## Stagnation in living standards

Better living conditions, greater access to opportunities such as extracurricular activities, help and support with negotiating systems such as higher education or finding a higher paid job, can all contribute to a healthier life. However, the long period of wage stagnation has limited the extent to which people can improve their living standards. In 2019/20 median household income in Scotland was £70 per week lower than if pre-2010/11 growth trends had continued. Such a pattern can be exacerbated by the accumulation of poorer health associated with worse socioeconomic outcomes.

As in the rest of the UK, the occupations of workers in Scotland are strongly associated with those of their parents. People with parents who worked in higher paid managerial or professional occupations are twice as likely to work in similar occupations than people with parents who did not. There is no evidence that occupational mobility between cohorts is increasing.

People who grew up in a household where nobody was in work are themselves more likely to be out of work, and much more likely to have poor health when adults. That more limited income due to a lack of work increases the likelihood of experiencing poor health can become self-reinforcing. Poorer health can in turn limit chances of being able to work or to find work.

Through life, the household income[§] that people experience fluctuates, moving between higher and lower levels of income, which may reflect changes in household composition or employment and pay. However, some people experience persistently low income. Almost two-thirds of households with the lowest 10% of incomes in 2010/11 still had income among the poorest 30% of incomes 10 years later. Over half of people (56%) in the bottom 30% of incomes in 2010/11 were still in that part of the distribution 10 years later.

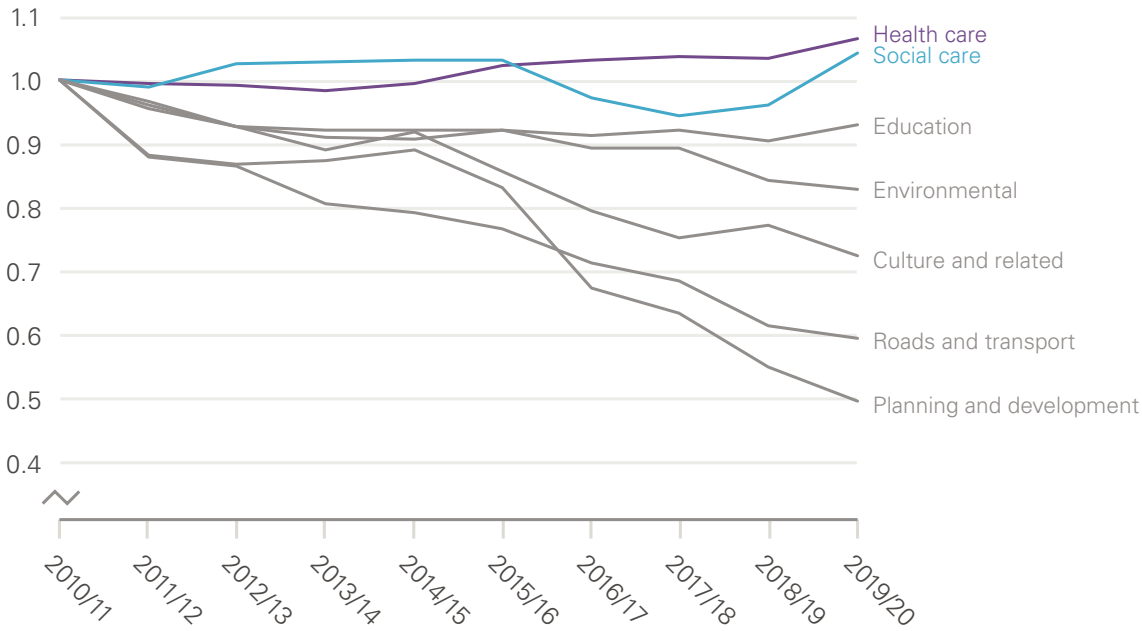
§ Measured on an equivalised basis, which takes into account that the same level of income cannot provide the same standard of living in a larger household than a smaller one.

# Fragility of public services and fiscal austerity

Public services play an important role in building and maintaining good health across a wider range of mechanisms including education, housing and employment, as well as health and social care services. The quality and accessibility of public services plays a role in determining the extent that the factors discussed – multiple disadvantage and a lack of social mobility – are allowed to form or persist.

In the decade prior to devolution, there were sustained real-terms increases in public spending. But austerity policies in the 2010s led to a much tighter settlement for public services.[29] By 2016/17, the Scottish government's resource block grant was 6% lower in real terms than it had been in 2010/11, and only just returning to 2010/11 levels by 2019/20.

**Figure 11: Different areas of spend have been prioritised over the past decade**
Change in real-terms per capita spend on public services: Scotland, 2010/11–2019/20




Source: Fraser of Allander Institute analysis of Provisional Outturn and Budget Estimates, Scottish government (various years); Government Expenditure and Revenue Scotland (Scottish government, 2021)
Notes: Chart shows resource spending, capital investment spending is excluded

### Health and social care

Spending on health care in Scotland is now 4% higher per person than in the rest of the UK, falling from 10% higher in the 2000s. It has previously been estimated that relative to the rest of the UK, Scotland requires around 10% more per person funding due to differences in the population's age structure and additional health needs.[30] In the decade to 2009/10, the Scottish government increased health spend[¶] by an average of 5% a year in real terms. Between 2010/11 and 2019/20, increases in average spend reduced to 1% a year in real

¶ Health spending largely consists of spending on the NHS, but also includes spending by local authorities and some third sector providers in areas such as mental health services and alcohol and drugs policy.

terms, despite the Scottish government estimating that real-term increases of 3–4% a year would be necessary to meet demographic and cost pressures. By 2019/20, health spending in Scotland was £3bn to £4bn lower than it would have been had it grown at 3–4% per annum from 2009/10.

There is no evidence that reductions in health care spending were offset by increased social care activity – per capita spending on social care had been broadly flat for most of the last decade. This slowdown in health spending is arguably the channel by which austerity made its most immediate contribution to Scotland's stalling of mortality improvements between 2012 and 2019. This is because it had a direct impact on the ability to maintain the quality of care and support for people with acute health needs.

### Local government spending

The core local government revenue settlement reduced by £750m in real terms between 2013/14 and 2017/18, equivalent to a 7% real-terms reduction. This led to real-term cuts for public services funded by local government, although these were lower overall than in England due to the greater priority for additional funding placed on health services in England. As shown in Figure 11, cuts were not experienced evenly. Spending on schools and social work were back at 2010/11 levels by 2021/22, although schools experienced several years of reduced spend. Spending on environmental services fell by 10%, while roads and transport, planning and economic development, and cultural services by over 20%.

Regardless of efforts by local authorities to increase efficiencies to meet the demands of reduced budgets, spending cuts on this scale will lead to a reduction in the level or quality of service provision. While these may not have a direct and immediate impact on mortality, cuts to services can have an immediate impact on health through reduced provision of services such as free school meals and children's centres. And over a longer term, an indirect impact on health by limiting education provision and reducing the quality of local community services and the environments that people live in.

### Austerity and health

Estimating the effect of austerity measures on health is complicated. This is because of the variety of ways different factors can be affected by austerity and then in turn can influence health in different ways; the time lags between changes in spend and the eventual impact on health; and the various ways in which services may have been altered. The most immediate direct impacts are likely through reduced access to or quality of services such as health care, social care and public health that have a direct impact on the most acute health need and mortality. An impact on broader health outcomes, such as mental health or longer term effects on mortality, is more likely through provision affecting the wider determinants of health, such as education, housing, and social security support.

The longer term deterioration in funding and the quality of services has also reduced the resilience of institutions, communities and individuals to cope with future shocks. Consequentially, individuals with acute health need have an increased mortality risk and people experiencing disadvantage are at greater exposure to the impact of shocks, such as the cost-of-living crisis.

# Risks to future health

4

Some population groups are experiencing deteriorations in several different health outcomes or influences at the same time, compounding the likelihood of persistent, or even widening, health inequalities. These range from early childhood development to the impact of the cost-of-living crisis and access to services for acute health need. It is a significant cause for concern that these factors appear to combine, leaving people in the most deprived areas to fall further behind.

Failing to take early action to maintain good health and prevent deterioration will create future costs for the health care system, the economy and society. It will also mean greater challenges for people living day-to-day with poor health. Understanding how these factors are combining to create a greater risk to health than any one taken in isolation – and often the cumulative affect amplifies the risk – can guide policy attention where it is most needed.

## Children not getting the best start in life

Early childhood development and the school years play a crucial role in determining future health. Poor outcomes in childhood can continue to have significant implications in life. For example, school readiness affects educational attainment, eventual access to job opportunities and can negatively affect lifetime income and ultimately health.

There are already wide health inequalities in the very earliest stages of childhood. These are compounded by inequalities in determinants of health which, if unaddressed, risk a further relative deterioration in health for the most disadvantaged children. In the past decade, inequalities have widened for infant immunisation uptake, infant mortality, low birthweight and childhood obesity.

‘There are already wide health inequalities in the very earliest stages of childhood.’

Since 2013, while the proportion of 27–30-month-old children with development concerns has fallen across all levels of deprivation, the rate of fall has been faster in the least deprived areas compared with the most deprived areas. Relative inequalities have slightly widened and outcomes of children from the most deprived areas in 2019/20 only matched outcomes of the children from the next deprived fifth of areas recorded in 2013/14.

There is also a significant poverty-related attainment gap for primary school pupils in Scotland: pupils living in the most deprived fifth of local areas have lower levels of educational attainment than those from less deprived neighbourhoods. This has not closed over the past two decades. A similar gap exists for secondary age children and, despite signs of an improvement by 2019/20, the impact of the pandemic has reversed any progress.

These inequalities are a result of the circumstances in which children live, including child poverty. This has likely been exacerbated by the cost-of-living crisis. Families with children are also increasingly likely to live in the private rented sector, which tends to be of lower quality and affordability than other tenures.

## Men in the poorest communities

Young to middle-aged men in Scotland are at particular risk of poorer health. There has been declining engagement with health services among this group, who are most likely not to attend hospital appointments.

This group is also the most likely to suffer from deaths of despair,[**] with the exponential rise in drug deaths concentrated among men in their mid-30s to early-60s. Within cohorts the greatest risk of drug deaths is for people in their 30s. Suicide, alcohol and drugs are leading causes of death for men aged 15–44 years. For this age group they also account for two-thirds of absolute inequalities in total mortality. This greater risk of deaths of despair relates to a higher likelihood of experiencing multiple disadvantage (discussed in Section 3). Being younger than the age of 40 years, single, white and male was most strongly associated with experiencing severe multiple disadvantage.

> 'Within cohorts the greatest risk of drug deaths is for people in their 30s.'

Economic trends also point to younger men being at greater risk of poor health in the future through reduced earning potential. Meanwhile the gender gap in higher education participation is wide and has been growing over time. By 2020/21, male participation rates in higher education were 16 percentage points lower than for women.

Employment rates for men aged 16–24 years in Scotland fell by 7 percentage points, from 65% to 58% between 2004 and 2019. Men born since 1985 have started work in lower paid occupations than cohorts that came before them and are less likely to experience earnings progression in the following years.[31] Young men are more likely to work in lower paid and part-time roles in the service sector than previous generations, who were more likely to work in manufacturing roles.[32]

## Declining access to preventative health care and treatment

In Scotland, use of some preventative services has been declining, with greater falls among people living in the most deprived areas. For example, childhood immunisation rates – previously a success story in Scotland – are falling and differences in rates between the most and least deprived areas have been widening. For women there have also been worrying declines in overall rates of cervical screening.

There have been some improvements such as in timely antenatal screening and take up of bowel screening, though in the case of the latter rates in the most deprived areas still fall below national targets.

In some areas there has been little change in outcomes in the past decade. Amenable mortality rates (ie deaths that can be prevented by treatments after the onset of disease) were improving in the 2000s, but the past decade has seen little progress. Amenable

** Deaths of despair is collective term referring to deaths relating to suicide, drug overdoses and alcoholism.

mortality rates in the most deprived fifth of areas have only caught up to where rates in the next most deprived fifth of areas were in around 2007. Inequalities have remained wide. Amenable mortality in the most deprived fifth of areas is almost three times that in the least deprived.

Regardless of changes over the past two decades, wide gaps remain in the rate of access for treatment between people living in the least and most deprived areas. Even where improvements have been made in bowel screening and missed hospital outpatient admissions, for example, access for people in the most deprived areas is still worse than in the least deprived areas two decades ago. Multiple emergency admissions have remained over twice as high in the most deprived fifth of areas compared with the least.

Barriers to accessing health care services that create inequalities include the extent to which the timing and flexibility of appointments align with people's lives, mistrust of services and whether people realise that an ongoing health problem requires treatment. Without meaningful change to service provision, these longstanding inequalities will remain and leave a significant risk of harm to those with acute health who do not receive treatment.

Similar to the situation in England, the NHS in Scotland continues to be under huge pressure with increasingly long waits in emergency departments[33] and delays in treatments.[34] This will make progress on delivering services more challenging. Dealing with the COVID-19 pandemic meant refocusing limited resources, which led to a backlog of planned treatments or new assessments. Social restrictions also reduced the extent to which people accessed health care. Explanations for increased delays also include a lack of capacity, both from staffing and physical capacity within hospitals due to a shortage of social care capacity. Longer waits or an inability to access treatments risks worsening health and deepening existing poor health.

## The impact of the cost-of-living crisis on the poorest

The cost-of-living crisis will have a greater impact on the poorest households who spend a much greater share of their budgets on essentials. These essentials – such as food and fuel – are experiencing the greatest rises in cost. This will have significant impact on health through limiting individuals' ability to afford basics and necessities for a healthy standard of living, such as a warm home and enough nutritious food.

Increased financial strain also risks a greater share of people across the income spectrum falling into problem debt. This may also increase the burden of mental health issues through stress and anxiety.

Significant mitigation has been put into place by the UK and Scottish governments. The UK government has implemented an Energy Price Guarantee equivalent to £2,500 a year, rising to £3,000 from April.[35] It is also providing a number of lump sum payments giving additional financial support to lower income, disabled and pensioner households.[36] It has also committed to the usual uprating practices of increasing working-age benefits by CPI inflation and to maintain the state pension triple lock.

The Scottish government has gone further by including an additional child payment to low-income families, a Winter Heating Payment Allowance and measures to prevent problem debt and evictions.[36] Despite these efforts UK household incomes are expected to drop by 7% between 2021 and 2023, primarily due to high inflation.[11] It remains uncertain how families will be able to cope particularly given that the pandemic has left many families, especially low-income and single-parent families,[37] in a less resilient position for further financial shocks.

## Outcomes for the most disadvantaged communities are becoming detached from the majority

Across all health indicators, people living in the most deprived areas have the worst outcomes. There is a similar pattern in health outcomes across areas of social disadvantage, such as income and occupational status. This is a well-established pattern, with the health gap between the most deprived 20% and the next most deprived fifth often greater than between any two other adjacent groups. Of particular concern is the widening gap in health between people living in the most deprived fifth of areas and the rest of the population over the past decade.

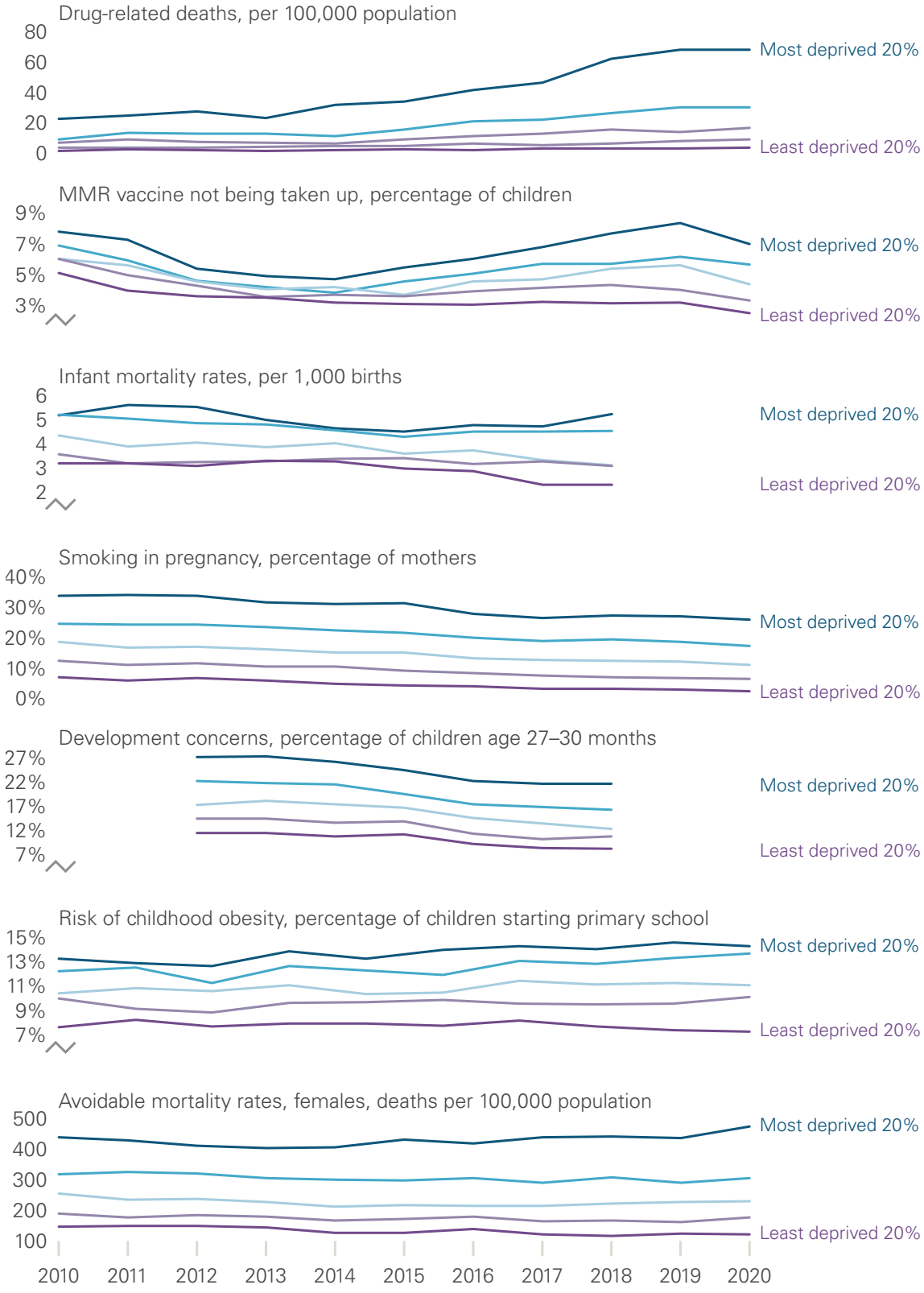
'Of particular concern is the widening gap in health between people living in the most deprived fifth of areas and the rest of the population.'

Figure 12 shows how this gap – whether relative, absolute or both – has widened across a range of health measures.[††] This is shown most starkly in the greater rate of drug deaths among people in the most deprived areas. Between 2001 and 2020, the overall rate of drug deaths increased from 6.2 per 100,000 to 25.1 per 100,00. This has been driven by the increase in deaths in the most deprived areas, reaching 68.2 deaths per 100,000 people by 2020 – this is18 times as high as in the least deprived areas.

In the area of child health, the absolute gap in MMR vaccine uptake in 24-month-olds between the most and least deprived areas has increased from 0.8% in 2014 to 4.5% in 2021 – driven by an increased uptake in less deprived areas. For infant mortality, rates have improved or stayed steady for all except those in the most deprived areas where there has been an increase in infant mortality rates since 2015. The gap in the risk of childhood obesity between most and least deprived areas had increased to 7 percentage points by 2019.

†† Where data are an average of multiple years, we refer to the final year of the period, and in the case of financial years the year starting in April.

**Figure 12: People living in the most deprived areas are falling behind everyone else**
Various indicators of health: Scotland, 2010–2020




Source: University of Glasgow, Health Inequalities in Scotland: Trends in death, health and wellbeing, health behaviours and health services since 2000
Notes: Some of the axes are truncated. Smoking in pregnancy is a financial year; healthy life expectancy is a 3-year average; infant mortality rate is a 3-year average; child development concerns is a financial year.

Overall improvements in the prevalence of smoking during pregnancy have led to a widening of relative inequalities. The absolute difference between women living in the most and least deprived fifth of areas has fallen, but because it has fallen faster in the least deprived areas, relative inequalities have widened. The prevalence of smoking during pregnancy was over 10 times higher among pregnant women living in the most deprived fifth of areas compared with the least in 2020. There is a similar pattern in the prevalence of children with early development concerns at age 27–30 months and birthweight.

An exception is adolescent mental health outcomes, where the gap between the most and least deprived has closed. However, this is because the share of people in the least deprived areas with mental health problems has increased, leading to a 'levelling down'.

In the case of drug deaths and the risk of childhood obesity, the gap between the second and third quintile is also growing. This suggests there are early signs that this widening of inequalities is no longer predominantly confined to the most deprived areas.

These trends, as demonstrated by Figure 12, are concerning as they suggest that the experiences of people living in the most deprived areas will lead to increasingly worse health outcomes compared with other groups, storing up further problems for the future.

Even where risk factors and behaviours are distributed more evenly, actual health outcomes are worse in more deprived areas, suggesting that other exposures and multiple factors mean people are less protected from worse health outcomes than other groups. This implies policies and interventions that focus only on health behaviour change (such as reducing alcohol consumption or increasing physical activity) are unlikely to have a meaningful impact on health inequalities.

## Early action can prevent inequalities widening further

There are clear emerging trends that appear to be exacerbating health inequalities. If left unaddressed these are likely to widen further in future. Some outcomes are longstanding where insufficient progress has been made historically, such as education and inequalities in accessing health care services. Others are the result of emerging trends, such as the decline in younger men's health, or stem from more immediate developments, such as the cost-of-living crisis.

These outcomes are contributing to a broader and concerning trend that people living in the most deprived areas are falling further behind everyone else. Immediate action is needed to reverse the lack of policy delivery progress of the past decade to head off and reverse these trends.

# What is holding back progress?

Scotland has the greatest powers of any of the UK's devolved nations, with areas of responsibility including health and social care, education and elements of social security and tax. The extent of these powers means that the Scottish government holds many of the levers to improve health and reduce health inequalities

There are challenges to maximising the impact of existing powers, including increasing divergence in policy direction at Westminster and the broader context of weak economic growth. Scotland's productivity levels have historically been lower than the rest of the UK and are now projected to grow more slowly in Scotland over the longer term due to an older population. Maximising the health of the population and reducing inequalities, while in itself an important aim, could also boost economic growth.

Despite these headwinds, failing to act could bring social and economic costs. Progress can be made by maximising the impact of action within current constraints. But doing so requires action across the whole of society – and collaboration across central and local government, public bodies, the voluntary and community sector, business and employers and the public.

'Progress can be made by maximising the impact of action within current constraints.'

## Scottish powers

The powers available to the Scottish government have gradually increased since the Scottish Government Act 1998. The timing and evolution of these powers are important in understanding the extent to which Scotland has taken the opportunity to reduce health inequalities over the past two decades. They also show the opportunities for future action.

Most recently, the Scotland Act 2016 provided for control of rates and bands of income tax and elements of social security including disability and carer benefits and the ability to top up existing benefits. This resulted in the establishment of the Scottish Child Payment (set out in more detail in Box 2).

The relatively recent introduction of new social security benefits, and the limited utilisation of tax powers to date, mean that the full impact of these measures is as yet unknown. The combination of the two provides the potential for significant redistribution of income within Scotland, with the child payment an important step in this direction. But this could go further, for example by reforming the council tax regime in ways that simultaneously contribute to reducing inequalities in wealth while also providing increased revenues.

## Box 2: The gradual devolution of powers to Scotland

| | Scotland Act 1988 | Scotland Act 2012 | Scotland Act 2016 |
|---|---|---|---|
| **Health and social services** | Health (with some exceptions) | | |
| **Education and early years** | Education and early years | | Maternal expense benefits |
| **Employment and quality of work** | Economic development<br>Employment training and careers advice | | Employment programmes |
| **Living standards** | | | Disability and carer benefits<br>Top-ups of reserved benefits<br>Discretionary housing payments<br>Universal Credit – vary housing element and payment frequency<br>Energy efficiency and fuel poverty<br>Consumer advice and advocacy |
| **Housing, sustainable places and communities** | Local government and local taxes<br>Sport, tourism and the arts<br>Transport (with some exceptions)<br>Housing and homelessness<br>Environment<br>Agriculture, forestry, fishing and food<br>Justice, policing and fire service | Stamp duty and landfill tax | Onshore oil and gas licensing<br>Further transport |
| **Revenue raising powers** | Limited variation of income tax rates | Capped infrastructure and resource borrowing powers<br>Introduce Scottish rate of income tax | Rates and bands on non-savings, non-dividend income tax<br>Air Passenger Duty and Aggregates Tax |

Scotland does not own all the levers to improve health or reduce inequalities. Other factors may set constraints on what is achievable. But the extent to which Scotland uses the levers available will determine how far those external factors bite. Mortality trends will partly relate to external factors (such as economic growth and living standards) and longer term factors that predate devolution (such as changes in smoking or obesity prevalence).

A contradictory direction of policy travel between the Scottish and UK governments can act as a brake on progress. Or, as in the case of elements of social security and in tackling child poverty, resources in Scotland are diverted from other areas to mitigate UK government policy effects.

The ability of governments to act also extends to soft powers, whether to influence at other levels of government, delivery partners or business without using formal regulatory powers. For instance, in relation to business – which has an important impact on health through employment opportunities as well as the goods and services it produces – government can set standards of best practice, which for the Scottish government is shown in its commitment to be a living wage employer, as well as through other terms and conditions of employment being offered to staff or contractors.

The manifesto of the elected government sets the broad direction and tone for the type of society a country wants to be. Convening powers can be used to bring key actors together to agree aims, raise awareness or mediate issues.

## Delivering with local government

The relationship between central and local government in Scotland is important in the effective delivery of the policies enabled by the Scottish government's powers. However, stakeholders felt that delivery can be limited by a centralised approach to budgeting that led to multiple small pots being allocated for specific policy areas. Budgets also tend to be set year to year, reducing the scope for longer term planning.

The period of fiscal austerity means that Scottish local authorities have experienced significant funding cuts over the past decade. They have also had increased statutory requirements placed on them that had to be prioritised over the delivery of other functions. That said, compared with England, cuts to local authority funding in Scotland were smaller. This is because the Scottish government chose to allocate less spend towards the NHS than in England, enabling it to use the extra funding to reduce the scale of cuts elsewhere.

## The implementation gap

Improving outcomes in any sector is consistently found to depend on the will to act, policies and ideas that are known to be effective, and the ability to implement these in a sustained manner. When it comes to improving health and reducing inequalities, action is needed across sectors. This places even greater emphasis on the importance of effective implementation and collaboration.

## Public health policy since devolution

Since devolution, several health policy plans and strategies in Scotland have focused to a greater or lesser extent on tackling health inequalities, notably:

- *Improving Health in Scotland: The Challenge*[38] in 2003 centred on individual risk factors such as obesity, tobacco and alcohol.
- *Closing the opportunity gap in 2004*[39] was a cross-departmental strategy aimed at reducing poverty with specific targets across employment, health, skills, income and recognised challenges in rural areas.
- *Equally Well*, the report of the Scottish government's Ministerial Task Force on health inequalities published in 2008 set out a programme for change across key priority areas including early years, cardiovascular disease and cancer, drug and alcohol problems and links to violence, and mental health and wellbeing. Its implementation plan included the establishment of eight test sites with a cross-sector approach to service improvement, recognising progress could not be achieved through health care alone.[40]
- Most recently the 2018 *Public Health Priorities for Scotland* and the establishment of Public Health Scotland in 2020, have provided a platform to set out national and local government priorities for health over the next decade.[41]

Despite this sustained policy attention, inequalities in health remain wide. In part this reflects the tendency for the policy implementation stemming from these strategies to emphasise downstream interventions. Unless the upstream conditions that shape health inequalities are tackled, progress will be limited to trying to pick up the consequences of social and economic inequality.

'Unless the upstream conditions that shape health inequalities are tackled, progress will be limited to trying to pick up the consequences of social and economic inequality.'

Recognising the cross-sector nature of the action required to improve health and reduce inequalities, the reasons for this lack of progress were explored as part of this review. This involved a series of workshops, interviews and surveys with stakeholders from across the wider health policy system.

It was generally accepted that tackling historical circumstances and entrenched inequalities is not easy. Nevertheless, there was recognition of a difference between the policy intent and the reality on the ground for people experiencing services – a persistent and growing 'implementation gap' – ultimately resulting in communities facing increasing inequalities. This implementation gap was seen to arise in multiple ways and at different points through the continuum of policymaking – between intent, design, delivery and experience.

## Box 3: The Christie Commission

Reporting in 2011, the Christie Commission set a vision for the effective delivery of public services in Scotland. Many of today's delivery difficulties demonstrate the significant progress needed for that vision to be realised. Many of the core principles set out chimed strongly with the issues blocking progress on health inequalities identified in this review.

### Key principles of reform from the Christie Commission[42]

The commission looked across the whole field of public service delivery, rather than specific aspects of public service reform. The work examined the challenges, obstacles and opportunities for public service policy and delivery. The commission mapped out a way forward for the reform of public services in Scotland. This included recognition of how services should be designed and then implemented, to identify and understand a particular issue.

The approach can be summarised by the following four priorities:

- People: Reforms must aim to empower individuals and communities by involving them in the design and delivery of the services.
- Partnership: Public service providers must work more closely in partnership, integrating service provision to improve their outcomes.
- Prevention: Expenditure must be prioritised on public services which prevent negative outcomes.
- Performance: The public services system – public, third and private sectors – must reduce duplication and share services to become more efficient.

A 10-years-on roundtable identified a lack of sufficient progress. It concluded that achieving greater progress in the delivery of public services in Scotland requires a shift to more preventative action, delivery at a local level and by local actors, with a greater level of public scrutiny.

# Why the lack of progress?

A survey of people working in the voluntary and community sector, delivery agencies and health services showed a strong recognition of an implementation gap, with 82% of those responding feeling it was a large or very large problem. This implementation gap was attributed to the following factors:

- **Short-termism in planning**: Already stretched budgets not being used most effectively because there is a failure to take a long-term approach to planning the best use of resources. This was related to the short-term nature of politics where rapidly designed policies are brought forward without enough time spent on understanding resourcing or delivery. It also reflects the annual budgeting nature of the Scottish block grant.
- **A centralised approach to policymaking**: While some policies – such as income redistribution – tend to benefit from centralised delivery, the coordination of more operational policy interventions tends to result in centralisation with a sense of micro-management of delivery from the centre. Community involvement in the policy development process is still too limited despite this forming a core part of policy rhetoric and widespread recognition of its importance. The efficacy of

Community Planning Partnerships has been questionable and provisions in the Community Empowerment Act 2014 to promote and facilitate public participation in local decision making have not yet been fully exploited.

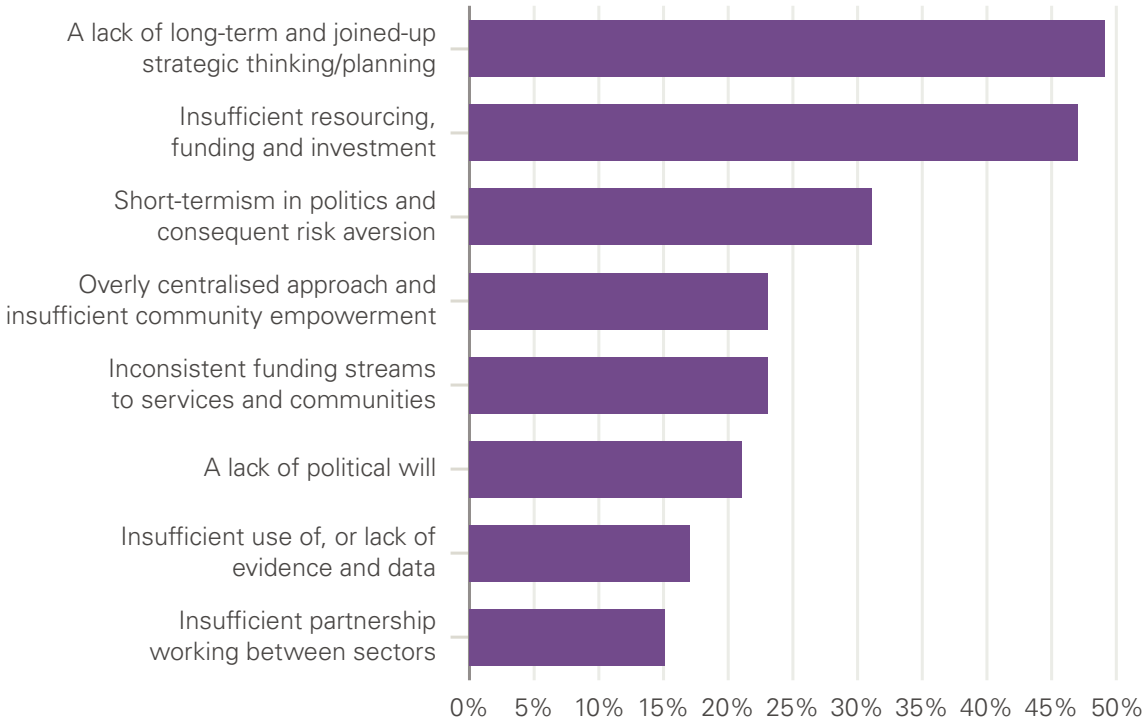
- **Poor use of money in the system**: Where there are separate pots of money for different policy priorities this can make it is difficult to deploy resources to reflect need in different local areas, or to adapt to emerging issues. It is not always the case that there is not enough money, rather that existing resources at times could be used to greater effect.
- **Scaling up success**: Examples of best practice and successful delivery exist but the level and quality of evaluation varies leaving a lack of understanding as to the impact of outcomes as well as more mechanistic delivery challenges. This hampers the ability to scale these either in different local areas or applying the approach to other policy areas. There has been little sign of change in the policy system to support the identification and greater take-up of successful approaches.
- **Lack of coherence across policy areas**: There was too little joining up between key policy areas where aims and outcomes aligned, preventing joint working. This approach is also built into operating structures and finances making it too easy to default to the practice.

**Stakeholder participant:**

'Our policies are generally well conceived with the intention of trying to make a positive and progressive difference, but are not delivered, resourced or thought through well in terms of delivery. We lack the spaces in Scotland for long-term thinking that joins up investment, planning and resource allocation.'

Figure 13 shows the most-cited barriers to implementation in our survey were a lack of long-term and joined-up strategic thinking/planning (49%); insufficient resourcing, funding and investment (47%); and short-termism in politics and consequent risk aversion (31%).

**Figure 13: Most cited barriers to greater policy progress**
Proportion of respondents deeming each item a top barrier to greater progress




Source: Diffley Partnership, stakeholder survey
Notes: Question asked, 'Which of the following would you say are the biggest barriers to making progress on reducing health inequalities in Scotland?' (Select up to 3); only categories receiving more than 15% shown

Three broad themes emerge in relation to the perceived barriers to implementation, from both the survey and in-depth discussions undertaken during the review.

- Policy design can in isolation be good, yet fail to recognise the context in which it is then applied – either in relation to other existing policy strands, the wider economic and political context or local conditions.
- A lack of trust between institutions involved in delivery – across national government, local government, agencies and the voluntary sector. This appeared to be caused in particular by a lack of empowerment among actors in the system or in engagement between sectors.
- The need for a growing maturity of the policy system. This was shown in several ways including the need for greater evaluation of what has worked, what has not and why. It was felt that policymaking was not led enough by evidence, with insufficient effective use of data and evidence in decision making and policy design. People perceived the lack of an independent voice, scrutiny, and challenge, with a fear of failure throughout the system preventing innovative approaches to delivery.

Business also plays a key role in determining health, through generating employment opportunities as well as the goods and services it produces and the way in which products are marketed. These can all have powerful positive and negative impacts on health and must be part of any successful society-wide approach to improving health and reducing

inequalities. One such example, which was beyond the focus of this review, is the critical role businesses play in shaping the food environment. In Scotland, this currently fails to support access to healthy food with excessive calorie intake leading to higher obesity rates.[43]

The cost of inaction to both individuals' health, and ultimately the economy and public services, means that achieving the maximum within existing constraints should be a priority. And all sectors need to play a role. Some barriers can be more easily overcome within current parameters, while others will require longer term reform to improve the parameters of the system in which people operate.

## The context for delivery in Scotland

Many of the issues highlighted apply in other nations and places. There are two features of the Scottish context that are important to consider in understanding the implementation gap.

### Geography

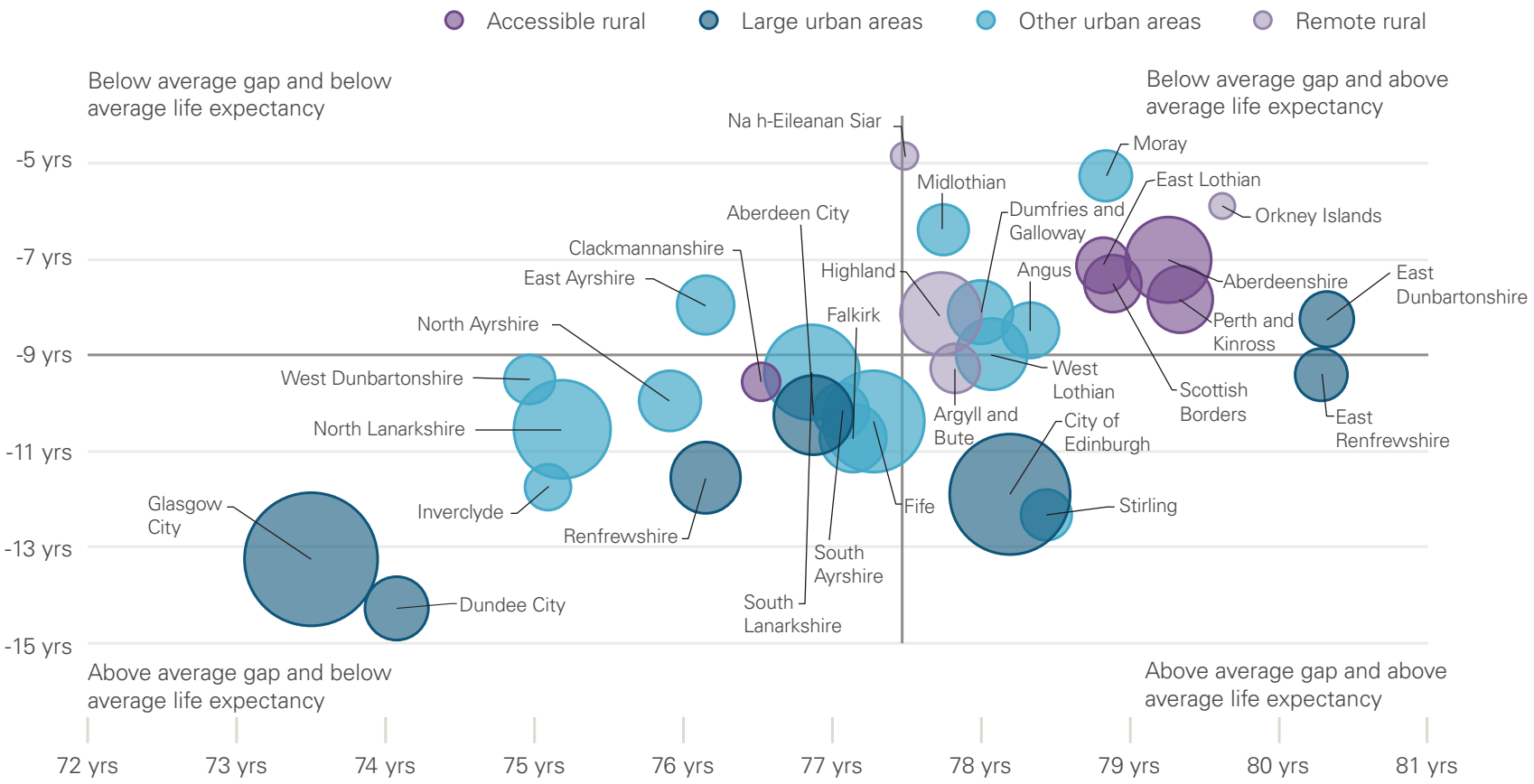
Scotland is the least densely populated country in the UK. It has a greater share of sparsely populated countryside with its most populous areas concentrated in the lowlands – the south and south-east coast. The largest urban areas have smaller populations than the largest in England and there is a much smaller share of medium-sized towns. This presents challenges for provision of public services given disperse populations and fewer large population centres to achieve economies of scale. Public service delivery has historically been higher on a per capita basis than on average in England, which may partly reflect these additional delivery costs.[44]

Figure 14 shows how period life expectancy at birth and the range of period life expectancy at birth within an area vary across local authorities. The range of life expectancy is measured by the absolute difference in life expectancy at birth between the least and most deprived 20% of neighbourhoods within a local authority. The figure also shows the rural-urban classification that applies to the largest share of the population within a local authority. The size of the bubble denotes population size. It highlights that lower life expectancy is correlated with higher inequality in life expectancy, but there is no clear pattern associated with rural-urban classification or population size.

Glasgow City and Dundee City are predominantly large urban areas with below average life expectancy and above average absolute inequality in life expectancy. North Lanarkshire, West Dunbartonshire and Inverclyde also have relatively low life expectancy and high absolute inequality in life expectancy but are predominantly classified as 'other urban areas'. East Lothian and the Scottish Borders are examples of predominantly accessible rural areas with above average life expectancy and below average inequality in life expectancy.

**Figure 14: Variation in life expectancy between local areas**

Male life expectancy by life expectancy deprivation gap in local authorities by predominant urban-rural classification and population size, Scotland, 2015–19




Size of bubble reflects relative population size.

Source: Health Foundation analysis using National Records of Scotland, mid-2021 population estimates, life expectancy by council and SIMD 2015–19; Scottish government, Urban Rural classification 2016

Notes: Predominant urban-rural classification is the largest percentage of population living in one of the 6-fold Urban Rural category: Large urban areas/Other urban areas/Accessible small towns/Remote small towns/Accessible rural/Remote rural; life expectancy deprivation gap is the absolute difference in period life expectancy at birth between the 20% most and least deprived areas within a local authority.

Within local authorities health outcomes and levels of deprivation can also vary significantly. Urban areas tend to have concentrations of both very deprived and very advantaged populations. Less populated rural areas tend not to contain the most deprived neighbourhoods, and some areas have none.

There are also significant variations in socioeconomic outcomes between different local areas in Scotland. For instance, 24.6% of children living in Glasgow City live in child poverty compared with 8.3% of children living in East Dunbartonshire. There is also wide variation in economic inactivity rates. In Midlothian, 83.7% of 16–64 year olds were economically active, compared with 69.4% in North Lanarkshire.

### A National Performance Framework

The National Performance Framework provides a set of outcomes aimed at creating a future Scotland that reflects the country's values and aspirations. It can also track progress in reducing inequality. The framework is broadly aligned with the United Nation's sustainable development goals. It also provides an opportunity to focus action across the policy system.

The framework gives a range of detailed indicators designed to encourage progress towards a wider goal. For instance, the broad goal 'children and young people growing up loved, safe and respected so they realise their full potential' has a supported indicator (one of several) of equality of children services, measured as the percentage of settings providing funded early learning and childcare achieving Care Inspectorate grades of good or better across four themes.[45]

Stakeholders suggested that the focus of policy delivery tended to be on achieving improvements in previously identified specific metrics, rather than coming back to broader aims, such as improving children's wellbeing and development. The consequence was felt to be a lack of accountability across different actors in the system for the broader aim, a sense of disempowerment when a different approach – outside of the metrics – could help achieve the wider aim, and failing to recognise opportunities for joint action across the system that could lead to greater overall improvements.

> **Stakeholder participant:**
>
> 'We have the National Performance Framework, but we don't use it well enough. We should use this more proactively to inform and drive decision making and resourcing across existing silos or organisational structures.'

## Building support for a radical shift in action

Deliberative work with the public conducted as part of this review has shown appetite for more radical action on health inequalities. Effective public support could help to galvanise a longer term preventative approach to tackle the fundamental drivers of health inequalities. A focus on lifestyle factors and acute health need is not inevitable. Rather our panel have called on government to lead a national conversation for a long-term, strategic, cross-sector approach. This echoes the calls of stakeholders shown in Box 4.

### Box 4: Principles for tackling health inequalities in Scotland from public and stakeholder engagement

**Deliberative public engagement**

- Use robust evidence and expertise on the most effective ways to tackle health inequalities to develop impactful interventions.
- Work in collaboration across political parties to develop a long-term plan for tackling health inequalities in Scotland to ensure consistency and continuity, rather than adversarial politics.
- Develop an effective and viable strategy to tackle health inequalities in Scotland that brings together all relevant stakeholders, including experts, practitioners (from health care and community services) and members of the public.
- The Scottish government should lead and stimulate a national conversation around health inequalities rooted in principles of fairness, and with transparency and honesty around its decision making.

**Stakeholder workshops and interviews**

- To get better at learning from different actors within the policy delivery system, understanding what works in different places and why as well as learning from international examples.
- Take a longer term approach to policymaking and service resourcing.
- Get better about sharing what works and how to deliver it across different localities.
- Be much more radical about the kind of change we want to see both in terms of structural change, operational change (with a recurring theme being the need for more relational and preventative services) and cultural change in terms of pooling resources and sharing accountability openly.

The cost of inaction to both individuals' health, and ultimately the economy and public services, means that achieving the maximum within existing constraints should be a priority. Effective policy development and delivery is difficult, and success often requires sustained, long-term action, leading to gradual change. However, the latest report from Audit Scotland emphasises the need for immediate and extensive public service delivery reform if policy goals are to be successfully met within tight fiscal constraints.

The final section concludes by setting out a future path for making greater progress in improving health and reducing inequalities in Scotland, arguing for a radical shift in the scale and pace of policy delivery.

# Bridging the implementation gap

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The past two decades have shown that in times of crisis those facing greatest disadvantage are hit the hardest. The societal fault lines shown starkly by the cost-of-living crisis and the COVID-19 pandemic reflect patterns witnessed in the aftermath of the 2008 financial crisis. It is time to take action to tackle inequalities and provide greater protections for the most affected groups.

Differences exist in health and the social and economic outcomes that influence health across the population of Scotland. Health inequalities reflect historical social and economic inequalities and their scale leads to Scotland having lower life expectancy than other countries in the UK, falling behind other European countries. Many, especially people living in poverty or more deprived areas, already have poor health at risk of further deterioration. The experience of multiple disadvantage, including a minority experiencing severe multiple disadvantage, is contributing to a growing gap in health outcomes.

## A society acting together to improve health and reduce inequalities

Political progress in moving towards more mature governance structures, institutions and shaping a more progressive society in Scotland has stalled in recent years. This reflects a combination of political inertia – related to the fallout from Brexit and renewed focus on independence – and a series of crises: weak economic growth post-2008, the pandemic and cost-of-living crisis.

The austerity of the 2010s was more than a reduction in spend on public services and social security. The effects of wage stagnation have led to an unprecedented slowdown in improvements in living standards that in turn has placed greater strain on families, particularly those with lower incomes, to maintain or improve their living standards. UK government policy decisions have exacerbated the situation through a series of cuts to working-age social security and public services. The consequence for an already vulnerable population is playing out in widening inequalities across a range of health outcomes, and signs of increasing poverty.

Progress in reducing inequalities in social and economic outcomes has been slight, with wide gaps remaining in educational attainment, a growing share of people living in the less secure private rented sector, and persistence of insecure work. This lack of progress provides little indication of health inequalities narrowing in future.

The broader economic and fiscal context does not excuse the persistent implementation gap in Scotland – between policy intent, delivery and people's experiences. Government has a role to play in setting the tone for a relentless pursuit of meaningful change and championing what is possible, providing the leadership and influence to enact it. Making headway will require a whole-society response including at all levels of government, business, the voluntary and community sector and the public.

There is also a strong mandate for action in Scotland. The public is concerned about inequalities and supports action, including greater investment in public services to support better health and raising taxes to do so. While an emphasis on health and inequalities can initially be interpreted as needing to focus on health care services or individual actions, our deliberative work has shown that the public supports long-term preventative action.

Stakeholders described an implementation gap pervading each stage of the policy process, from policy design to delivery, across sectors. The diagnosis offered by stakeholders varied but can be characterised as driven by short-termism, over-centralisation, a failure to prioritise and a perceived lack of trust between different actors in the system. Existing policy plans were often characterised as highly burdensome and constrictive of innovation and tailoring for local areas. This contrasts with an intent for greater community engagement and development of policy solutions in local areas.

The pandemic galvanised actors across the policy system to support immediate need. In many instances, necessity provided the catalyst to overcome barriers within the system. The lessons of success from such collaboration and cross-sector working should not be lost and can be built on.

## Turning the tide

Tackling health inequalities requires sustained focus over the long term. Action in the short term needs to build the foundations for longer term change, rather than creating near-term successes that are limited in scope and ultimately overwhelmed by wider pressures. Failure to prioritise the myriad issues that need to addressed is likely to diminish impact. Instead, appropriate short, medium and long-term measures need to be identified for sustained impact.

Fundamentally, all policy areas in Scotland must ensure that their activity helps to prevent the poorest and most disadvantaged in Scotland falling further behind. Our review also highlights three specific areas of concern that require immediate attention given current trends: drug-related deaths, the health of infants and children, and outcomes for young and middle-aged men. These should not take away from the need for wider action across all parts of society, and action here and elsewhere must mitigate the risk of narrowly focused interventions that treat symptoms rather than causes.

Our review has not aimed to create a set of detailed recommendations and achieving progress does not require another new strategy. Many of the elements identified as lacking from current policy processes are those set out over a decade ago by the Christie Commission. The shift required now is in the pace and focus of delivery, and recognition of the scale of reform required.

Existing strategies need to be built on and adapted to ensure there is collaboration across the delivery system based on practical action and shared goals. These should be captured within the National Performance Framework to provide a clearer link between overarching ambitions and specific policy goals. Achieving this requires taking greater steps to empower and engage all parts of society in developing and delivering solutions.

## Supporting renewed ambition and delivery

Our commitment to improving health and tackling inequalities in Scotland does not stop here. The Health Foundation plans to support renewed ambition in delivery, but this can only be successful if it is developed with and led by the public and actors within the policy system. Building on our independent review we will seek to support collaborative activity focused on:

- Maximising the delivery contribution at all levels and across sectors, determining and attributing appropriate responsibility with targets that reflect the change being sought on the ground.
- Evaluation and learning from existing policy interventions to recognise what does and does not work and ensure policy development is based on evidence – and how best to share and adapt what works across different localities and policy streams.
- Setting clear, focused and achievable short-term goals that are part of a longer term preventative approach to policy design, delivery and resourcing.
- Cross-sector working that allows for the pooling of resources and shared goals.

There are some obvious constraints on progress. The difficult fiscal context must be recognised and there are limits to change without greater collaboration between Scotland and the UK government.

Even so, the scale of health inequalities in Scotland is not inevitable. Existing funding can be reshaped to support a different approach to the delivery of hard-pressed public services. The pandemic demonstrated that agility in policy delivery and local practice is possible. The need to act at pace in tackling recent crises presents an opportunity for renewal.

> ‘The pandemic demonstrated that agility in policy delivery and local practice *is* possible.’

Taking action is essential. Progress can be achieved within existing powers and by maximising their use. For Scotland, the human and economic cost of inaction is simply too high, particularly for the poorest and most disadvantaged groups. The time to create a sustainable approach to closing the gap in health outcomes is now.

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The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK.

Our aim is a healthier population, supported by high quality health care that can be equitably accessed. We learn what works to make people's lives healthier and improve the health care system. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen.

We make links between the knowledge we gain from working with those delivering health and health care and our research and analysis. Our aspiration is to create a virtuous circle, using what we know works on the ground to inform effective policymaking and vice versa.

We believe good health and health care are key to a flourishing society. Through sharing what we learn, collaborating with others and building people's skills and knowledge, we aim to make a difference and contribute to a healthier population.

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