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Health, Social Care and Sport Committee

Tackling health inequalities in Scotland

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Health, Social Care and Sport Committee

To consider and report on matters falling within the responsibility of the Cabinet Secretary for Health and Social Care and matters relating to drugs policy.

hscs.committee@parliament.scot

Committee Membership

Convener
Gillian Martin
Scottish National Party

Deputy Convener
Paul O'Kane
Scottish Labour

Stephanie Callaghan
Scottish National Party

Sandesh Gulhane
Scottish Conservative and Unionist Party

Emma Harper
Scottish National Party

Gillian Mackay
Scottish Green Party

Carol Mochan
Scottish Labour

David Torrance
Scottish National Party

Evelyn Tweed
Scottish National Party

Tess White
Scottish Conservative and Unionist Party

Membership changes

1. The following changes to Committee membership occurred during the course of this inquiry:

    - On 26 May 2022, Tess White MSP replaced Sue Webber MSP.

Executive summary

The impact of inequalities

Individual, community and group experiences

2. The Committee recognises the effect of inequality on individuals, families and communities and that there are a number of communities that are disproportionately affected by inequality.

3. The Committee calls on policy-makers at all levels of Government to take proactive steps to ensure that future design and delivery of public services properly recognises and addresses the needs of those experiencing disadvantage. This approach should have the objective of reducing health inequalities including those resulting from multiple disadvantage.

Wider community and environmental influences

Housing

4. The Committee has heard compelling evidence of the essential connection between access to safe, secure, affordable housing and positive health and wellbeing outcomes.

5. The Committee notes existing Scottish Government commitments to achieving net-zero targets and tackling fuel poverty and the crucial role of upgrading Scotland's housing stock in fulfilling those commitments. In responding to this report, we call on the Scottish Government to set out details of the actions it is taking to improve housing in this context, associated timescales and, crucially, what contribution it anticipates these actions will make towards addressing health inequalities.

6. The Committee considers that further examination of the standard of housing in Scotland is necessary, including the quality and energy efficiency of Scottish housing stock. This should include an assessment of the contribution of policies in these areas towards reducing inequality and tackling health inequalities. We draw this to the attention of colleagues on the Local Government, Housing and Planning Committee.

7. The Committee considers that housing policy can make a positive contribution towards tackling health inequalities and improving public health outcomes. It notes the Local Government, Housing and Planning Committee's plans to scrutinise housing issues in more detail, including both affordable housing and retrofitting, vacant and derelict homes, and the impact of these on housing inequalities. We further draw this section of our report to the attention of colleagues on the Local Government, Housing and Planning Committee.

8. The Committee also draws this section of the report to the attention of colleagues on the Social Justice and Social Security Committee in relation to the impact of health inequalities on those experiencing homelessness, and the effects of

homelessness on health and wellbeing outcomes.

Community, planning and access to social and cultural opportunities

9. The Committee notes the significant impact planning policy can have on health outcomes and, if implemented poorly, in widening inequalities.

10. The Committee highlights the recommendations it made following its scrutiny of National Planning Framework 4 and considers planning policy an important area that can either help reduce health inequalities or increase them. It draws these to the attention of colleagues on the Local Government, Housing and Planning Committee, as part of their ongoing scrutiny of the implementation of NPF4.

11. The Committee notes the current work of the Finance and Public Administration Committee in scrutinising the Scottish Government's National Performance Framework. However, is aware this scrutiny will not focus on examining the national outcomes or monitoring action to alleviate poverty as a driver of poor health in society. The Committee notes that the national outcomes will be subject to statutory review in 2023 and calls on the Scottish Government to ensure action to alleviate poverty and reduce health inequalities is central to that review. The Committee would also welcome ongoing dialogue with committees across the Parliament to explore how a sustained focus on scrutinising delivery of the cross-portfolio ambitions of the framework throughout the session can be achieved.

12. The Committee supports Professor Gerry McCartney's call for an approach to tackling health inequalities based on the concept of "proportionate universalism.

13. In this context, as a specific example of such, the Committee reiterates the call made on the Scottish Government, as part of its inquiry into alternative pathways to primary care, that Community Link Workers should be embedded across all GP surgeries in Scotland.

14. The Committee urges the Scottish Government to ensure the impact on inequalities and health inequalities is a primary consideration in the future design and delivery of all public services.

Education and the early years

15. The Committee recognises the important role of education in addressing societal and health inequalities. It also commends the work of the Education, Children and Young People Committee and its focus on the role of the Scottish Attainment Challenge in addressing the poverty related attainment gap [1] .

16. The Committee calls on the Scottish Government, in responding to this report, to set out what action it is taking through the Best Start, Bright Futures programme to address the impact of poverty on children and young people and specifically what impact it expects this action to have in reducing health inequalities.

17. The Committee has been concerned to hear evidence during this inquiry that certain vulnerable families are experiencing de-facto exclusion from free childcare provision. The Committee calls on the Scottish Government to

undertake an urgent review of how this policy is being deployed across local authority areas, including what actions are required to eliminate specific obstacles to accessing free childcare provision and ensure vulnerable families receive the support they are entitled to and that provision is suitably funded. The Committee also draws this issue to the attention of colleagues on the Education, Children and Young People Committee, particularly in terms of its impact on addressing health inequalities.

18. The Committee has heard evidence of a range of policy measure to mitigate the effects of poverty on families, such as free bus travel, free prescriptions and free school meals. The Committee calls on the Scottish Government, within devolved powers and budget constraints, to continue prioritising actions with the aim of mitigating these effects.

Employment

19. The Committee has heard compelling evidence of the crucial role good employment has to play in addressing income inequalities and in promoting and preserving good mental and physical health. In this context, action to break down barriers to employment has an important role to play in tackling health inequalities.

20. The Committee recognises that powers over employment law, and the majority of work-related social security benefits, are reserved to the UK Government. The majority of the Committee agrees with the recommendation by the Glasgow Centre of Population Health that, within budget constraints, the UK Government should take action to align benefits and tax credits with inflation and to reinstate the uplift in Universal Credit introduced during the Covid-19 pandemic[i].

21. The Committee calls on the Scottish Government to strengthen its efforts to encourage public sector organisations to become living wage employers, and to encourage those that have already made that commitment but have yet to fulfil it to accelerate their progress. The Committee further requests that the Scottish Government, in responding to this report, provides an update on the percentage of Scotland's public sector workforce currently employed by living wage employers, a projection of how that is expected to increase over the next five years, and an outline of action it is taking to address any shortfall.

22. The Committee highlights evidence it has received of those actions the Scottish Government can take, within devolved powers, to address employability issues and eliminate barriers to employment. These include, for instance, using public procurement policy as a lever to encourage more organisations to become real living wage employers, expanding childcare provision and breaking down obstacles which prevent potential employees from taking up free childcare and therefore act as a barrier to employment. The Committee calls on the Scottish Government, in responding to this report, to set out what action it is taking or plans to take in the future to make progress in these areas and what it is doing to ensure its approach to tackling these barriers is properly informed by and

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i Tess White MSP and Sandesh Gulhane MSP dissented from this recommendation.

developed in partnership with people with lived experience.

23. Recognising the division of powers between the Scottish and UK Governments, the majority of the Committee calls on the UK Government to increase the statutory living wage to the real living wage, and to take further action to increase 'in-work' benefits to eliminate in-work poverty[ii].

24. The Committee highlights evidence submitted to this inquiry of the link between supportive employment and improved health outcomes . The Committee calls on the Scottish Government to set out what progress has been made towards implementing the recommendations from the 2019 review of the Scottish Government's health and work strategy, particularly in relation to reducing inequalities and addressing health inequalities and what further work still needs to be done.

25. The Committee draws the attention of colleagues on the Economy and Fair Work Committee to the important role employers across the public, private and third sectors have to play in tacking health inequalities by addressing in-work poverty and breaking down barriers to employment.

Public services

26. The Committee believes that, as outlined in the Christie Commission report a decade ago, reducing inequalities must continue to be a core objective of public service reform. The Committee calls on the Scottish Government, in responding to this report, to set out what progress has been made towards implementing the Christie Commission recommendations, particularly as these relate to reducing inequalities and addressing health inequalities.

27. While noting the Scottish Government's focus on redesigning and rebuilding public services as part of its Covid recovery strategy, the Committee highlights evidence submitted to this inquiry which suggests multiple instances where the design and delivery of public services are exacerbating inequalities rather than reducing them. It calls on the Scottish Government to bring forward an action plan designed to pinpoint and address these problems as a core element of ongoing public service reform.

28. If public services are to contribute positively to the objective of reducing inequalities in the future, the Committee believes that their design and delivery must become much more responsive to the needs, rights and preferences of people using those services. The Committee therefore calls on the Scottish Government, in responding to this report, to set out what it is doing to embed co-design and to work with those with lived experience in implementing any future public service reforms and how it will measure the success of this approach in reducing inequalities.

29. The Committee welcomes the Minister's update on the upcoming publication of a long-term delivery plan for the next phase of the national trauma training programme. We look forward to hearing more detail on how this can be

[ii] Tess White MSP and Sandesh Gulhane MSP dissented from this recommendation.

embedded within public sector services to improve working practices and what the Scottish Government will do to monitor and evaluate its contribution towards reducing inequalities.

30. The Committee welcomes the Minister's commitment to holistic person-centred care, based on a so-called "GIRFE" approach. To tackle inequalities effectively, the Committee believes that such a "no wrong door" approach needs to be applied more widely to public services beyond health and social care. The Committee draws this conclusion to the attention of colleagues on the Finance and Public Administration Committee as part of its ongoing scrutiny of public service reform.

Health in all areas

31. The Committee welcomes the Scottish Government's commitment to pursuing a "health in all policies" approach to policy-making. The Committee believes much wider and more systematic application of health inequality impact assessments is essential to achieving this objective. The Committee therefore calls on the Scottish Government, in responding to this report, to set out how it plans to achieve this including associated timescales, what further work it will undertake to measure and evaluate the benefits of HIIAs, and what additional guidance and support it will offer policy-makers to ensure the wider use of HIIAs has a material impact in reducing health inequalities and does not become simply a 'box-ticking' exercise.

32. The Committee is particularly interested in the approach taken by the Welsh Senedd, whereby legislation in Wales has made the completion of health impact assessments a statutory requirement on public bodies [2] . The Committee draws this development to the attention of colleagues on the Equalities, Human Rights and Civil Justice Committee and suggests that Committee might be interested in undertaking further scrutiny of potential legislative action to embed the objective of tackling inequalities in general and health inequalities in particular into all aspects of public policy-making in Scotland.

33. The Committee would like to see a similar approach taken at a UK Government level to the application of HIIAs, and further analysis of how the implementation of reserved policies affects health outcomes and mortality rates.

34. The Committee sees the Fairer Scotland Duty as a start to work to prioritise tackling inequality in all areas. However, the Equality and Human Rights Commission's recent evaluation highlights concerns that the duty is not being used as intended. The Committee urges the Scottish Government to undertake further work to monitor the effectiveness of the duty, and support organisations to prioritise it in decision-making processes.

Informal caring as a social determinant of health

35. This Committee has heard extensive evidence that informal and unpaid caring is a social determinant of health. This has highlighted that caring for someone has a disproportionate impact on health outcomes and that informal carers face significant health inequalities as a result.

36. The Committee believes the Scottish Parliament and the Scottish Government should formally recognise and acknowledge that caring is a social determinant of health. In so doing, the Scottish Government, and Public Health Scotland, must ensure that more targeted support for carers is considered and reflected in the future development of public health policy and strategies.

37. The Committee further recommends that the Scottish Government should actively promote the Carers Positive Award Scheme as an example of good practice and, to further reinforce public sector employer support for carers, consider making participation in the scheme a statutory requirement for all public sector organisations, as well as those that receive public funding.

38. The Committee draws the attention of the Scottish Government and its colleagues on the Social Justice and Social Security Committee to the potential development of a carer poverty strategy and creation of a Scottish carers assistance benefit, as advocated by a number of contributors to the inquiry. The Committee believes these proposals would merit further exploration and scrutiny as a means of delivering fairer financial support for carers and tackling health inequalities experienced by carers.

39. The Committee is concerned by evidence it has heard during this inquiry that women and carers are disproportionately affected by welfare conditionality and the impact this has on health inequalities. The Committee urges the Scottish and UK Governments to review the specific impact of welfare conditionality on women and carers and identify what more needs to be done to tackle the health inequalities they experience as a result.

Fundamental causes of health inequalities

40. The Committee has heard strong evidence of the interconnection between levels of poverty and levels of health inequality and the severe negative impact poverty has on health and wellbeing outcomes. On this basis, as well as being a socio-economic problem, the Committee believes tackling poverty must be considered to be a major public health priority at all levels of Government. The Committee calls on the Scottish Government to set out in detail what it is doing, within its devolved competence, to tackle poverty as a public health issue, what impact it expects these interventions to have in reducing health inequalities and how this impact will be measured and evaluated.

41. As an integral part of future financial scrutiny work, the Committee will consider and evaluate what impact Scottish Government spending decisions are likely to have in reducing or exacerbating health inequalities. It also draws this to the attention of colleagues on committees across the Parliament, particularly as this relates to spending decisions beyond this Committee's own direct policy remit, for instance in relation to funding programmes designed to tackle poverty.

42. The Committee commends the work of the Social Justice and Social Security Committee in undertaking an inquiry into low incomes and problem debt and has been particularly struck by evidence submitted to that inquiry outlining what actions people on low incomes are compelled to take to survive and the effects this has on budgeting decisions. We encourage the Social Justice and Social

Security Committee to continue its scrutiny of issues around poverty, low income and social security during this session, including the implications of policy development in these areas for tackling health inequalities.

43. The Committee echoes the recommendations in the Social Justice and Social Security Committee report, Robbing Peter to pay Paul: Low income and the debt trap , which calls for a shift the burden of responsibility away from the individual and onto systems, and for current complexities around eligibility for benefits to be eliminated.

Income

44. Evidence submitted to this inquiry demonstrates the close correlation between income and inequality and the importance of taking action to raise incomes as a means of reducing health inequalities in that context. Evidence equally suggests that, while also being particularly effective in tackling inequalities, universal interventions on income have the additional benefit of eliminating feelings of stigma or shame otherwise experienced by those on low incomes.

45. The Committee requests that the Scottish Government provide an update on the work of the minimum income guarantee steering group and progress towards implementing a minimum income guarantee to address existing gaps in the social security system that may be hampering progress in tackling health inequalities. As part of this update, we invite the Scottish Government also to set out any specific obstacles it is encountering to implementation of a minimum income guarantee and what action it intends to take to address these.

46. The Committee calls on the Scottish Government to continue discussions with the UK Government with a view to overcoming obstacles to the timely and effective implementation of a minimum income guarantee in Scotland and to keep it informed of progress[iii].

47. The majority of the Committee asks the Scottish Government to work with the relevant UK agencies to consider whether a pilot of a universal basic income could take place in Scotland in order to begin to address health inequalities[iv].

Social security

48. The Committee acknowledges that people's experiences of social security systems have been that they are not felt to be compassionate or fair, and have exacerbated feelings of stigma. It considers that these systems could be more supportive, inclusive and informative and draws this to the attention of colleagues on the Social Justice and Social Security Committee when undertaking ongoing scrutiny of social security policy and implementation of devolved benefits in Scotland, and the UK benefits that work alongside them.

49. The Committee has heard evidence that welfare conditionality has resulted in a reduction in the income levels of benefit claimants since 2010. To tackle health

[iii] Tess White MSP and Sandesh Gulhane MSP dissented from this recommendation.
[iv] Tess White MSP and Sandesh Gulhane MSP dissented from this recommendation.

inequalities effectively, it calls on the UK Government to address this issue as a priority.

50. The Committee highlights to colleagues in the UK Parliament the evidence gathered by this inquiry related to the UK social security system and, in particular (as currently operated) the impact it is having on efforts to tackle health inequalities in Scotland. The Committee would actively welcome an ongoing open dialogue across Parliaments in the UK and between the Scottish and UK Governments to explore how the future design and funding of social security policy can be delivered in a way that reduces and ultimately eliminates health inequalities.

51. We draw this section of the report to the attention of the UK Minister for Social Security with a request to respond to the relevant recommendations the Committee has made. We would further encourage colleagues on the Social Justice and Social Security Committee to explore the possibility of inviting the UK Minister to give evidence on UK social security policy and would welcome the opportunity for such an evidence session to address the impact of social security policy on health inequalities and action to tackle them.

52. The Committee highlights to the Scottish Government evidence it has received of the adverse impact the implementation of certain devolved social security benefits is currently having on efforts to tackle health inequalities. It calls on the Scottish Government to undertake a review of implementation of the Scottish disability and carers benefits and the carers allowance supplement to ensure there are no adverse impacts with respect to tackling health inequalities affecting claimants. More broadly, the Committee believes future implementation of social security policy in Scotland and at a UK level should be subject to the systematic application of health inequality impact assessments as advocated elsewhere in this report.

Covid-19 pandemic

53. The evidence is clear that, while the Covid-19 pandemic has accelerated the increase in health inequalities in Scotland, these were already on a rising trajectory prior to the pandemic. In this context, the Committee has heard significant concerns that a return to "business as usual" in the delivery of public services during Covid recovery risks critically undermining ongoing efforts to tackle health inequalities.

54. The Committee considers reducing health inequalities will be pivotal to the success of recovery and renewal work. As such, it calls on the Scottish Government, in responding to this report, to set out how all aspects of its Covid recovery strategy contribute positively to the goal of reducing and eliminating health inequalities.

55. As set out in its statement of priorities, the Committee commends the Covid-19 Recovery Committee's commitment to "…prioritise its scrutiny on COVID-19 recovery, with a specific focus on health inequalities" [3] . We encourage the Covid-19 Recovery Committee to continue its consideration of health inequalities

as part of ongoing scrutiny of delivery of the Scottish Government's Covid recovery strategy. In this context, the Committee further notes with interest the Covid-19 Recovery Committee's forthcoming inquiry on the impact of the pandemic on the Scottish labour market.

Cost of living

56. The Committee has been particularly concerned to hear evidence of the proportionately greater negative impact the rising cost of living is having on those groups already experiencing health inequalities, including those already living in poverty and those with a disability. The Committee concludes that, without concerted and appropriately targeted action to address this at UK, Scottish and local Government levels, the sharply rising cost of living is likely to contribute to a further acceleration in rising health inequalities, the impact of which will continue to be felt by generations to come.

57. The Committee highlights evidence that there is a role for all levels of government to play in addressing the negative societal impact of the rapidly rising cost of living. In this context, it concludes that a key criterion for measuring the success or otherwise of any and all government action to address the rising cost of living must be its impact in reducing health inequalities. It therefore calls on the Scottish Government, in responding to this report, to set out how it will ensure that any action on cost of living it is taking, now or in the future, contributes positively to the goal of reducing and eliminating health inequalities.

58. Similarly, the Committee calls on the UK Government to take urgent action to mitigate the effects of the increased cost of living and rising energy costs and to reduce health inequalities by making energy and life more affordable for all.

59. The Committee also wishes to draw the attention of its colleagues on the Economy and Fair Work Committee to the findings and recommendations contained in this section of the report and to encourage that Committee to have these in mind in undertaking ongoing scrutiny of the Scottish Government regarding its response to the rising cost of living.

Future scrutiny and action

60. The Committee considers that policy action to date has been insufficient to address health inequalities and therefore concludes that additional action is urgently needed across all levels of Government to resolve this.

61. The Committee has heard strong evidence to support its view that coordinated and preventative action is needed across different levels of government and a broad range of different policy areas to tackle health inequalities effectively. Responsibility for taking action will variously fall within the remits of local communities and local government, the Scottish Government and the UK Government. Parliaments and elected politicians at all levels equally have a responsibility to ensure tackling health inequalities continues to be a focus for preventative policy action and to scrutinise the impact and effectiveness of this action.

62. The Committee calls on the Scottish Government to consider the development of a tool kit that will enable policy-makers at all levels of government, quickly and easily, to audit all relevant policies within their respective remits to determine their impact on health inequalities. The Committee further calls on the Scottish Government to commission the development of best practice guidance, supported by further research, to help policy-makers maximise the positive impact and mitigate any unintended negative impact any existing and future policy decisions may have on tackling health inequalities.

Cross-committee scrutiny

63. The Committee draws this report to the attention of all Scottish Parliament committees and encourages colleagues across the Parliament to be cognisant of the need to maintain a focus in future scrutiny work, wherever relevant, on tackling health inequalities and the societal inequalities that underly them.

64. Given the overarching imperative to ensure all public policy contributes to improved health and wellbeing, the Committee would advocate a 'health in all areas approach' to future Scottish Parliament scrutiny and draws this to the attention of the Scottish Parliament Bureau and Conveners' Group. The Committee believes its recommendation in favour of the Scottish Government developing a health inequalities audit tool kit and best practice guidance for policy-makers would be helpful to Scottish Parliament committees in undertaking ongoing scrutiny of progress in tackling health inequalities over the course of this session and beyond.

Cross-portfolio collaboration

65. The Committee welcomes the commitment demonstrated by the Minister for Public Health, Women's Health and Sport to tackling health inequalities and her contribution to the Committee's inquiry. At the same time, given the Minister's emphasis on the importance of breaking down silos, the Committee regrets that the Scottish Government declined the opportunity, as part of the inquiry, for relevant Ministers to participate in a cross-portfolio roundtable discussion to explore potentially successful preventative strategies for tackling health inequalities. We would actively welcome the opportunity to engage with the Scottish Government on this basis in the future.

Localities and communities

66. The Committee is concerned by evidence that, despite strong rhetoric in support of action to tackle them, the level of health inequalities in Scotland remains higher than in England.

67. The Committee recognises the benefit of giving local government the autonomy to innovate and to explore new ways of tackling health inequalities. However it also notes evidence as part of the inquiry which suggests a lack of strategic coordination could exacerbate inequality in some instances. We draw this evidence to the attention of colleagues on the Local Government, Housing and Planning Committee.

Scottish Government strategy and action

68. The Committee notes there is no overarching strategy for tackling health inequalities in Scotland at the current time. However, the Committee believes there needs to be an overarching strategy or set of principles to guide policy-making and foster active collaboration across portfolios to ensure all relevant policy areas and all levels of Government are contributing positively towards tackling health inequalities. The Committee invites the Scottish Government to consider how this might best be achieved and, in responding to this report, to set out what steps it intends to take to improve cross-government and cross-sectoral efforts to tackle health inequalities.

69. As is already implied by the priority objectives the Scottish Government has set for Covid recovery, the Committee believes reducing health inequalities must be a core outcome of the Covid Recovery Strategy published in October 2021. The Committee intends to undertake continued scrutiny and evaluation of the Strategy's implementation with a view to evaluating its performance against that specific outcome. We would equally draw this to the attention of colleagues on the Covid-19 Recovery Committee to consider this as a core element of their ongoing scrutiny of the Strategy and would welcome the opportunity to undertake further joint scrutiny in this area in future years of this session.

70. Given the combination of reserved and devolved policy responsibilities reflected in this report, the Committee calls on the Scottish Government to provide the Committee with regular updates on progress in tackling health inequalities, and refers this report to the UK Government and the Scottish Affairs Select Committee at Westminster.

Introduction

71. During this inquiry, the Committee has heard that actions to date to reduce health inequalities have largely failed, with health inequalities widening instead of narrowing. During the first formal evidence session, Professor Gerry McCartney from the University of Glasgow set out various historic factors that have had negative impacts on health and health inequalities:

> Back in the 1950s, Scotland was among the average for rates of life expectancy across Europe and in other higher-income countries. Scotland then slowly drifted apart as its rate of improvement was a bit slower, but that became really apparent from the 1980s onwards—that is when the departure from the European means happened.
>
> David Walsh [at the Glasgow Centre for Population Health] led a huge programme of work that looked at excess mortality—the higher rate of mortality after accounting for the socioeconomic circumstances that pertain in Scotland, which some people have termed the Scottish effect or the Glasgow effect. We have tried to get rid of that, because all that research made it clear that the effect was political—it was about the decisions that were made in the run-up to the 1980s about urban policy, new towns policy and deindustrialisation. That was all exacerbated by the change in economic policy...which led to the widening of income inequalities and to privatisation. That was the initial phase.
>
> From 2010 onwards, austerity has further widened health inequalities...Covid has then impacted on that. We have had three important waves of negative impacts on health [4] .

72. The Committee is in agreement with Professor Petra Meier that "the unfairness in health inequalities and health outcomes is appalling, because there is nothing more precious than life [5] ". The Committee considers that urgent action is needed to address health inequalities across all levels of Government and sets out its recommendations for achieving this in this report.

What are health inequalities?

73. Health inequalities are commonly understood to be unjust and avoidable differences in people's health across the population and between different groups [6] .

74. It is internationally accepted that the fundamental causes of health inequalities lie largely outside the health system; health inequalities are a symptom rather than the cause of the problem. Health inequalities arise from the unequal distribution of income, wealth and power and the societal conditions this creates. Known as the social determinants of health, these conditions impact on all spheres of life, including education, employment, housing, access to services and social and cultural opportunities, and they shape individuals' experiences and lifestyle behaviours.

75. The Committee accepts this as the starting point for its inquiry on health inequalities and does not seek to replicate work to discuss or debate these accepted definitions.

Instead, this inquiry seeks to understand the current picture of health inequalities in Scotland, what action is needed to reduce wider inequalities, and where future scrutiny should focus to ensure that happens.

2014 inquiry on health inequalities

76. In session 4 our predecessor Committee, the Health and Sport Committee, conducted an inquiry into health inequalities [7] . Its report, published in January 2015, set out the evidence and complexity of the problem of health inequalities in Scotland.

77. Our predecessors also recognised that tackling health inequalities was not an issue for the health service alone and that they "would not be reduced without action to reduce inequalities in every other policy area and across every portfolio [8] ".

78. On 26 March 2015 , Conveners across Scottish Parliament Committees were invited to join together to debate the findings of our predecessor's inquiry and agreed that cross-portfolio action was required.

79. In the Scottish Government's response to our predecessor's report, the then Minister for Sport, Health Improvement and Mental Health noted:

> The Committee's conclusions concerning the primary causes and the need for coherence across portfolios resonates with the Government's developing and on-going strategy as we seek to tackle this most complex of problems [9] .

2022 inquiry on health inequalities

80. The Health, Social Care and Sport Committee agrees with our predecessor Committee's conclusion that cross-portfolio actions are needed to address health inequalities [10] and acknowledges that tackling inequalities has been a priority for every Scottish Government since devolution.

81. However, the existing evidence base suggests that the prevalence of inequalities persists. Over the last seven years since our predecessor's report, Scotland has also faced considerable new challenges and pressures that could have exacerbated pre-existing inequality.

82. To say the Covid-19 pandemic has had significant direct and indirect effects on people's lives is an understatement. Covid-19 has increased the vulnerability of groups and communities, and has resulted in poorer health and wellbeing outcomes for many. However, it has also been reported that harms from the pandemic have not been equally distributed across all groups in society [11] .

83. The Committee was interested to look at what progress has been made towards tackling health inequalities since its predecessor published its report, particularly in relation to the impact of the Covid-19 pandemic. To this end, in October 2021, it agreed to undertake a new inquiry into health inequalities in Scotland.

84. This inquiry was designed to explore:

- what progress has been made in Scotland in tackling health inequalities since our predecessor's 2015 report,
- what impacts additional factors, such as the pandemic, have had on health inequalities and action to address them, and
- opportunities to reduce health inequalities and increase preventative work to tackle inequalities before they impact on individuals' health and wellbeing outcomes.

85. During the course of the inquiry, the Committee heard evidence that the increasing cost of living, since early 2021 [12] , should also be considered as an important factor currently affecting health inequalities.

Inquiry structure

86. The Committee issued a general call for evidence in February 2022, asking the following questions:

1. What progress, if any, has been made towards tackling health inequalities in Scotland since 2015? Where have we been successful and which areas require more focus?
2. What are the most effective approaches to tackling health inequalities and how successful is Scotland in pursuing such approaches?
3. What actions would you prioritise to transform the structural inequalities that are the underlying cause of health inequalities?
4. What has been the impact of the pandemic both on health inequalities themselves and on action to address health inequalities in Scotland? Please note, the Committee is interested in hearing about both positive and negative impacts.
5. Can you tell us about any local, regional or national initiatives throughout the pandemic, or prior to it, that have helped to alleviate health inequalities or address the needs of hard to reach groups? How can we sustain and embed such examples of good practice for the future?
6. How can action to tackle health inequalities be prioritised during COVID-19 recovery?
7. What should the Scottish Government and/or other decision-makers be focusing on in terms of tackling health inequalities? What actions should be treated as the most urgent priorities?
8. What the role should the statutory sector, third sector and private sector have in tackling health inequalities in the future?

The Committee received 114 responses in total.

87. Committee Members undertook a series of informal engagement sessions on 20

and 23 May 2022 to help understand individuals' experiences in relation to health inequalities. These sessions provided an opportunity to hear first-hand accounts of individual experiences and the views of third sector support organisations. An anonymised summary of points raised during these sessions was produced to inform oral evidence sessions.

88. As part of its inquiry, the Committee also held the following formal sessions.

Formal evidence sessions

24 May 2022	• **One formal private session with Scottish Government and Public Health Scotland.** • **One formal public session focusing on recent work to tackle, and progress in addressing, health inequalities since 2015.**
31 May 2022	• One formal public session to examine the impact of the pandemic on health inequalities and actions to tackle health inequalities. • One formal public session examining good practice examples to tackle health inequalities from during, and before, the pandemic.
14 June 2022	• One formal public session informed by the informal engagement events on 20 and 23 May 2022.
21 June 2022	• One formal public session to explore potential policy options in Scotland.
28 June 2022	• One formal public Ministerial session.

Links to the responses to the call for views and the Official Report of Committee meetings can be found in Annexe A.

The policy landscape

89. There is currently no overarching national strategy for tackling health inequalities in Scotland. However, health inequalities have been highlighted as a priority area of focus for all Scottish Governments since devolution, beginning with the 1999 White Paper, 'Towards A Healthier Scotland' [13] .

90. In 2007 the Scottish Government established a Ministerial Task Force on Health Inequalities to identify and prioritise practical actions to reduce widening health inequalities in Scotland. The Task Force highlighted the importance of health inequalities and sought to monitor progress in work to tackle them, producing a number of key documents:

- Equally Well and the Equally Well Implementation Plan in 2008
- Equally Well review in 2010
- A second review of Equally Well in 2014

91. The Task Force recommended a range of indicators of health inequalities that should be monitored over time. The results of this monitoring are published each year in the Long-term monitoring of health inequalities reports . The Committee's consideration of these indicators and performance against them will be discussed further in the progress section of this report .

92. In 2011, the Christie Commission on the future delivery of public services set out nine priorities and eight recommendations for new approaches to public service delivery. Given the interconnected nature of inequalities, these recommendations encouraged a stronger focus on preventative, collaborative approaches to tackling inequality and involving people with lived experience in the design and development of services .

93. In 2018, the Scottish Government published six Public Health Priorities for Scotland . These set out key areas of focus to improve the health of the population. Each of the priority areas are relevant to addressing health inequalities and variously address individual lifestyle factors, social and community networks, living and working conditions, and socio-economic conditions. In particular, Priority 5 addresses poverty and inequality as key challenges to the health of Scotland's population:

> Priority 5: A Scotland where we have a sustainable, inclusive economy with equality of outcomes for all [14]

94. The National Performance Framework details the Scottish Government's future vision for Scotland and sets out a framework to enable collaborative working to achieve its 11 National Outcomes. A number of the Outcomes are relevant to health inequalities and their determinants, including:

- tackling poverty,
- building inclusive communities,

- tackling income inequalities, and
- those outcomes related to education, children and young people and health .

It also explicitly links to the United Nation's Sustainable Development Goals , which includes a goal to reduce inequalities.

95. Action to address inequalities in general also features as a key theme in the Scottish Government's current (2021-22) Programme for Government and a 'fairer and equal society' is one of the five priorities of the Scottish Government's recently published Strategy for Economic Transformation .

96. During the course of its inquiry, the Committee has heard that to be effective, action to address the social determinants of health is required at multiple levels of government, with the relevant powers lying at local, Scottish and UK-wide levels[v].

v The Scottish Parliament has power to make laws on a range of issues known as devolved matters. Some issues that have a UK or international impact remain the responsibility of the UK Parliament alone. These are known as reserved matters. For more information visit the Scottish Parliament website: Devolved and Reserved Powers | Scottish Parliament Website

Progress

97. Responses to the Committee's call for views were largely negative regarding the progress that Scotland has made in tackling health inequalities in the seven-year period since our predecessor's report. During formal evidence, Professor Gerry McCartney from the University of Glasgow stated:

> We should be under no illusions about the lack of progress towards narrowing health inequalities and the challenge that we face in Scotland [15] .

98. When asked about any progress made in tackling health inequalities, many of the submissions to the Committee's written call for views refer to the most recent Long-term monitoring of health inequalities report , which was released in March 2022.

99. The report headlines state that absolute inequalities (which refers to the gap between the most and least deprived areas) have narrowed with respect to several indicators, namely heart attack hospital admissions (under 75s), coronary heart disease (CHD) deaths (aged 45-74), alcohol-related admissions (under 75s), alcohol specific deaths (aged 45-74) and low birthweight.

100. However, for all other indicators of absolute inequalities, the report indicates that the gap had either widened or there was little to no change [16] . The following indicators showed a widening of the gap:

- The gap in healthy life expectancy in males has increased from 22.5 years in 2013-15 to 23.7 years in 2018-2020
- The gap in premature mortality rates increased to its highest point since 2004 (680.4 per 100,000 in 2020 and 683.2 per 100,000 in 2004)
- In 2020, the absolute gap in cancer deaths was the highest it has been since 2015 at 353.7 per 100,000
- the gap for all-cause mortality (aged 15-44) reduced to 159.6 per 100,000 in 2013 , and has since risen. In 2020 it was 241.1 per 100,000.
- The gap for drug-related hospital admissions has increased overall since the start of the time series to reach a high of 696.1 per 100,000 in 2019/20 before falling slightly to 625.1 per 100,000 in 2020/21.

101. The report also monitors relative inequalities. This is the extent to which health outcomes are worse in the most deprived areas compared to the average throughout Scotland. It is possible for absolute inequalities to improve, but relative inequalities to worsen. The report shows the relative index of inequalities (RII) has increased to its highest level since reporting began, from 0.38 to 0.44 for males and from 0.36 to 0.43 for females between 2013-2015 and 2018-2020 [17] .

102. The Committee is aware that, while giving a broad overview, these indicators do not give a complete picture of the range of social and economic factors that form the basis of this inquiry, nor do they give a sense of the impact of health inequalities on daily life.

The impact of inequalities

103. Examining the impact of inequalities, the Committee took evidence in the following areas:

- Individual, community and group experiences, including access to services and participating in social and cultural activities.
- Wider community and environmental influences, including education, employment, housing and community assets.
- Fundamental causes and the social determinants of health, including poverty, income, wealth and the distribution of wealth.

Individual, community and group experiences

104. As part of its inquiry, the Committee sought to understand individuals' experiences of health inequalities by engaging with 48 organisations over four informal engagement events. Thirteen of these organisations acted as facilitators in setting up break-out rooms involving participants with lived experience [18] .

105. During these events, the Committee heard significant evidence of the impact of inequality[vi] on the mental, emotional, physical, financial and social health of individuals, communities and groups [19] .

106. The Committee heard from a range of individuals and communities disproportionately affected by inequalities, often described as marginalised, hard-to-reach or disadvantaged communities. They include individuals with:

- specific characteristics such as ethnicity, race, sexuality or gender;
- specific or long term conditions, such as Myalgic Encephalomyelitis (ME) or Chronic Fatigue Syndrome (CFS), mental health conditions, HIV, diabetes, oral health, alcohol misuse, coronary heart disease, and cancer;
- no recourse to public funds, such as migrants and asylum seekers;
- experience of justice system involvement, such as those currently or previously incarcerated;
- informal caring responsibilities;
- additional support needs;
- experience of poor housing or homelessness, or those living in areas of deprivation.

107. These individuals, communities and groups are often those that experience stigma

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vi Inequity and inequality are often used interchangeably. Inequity refers to unfair and avoidable inequalities arising from human behaviour. Inequality refers to the uneven distribution of resources. Throughout this report, the term inequality has been used to describe both inequality and inequity as both result in unjust differences.

and discrimination. They can be excluded from participating in daily social life and have difficulties accessing public services. During evidence, the Committee heard that life and health outcomes are not improving for those living in these communities.

108. Dr Ima Jackson from the Scottish Migrant Ethnic Health Research Strategy Group spoke in particular of systemic racism in society and its effects on every aspect of life and on individuals' health. Speaking in support of Dr Jackson's evidence, Ed Pybus from the Child Poverty Action Group in Scotland added:

> We know that systemic racism means that certain communities are more likely to be in poverty. For example, our research found that people from such communities find it harder to access childcare, which has a knock-on impact in that they are unable to work. That then has an impact on poverty, which itself has an impact on health inequalities. Systemic racism therefore operates in many layers [20] .

109. In oral evidence, Claire Stevens from Voluntary Health Scotland spoke about the role of the third sector over the past seven-year period and continued efforts by organisations to mitigate the effects of inequalities on communities. She spoke of the increased social isolation, loneliness and stigma that these communities face, describing them as "those who have simply been left behind or overlooked by public policy and services. [21] "

110. The Committee also heard accounts suggesting that factors such as the pandemic, public funding cuts and the rising cost-of-living have caused further considerable negative impacts on health outcomes and inequalities. The evidence indicates that these impacts have considerably exacerbated pre-existing inequality and negatively impacted on individuals and communities.

111. In its written submission, South Lanarkshire Integration Joint Board noted:

> With the best will in the world, given that Scotland was struggling to address inequalities prior to the pandemic the task will be even harder going forward [22] .

112. During the inquiry, the Committee heard evidence suggesting not everyone in an established 'community' or group will have the same experiences or needs. People have intersecting identities and as a consequence can often experience multiple disadvantage. For example, a group of participants in one informal engagement event highlighted the experiences of ethnic minority, LGBT, asylum seekers and the multiple disadvantages they are exposed to as a result of these intersecting identities.

113. The Committee recognises the effect of inequality on individuals, families and communities and that there are a number of communities that are disproportionately affected by inequality.

114. The Committee calls on policy-makers at all levels of Government to take proactive steps to ensure that future design and delivery of public services properly recognises and addresses the needs of those experiencing

disadvantage. This approach should have the objective of reducing health inequalities including those resulting from multiple disadvantage.

Wider community and environmental influences

115. In November 2008, Professor Sir Michael Marmot was invited by the UK Government to chair an independent review to propose effective evidence-based strategies for reducing health inequalities in England. In February 2010, the final report of the independent review, Fair Society, Healthy Lives (known as the Marmot Review) was published. Although focused on reducing health inequalities in England, this report's conclusions and recommendations could be considered equally applicable to addressing health inequalities in Scotland. The report concluded that reducing health inequalities requires action on six policy objectives:

    1. Give every child the best start in life
    2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
    3. Create fair employment and good work for all
    4. Ensure healthy standard of living for all
    5. Create and develop healthy and sustainable places and communities
    6. Strengthen the role and impact of ill-health prevention.

116. During the Committee's inquiry, the areas set out in these objectives were frequently raised as key factors that affect health and wellbeing outcomes. Almost all submissions to the Committee's call for views refer to the need to address these "social determinants of health". In this context, this section of our report sets out the evidence gathered as part of this inquiry, in relation to:

    - housing,
    - community, planning and access to social and cultural opportunities,
    - education and the early years,
    - employment, and
    - public services.

117. The Committee also heard numerous accounts of the experiences of unpaid and informal carers in relation to each of these areas and we will also consider evidence that unpaid caring should be defined as a social determinant of health.

Housing

118. There is substantial pre-existing evidence to demonstrate the significant role of

housing in either reducing or reinforcing health inequalities [23] . The World Heath Organisation notes the link between social and environmental inequality and poor housing conditions and how that translates into health inequality, which then further affects quality of life and well-being [24] .

119. The Committee heard a range of evidence on the importance of housing in addressing health inequalities during its inquiry. During oral evidence, Karen Lewis from the Hub in Dumfries and Galloway stated its importance:

> When we talk about health, wellbeing and social justice of any kind, it is a given that one of the basic needs in life is a home where a person feels that they are secure and can put down roots and build a life [25] .

120. During informal engagement events, individuals told the Committee of the challenges of living in cold, damp homes and how this can lead to poor physical and mental health [26] .

121. In written evidence, Diabetes Scotland highlighted evidence showing the link between type 2 and gestational diabetes and poor housing, noting that:

> One study found every housing condition rated fair to poor to be associated with around a doubled risk of developing type 2 diabetes [27] .

It also noted the relationship between poor quality housing and poverty, reporting that of the people living in poverty in Scotland 41% are social renters, 26% are private renters and 33% are homeowners. It further noted that rented accommodation is more likely to be substandard, with consequent negative impacts on individuals' health:

> Rates of type 2 diabetes have also been proven to be significantly higher and concentrated in areas characterised by lower incomes and crowded housing [28] .

122. Dr David Walsh reflected on the actions of the Scottish Government to mitigate the effects of austerity measures in relation to housing, noting:

> The Scottish Government has done good things. For example, at the start of austerity, when the bedroom tax came in, the Scottish Government helped by basically making up for it through discretionary housing payments. As Gerry McCartney mentioned, it has also brought in a new social security payment—the Scottish child payment—for those on low incomes [29] .

123. During informal engagement events hosted by the Committee as part of its inquiry, the Committee heard evidence that council and social housing can often be both insecure and unsuitable. As an example, insecure housing could be a result of renting in the private rented sector and unsuitable housing could include instances where houses are poorly ventilated or insulated. Individuals also told us of the challenges of heating properties while at the same time prioritising energy use to power equipment associated with caring responsibilities. [This issue is addressed in more detail under the section of this report relating to cost-of-living] .

124. The Minister for Public Health, Women's Health and Sport recognised the need for

quality social housing while also acknowledging the challenges associated with improving housing stock:

> The quality of rural housing stock and the difficulty of bringing the insulation up to an appropriate grade to mitigate fuel poverty is a challenge. That is vital in relation to reaching our net zero ambition and tackling fuel poverty. We have kind of done the low-hanging fruit. Upgrading insulation is easy in large-scale modern housing in an urban setting, but it is a much tougher job in a rural setting with more dispersed housing, different types of housing and different qualities of housing stock. We will have to get into that challenge. That illustrates the need to work together. If we are going to achieve either or both of the ambitions of tackling fuel poverty and aiming for net zero, we have to get in about the challenging issue of improving the housing stock in rural areas [30] .

125. During a breakout session supported by the Cyrenians, the Committee heard evidence of a range of experiences leading to homelessness and the subsequent impact on individuals accessing housing services. We heard about the complex interaction between homelessness, housing, physical health, mental health and financial help, making it increasingly difficult for the individuals affected to seek and receive support to improve their situation. Karen Lewis, from the Hub in Dumfries and Galloway, also noted that while there can sometimes be complexities which make it difficult to meet needs, poverty can also be a key driver of homelessness.

126. Toni Groundwater from Families Outside also highlighted some of the barriers homeless individuals face accessing services:

> We know that simply not having an address is a barrier to people being able to register with a GP and get much-needed medication [31] .

127. In a blog published following the Committee's informal engagement events, Voluntary Health Scotland, who assisted the Committee in establishing, facilitating and chairing the events on behalf of the Committee, noted the link identified during the sessions between homelessness and health and the subsequent impact on health services:

> We heard the majority of Community Link Workers operated in areas of high deprivation, and they spoke with housing representatives all the time. It was stressed that there’s nothing GPs can do in ten minutes to help in these situations. Poor housing conditions lead to ill health, including poor mental health. Poor mental health doesn’t get you extra consideration in housing applications. By not addressing housing issues these problems are pushed into primary care [32] .

128. Karen Lewis gave evidence of issues within the private rented sector around affordability of housing and housing insecurity associated with universal credit. She articulated the effects this has on mental health and wellbeing:

> Sue has to make up a shortfall of £135.70 a month out of her personal universal credit of £76 a week to maintain her home. I put it to you that the level of stress and anxiety that people experience about those issues absolutely affects their mental health and wellbeing and undermines their capacity to build a life, because they are constantly worrying about them [33] .

129. Dr Sharon Wright added further weight to this point, drawing comparisons with the findings of her research at the University of Glasgow into the correlation between universal credit and housing insecurity:

> A lot of people whom I have spoken to about claiming benefits have been very scared of losing their home... Because universal credit also includes the housing payment, people are really worried that, if they are late for their appointment by even five minutes, they will end up losing their home. You would think that such fears would be irrational, but they are actually rational, because that is how the system is designed. All of these things are interconnected, and people are really scared of losing them [34] .

130. The Committee has heard compelling evidence of the essential connection between access to safe, secure, affordable housing and positive health and wellbeing outcomes.

131. The Committee notes existing Scottish Government commitments to achieving net-zero targets and tackling fuel poverty and the crucial role of upgrading Scotland's housing stock in fulfilling those commitments. In responding to this report, we call on the Scottish Government to set out details of the actions it is taking to improve housing in this context, associated timescales and, crucially, what contribution it anticipates these actions will make towards addressing health inequalities.

132. The Committee considers that further examination of the standard of housing in Scotland is necessary, including the quality and energy efficiency of Scottish housing stock. This should include an assessment of the contribution of policies in these areas towards reducing inequality and tackling health inequalities. We draw this to the attention of colleagues on the Local Government, Housing and Planning Committee.

133. The Committee considers that housing policy can make a positive contribution towards tackling health inequalities and improving public health outcomes. It notes the Local Government, Housing and Planning Committee's plans to scrutinise housing issues in more detail, including both affordable housing and retrofitting, vacant and derelict homes, and the impact of these on housing inequalities. We further draw this section of our report to the attention of colleagues on the Local Government, Housing and Planning Committee.

134. The Committee also draws this section of the report to the attention of colleagues on the Social Justice and Social Security Committee in relation to the impact of health inequalities on those experiencing homelessness, and the effects of homelessness on health and wellbeing outcomes.

Community, planning and access to social and cultural opportunities

135. On its website, Public Health Scotland highlights the impact of social and physical environments on mental and physical health and wellbeing [35] . In 2019, the Scottish Government reviewed progress in delivering its National Performance Framework

and highlighted the importance of place, communities and environments for health and wellbeing:

> The places and neighbourhoods where people live and grow-up shape the opportunities people have and can influence their life course, and are increasingly recognised as important for physical and mental health and overall wellbeing [36] .

136. This was also reflected in the evidence received as part of this inquiry. During informal engagement events, the Committee heard evidence of the negative impact on health and wellbeing of loneliness and social isolation, of a lack of community assets for individuals and communities to engage and socialise, of the erosion of social networks, latterly as a result of the pandemic, and of poor town planning and accessibility of services [37] .

137. Affordability and accessibility of transport connections to access services were highlighted by many contributors, with individuals unable to afford transport costs and calling for improved accessibility of public transport. Problems with accessing transport were said to be particularly acute in rural areas where transport networks are under-developed. However, people living in urban areas also reported problems with accessing services where they are located due to time and cost constraints. Affordability of transport was highlighted as a key barrier to accessing services on the basis that, if someone is unable to afford the bus fare , they would be unlikely to walk for hours to attend those services [38] .

138. These issues were also reflected in the Committee's consideration of the draft National Planning Framework 4 [39] , where witnesses questioned the universal applicability of the "20 minute neighbourhood" concept, particularly in more remote and rural areas.

139. Claire Stevens, from Voluntary Health Scotland, told the Committee that lower levels of social capital and community connectedness are associated with higher levels of health inequalities. She highlighted the Zubairi Report which explored the lived experience of individuals experiencing loneliness and social isolation in Scotland in 2018. This report makes the case that loneliness and social isolation should be considered as a public health issue on the basis that they are "triggered, exacerbated and maintained by the social and economic circumstances in which people live including the level of resources such as financial power, knowledge and social capacity that are available to them [40] ".

140. A key conclusion of the report is that, as a means of reducing loneliness and social isolation and addressing health inequalities associated with these, community assets and environments need to be designed to be inclusive spaces:

> Places and spaces are central to tackling loneliness and social isolation as they encompass both the physical environment where social contact occurs such as our homes, streets, public areas, natural spaces and the mobility of people across these - as well as the social environment that is the relationships, social contact and support networks that exist within a place. Places, spaces and the links between them that are well-informed by those that will use them, well designed, maintained and resourced, are key to nurturing quality relationships and developing a sense of belonging and purpose [41] .

141. Dr Gillian Purdon from Food Standards Scotland emphasised to the Committee the impact of the planning and design of the food environment on health and in particular the importance of:

> "scrutinising the proliferation of fast-food outlets, which are particularly of concern in our most deprived neighbourhoods, and trying to improve access to healthy, affordable and culturally appropriate food" [42] .

142. In its written response, Obesity Action Scotland refers to obesogenic environments in Scotland and argues that the prevalence of these environments can make unhealthy lifestyles the default option in some areas. It goes on to highlight the need for improved understanding of the impact decisions in policy areas other than public health can have on health inequalities. In particular, it draws attention to the impact planning policy can have on food choices and rates of physical activity within communities:

> the planning system...has a crucial role to play in the creation of obesogenic environments, through decisions to permit planning applications of unhealthy food businesses, both in terms of location and density, and other factors including lack of green space [43] .

143. In January 2022, the Committee took evidence as part of the Parliament's cross-committee scrutiny of the draft National Planning Framework 4. In our letter to the Local Government, Housing and Planning Committee [vii] we concluded that the Framework's priorities and principles need to take greater account of health and wellbeing, due to the significant impacts planning policy and the design of neighbourhoods can have on health and wellbeing outcomes.

144. Dr Peter Cawston, from GPs at the Deep End spoke powerfully of his work as a principal GP in a deep-end practice[viii] in Drumchapel. Dr Cawston outlined his view that "health inequalities mean somewhere between a sense of meaninglessness and a sense of rage. [44] " He spoke of the importance of working to promote community assets and community cohesion as a means of building capacity, resilience and wellbeing:

> Over the past seven years, we have tried to become a more community-linked practice to understand that, as medical practitioners, we can make the most difference to people's lives if we work alongside the community where we work and help people to access all the resources that are there. Many of those resources are very fragile, and many of them have disappeared, but I believe that strong general practice and primary care that is supported by a community that has a lot of resources for wellbeing can make a huge difference. The community link workers in our practice have helped us to help our patients and individuals find resources and assets in the community [45] .

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vii The Local Government, Housing and Planning Committee led the Scottish Parliament's cross committee scrutiny of the National Planning Framework 4.

viii Deep end practices are calculated based on the percentage of practice patients living in datazones defined as the 15% most deprived. See the University of Glasgow - The Scottish Deep End Project for more information.

145. During the same session, Dr Shari McDaid from the Mental Health Foundation noted that activities to increase social connectedness, improve community environments, create community spaces and foster participation in community decision making are key to tackling health inequalities:

> It is no good putting up a website that tells us to go for a walk to look after our mental health during the pandemic if we live in a neighbourhood where it is not safe to go for a walk [46]

146. Professor Gerry McCartney from the University of Glasgow, urged caution in focusing a place-based approach to tackling health inequalities purely in areas of deprivation, arguing this would be unlikely to be effective in tackling health inequalities across the population as a whole:

> Health inequalities are seen across the entire population, not just in deprived areas. Most deprived individuals do not live in deprived areas, so such an approach will not target those groups. Also, that approach ignores the economic relationship between social groups and instead almost pretends that people's deprivation status is independent of those relationships. Therefore, we need to think about how to address the economic design of the country, which leads to widening income, wealth and power inequalities [47] .

147. Instead, Professor McCartney called for a "proportional universal approach[ix], whereby effective interventions are introduced that impact most in deprived areas, but have an impact across the gradient in proportion to need [48] ".

148. In our recent inquiry exploring alternative pathways into primary care the Committee explored the role of Community Link Workers and of primary care in mitigating health inequalities. A number of the written submissions to this inquiry also highlighted the deployment of Community Link Workers in Deep End GP practices as an example of best practice that should be encouraged to continue, with several submissions arguing for these to now be further embedded across all GP surgeries.

149. When asked about the roll-out of Community Link Workers in Scotland, the Minister for Public Health, Women's Health and Sport noted:

> We have...more than 300 community link workers now employed across Scotland through the primary care improvement fund. From this year, we will build on their successes with the introduction of the new multidisciplinary mental health and wellbeing teams in primary care, which will include new community link workers and put an emphasis on social support and social prescribing, where that is appropriate for the person. [49] .

150. The Minister also spoke about the establishment of the community link worker network, through Voluntary Health Scotland, to strengthen those roles and increase wider understanding of the contribution that link workers make to tackling health inequalities.

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ix Proportionate universalism is resourcing and delivering universal services at scale, whereby services are universally available to all, not only for the most disadvantaged. These services can then respond flexibly to need. See Proportionate universalism and health inequalities for more information.

151. The Committee notes the significant impact planning policy can have on health outcomes and, if implemented poorly, in widening inequalities.

152. The Committee highlights the recommendations it made following its scrutiny of National Planning Framework 4 and considers planning policy an important area that can either help reduce health inequalities or increase them. It draws these to the attention of colleagues on the Local Government, Housing and Planning Committee, as part of their ongoing scrutiny of the implementation of NPF4.

153. The Committee notes the current work of the Finance and Public Administration Committee in scrutinising the Scottish Government's National Performance Framework. However, is aware this scrutiny will not focus on examining the national outcomes or monitoring action to alleviate poverty as a driver of poor health in society. The Committee notes that the national outcomes will be subject to statutory review in 2023 and calls on the Scottish Government to ensure action to alleviate poverty and reduce health inequalities is central to that review. The Committee would also welcome ongoing dialogue with committees across the Parliament to explore how a sustained focus on scrutinising delivery of the cross-portfolio ambitions of the framework throughout the session can be achieved.

154. The Committee supports Professor Gerry McCartney's call for an approach to tackling health inequalities based on the concept of "proportionate universalism.

155. In this context, as a specific example of such, the Committee reiterates the call made on the Scottish Government, as part of its inquiry into alternative pathways to primary care, that Community Link Workers should be embedded across all GP surgeries in Scotland.

156. The Committee urges the Scottish Government to ensure the impact on inequalities and health inequalities is a primary consideration in the future design and delivery of all public services.

Education and the early years

157. During the inquiry, the Committee heard evidence of the important role education has to play as a determinant of health outcomes, playing a key role in shaping lifelong health and wellbeing. The World Health Organisation's Commission on the Social Determinants of Health notes that educational attainment is linked to improved health outcomes, and has subsequent associated effects on adult income, employment and living conditions.

158. The Scottish Public Health Observatory notes that, as well as educational attainment, education also plays a vital role in developing values, emotional intelligence and social functioning skills [50] . In turn, this can affect mental wellbeing, resilience, and the ability to cope with adversity in later life.

159. The Scottish Government's Equally Well Report notes that education is one of several key entry points to effectively reduce social and health inequalities.

160. Our predecessor Committee also set out the effects of poverty on children in its

inquiry into health inequalities. During that inquiry Professor Sir Michael Marmot highlighted that:

> People —near the top have worse health than those at the top, people in the middle have worse health than those near the top and so on. The same applied to children, in relation to physical development and growth, cognitive, linguistic, social and emotional development, performance in school and the socioeconomic characteristics of their parents or the area in which they lived. The lower the socioeconomic level, he said, the worse the performance [51] .

161. The Committee recently conducted an inquiry on the health and wellbeing of children and young people . Our inquiry report highlights that poverty and inequality remains a major issue affecting children and their life chances. Helen Happer from the Care Inspectorate highlighted the huge negative impact of poverty on levels of health inequality:

> We know that health inequalities in Scotland are huge and that, when children experience poverty and disadvantage from an early age, their health—not just their mental health but their physical health—is blighted. Some structural things really need to happen to address poverty and disadvantage for children and young people [52] .

162. While we do not seek to repeat our previous inquiry, we heard evidence from several sources of the effects of poverty on children and the critical importance of addressing poverty and inequality in the early years.

163. Giving evidence to this inquiry, Professor Gerry McCartney noted existing examples of policy initiatives that have helped to mitigate inequalities:

> I want to highlight three things that I think have mitigated the stark problem...The first is the introduction of the Scottish child payment. We know that health inequalities are a result of inequalities in income, wealth and power in society and it is because those inequalities have continued to widen that health inequalities have continued to widen. The Scottish child payment, however, starts to mitigate some of the rises in child poverty that we have seen and makes it less bad than it would otherwise have been. That is important because mitigation can make a difference.
>
> It is also worth mentioning the furlough scheme. Had it not been for that, people would have been without incomes for a prolonged period during the pandemic, so it is important to recognise that the furlough scheme was a saviour.
>
> Finally, at a time when costs are rising, we know that some things have reduced people's costs, such as free bus travel for some groups, free prescriptions and free school meals. They reduce the costs that families face, so they are also important in reducing the real effect of poverty on people's lives.
>
> However, a wide range of unhelpful policies, particularly on the macroeconomic scale, have driven inequalities in income, wealth and power. Not many of those are within devolved competence, if we are honest about it. We continue to have an economic design that drives widening economic inequalities and that, in consequence, causes health inequalities to widen. [53] .

164. In the Minister for Public Health, Women's Health and Sport's response to the Committee's inquiry into the health and wellbeing of children and young people, the Minister highlighted the Scottish Government's commitment to increase this payment further:

> Our efforts in 2022-23 will be backed by up to £113 million of additional investment, including new parental employability support, further increasing the value of our Scottish Child Payment to £25 per child, per week [54]

165. In that response, the Minister also sets out a range of policy commitments designed to mitigate the impact of poverty and inequality on children and young people, including "wide ranging action through 'Best Start, Bright Futures[x]' focused on increasing household incomes, tackling the cost of living and improving family wellbeing and outcomes. [55] "

166. In evidence to this inquiry, the Minister noted the impact of prioritising investment in high-quality early learning and childcare to reverse the attainment gap between the most and least deprived families. The Minister stated:

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x Best Start, Bright Futures is the second tackling child poverty delivery plan due under the Child Poverty (Scotland) Act 2017. It outlines action for the period 2022 to 2026. For more information see Best Start, Bright Futures: Tackling Child Poverty Delivery Plan 2022-2026.

> We found that investment in high-quality early learning and childcare has a direct impact on the individual child. It can literally close the attainment gap before it appears. We know that children from the poorest backgrounds are, when they present at school at the age of five, about 18 months behind their peers in language, literacy and numeracy. High-quality early learning and childcare can reverse that. We need the priority to be on eligible two-year-olds—about 25 per cent of children in Scotland are eligible for accessing provision early—in order to close that attainment gap. [56] .

167. The Minister further acknowledged the importance of family situations:

> A lot of families are living...under immense pressure, just to earn enough money to cover their household bills. The provision of high-quality early learning and childcare by the state gives them room to manoeuvre and to have family time, which is really important for them and for their children [57] .

168. However, during our informal engagement events, participants told us about a lack of accessible nursery and childcare for those caring for disabled children and argued that this has effectively excluded the families affected from accessing free childcare provision provided by the Scottish Government. The Committee also heard this could be an issue for those families where parents do not have jobs with a standard Monday-Friday work pattern and that this most typically applies to those in low-paid jobs and families at greatest risk of living in poverty [58] .

169. The Committee recognises the important role of education in addressing societal and health inequalities. It also commends the work of the Education, Children and Young People Committee and its focus on the role of the Scottish Attainment Challenge in addressing the poverty related attainment gap [59] .

170. The Committee calls on the Scottish Government, in responding to this report, to set out what action it is taking through the Best Start, Bright Futures programme to address the impact of poverty on children and young people and specifically what impact it expects this action to have in reducing health inequalities.

171. The Committee has been concerned to hear evidence during this inquiry that certain vulnerable families are experiencing de-facto exclusion from free childcare provision. The Committee calls on the Scottish Government to undertake an urgent review of how this policy is being deployed across local authority areas, including what actions are required to eliminate specific obstacles to accessing free childcare provision and ensure vulnerable families receive the support they are entitled to and that provision is suitably funded. The Committee also draws this issue to the attention of colleagues on the Education, Children and Young People Committee, particularly in terms of its impact on addressing health inequalities.

172. The Committee has heard evidence of a range of policy measure to mitigate the effects of poverty on families, such as free bus travel, free prescriptions and free school meals. The Committee calls on the Scottish Government, within devolved powers and budget constraints, to continue prioritising actions with the aim of mitigating these effects.

Employment

173. In 2019, the Scottish Government published a report from the review of its health and work strategy. The review concluded that good work is a key determinant of good health, and conversely good health is essential to productive work. It also provided a call to action to make fair and healthy work a reality in Scotland [60] . Recommendations from that review focused on enabling and supporting access to fair, healthy and sustainable work, including support for both local and national employers to improve their workplace health practices.

174. During our inquiry, the Committee heard evidence of challenges to health and wellbeing related to job seeking, job insecurity, in-work poverty, low incomes, a lack of information on employee rights, caring responsibilities and a failure to protect staff wellbeing, and the indirect consequences of changes in the labour market.

175. Dr Shari McDaid highlighted the negative mental health impacts of financial strain and precarious employment:

> The fundamental key drivers of mental distress and poor mental health that result in diagnoses of mental health problems include living in lower socioeconomic conditions, facing financial strain or living in poverty, earning below the real living wage and being in precarious employment [61] .

176. During a breakout session supported by PAMIS at one of our informal engagement events, the Committee heard evidence of how employment can protect adult caregivers from mental and physical health problems. One participant described the effects of caring for those with profound and multiple learning disabilities and the need to be valued outwith their carer role, speaking of the negative impact on self-worth when barriers associated with accessing work in conjunction with their caring role made this impossible. Similarly, the breakout session supported by the Coalition of Carers outlined how employment can aid emotional wellbeing but also highlighted that employment can be incompatible with social security restrictions [62] .

177. In the Committee's informal engagement events, many participants argued in favour of improved awareness of employment rights and a duty on employers to support their workforce and to address inequalities. The Committee heard that there can be a big difference between employment and good employment. Suggestions for practical solutions to address this issue included [63] :

- promotion of the Carers Positive Scheme for employers,
- increasing flexibility around caring responsibilities, especially in regard to weekend working, where there is limited other support available,
- ensuring work places are age-inclusive, and
- ensuring all employees are aware of their employment rights, especially in regard to migrant workers.

178. Professor Sir Michael Marmot referred to his work in England during evidence, with the recognition that "all the evidence suggests that what we say about England applies even more to Scotland and to Wales [64] ". He highlighted three historic

phases in relation to health inequalities and actions required at various levels of Government to address them, including a focus on employment:

> The first is what happened after 2010; the second is the pandemic; and the third is the cost of living crisis. I will take the first—what happened after 2010. In England, I did the so-called Marmot review, “Fair Society, Healthy Lives”. We had six domains of recommendations for what was needed to address health inequalities: giving every child the best start in life; education and lifelong learning; employment and working conditions; everyone having at least the minimum income necessary for a healthy life; healthy and sustainable places...Our review of the evidence suggested that, if those six domains of recommendations were followed, health would improve and health inequalities would diminish [65] .

179. The prevalence of in-work poverty was discussed during one of the Committee's informal engagement sessions. In a blog published following the events, Voluntary Health Scotland recalled the observations of participants regarding some of the causes and effects of in-work poverty:

> There was an acknowledgement that employment was no longer a route out of poverty. This was often attributed to the Universal Credit system which participants suggested operated based on the full-time model of work. This had a significant impact on older women who could no longer care for grandchildren due to the rise in pension age. This then leads to intergenerational challenges for families in accessing childcare and employment [66] .

180. The role of social security policy in addressing health inequalities is explored in more detail later in this report.

181. Giving evidence, Dr David Walsh from the Glasgow Centre for Population Health told us some of the biggest increases in poverty levels witnessed before the recent sharp rises in cost-of-living were among the employed:

> In-work poverty relates to all sorts of issues that we know about, such as zero-hours contracts and the gig economy [67] .

182. In support of this view, Professor Gerry McCartney outlined to the Committee the widespread prevalence of in-work poverty.

> That is because wages are not high enough, people are not getting enough hours, or their work is precarious, so they are in and out of work or they are not getting the hours that they need every week [68] .

183. Witnesses were generally positive about the effect the introduction of the living wage has had in addressing in-work poverty. While a living wage would not support those who are out of work, such as those with caring responsibilities or health conditions that prevent them from working, Professor McCartney argued that a living wage was "certainly a very important part of the mix to reduce income inequalities in the country. [69] " Dr Sharon Wright suggested that "promoting the living wage or a requirement for the living wage to be paid would be helpful. [70] "

184. Professor McCartney also noted the existence of often confusing terminology

around the living wage:

> The living wage in Scotland is a voluntary sign-up scheme that most public sector agencies have engaged with or are working towards. The minimum wage, which regulates all wages in the economy, is set by the UK Parliament and has recently been rebadged as the living wage, but it is at a slightly lower level than the Scottish living wage. I say that to be clear about which living wage we are talking about in different circumstances. The living wage is very much needed; it also needs to be higher, because the majority of people in poverty at the moment are in in-work poverty [71] .

185. In separate evidence sessions, Dr Walsh and Dr Wright noted that powers to address in-work poverty via employment legislation do not currently lie with the Scottish Government. Dr Walsh concluded:

> If we do not narrow socioeconomic inequalities in society, we will not succeed in narrowing health inequalities... It is important to understand that. It is also really problematic for Scotland, because, in order to narrow those socioeconomic inequalities, we need to have the relevant powers. Scotland has some powers. We can change income tax rates and bands and we have a very small number of social security powers. However, it remains the case that, as Gerry McCartney said, the vast majority of taxation, social security and other relevant legislative areas such as employment law remain reserved to Westminster [72] .

186. Bill Scott from the Poverty and Inequality Commission argued that while the Scottish Government is unable to set the real living wage for all employees, there were actions the Scottish Government couldtake in relation to addressing barriers to employment:

> I can say only that the Scottish Government's inability to set the real living wage for all employees prevents that wage from being applied to every sector of employment. Those kinds of additional powers would be welcome and would help get the vast majority of employers to pay the real living wage. There are things that we can do. The Scottish Government has said that those involved in procurement contracts must pay the real living wage to all those employed under those contracts. That is one way of driving the adoption of the real living wage among employers, because they will know that, in order to get a Scottish Government contract, they will have to pay it to their workers. If Scotland had responsibility for more employment law, it would assist with the adoption of the real living wage, but we can do things here and now to drive wages up [73] .

Mr Scott also suggested there is a role for the Scottish Government to address this issue via procurement practices and by expanding childcare provision:

> We can do that through procurement, through encouraging employers to pay the real living wage and through expanding childcare provision, which allows more women to work more hours...The Scottish Government has said that those involved in procurement contracts must pay the real living wage to all those employed under those contracts. That is one way of driving the adoption of the real living wage among employers, because they will know that, in order to get a Scottish Government contract, they will have to pay it to their workers. If Scotland had responsibility for more employment law, it would assist with the adoption of the real living wage, but we can do things here and now to drive wages up [74] .

187. During the Ministerial evidence session, Michael Kellet, Co-Director of Population Health at the Scottish Government, spoke of the important role of anchor institutions in reducing health inequalities:

> An example of that is our work on positioning national health service and social care providers as anchor institutions in our communities, working with others such as housing associations, local government and universities to nurture the conditions for health and wellbeing. NHS and social care providers are significant sectors across Scotland, and they are well placed to provide opportunities in local communities by increasing access to employment in health and care and making available NHS land and buildings to support communities' health and wellbeing [75] .

188. In written evidence, NHS Highland highlighted its work to improve employer responsibilities around fair work:

> We have also tried to consider what we can do as a Board to support Fair Work and employment opportunities for those who would benefit from this and have worked in partnership with others to consider how we can tackle poverty [76] .

189. In formal evidence, Ed Pybus noted that NHS Highland and Highland Council are becoming real living wage employers and argued that organisations could do more to promote fair work and eliminate barriers to employment:

> It is about considering an organisation's policies through the lens of tackling child poverty, health inequalities and the barriers to employment that people face, and it is also about allowing flexible working and other approaches that let people work within their caring responsibilities [77] .

190. Voluntary Health Scotland made a similar point in its written response, arguing that responsibility for addressing health inequalities extends beyond the Scottish and UK Governments, and that public, private and third sector employers also have responsibilities to support their workforce [78] .

191. Ed Pybus also went on to argue the case in favour of universal provision of support to break down barriers to employment and an approach based on the principle of "proportionate universalism":

> We are big supporters of universal provision, which removes stigma and increases uptake rates, as I have mentioned. It is no good having a system if people are not taking it up, so there must be ways that there can be universal support for people. One of the key areas that we have been considering is childcare, which has knock-on impacts, as people can enter employment and reduce costs if the cost of childcare can be reduced. That could be looked at.

192. The Committee has heard compelling evidence of the crucial role good employment has to play in addressing income inequalities and in promoting and preserving good mental and physical health. In this context, action to break down barriers to employment has an important role to play in tackling health inequalities.

193. The Committee recognises that powers over employment law, and the majority of work-related social security benefits, are reserved to the UK Government. The majority of the Committee agrees with the recommendation by the Glasgow Centre of Population Health that, within budget constraints, the UK Government should take action to align benefits and tax credits with inflation and to reinstate the uplift in Universal Credit introduced during the Covid-19 pandemic[xi].

194. The Committee calls on the Scottish Government to strengthen its efforts to encourage public sector organisations to become living wage employers, and to encourage those that have already made that commitment but have yet to fulfil it to accelerate their progress. The Committee further requests that the Scottish Government, in responding to this report, provides an update on the percentage of Scotland's public sector workforce currently employed by living wage employers, a projection of how that is expected to increase over the next five years, and an outline of action it is taking to address any shortfall.

195. The Committee highlights evidence it has received of those actions the Scottish Government can take, within devolved powers, to address employability issues and eliminate barriers to employment. These include, for instance, using public procurement policy as a lever to encourage more organisations to become real living wage employers, expanding childcare provision and breaking down obstacles which prevent potential employees from taking up free childcare and therefore act as a barrier to employment. The Committee calls on the Scottish Government, in responding to this report, to set out what action it is taking or plans to take in the future to make progress in these areas and what it is doing to ensure its approach to tackling these barriers is properly informed by and developed in partnership with people with lived experience.

196. Recognising the division of powers between the Scottish and UK Governments, the majority of the Committee calls on the UK Government to increase the statutory living wage to the real living wage, and to take further action to increase 'in-work' benefits to eliminate in-work poverty[xii].

197. The Committee highlights evidence submitted to this inquiry of the link between

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xi Tess White MSP and Sandesh Gulhane MSP dissented from this recommendation.
xii Tess White MSP and Sandesh Gulhane MSP dissented from this recommendation.

supportive employment and improved health outcomes . The Committee calls on the Scottish Government to set out what progress has been made towards implementing the recommendations from the 2019 review of the Scottish Government's health and work strategy, particularly in relation to reducing inequalities and addressing health inequalities and what further work still needs to be done.

198. The Committee draws the attention of colleagues on the Economy and Fair Work Committee to the important role employers across the public, private and third sectors have to play in tacking health inequalities by addressing in-work poverty and breaking down barriers to employment.

Public services

199. In 2011, the Christie Commission on the future delivery of public services highlighted that attitudes and approaches to public services were outdated and needed to change. It recommended that public service reform should be centred on four key objectives, namely:

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

200. In a recent blog, Audit Scotland noted the important role of public services in tackling inequalities:

> Public services are crucial to tackling Scotland's endemic inequalities. Public services are social investments; they educate and house people, keep people healthy, and enable transport and communications. They contribute to improving the economy by helping people develop workforce skills, provide direct and indirect employment and generate opportunities for the private sector. [79]

201. While giving evidence to the inquiry, Professor Sir Michael Marmot of University College London noted that life expectancy has failed to improve and health inequality has grown in the decade between 2010 and 2020. He went on to argue that this has coincided with a time period when poverty has increased and investment in public services has fallen. [80]

202. Major public service reform was initiated in Scotland in 2016 when the Public Bodies (Joint Working) (Scotland) Act 2014 came into force with the objective of

bringing about the integration of health and social care. This process of integration was designed to support the provision of personalised, person centred care and flexible services that shift care provision to the community. This ambition was set out in the Scottish Government's 2020 Vision , published in 2011.

203. Audit Scotland has repeatedly highlighted significant challenges with improving outcomes through the process of integration [81] . Furthermore, the 2021 Feeley Review, an independent review of adult social care, noted:

> Progress has been patchy. In particular it is evident that the ambition... – that whether money for support and services is from an “NHS budget” or a “Local Authority budget” should be of no importance to the person using services – has not been achieved. This is not merely an accounting problem. It is a significant impediment to the wellbeing of people who use health and social care support services, because it gets in the way of early intervention and preventative approaches, and it is a significant barrier to innovation for people working in health and social care support [82] .

204. In evidence to the Committee, Dr Peter Cawston spoke candidly about the negative impact public services can have in exacerbating health inequalities:

> one of the most soul destroying things for me as a health professional has been witnessing on a daily basis how the national health service sometimes unwittingly and sometimes deliberately widens health inequalities and perpetuates divisions in many ways [83] .

205. Dr Cawston went on to outline how current systems are often set up primarily to facilitate organisational structures and processes rather than focusing on supporting individuals in receipt of care. He illustrated this with several examples from his own GP surgery:

> An example of that comes from referral to another service of a patient who had mental health problems and did not open letters or read them because they found them threatening. A referral that I made asked if the service could telephone with an appointment time, rather than send a letter. The referral was rejected on the basis that it is not that kind of service: the service sends letters, and that is that [84] .

> Another example is of a patient who turned up on the wrong day for an urgent suspected cancer X-ray referral and was turned away because they had missed their appointment even though the request was sitting there and the service operated a walk-in element. However, because they did not follow the referral procedure exactly, they were turned away [85] .

> People are travelling to pain clinics that are three bus journeys away because investment is in a centralised specialised service, which presents a barrier to them [86] .

206. However, Professor Gerry McCartney noted that health and social care services aren't the only public services that can have an impact on health and wellbeing outcomes:

> All public services, and indeed services from other providers—whether that is police services, housing or health services—contribute to the things that make populations healthy or unhealthy. Those providers all matter—they all contribute and they all need to provide services in accordance with people's needs [87] .

207. As a further example of the failure of public services to focus on the needs of service users, Professor Petra Meier from the University of Glasgow shared a recent experience of refugees seeking employment:

> I am currently supporting Ukrainian refugees, and the way in which they have to engage with services, and the sometimes disrespectful way in which services deal with them, is just heartbreaking... Someone can be asked to go to a jobcentre, which requires an hour-and-a-half round trip on the bus, only for them to be told that the person they were supposed to see is not there and they will have to come back the next day. When they say that they have a job interview then, they can be told that they will still have to attend the jobcentre at that time. Such experiences take away people's sense of agency—of being able to control their fortunes—in a way that is really demoralising [88] .

208. During the Committee's informal engagement events, we heard examples of a lack of coordination or integration of public services, across all sectors. We heard accounts of individuals and families presenting at services, regardless of whether that was to access support with employment, housing, or health, where the focus was on addressing one isolated element of their needs rather than offering them holistic support. For example, housing services would focus on addressing homelessness without supporting or co-ordinating support to treat drug addictions or any underlying mental health issues that individual might also be experiencing [89] .

209. We also heard how difficult it can be to navigate benefits and other support systems. Karen Lewis offered a particular example:

> Yesterday, I tried to ring up the benefits section for someone. I was on the phone for 55 minutes before the call was cut off because the office had closed; I was trying from just before 5 past 4 till 5 o'clock. I was using my work phone and I am paid for that time, but if I was someone who was under stress, I would have just given up. It is defeating to have to wait so long. We must look at simplifying access and having decently funded support services that assist people to navigate their way through such processes. Benefits are not being taken up because there is a lack of such support. It seems to be the case that it is the people with the highest capacity who are more likely to get benefits and support than others. That builds inequality in a group of people who already face inequality. There are different layers of it. From a social justice perspective, that is not acceptable [90] .

210. During the informal engagement events, participants argued the case for improved access to advocacy support to help them navigate support services at a time when they may be vulnerable. Contributors also complained of service providers demonstrating a perceived lack of respect for human rights and a lack of flexibility [91] .

211. Dr Cawston argued that public service providers need to take a trauma informed approach to public service provision:

> Tackling ... stigma involves every person who works in a health and social care setting ... having a better understanding of how trauma impacts throughout a person's life, and how it affects ... behaviour [92] .

212. On the question of taking a trauma-informed approach, the Minister for Public Health, Women's Health and Sport told the Committee:

> ...since 2018, the Government has invested more than £5 million in a national trauma training programme. A total of £3.2 million in funding has been distributed to local authorities, to enable them to work with community planning partners to further that agenda. Our commitment is that by April next year, we will publish a long-term delivery plan for the next phase of the national trauma training programme [93] .

213. During the inquiry, we heard evidence in support of a better integrated approach to public service delivery. During a number of the evidence sessions, there was discussion about the general need for a holistic, person-centred approach to service delivery, which addresses all aspects of a person's experience. Participants argued that an individual presenting at one service should be able to receive comprehensive support to address all of their needs, rather than just one specific aspect of these.

214. Several individuals and organisations spoke about the need for a co-ordinated approach to service delivery in Scotland. Some expressed support for a 'no wrong door approach', which establishes hubs bringing together an integrated range of options, services and outreach to support individuals. Others advocated the need for specialist community link workers in a range of fields. While proposed approaches to supporting individuals varied, there was consensus that some central co-ordination was required to make public services seamless for individuals. It was argued that such an approach could help to empower individuals to access the support they need.

215. Karen Lewis highlighted a single access point model that has been piloted in an area of Dumfries and Galloway during the Covid-19 pandemic. However, she also highlighted that such models require advanced development and appropriate resources to be effective:

> There is the kernel of a good idea in that...However, the model is operated by computer algorithms, so unless an organisation is in the loop and its service is included in the single access point, a person will never get referred to it. There is something in that model that could work and be innovative because it means that people will not be passed from pillar to post and have to tell their story over and over again. People will be sent to the right organisation straight away, whatever sector it is in. However, the model should include a much wider framework [94] .

216. When asked about priorities for future action, Dr Cawston argued the need for much better integration of community assets with health services at a local community level:

> There needs to be a long-term commitment to communities that are wrapped around health services being the places where we make the change in health inequalities...Many community assets have short-term funding and live very precarious lives. If they had the same level of commitment and support as the public sector does, and if they were integrated with health services rather than being seen as a separate thing, they could make a huge difference to health inequalities. All sectors need to be integrated through the community [95] .

217. As a means of delivering a more user-focused and better integrated approach to service delivery, the Minister drew comparisons with the existing GIRFEC approach[xiii] to supporting children and young people. The Minister advocated the development of a 'GIRFE' approach which would have the aim of "getting it right for everyone, every time". Michael Kellet went on to outline the principles underlying such an approach:

> The focus on how we wrap our services around an individual to understand them and best meet their needs is building on the GP contract. It is the central focus of the preventative and proactive care reform programme that the minister talked about earlier. That is about building a multidisciplinary team, which is sometimes called the principal care team, to ensure that care goes beyond health, into housing and other support. That is important [96] .

218. The Committee believes that, as outlined in the Christie Commission report a decade ago, reducing inequalities must continue to be a core objective of public service reform. The Committee calls on the Scottish Government, in responding to this report, to set out what progress has been made towards implementing the Christie Commission recommendations, particularly as these relate to reducing inequalities and addressing health inequalities.

219. While noting the Scottish Government's focus on redesigning and rebuilding public services as part of its Covid recovery strategy, the Committee highlights evidence submitted to this inquiry which suggests multiple instances where the design and delivery of public services are exacerbating inequalities rather than reducing them. It calls on the Scottish Government to bring forward an action plan designed to pinpoint and address these problems as a core element of ongoing public service reform.

220. If public services are to contribute positively to the objective of reducing inequalities in the future, the Committee believes that their design and delivery must become much more responsive to the needs, rights and preferences of people using those services. The Committee therefore calls on the Scottish Government, in responding to this report, to set out what it is doing to embed co-design and to work with those with lived experience in implementing any future public service reforms and how it will measure the success of this approach in reducing inequalities.

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xiii Getting it right for every child (GIRFEC) supports families by making sure children and young people can receive the right help, at the right time, from the right people. The aim is to help them to grow up feeling loved, safe and respected so that they can realise their full potential. More information is available on the Scottish Government Website.

221. The Committee welcomes the Minister's update on the upcoming publication of a long-term delivery plan for the next phase of the national trauma training programme. We look forward to hearing more detail on how this can be embedded within public sector services to improve working practices and what the Scottish Government will do to monitor and evaluate its contribution towards reducing inequalities.

222. The Committee welcomes the Minister's commitment to holistic person-centred care, based on a so-called "GIRFE" approach. To tackle inequalities effectively, the Committee believes that such a "no wrong door" approach needs to be applied more widely to public services beyond health and social care. The Committee draws this conclusion to the attention of colleagues on the Finance and Public Administration Committee as part of its ongoing scrutiny of public service reform.

Health in all areas

223. A key aim of the inquiry has been to look at what action is needed to ensure addressing health inequalities is considered a priority in all relevant areas of policy development. Written responses to the Committee's call for views noted the benefit of wider use of equality impact assessments (EQIAs). In particular, several submissions argued for the systematic use of Health Inequalities Impact Assessments (HIIA) as a mechanism for giving greater priority to tackling health inequalities in the development of policy[xiv] . HIIAs go beyond the public sector's legal duty under the Equality Act 2010 to assess equality impacts (EQIA) by also assessing the impact on:

- health inequalities
- people with protected characteristics
- human rights
- socioeconomic circumstances.

224. In its written submission, NHS Lothian described the systematic use of HIIAs as a "health in all policies" approach which should encourage prioritisation of health in planning and decision making [97] .

225. During the Committee's scrutiny of the National Planning Framework 4 (NPF4) earlier this session, the Committee heard evidence that local planning policy and decision-making currently fails to take account of health impacts on a population. During formal evidence, witnesses argued that HIIAs should be applied as a mechanism for measuring the impact of planning decisions on different population groups as part of the implementation of NPF4 [98] .

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xiv Health Inequalities Impact Assessment (HIIA) is a tool to assess the impact on people of applying a proposed, new or revised policy or practice. More information can be found on the Public Health Scotland website: What is an HIIA - Health Inequalities Impact Assessment (HIIA) - Tools and resources

226. During this inquiry, Karen Lewis emphasised the importance of carrying out impact assessments to ensure policies do not have unintended consequences:

> We should perhaps consider asking or requiring that mental health and wellbeing, rurality and poverty are part of the impact assessments, so that no operationalised policy has unintended consequences for those who have to live the life [99] .

227. Addressing the inclusion of HIIAs in planning and decision-making, Claire Stevens stated that while Voluntary Health Scotland would support the requirement for public sector organisations to conduct health inequalities impact assessments so that health is considered in every portfolio, this would need to be undertaken carefully to ensure it was done in a meaningful way:

> Ostensibly, it would be easy for health inequalities impact assessments to be used routinely across the board in decision making and planning, whether that is through the national planning framework structure, for example, or in any other decision making across public services or public policy. We would certainly say that that could at least be done. The danger, of course, is that it becomes a tick-box exercise [100] .

228. Ms Stevens further noted that there was little evidence currently available on the effectiveness of HIIAs.

229. The Minister for Public Health, Women's Health and Sport emphasised the Scottish Government's commitment to a "health in all policies" approach to ensure health inequalities and the wider determinants of health are fully considered in all policies and programmes. The Minister stated:

> Ultimately, we would like to see the use of HIIAs within a health in all policies approach. There is a great deal of learning to be taken from countries such as Wales, which made the use of HIIAs a statutory requirement for public bodies when the Public Health (Wales) Act 2017 was passed by the Welsh Senedd. I am interested in taking that approach in Scotland [101] .

230. In April 2018 legislation came into force introducing a Fairer Scotland Duty [102] . The Duty asks public bodies to pay due regard to how they can reduce inequalities of outcome caused by socioeconomic disadvantage.

231. In a written response [103] to the Committee following formal evidence, the Minister for Public Health, Women's Health and Sport highlighted case studies that she argued demonstrate the positive impact of the introduction of the Fairer Scotland Duty. The Minister also highlighted the Equality and Human Rights Commission's recent evaluation of fulfilment of the socio-economic duty in Scotland and Wales [104] , as set out in Part 1 of the 2010 Equalities Act. The report found:

> In Scotland, the introduction of the duty helped those public bodies that were already considering socio-economic disadvantage and inequalities of outcome to review and formalise their processes, and strengthened the need for this consideration across a range of staff levels [105] .

232. However, the evaluation also highlighted that public bodies face a number of

challenges in implementing the duties, including "developing systems that avoided 'box-ticking' consideration of socio-economic disadvantage [106] ".

233. The Committee welcomes the Scottish Government's commitment to pursuing a "health in all policies" approach to policy-making. The Committee believes much wider and more systematic application of health inequality impact assessments is essential to achieving this objective. The Committee therefore calls on the Scottish Government, in responding to this report, to set out how it plans to achieve this including associated timescales, what further work it will undertake to measure and evaluate the benefits of HIIAs, and what additional guidance and support it will offer policy-makers to ensure the wider use of HIIAs has a material impact in reducing health inequalities and does not become simply a 'box-ticking' exercise.

234. The Committee is particularly interested in the approach taken by the Welsh Senedd, whereby legislation in Wales has made the completion of health impact assessments a statutory requirement on public bodies [107] . The Committee draws this development to the attention of colleagues on the Equalities, Human Rights and Civil Justice Committee and suggests that Committee might be interested in undertaking further scrutiny of potential legislative action to embed the objective of tackling inequalities in general and health inequalities in particular into all aspects of public policy-making in Scotland.

235. The Committee would like to see a similar approach taken at a UK Government level to the application of HIIAs, and further analysis of how the implementation of reserved policies affects health outcomes and mortality rates.

236. The Committee sees the Fairer Scotland Duty as a start to work to prioritise tackling inequality in all areas. However, the Equality and Human Rights Commission's recent evaluation highlights concerns that the duty is not being used as intended. The Committee urges the Scottish Government to undertake further work to monitor the effectiveness of the duty, and support organisations to prioritise it in decision-making processes.

Informal caring as a social determinant of health

237. During the inquiry, Richard Meade from Carers Scotland argued:

> The health inequity gap that is caused by caring has not been closed since the establishment of the Scottish Parliament; it is actually growing [108] .

238. In 2021, Public Health England conducted a rapid review of reviews and an analysis of data from the GP Patient Survey with the aim of exploring the consequences of being an unpaid carer of older people and how best to support this group of carers [109] . Evidence from that report highlights the disparities in health and other outcomes between carers and non-carers. The report concludes that caring is a social determinant of health, noting that carers face particular vulnerabilities and may benefit from targeted support. However, it also recommends further research to determine what form that support should take.

239. In a report into Scotland's Carers in 2015, the Scottish Government found more than a third of carers reported caring having a negative impact on their health, and a direct correlation between a carer providing increased levels of care and a decreased likelihood of that carer reporting good health.

240. Richard Meade highlighted the experiences of unpaid and informal carers in formal evidence to the Committee. He emphasised evidence that unpaid carers experience poorer quality of life and poorer mental and physical health outcomes when compared directly with those who do not provide care. He further stated:

> The failure to provide systematic support for carers has created a public health crisis [110] .

241. Experiences of caring responsibilities and the impact on the health and wellbeing of carers were highlighted in detail across the Committee's informal engagement events. The Committee heard testimony from individuals and organisations about this impact, specifically [111] :

- The financial impact of caring, including additional energy costs, barriers and challenges to employment, and eligibility for and access to social security benefits.
- The physical impact of caring, including effects of chronic stress, neglect of carer health due to prioritisation of the cared person, and increased susceptibility to certain health conditions.
- The emotional impact of caring, including stress, depression and other mental health issues, not feeling valued and supported, and experiencing carer burnout.

242. Participants reported that carer's own care needs are often unmet and that minimal support is available for carers [112] . Research by Public Health England suggests that carers are 16 per cent more likely to be living with two or more health conditions than non-carers, with arthritis and high blood pressure being the most common conditions [113] . Richard Meade noted during evidence:

> The higher the intensity of the caring that is provided, the poorer the outcomes are. The longer a person has been a carer, the greater the impact on their physical health, which deteriorates over time at a greater and faster rate than the rate for those who do not provide care [114] .

243. In relation to the financial impacts of caring, Richard Meade also spoke about how increases in utility bills for heating and electricity can affect people with caring responsibilities disproportionately:

> Someone who is caring for a person who has medical equipment in the house that needs to be on 24/7 simply cannot turn that off. How will they be able to meet those costs? We have seen examples of carers who face bills of tens of thousands of pounds a month because of those costs. That is extreme, but it is not uncommon that families with people with disabilities and carers are facing huge challenges to heat their homes and to keep their homes running on such limited financial resources [115] .

244. The Committee heard during its informal engagement events that the recent sharp rise in the cost of living has further exacerbated this situation and pushed more carers into extreme poverty [116] .

245. During a breakout session supported by the Coalition of Carers, the Committee heard that many carers have to give up work to fulfil their caring responsibilities while young carers have to sacrifice homework, socialising with friends, and opportunities for extra-curricular activities and work experience [117] .

246. In another breakout session supported by PAMIS, participants spoke of the stress and anxiety of caring for someone and how the pandemic and the subsequent rise in the cost of living has exacerbated these issues. Carers reported that during the pandemic, Self-Directed Support (SDS)[xv] vanished, leaving carers terrified of getting sick and not being able to continue in their caring role as well as being worried that the person they were caring for would get ill and potentially die [118] . In its written submission, the Health and Social Care Alliance Scotland (the ALLIANCE) highlighted the additional pressures faced by carers during the pandemic:

> Unpaid carers have reported practical and emotional challenges of providing ongoing care during lockdown: people were providing more care for loved ones without access to support and respite [119] .

247. Dr Shari McDaid highlighted that carers are often neglectful of their own needs and that this impacts negatively on their mental health:

> I am thinking particularly of carers and people with disabilities, who are resourceful and may not see themselves as deserving of a mental health intervention. However, they are also at a higher risk of isolation, loneliness and mental health difficulties because of those factors [120] .

248. In its written evidence, the Carers Trust Scotland noted the results of the 2019/2020 Health and Care Experience Survey which found only 38% of unpaid carers reported caring had not had a negative impact on their health and wellbeing [121] . They also highlighted that the 2021 State of Caring report by Carers UK found that the pandemic had contributed to a further decline in carer wellbeing, with 31% of carers describing their mental health as bad or very bad [122] .

249. Participants also highlighted a gap between legislation and the day-to-day reality for carers, noting a lack of support from employers, a lack of respite, problems balancing social security benefits with employment, having to advocate for the cared for person and getting insufficient support to do so, and a lack of training to allow them to undertake their caring role [123] .

250. In its written submission, the Glasgow Centre for Population Health cited examples of policy programmes and directives which aim to mitigate and alleviate the impacts

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xv There are four options available under Self-Directed support. Individuals can choose and organise their own support and employ their own staff, choose support and opt for either the council or support provider to arrange care, opt for the council to choose and arrange support, or opt for a mix of all three options.

of poverty and austerity, citing examples such as recent increases in the Carers Allowance [124] .

251. The Minister for Public Health, Women's Health and Sport set out a range of social security measures intended to mitigate the impacts of sharp increases in the cost of living in Scotland, including support for carers:

> nearly 82,000 unpaid carers have received £491.40 of additional support this year through the carers allowance supplement [125] .

252. Richard Meade noted that Carers Scotland were supportive of the carers allowance supplement but also further highlighted challenges with eligibility and accessing social security benefits:

> We welcome the carers allowance supplement, but that is simply not enough to meet all the challenges. We know that, as soon as someone who is working as a carer hits £132, they lose any entitlement to carers allowance. Equally, someone of pensionable age who receives any kind of pension will not get carers allowance, either. In Scotland, carers allowance reaches only about 90,000 carers. Lots of carers really struggle [126] .

He further noted opportunities around proposals to create a Scottish carers assistance benefit, and 'to create a far better, far fairer and much more supportive carers benefit' [127] .

253. In her evidence, Dr Sharon Wright also spoke about the impact of welfare conditionality[xvi] on carers:

> The system that is meant to protect people is not functioning properly, which has detrimental impacts on unpaid carers... Two actions are required. Cuts to the value of UK benefits need to be reversed. One of the biggest impacts is from the benefits freeze, which went on for several years and brought inadequate incomes down even lower, such that people who were claiming benefits, including those in work, had falling incomes relative to the rising cost of living. To deal with that, the Scottish Parliament could lobby Westminster to increase the rate of universal credit. The second major issue with social security is conditionality. That is very damaging because it also applies to the partners of claimants, who might be carers, and it also applies to people who are claiming universal credit while in work, such as people who are in low-paid or part-time work. That includes a set of older women who have received less attention; women in their 60s, who would expect to be in retirement. There is a lot that can be done to improve the system. The Scottish Parliament's powers could be used to increase the carers allowance supplement and the Scottish child payment. What is needed in the long term is a major programme of reform to build support for progressive taxation. In the Scottish spending review, it was clear that there is not enough money for the enormous void between the support that is needed and the support that is actually available. [128]

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xvi Welfare conditionality is when accessing benefits is conditional on an individual agreeing to meet particular obligations or patterns of behaviour. This briefing from the Joseph Rowntree explains the concept in more detail.

254. During our informal engagement events, suggestions for improvements to address health inequalities experienced by carers included a statutory requirement on employers to support carers through programmes such as the Carers Positive Award Scheme[xvii], the appointment of young carer workers in schools, and development of a fairer benefits system for carers [129] . Giving evidence to the Committee, Richard Meade also advocated development of a carer poverty strategy, in line with the Scottish Government's existing child poverty strategy:

> We are very much in favour of it [Scottish Government] having a carer poverty strategy, too, to address some of the unique conditions that carers face and to look at how we might use the powers of the Scottish Parliament to address the poverty that they face [130] .

255. This Committee has heard extensive evidence that informal and unpaid caring is a social determinant of health. This has highlighted that caring for someone has a disproportionate impact on health outcomes and that informal carers face significant health inequalities as a result.

256. The Committee believes the Scottish Parliament and the Scottish Government should formally recognise and acknowledge that caring is a social determinant of health. In so doing, the Scottish Government, and Public Health Scotland, must ensure that more targeted support for carers is considered and reflected in the future development of public health policy and strategies.

257. The Committee further recommends that the Scottish Government should actively promote the Carers Positive Award Scheme as an example of good practice and, to further reinforce public sector employer support for carers, consider making participation in the scheme a statutory requirement for all public sector organisations, as well as those that receive public funding.

258. The Committee draws the attention of the Scottish Government and its colleagues on the Social Justice and Social Security Committee to the potential development of a carer poverty strategy and creation of a Scottish carers assistance benefit, as advocated by a number of contributors to the inquiry. The Committee believes these proposals would merit further exploration and scrutiny as a means of delivering fairer financial support for carers and tackling health inequalities experienced by carers.

259. The Committee is concerned by evidence it has heard during this inquiry that women and carers are disproportionately affected by welfare conditionality and the impact this has on health inequalities. The Committee urges the Scottish and UK Governments to review the specific impact of welfare conditionality on women and carers and identify what more needs to be done to tackle the health inequalities they experience as a result.

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xvii Carers Scotland, on behalf of the Scottish Government, is operating an award scheme to recognise employers in Scotland who support carers in their workforce. More information is available at www.carerpositive.org .

Fundamental cause of health inequalities

260. During the inquiry, we heard multiple accounts of the causes of inequality. During evidence Professor Gerry McCartney stated:

> We know that health inequalities are a result of inequalities in income, wealth and power in society and it is because those inequalities have continued to widen that health inequalities have continued to widen [131] .

261. 74 of the 114 responses to the Committee's call for views highlighted the link between poverty and health inequalities. It was a key theme in all of the Committee's informal engagement events and has been discussed extensively during our formal evidence sessions. The evidence base shows that, even before the pandemic and the current sharp rises in cost of living, inequalities have been rising as a result of the rise in poverty.

262. Professor Sir Michael Marmot told us that life expectancy had more or less stopped improving over the last 10 years, the social gradient[xviii] has become steeper and life expectancy for the poorest people has gone down [132] . He further outlined that, in his opinion, while policies are more likely to improve health and reduce health inequalities than the policies that are coming out of Westminster, health inequalities in Scotland are deeper than they are in England. Describing trends in health inequalities, Dr David Walsh told us that mortality rates in the poorest communities have increased across the whole of the UK as a consequence of widening inequalities [133] :

> You can therefore trace the effects of austerity through well-understood pathways to—ultimately and tragically—early death [134] .

Professor Gerry McCartney issued a warning that rising mortality rates within the poorest communities are likely to get worse, and quickly, as a result of recent developments [135] .

263. Giving evidence to the inquiry, the Minister for Public Health, Women's Health and Sport referred the Committee to work undertaken by the Glasgow Centre for Population Health to examine the correlation between poverty and economic policy. She argued:

> The recent report from the University of Glasgow and the Glasgow Centre for Population Health attributes stalling life expectancy trends in Scotland directly to United Kingdom-led austerity measures. The report makes a number of key recommendations, including protecting the real incomes of the poorest groups, especially with the currently escalating inflation rates. The evidence strongly suggests that implementing such measures would reverse death rates and reduce the widening health inequalities that we see [136] .

264. In his evidence, Ed Pybus articulated the need to address poverty in order to tackle health inequalities effectively:

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xviii "The social gradient"is a term used to describe when people who are less advantaged in terms of socioeconomic position have worse health than those who are more advantaged.

> It is pretty clearly established that health inequalities come about because of poverty and wealth and income inequalities. The best way of addressing health inequalities is to address poverty. Treating poverty as a public health crisis is the way to deal with health inequalities [137] .

265. Professor McCartney argued that, in tackling health inequalities, a reliance on behavioural science approaches, which target interventions and messaging to individuals has not addressed the fundamental causes of inequalities and has not made a big difference. He further argued that more thought needs to be given to management of the economy and ways in which this can lead to widening income, wealth and power inequalities [138] . Dr Walsh supported this position and concluded that without action to narrow socioeconomic inequalities in society, efforts to narrow health inequalities will fail [139] . Bill Scott similarly argued for radical reform of the economic system [140] .

266. During evidence there was considerable discussion of the division of policy responsibilities between different levels of government. For instance, as previously discussed in relation to employment legislation, there are certain policy areas that affect health inequalities that are reserved to the UK Parliament. These include aspects of fiscal, economic and monetary policy, and social security. Dr Walsh argued that this limits the capacity of the Scottish Government to intervene itself in certain areas to address health inequalities:

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

267. Claire Sweeney from Public Health Scotland noted that while a number of areas are reserved and outwith the Scottish Parliament's legislative competence, local action could still be taken within these constraints to mitigate some of the effects of the underlying causes of poverty and inequality:

> Giving people more money is absolutely the biggest thing that can be done—for sure, there are reams of public health evidence that say that. However, if we just focus on that, it lets everybody else off the hook, and there is lots that we can do in Scotland [141] .

268. The Committee has heard strong evidence of the interconnection between levels of poverty and levels of health inequality and the severe negative impact poverty has on health and wellbeing outcomes. On this basis, as well as being a socio-economic problem, the Committee believes tackling poverty must be considered to be a major public health priority at all levels of Government. The Committee calls on the Scottish Government to set out in detail what it is doing, within its devolved competence, to tackle poverty as a public health issue, what impact it expects these interventions to have in reducing health inequalities and how this impact will be measured and evaluated.

269. As an integral part of future financial scrutiny work, the Committee will consider and evaluate what impact Scottish Government spending decisions are likely to have in reducing or exacerbating health inequalities. It also draws this to the attention of colleagues on committees across the Parliament, particularly as this relates to spending decisions beyond this Committee's own direct policy remit, for instance in relation to funding programmes designed to tackle poverty.

270. The Committee commends the work of the Social Justice and Social Security Committee in undertaking an inquiry into low incomes and problem debt and has been particularly struck by evidence submitted to that inquiry outlining what actions people on low incomes are compelled to take to survive and the effects this has on budgeting decisions. We encourage the Social Justice and Social Security Committee to continue its scrutiny of issues around poverty, low income and social security during this session, including the implications of policy development in these areas for tackling health inequalities.

271. The Committee echoes the recommendations in the Social Justice and Social Security Committee report, Robbing Peter to pay Paul: Low income and the debt trap , which calls for a shift the burden of responsibility away from the individual and onto systems, and for current complexities around eligibility for benefits to be eliminated.

Income

272. During the inquiry, we heard a lot of evidence on the impact social security policy can have on tackling inequalities, including health inequalities, and the importance of increasing income as a key measure to reduce poverty. Income is inextricably linked to employment, which is discussed in more detail in another section of this report alongside consideration of the living wage. However, as evidence to the inquiry demonstrates, those considerations do not take into account individuals who are not employed or families where no-one is working. The Joseph Rowntree Foundation reported in 2021 that 54% of people who are in families where no one is working are in poverty.

273. During the inquiry, the Committee received many suggestions of ways to increase household income and evidence in support of concepts such as a universal basic income and minimum income guarantees as a way of tackling income inequality, as well as hearing calls for an even stronger focus on tackling child poverty. We heard evidence of an alignment between action to address child poverty and providing families with a basic income. Ed Pybus told us:

> The immediate way of tackling child poverty is by investing in social security and making cash payments to low-income households. That is how to deal with it. We have shown that that works. Ensuring that families have adequate incomes is the best way of investing in tackling long-term health inequalities [142] .

274. In relation to a universal basic income and a minimum income guarantee, Mr Pybus told us, in his capacity as a member of a minimum income guarantee steering group, that while both measures could be expected to reduce health inequalities,

more work is needed to define these concepts more clearly:

> Poverty causes health inequalities. Both universal basic income and a minimum income guarantee would help to resolve poverty, so should help to reduce health inequalities. The devil is in the detail as to what can be achieved and what we mean by universal basic income or minimum income guarantee [143] .

275. There was support from Professor Petra Meier and Dr Shari McDaid for the implementation of universal policies around minimum incomes, and the effect that would have on mental health and wellbeing. Professor Meier expressed support for policies such as the promotion of a wellbeing economy, community wealth building and establishment of a minimum income guarantee. Dr McDaid told the Committee about the Mental Health Foundation's research into the effects of a universal basic income. It found that implementing a universal income would reduce the conditionality of social security benefits and that this would play a key role in protecting mental health:

> It is not enough to put more money in someone's pocket; that must be done in such a way that they do not have many hoops to jump through to get access to that income. Introducing a minimum income guarantee in the right way, by reducing as much of the conditionality as possible, could be very helpful [144] .

276. Bill Scott addressed issues relating to stigma and shame associated with coming from a poorer household and claiming social security support. He emphasised his view that universal provision was central to overcoming those issues, arguing as an example that providing universal free school meals removes the stigma those from poorer households feel in claiming free school meals if these are means tested. He further noted:

> [In relation to] a minimum income standard, everyone should be able to expect a certain minimum household income that allows them to participate fully. Once we achieve that, we will open up possibilities. Many households cannot take the opportunities that are there, not only because of shame or stigma but because of the barriers of low income. They cannot afford public transport or childcare. Free childcare for more families is disproportionately helpful to poorer families...The essentials of life include the ability to participate in public life. If people cannot do that without a sense of shame, they lose self-worth, and that damages their mental and physical health [145] .

277. Dr McDaid also highlighted the importance of ensuring that the "experience of obtaining a minimum income is nonstigmatising and respectful [146] " noting that improving income would be insufficient of itself if the associated shame and stigma are not also addressed.

278. Bill Scott went on to speak about the effects of poverty on children, arguing the case in favour of a minimum income guarantee to tackle current harms and future impacts of the effects of poverty on children:

> A minimum income guarantee is a floor that stops that from happening and has an impact on the health of children—on dietary health, apart from anything else—and the ability to participate without a sense of shame, which is important to children. The cost of living crisis will make things significantly worse for a larger proportion of households. Unless we address that properly, we will live with its consequences in the impact on physical and mental health for a further generation [147] .

279. Professor McCartney, who chaired the Scottish citizens basic income feasibility study and sits on the minimum income guarantee steering group, argued that the concept of a universal basic income is a promising intervention but that there is a need for further research and piloting work to identify potential risks and financing models. He concluded:

> We recommended that it [universal basic income] be piloted, but we do not yet have the co-operation of the necessary UK agencies to allow piloting to take place. On that basis, we are looking at minimum income guarantees, using the existing powers in Scotland to shore up the holes—[Interruption.]—in the benefits system to ensure that people do not fall through the cracks and experience poverty. I think that it is a really promising approach that could, I hope, reduce the number of people who experience poverty and all its consequences [148] .

280. Dr Wright also spoke about the benefits of a minimum income guarantee, but expressed her view that this would be most effective if implemented in conjunction with further devolution of social security benefits. She argued its effects could be somewhat limited within the constraints of current devolved powers and expressed concerns about the impact of delayed action to support those in poorer communities:

> In the long term, the minimum income guarantee that the Scottish Parliament is currently looking at is promising, but it depends on a number of different scenarios. A minimum income guarantee could be most effective if the Scottish Parliament were to get increased powers over social security, which would be most likely if there was a vote for independence, although it would not be guaranteed. If a minimum income guarantee operated under the current powers or a partially increased set of powers over social security, it could be quite limited. It could be that a minimum income guarantee would operate alongside the universal credit system. I have two concerns about that. First, it might take a long time to get going—four years at least, but perhaps more. Secondly, it might have to operate alongside major parts of the existing system, such as universal credit. Therefore, I urge you not to wait to make your recommendations but to just press ahead and ask for increases straight away, because people are really struggling. Many people have very low incomes, and you can see that that is so much worse now than it was a decade ago, before we had universal credit, before the benefits freeze, and before the five-week wait and all these deductions. A minimum income guarantee makes us hopeful for the future, but I do not think that we can wait for that rather than taking action, because while we are waiting for that to come in, health inequalities will worsen and people in poorer communities will literally be dying [149] .

281. Evidence submitted to this inquiry demonstrates the close correlation between income and inequality and the importance of taking action to raise incomes as a means of reducing health inequalities in that context. Evidence equally suggests that, while also being particularly effective in tackling inequalities, universal interventions on income have the additional benefit of eliminating feelings of stigma or shame otherwise experienced by those on low incomes.

282. The Committee requests that the Scottish Government provide an update on the work of the minimum income guarantee steering group and progress towards implementing a minimum income guarantee to address existing gaps in the social security system that may be hampering progress in tackling health inequalities. As part of this update, we invite the Scottish Government also to set out any specific obstacles it is encountering to implementation of a minimum income guarantee and what action it intends to take to address these.

283. The majority of the Committee calls on the Scottish Government to continue discussions with the UK Government with a view to overcoming obstacles to the timely and effective implementation of a minimum income guarantee in Scotland and to keep it informed of progress[xix].

284. The majority of the Committee asks the Scottish Government to work with the relevant UK agencies to consider whether a pilot of a universal basic income could take place in Scotland in order to begin to address health inequalities[xx].

Social security

285. During the course of the inquiry, the Committee heard a variety of evidence related to the social security system. This evidence points to an inextricable link between social security, income and employment. The impact of both income and employment on tackling health inequalities is discussed in more detail in other sections of this report as is social security policy as it relates to the situation of informal carers .

286. The Department for Work and Pensions (DWP) has overall responsibility for much of the benefits system in the UK. The Scotland Act 2016 transferred new social security powers to the Scottish Parliament. The Social Security (Scotland) Act 2018 established a framework for exercising these devolved social security powers, Social Security Scotland , and devolved 11 existing social security benefits to Scotland. These included [150]

- Ill Health and Disability Benefits: Disability Living Allowance, Personal Independence Payment, Attendance Allowance, Severe Disablement Allowance
- Industrial Injuries Disablement Benefit
- Carers Allowance

xix Tess White MSP and Sandesh Gulhane MSP dissented from this recommendation.
xx Tess White MSP and Sandesh Gulhane MSP dissented from this recommendation.

- Sure Start Maternity Grant
- Funeral Expenses
- Cold Weather Payments and Winter Fuel Payments
- Discretionary Housing Payments
- Some powers in relation to payments of Universal Credit

287. Control of some social security benefits remains reserved to the UK Government [151] , including for example:

- Universal Credit, which replaces Jobseeker's Allowance, Employment Support Allowance, Income Support, Working Tax Credits, Child Tax Credits and Housing Benefit
- Contributory Job Seeker's Allowance
- Contributory Employment Support Allowance
- Child Benefit
- Maternity Allowance
- State Pension
- Pension Credit
- Bereavement benefits: Bereavement Allowance, Bereavement Payment, Widowed Parents Allowance

288. The Scottish Government has also introduced new benefits such as the Scottish Child Payment, which do not have a direct equivalent elsewhere in the UK. As noted in the education and early years sections of this report , Professor Gerry McCartney expressed his view to the inquiry that this benefit should be considered as an example of good practice in tackling health inequalities. [152]

289. Dr David Walsh from the Glasgow Centre for Population Health highlighted the important role of social security in combating health inequalities and inequalities more generally:

> Social security is a massive area. It should be a safety net to help people when they are in difficulty, not something with which we punish people, which is basically what the UK Government has done with aspects of austerity, such as the conditionality of benefits [153] .

290. Dr Sharon Wright spoke in-depth about her research at the University of Glasgow into the lived experiences of people who claim social security benefits. She described the experiences of individuals living in poverty and destitution while claiming social security benefits. Dr Wright went on to outline some key findings from her research:

> The source of the problem is the UK system, which should be protecting people from poverty and preventing it but is not operating effectively because of more than a decade of cuts and reforms. Those reforms and cuts have operated as a large-scale disincentive strategy, so people who should claim support are put off doing that...Several reports and a lot of research show that, rather than alleviating poverty, universal credit is actually driving it. That is because the rate of universal credit is not generous enough—it does not give people the money that they need to cover their basic survival needs—and because of frequent deductions [154] .

291. During the Committee's informal engagement events, participants recounted largely negative experiences of accessing Universal Credit including issues with welfare conditionality[xxi], sanctions[xxii] and benefit deductions[xxiii] and the knock-on impact these issues had on their experience of living in poverty, including significantly increased stress, anxiety and other mental health issues. We also heard evidence of particular issues encountered in negotiating the social security system by women, migrant workers, and asylum seekers with no recourse to public funds [155] .

292. Dr Wright went on to outline why, in her view, the social security system is not only failing to tackle inequalities but is actually exacerbating them:

> The situation is that unprecedented cuts to UK social security for more than a decade are combining with welfare conditionality to push people towards work, even when that is not realistic for them [156] .

> The world's harshest sanctions regime...contributes to stigma, hardship and people's need to use food banks [157] .

> About half of all universal credit recipients have deductions made from the amount of benefit that they get. To begin with, it is an inadequate amount, and then it is cut further by deductions. A lot of the money that is coming in is going straight out to repay existing debts [158] .

293. Organisations participating in our informal engagement events reported individuals they support do not always understand what they are entitled to when accessing social security, and often experience difficulty trying to navigate two different systems (i.e. the UK system and the Scottish one). Participants made the case for a more compassionate, joined up and easy to navigate social security system. Organisations also argued that further work is needed to increase uptake rates and widen eligibility criteria [159] .

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xxi Welfare conditionality refers to where benefits are dependent on an individual agreeing to meet particular obligations or patterns of behaviour.

xxii Sanctions refers to stopping or reducing of benefits if an individual does not meet one or more conditions of their benefit claim.

xxiii Benefit deductions refers to the DWP power to automatically deduct money from individuals' benefit payments. Payments can be taken for debts such as benefit overpayments, Universal Credit Advances and council tax arrears, and other debts such as energy or rent arrears.

294. Ed Pybus provided further evidence of issues associated with rates of uptake of social security benefits arising from barriers to access:

> We know that the take-up rates of means-tested benefits can be relatively low—for example, maybe only 70 per cent of children who are eligible get the Scottish child payment—so, as well as having in place such social security systems, we need to address the barriers to access, through the intersectional approach [160] .

295. Organisations also questioned whether sufficient data was available to be able to accurately assess the effectiveness of benefits and the impact of sanctions. This was a theme also explored by Professor McCartney in his evidence. He raised particular concerns about a lack of shared data:

> It would also be ideal if we could get linkages to Department for Work and Pensions and Her Majesty's Revenue and Customs data, which we have been asking for for more than a decade. We still do not have those linkages, which means that we cannot do individual level studies of the whole population on the impact of sanctions policies on benefits, for example. We have to rely on some our panel surveys, such as the understanding society survey, which takes a sample of the population and allows us to look at those impacts [161] .

296. Professor McCartney also highlighted a need to gather more routine data in Scotland to measure the socioeconomic position of individuals. He suggested this data could classify individuals, for example, according to their occupational social class, levels of educational attainment and income. He argued that such an approach "would fill a massive gap in what we currently know about the experience of inequalities of all kinds in Scotland" [162] .

297. Claire Stevens suggested that contributions by participants during the informal engagement events pointed to distinct differences in experience of interacting with the UK and Scottish social security systems:

> We heard a great deal about the UK Westminster benefits system and very positive things about the Scottish social security system [163] .

298. However, Ed Pybus also noted that the rules governing some devolved benefits have simply mirrored those applied when they were previously reserved:

> More broadly, in parts of the social security system that have been devolved, the rules have mirrored some of the rules in the UK system, which did not need to happen. For example, the past presence test, which does not impact people with no recourse to public funds but impacts people who arrive in the UK, has been mirrored in the Scottish disability and carers benefits, although there is no reason for the Scottish Government to do that. [164] .

299. Dr Wright gave another example of this mirroring approach in relation to the devolved carers allowance supplement and the level of payment it provides to claimants:

> We also need to be honest about the Scottish social security system. It has deliberately taken a different alternative approach that offers dignity, fairness and respect, but we need to acknowledge that the carers allowance supplement was set at the level of jobseekers allowance. Therefore, in that sense, it mimics and is anchored in the UK system, which does not offer people enough money to meet their basic needs. We could make a different choice by tying our Scottish benefit payments to minimum income standards that actually ensure that people have enough money to live on [165] .

300. Witnesses also suggested specific improvements to social security they would like to see the Scottish Government take forward, including [166] :

- lobbying Westminster to increase the rate of universal credit;
- using its powers to increase the carers allowance supplement and the Scottish child payment;
- creating a far better, far fairer and much more supportive carers assistance benefit (which is currently subject to public consultation);
- ensuring people are aware of what they are entitled to; and
- undertaking a major programme of reform with the long-term aim of building support for a more progressive approach to taxation.

301. Bill Scott stated his view that there are actions that could be taken by the Scottish Government to mitigate the impact of the rising cost of living on health inequalities. However, he added:

> I do not think that we can fully mitigate the cost of living impacts in Scotland. Control over the vast majority of means-tested benefits, which are the most effective way of delivering support to low income families, is held at the UK Government level [167] .

302. During the inquiry, views were also expressed about the merits of devolving additional social security powers and benefits, and about proposals for a universal basic income. These themes have already been explored elsewhere in this report.

303. The Committee acknowledges that people's experiences of social security systems have been that they are not felt to be compassionate or fair, and have exacerbated feelings of stigma. It considers that these systems could be more supportive, inclusive and informative and draws this to the attention of colleagues on the Social Justice and Social Security Committee when undertaking ongoing scrutiny of social security policy and implementation of devolved benefits in Scotland, and the UK benefits that work alongside them.

304. The Committee has heard evidence that welfare conditionality has resulted in a reduction in the income levels of benefit claimants since 2010. To tackle health inequalities effectively, it calls on the UK Government to address this issue as a priority.

305. The Committee highlights to colleagues in the UK Parliament the evidence gathered by this inquiry related to the UK social security system and, in particular (as currently operated) the impact it is having on efforts to tackle health inequalities in Scotland. The Committee would actively welcome an ongoing open dialogue across Parliaments in the UK and between the Scottish and UK Governments to explore how the future design and funding of social security policy can be delivered in a way that reduces and ultimately eliminates health inequalities.

306. We draw this section of the report to the attention of the UK Minister for Social Security with a request to respond to the relevant recommendations the Committee has made. We would further encourage colleagues on the Social Justice and Social Security Committee to explore the possibility of inviting the UK Minister to give evidence on UK social security policy and would welcome the opportunity for such an evidence session to address the impact of social security policy on health inequalities and action to tackle them.

307. The Committee highlights to the Scottish Government evidence it has received of the adverse impact the implementation of certain devolved social security benefits is currently having on efforts to tackle health inequalities. It calls on the Scottish Government to undertake a review of implementation of the Scottish disability and carers benefits and the carers allowance supplement to ensure there are no adverse impacts with respect to tackling health inequalities affecting claimants. More broadly, the Committee believes future implementation of social security policy in Scotland and at a UK level should be subject to the systematic application of health inequality impact assessments as advocated elsewhere in this report.

Additional factors

308. This inquiry was keen to explore what impacts recent additional factors such as the pandemic and rapidly rising cost-of-living have had on health inequalities and action to address them. Members heard stories of those who, prior to these factors coming into play, were already marginalised and disadvantaged, and are now facing destitution as a result of these additional impacts. The Committee has also heard evidence supporting the critical importance of building resilience to be able to respond effectively to such additional shocks and impacts.

309. During evidence, David Finch of the Health Foundation highlighted:

> The remaining resilience of families would be a concern...those families have already gone through the pandemic, when lower-income households were more likely to build up debt. Those families will now be coming into the cost of living crisis, when lower-income households are likely to face higher inflation rates. The knock-on health impacts of that are a significant concern [168] .

Covid-19 pandemic

310. The Covid-19 pandemic profoundly affected millions of lives globally, both directly in terms of illness and deaths caused by the virus and indirectly through restrictions and changes that affected the way individuals live, work and connect with others, the way systems and services operate and the way countries are governed.

311. The Scottish Government published its Covid recovery strategy in October 2021 [169] . The strategy includes a recognition that the pandemic may have exacerbated health inequalities and acknowledges the effects of the pandemic on income and employment. It makes direct reference to the need to tackle health inequalities, including addressing some of the key upstream drivers of health inequalities such as poverty and making "community involvement and empowerment both in service design and delivery the norm, not the exception [170] ". The strategy's recommendations also include a focus on behavioural approaches in relation to diet and physical exercise, and place-based approaches to tackling health inequalities within communities. It further sets out:

> We will support our health and social care providers to be anchor institutions and to do what they can to reduce socioeconomic inequalities within their local community through their employment, procurement and use of assets [171] .

312. As already set out in this report, the inquiry heard extensive evidence that inequalities in general and health inequalities in particular continued to increase across the population during the years leading up to the pandemic. Professor Sir Michael Marmot noted that the pandemic has "exposed and amplified the underlying inequalities in society [172] ":

> What that means is that the causes of inequality in Covid were very similar to the causes of inequalities in health more generally. Yes, we have to control the virus, but we also have to deal with the inequality [173]

313. There is consensus in all of the evidence considered as part of this inquiry that Covid exacerbated pre-existing societal and health inequalities. In its Covid recovery strategy, the Scottish Government recognise that those facing the most disadvantages in life have been more likely to get seriously ill, more likely to be hospitalised, and more likely to die [174] . Evidence suggests they have also been the hardest hit socially, educationally and economically by the restrictions to control the virus. This is further reflected in the Chief Medical Officer's 2022 annual report:

> Many of those communities that have experienced the worst effects of *COVID-19* are those who were already disadvantaged by inequalities in the wider determinants of health; including income, housing, employment opportunity and wider access to services [175] .

314. This section of the report outlines a range of specific areas where inequalities have been exacerbated during the period of the Covid-19 pandemic. However, the Committee wishes to emphasise that this is by no means exhaustive and cannot reflect the full range of impacts the pandemic has had in worsening health inequalities.

315. Bill Scott highlighted the disproportionate effect of the pandemic on some specific groups which can be considered to already have been some of the most marginalised in society [176] :

> If you were from a black or minority ethnic community, you were significantly more likely to die from Covid...
>
> Analysis by the Office for National Statistics shows that 58 per cent of all Covid deaths were among disabled people, although they make up only about one in five of the population, so you can understand that the risk was way, way higher for those households...
>
> The caring responsibilities that were thrust on to women have also caused significant mental health issues in the population...
>
> From what we have seen, we think that destitution rose by about 50 per cent during the pandemic, which probably means that about 75,000 children went without food on a day during the past year.

316. Dr Ima Jackson drew attention to the pre-existence of systemic racism within society prior to the pandemic, but also argued that the pandemic had served to shine a light on the issue:

> That moment of realisation more publicly and more generally was a key moment in society's understanding of how the processes that we use, the lives that we live and the ways in which we all operate in society have been creating health inequalities that were evidenced throughout the pandemic [177] .

317. The Minister for Public Health, Women's Health and Sport also addressed the issue of systemic racism in her evidence to the Committee:

> In addition, the experience of the pandemic highlighted that members of black and minority ethnic communities were more likely to work in jobs that meant that they were exposed to the virus, more likely to live in housing that meant that the virus spread through their families, and more likely to live in poverty. Those are all systemic issues to which we cannot close our eyes—we have to acknowledge them [178] .

The Minister continued by broadening her focus to other examples of systemic inequalities:

> That does not mean that those issues are easy to tackle. Every society has to focus on ways of tackling the systemic inequalities that have built up over centuries and sometimes—in the case of women—millennia. There is not one society in the world that does not have a challenge with inequality for women. We have to acknowledge how difficult it is to tackle those things, acknowledge that they are there, and have our eyes and minds open to ways to improve the situation [179] .

318. Many organisations provided evidence, both in written submissions and during the informal engagement events, to demonstrate there has been an increase in poverty during the pandemic. Ed Pybus highlighted the difference in experiences of Covid between the most and least deprived:

> Low-income households were far more affected by the pandemic's negative impacts on their finances than high-income households. The pandemic also exacerbated income inequality, which then had the knock-on effect of exacerbating health inequalities...For example, 36 per cent of low income households had to increase their expenditure during the pandemic...whereas 40 per cent of people with the highest incomes decreased their costs [180] .

319. In addition to the effect of the pandemic on education and socialisation, Claire Sweeney suggested children living in poverty will have experienced the worst of the pandemic:

> It is clear that the families who were struggling with income before the pandemic were most badly affected [181] .

320. As previously addressed in this report's examination of those with caring responsibilities , the Committee heard evidence of carers suffering heightened stress and anxiety about being potentially unable to fulfil their caring duties as a result of getting sick with the virus and that the person they were caring for could get ill and potentially die. During the informal engagement events, the Committee also heard evidence that people with disabilities and parents with disabled children faced particular challenges due to their reliance on services delivered in their own homes, which suddenly became no longer available due to Covid restrictions [182] . Bill Scott also noted that "proportionally more disabled people are still self-shielding" [183] and that while the trend towards providing certain services online rather than face-to-face was beneficial to many, this could exclude disabled people in particular from accessing services.

321. The Committee further heard evidence that restrictions imposed by the pandemic

have prevented service provision from addressing existing inequalities and further created a backlog of unmet need in health and social care services. Claire Sweeney told the Committee:

> Beyond that, the pandemic has made it difficult to address inequalities because of the pause in the various services and reduced capacity to pick up on some of the pre-existing challenges [184] .

322. While much of the evidence to the inquiry points to a general consensus that the pandemic had an overall negative impact on inequalities, some written submissions highlighted certain positive impacts, including:

- Innovations in health and social care services to respond to challenges created by the pandemic
- Cases of increased community connections, with people for instance offering support to neighbours who were isolating
- Behavioural and lifestyle changes, such as increased physical exercise.
- Greater awareness of public health messages.

323. Written submissions also offered several examples of good practice observed during the pandemic in mitigating the impact of health inequalities on individuals. These included:

- increased participation in breast screening for people with disabilities through the Breast screening project undertaken by Renfrewshire Disability Resource Centre [185] .
- Distribution of small grants to a range of organisations across South Lanarkshire by VASLan (a local Third Sector Interface) to tackle social isolation [186] .
- Provision of psychological support and access to food and other daily products by the Grampian Humanitarian Assistance Hub [187] .
- NHS Lothian's Integrated Impact Assessment (IIA) of its COVID-19 vaccination programme to identify those most likely to encounter barriers in accessing vaccinations with a view to overcoming those barriers [188] .

324. While taking evidence at its meeting on 31 May 2022, the Committee also heard about the following initiatives to tackle health inequalities that were set up either prior to or during the pandemic [189] :

- BEMIS – Vaccine Information Fund
- Clackmannanshire Council – Community Wealth Building
- Food Standards Scotland – a range of food related initiatives
- South Lanarkshire Council – Adult No One Left Behind

325. Written responses further highlighted a number of national examples of good practice , such as the work of Community Link Workers within GP practices, the Scottish Government's National Vaccine Inclusion Group, NHS Pharmacy First and the provision of early medical abortion at home during the pandemic.

326. Evidence to the Committee highlighted an opportunity to capitalise on increased awareness and interest around health inequalities, and to ensure that there is a continued focus on tackling them in the future. In its submission, Public Health Scotland stated:

> The pandemic has led to an increased awareness of health inequalities and their causes that may provide greater public support for effective action on their causes. Throughout the pandemic, the media covered the disproportionate impact that COVID-19 had on marginalised groups, including individuals in insecure work, those experiencing homelessness, care home residents, disabled people, and ethnic minority communities. This could help public institutions go further in ensuring universal services are provided proportionate to need. Public support has also increased for strong government action to protect the economy, health, and wellbeing [190] .

327. In the context of the pandemic, Claire Sweeney highlighted the importance of working with communities to plan and deliver services to ensure they are suitably catered to their needs. Dr Cawston supported this view while arguing that this had been equally applicable in pre-pandemic times. Ms Sweeney told us:

> One of the strong messages that came out of the Covid pandemic, across a range of areas, was that we need to work more closely with local communities to get such change to happen, so that services are appropriate and tailored and so that people feel that they are engaged and involved in how such services are planned [191] .

328. Other submissions described how the pandemic had brought about the rapid adoption of new approaches and emphasised the importance of ensuring these innovations are not lost in the return to normality following the pandemic. In its submission, Voluntary Health Scotland suggested that such innovations were often facilitated by a relaxation of restrictions by funders and commissioners in response to the pandemic, but noted that this situation was now being reversed again:

> During the pandemic’s lockdowns much of the third and community sector adapted quickly to innovate and support people with a wide range of new and existing needs. In doing so they often benefited from funders and commissioners being more flexible about how grants and contracts could be used. This shows where there’s a will there’s a way for more effective partnership working, more trust and less bureaucracy. We are starting to hear though that those barriers to service delivery have returned and disappointingly funders are removing this flexibility [192] .

As part of the return to pre-pandemic normality, Scottish Care also noted with regret the gradual disappearance of additional protections and supports that had previously been put in place during the course of pandemic:

> In wider society and within statutory and governmental departments we are seeing a creeping return to normal and the winding down of supportive and protective measures [193] .

329. Throughout the inquiry, the Committee heard evidence in support of efforts to return systems and services to pre-pandemic levels to provide the necessary capacity to begin tackling the backlogs created by the pandemic. In oral evidence, Claire Sweeney outlined what Public Health Scotland is doing to enable this to happen:

> In Public Health Scotland, we have introduced a new approach to whole-system modelling so that we work closely with public sector providers to work through the implications of getting systems back up on their feet after Covid [194] .

330. However, many contributors to the inquiry equally recognised that merely returning to pre-pandemic levels of service would be insufficient to tackle health inequalities effectively. While the pandemic contributed to an accelerating increase in inequalities, many pointed out that these had already been increasing pre-pandemic. Obesity Actions Scotland noted:

> Action...needs to be prioritised to tackle health inequalities and to avoid a return to levels of poor pre-pandemic health [195] .

331. Audit Scotland's recent 2022 report into Local Government notes:

> Recovery and renewal are not about returning to the pre-pandemic status quo. The process of recovery and renewal includes directing resources to help ensure that services can restart and are reshaped to meet the new needs of the local area, to address the harm caused by the pandemic, to support economic recovery, to empower communities, to address inequalities, and to tackle key priorities including climate change, growing poverty, and the long-standing need for public service reform [196]

332. While giving evidence to the Committee on 31 May 2022, Ed Pybus and Bill Scott both highlighted the importance of prioritising action to tackle poverty and of reforming economic policy to achieve that goal as part of Covid recovery. Mr Scott noted:

> I do not think that recovery from Covid can be divorced from the economic recovery [197] .

Mr Pybus added:

> In a way, this is not difficult—we know what we need to do. It is just that the whole system needs to work together to lift households out of poverty and break down barriers, and that, in turn, will deal with those health inequalities. I know that it sounds easy [198] .

333. Professor Gerry McCartney raised concerns that economic policies could simply revert to where they were prior to the pandemic and that this would be highly detrimental to tackling health inequalities:

> My worry is that, if we return to the economic policies that we had prior to the pandemic, we cannot expect the improvements to continue—we will go back to the flatlining that we saw from 2012 onwards. We have talked a lot about mortality, but healthy life expectancy has been declining for that period. If we combine mortality experience with people's self-reported health, that has been getting worse since 2012. The worry is that that will continue on that trajectory [199] .

334. The evidence is clear that, while the Covid-19 pandemic has accelerated the increase in health inequalities in Scotland, these were already on a rising trajectory prior to the pandemic. In this context, the Committee has heard significant concerns that a return to "business as usual" in the delivery of public services during Covid recovery risks critically undermining ongoing efforts to tackle health inequalities.

335. The Committee considers reducing health inequalities will be pivotal to the success of recovery and renewal work. As such, it calls on the Scottish Government, in responding to this report, to set out how all aspects of its Covid recovery strategy contribute positively to the goal of reducing and eliminating health inequalities.

336. As set out in its statement of priorities, the Committee commends the Covid-19 Recovery Committee's commitment to "…prioritise its scrutiny on COVID-19 recovery, with a specific focus on health inequalities" [200] . We encourage the Covid-19 Recovery Committee to continue its consideration of health inequalities as part of ongoing scrutiny of delivery of the Scottish Government's Covid recovery strategy. In this context, the Committee further notes with interest the Covid-19 Recovery Committee's forthcoming inquiry on the impact of the pandemic on the Scottish labour market.

Cost of living

337. The recent rapid rise in the cost-of-living has also had a significant impact on health inequalities and has further compounded existing inequalities which were worsened by the pandemic. During the Committee's informal engagement events, we heard evidence that the number of households with outgoings significantly exceeding incomes is increasing rapidly, often resulting in those households having to choose between eating and heating [201] .

338. Professor Sir Michael Marmot noted the differential impacts of increased living costs on low and high income households. In short, by comparison with those not in poverty, the impact on those already living in poverty is substantially greater:

> Then, we have the cost of living crisis. As I am sure that you know well, inflation of 10 per cent has a much bigger impact on households with low incomes than it does on households with higher incomes, because food and energy make up a higher proportion of the expenditure of low-income households. An overall inflation rate of 10 per cent means something like 8 per cent for households in the top decile of earnings and 14 per cent for households in the bottom decile [202] .

339. Gill Bhatti from South Lanarkshire Council told the Committee about work being undertaken locally to support people with health conditions or other circumstances that make finding sustainable employment difficult. She highlighted some of the effects of the higher cost of living on employment:

> The issues are a little exacerbated at the moment, with cost of living concerns compounding precarious employment and some of the pressures around pay [203] .

340. In its blog published following attendance at the Committee's informal engagement events, Voluntary Health Scotland noted the particularly severe impact the increased cost of living is having on individuals with complex conditions and the elderly, as well as the knock-on impact this had on participation in activities that could prevent future ill health:

> The cost of living was a pressing concern throughout all the evidence conveyed to MSPs. We heard that people with MS will face an additional £200 per week on average in bills. People had stopped social and recreational activities due to the associated cost, which reduced their exercise, increased isolation and worsened inequalities. In some cases, people were even stopping treatment and self-management. There were significant concerns pensioners were being pushed into fuel poverty and suggestions we should be increasing benefits rates and expanding the eligibility criteria [204] .

341. Aside from the immediate impacts of increased poverty on health outcomes, Bill Scott argued that the increased cost of living was also likely to impact negatively on the health and wellbeing of future generations:

> The cost of living crisis will make things significantly worse for a larger proportion of households. Unless we address that properly, we will live with its consequences in the impact on physical and mental health for a further generation [205] .

342. Professor Gerry McCartney raised concerns that the increased cost-of-living risked increasing mortality rates in the poorest communities and made the case for a more preventative and protective approach to economic policy to avert this:

> It is ultimately a question about priorities. If the inflation in the cost of living that people are facing is not addressed by policy, it will have massive consequences for the real experience of poverty and, as a result, it will have real consequences for people's health. The trends that David Walsh has described in such detail around rising mortality for our poorest communities will get worse, and they will get worse faster, if those challenges are not addressed properly [206] .

343. Claire Sweeney spoke about Public Health Scotland's work tracking various existing or potential measures to tackle the impact of the rising cost of living on health outcomes. In so doing, she highlighted a number of policy areas that have already been addressed in detail elsewhere in this report:

> Some that spring to mind are measures on fair work, employment, the consequences of the crisis for people's health, access to food banks and issues to do with the impact on education. The impact is multifaceted and, with a range of agencies, we are tracking it across many different measures across Scotland. A lot can be done by harnessing the power of the public spend that is available in Scotland [207] .

344. The Minister for Public Health, Women's Health and Sport set out actions being taken by the Scottish Government to mitigate the impact of the increased cost-of-living on households. The Minister outlined the level of the Scottish Government's commitment to action in this area:

> The cost of living crisis is impacting on every household in the UK, and the Scottish Government will continue to do everything in its power, within its fixed budget, to ensure that people, communities and businesses are supported as much as possible [208] .

345. At the same time, the Minister highlighted particular challenges with targeting support towards those individuals and households most in need, using the example of the cost-of-living payment:

> The Scottish Government is frustrated, because as a result of the pandemic it has discovered that there are not always easy mechanisms in place to get money into people's hands. I am sure that the Government will reflect on that. The mechanisms will improve with the growth of the social security system, but it is not always easy for us to identify the individuals who need the most help and get the money to them. Kate Forbes was very frank about the compromise to be made in getting the money to the people who needed it most and fast while knowing that some people who got it would not need it [209] .

346. The Minister went on to express her support for the concept of "proportionate universalism" to be applied in taking action to tackle health inequalities:

> I agree with Professor Marmot's position that action to reduce health inequalities must be proportionate, with more intensive action lower down the social gradient. However, action also has to be universal to raise and flatten the whole gradient [210] .

347. The Committee has been particularly concerned to hear evidence of the proportionately greater negative impact the rising cost of living is having on those groups already experiencing health inequalities, including those already living in poverty and those with a disability. The Committee concludes that, without concerted and appropriately targeted action to address this at UK, Scottish and local Government levels, the sharply rising cost of living is likely to contribute to a further acceleration in rising health inequalities, the impact of which will continue to be felt by generations to come.

348. The Committee highlights evidence that there is a role for all levels of government to play in addressing the negative societal impact of the rapidly rising cost of living. In this context, it concludes that a key criterion for measuring the success or otherwise of any and all government action to address the rising cost of living must be its impact in reducing health inequalities. It therefore calls on the Scottish Government, in responding to this report, to set out how it will ensure that any action on cost of living it is taking, now or in the future, contributes positively to the goal of reducing and eliminating health inequalities.

349. Similarly, the Committee calls on the UK Government to take urgent action to mitigate the effects of the increased cost of living and rising energy costs and to reduce health inequalities by making energy and life more affordable for all.

350. The Committee also wishes to draw the attention of its colleagues on the Economy and Fair Work Committee to the findings and recommendations contained in this section of the report and to encourage that Committee to have these in mind in undertaking ongoing scrutiny of the Scottish Government regarding its response to the rising cost of living.

Future scrutiny and action

351. The agreed aim of this inquiry was to explore opportunities to reduce health inequalities and increase preventative work to tackle inequalities at source, before they impact on individuals' health and wellbeing outcomes.

352. The evidence explored in this inquiry adds further weight to the conclusion that a preventative approach is needed to tackle health inequalities effectively. Professor Sir Michael Marmot stressed his view that what happens across the whole Government is key to improving public health and tackling health inequalities [211] . He argues that no single policy measure can be identified that would address health inequalities. Instead, he argued that every Minister should be a health Minister and it is necessary to "put equity in health and wellbeing at the heart of all policy making [212] ".

353. Giving strength to this argument, the Committee has heard a range of evidence, explored within this report, that policy-makers operating across a wide spectrum of different policy areas need to place a specific emphasis on tackling inequalities in policy development and implementation. These areas include, for example, housing, town planning, communities, transport, social security, employment rights, social justice, and education.

354. The Committee considers that policy action to date has been insufficient to address health inequalities and therefore concludes that additional action is urgently needed across all levels of Government to resolve this.

355. The Committee has heard strong evidence to support its view that coordinated and preventative action is needed across different levels of government and a broad range of different policy areas to tackle health inequalities effectively. Responsibility for taking action will variously fall within the remits of local communities and local government, the Scottish Government and the UK Government. Parliaments and elected politicians at all levels equally have a responsibility to ensure tackling health inequalities continues to be a focus for preventative policy action and to scrutinise the impact and effectiveness of this action.

356. The Committee calls on the Scottish Government to consider the development of a tool kit that will enable policy-makers at all levels of government, quickly and easily, to audit all relevant policies within their respective remits to determine their impact on health inequalities. The Committee further calls on the Scottish Government to commission the development of best practice guidance, supported by further research, to help policy-makers maximise the positive impact and mitigate any unintended negative impact any existing and future policy decisions may have on tackling health inequalities.

Cross-committee scrutiny

357. The Committee has sought to take a collaborative approach to this inquiry in an effort to achieve cross-portfolio scrutiny of health inequalities and to develop

recommendations spanning multiple areas of policy.

358. With this objective in mind, the following committees were consulted on the design of the inquiry:

- COVID-19 Recovery Committee
- Economy and Fair Work Committee
- Equalities, Human Rights and Civil Justice Committee
- Local Government, Housing and Planning Committee
- Social Justice and Social Security Committee

359. Maggie Chapman MSP, Pam Duncan-Glancy MSP and Alexander Stewart MSP from the Equalities, Human Rights and Civil Justice Committee participated in informal engagement events hosted by the Health, Social Care and Sport Committee on 23 May 2022. The Committee formally acknowledges and welcomes these Members' contributions to the inquiry.

360. The Committee acknowledges that pressure of work faced by other committees meant that greater cross-committee collaboration was not possible as part of this inquiry. However, it hopes to work with committees across the Parliament in the future to ensure there is a genuine cross-committee approach to scrutinising work to tackle health inequalities and the broader societal inequalities underlying them. This report highlights a number of areas across committee remits where future consideration could be beneficial to informing and improving public policy.

361. The Committee draws this report to the attention of all Scottish Parliament committees and encourages colleagues across the Parliament to be cognisant of the need to maintain a focus in future scrutiny work, wherever relevant, on tackling health inequalities and the societal inequalities that underly them.

362. Given the overarching imperative to ensure all public policy contributes to improved health and wellbeing, the Committee would advocate a 'health in all areas approach' to future Scottish Parliament scrutiny and draws this to the attention of the Scottish Parliament Bureau and Conveners' Group. The Committee believes its recommendation in favour of the Scottish Government developing a health inequalities audit tool kit and best practice guidance for policy-makers would be helpful to Scottish Parliament committees in undertaking ongoing scrutiny of progress in tackling health inequalities over the course of this session and beyond.

Cross-portfolio collaboration

363. To achieve effective cross-portfolio collaboration in identifying future actions to tackle health inequalities, the Committee's original intention had been to invite Ministers from across several different portfolios to give evidence to the inquiry in the form of a collaborative roundtable discussion. The Committee felt this would

have reflected the reality that the underlying causes of health inequalities cut across a broad range of policy areas spanning the remits of many different Ministers and Scottish Government departments and therefore require a cross-cutting policy response in order to be effective.

364. In the end, the Minister for Public Health, Women's Health and Sport was the only Minister to attend the Ministerial session on the 28 June 2022, on the understanding that she would be giving evidence to the inquiry on behalf of the Scottish Government as a whole. During the session, the Minister set out her view that:

> ...the Parliament needs to be a public health Parliament in which all parties come together to consider how we work jointly to tackle issues ...we all have a collective responsibility to address health inequalities—it is not the sole responsibility of health and social care...We recognise that addressing the wider determinants of health such as poverty and inequality requires cross Government working and partner-led action. The answers to health inequality do not lie simply in my public health portfolio [213] .

365. During the same session the Minister also acknowledged a general tendency towards silo working across all spheres of life but equally highlighted the Scottish Government's collective commitment to recognising the benefits of working together and collaboratively across policy portfolios:

> A role of the Deputy First Minister—and something that is a really key part of our Covid recovery—is to try to bust silos right across Government. It is almost a human norm that we create these silos in our work, but the Deputy First Minister's role across Government is to bust them by regularly bringing groups of ministers together and ensuring that we are all aware of each other's work, that it is all aligned and that we are getting the maximum impact from across Government in tackling the really thorny issues that Scotland faces [214] .

366. The Committee welcomes the commitment demonstrated by the Minister for Public Health, Women's Health and Sport to tackling health inequalities and her contribution to the Committee's inquiry. At the same time, given the Minister's emphasis on the importance of breaking down silos, the Committee regrets that the Scottish Government declined the opportunity, as part of the inquiry, for relevant Ministers to participate in a cross-portfolio roundtable discussion to explore potentially successful preventative strategies for tackling health inequalities. We would actively welcome the opportunity to engage with the Scottish Government on this basis in the future.

Localities and communities

367. Scotland's local authorities are currently responsible for a range of public services, including education, social care, roads and transport, some aspects of economic development, housing and planning, environmental protection, waste management, cultural and leisure services [215] .

368. During the inquiry, a range of witnesses drew attention to the important role of local

authorities in mitigating the effects of some of the underlying causes of health inequalities. There was agreement that, by focusing on delivery of the following, local authorities could improve health outcomes by addressing some of the underlying causes of health inequalities:

- high quality affordable housing;
- accessible and affordable public transport;
- improved town planning, including access to green space, communal space and public services;
- improved mechanisms for planning considerations, including ensuring health is a priority in planning applications, licensing and permits;
- investing in wellbeing communities, including increasing social capital and participation, and protecting and promoting community assets.

369. The Committee heard evidence of a range of policies and initiatives exercised at a local authority level which have helped to improve life chances and community health and resilience, while also tackling health inequalities. In a letter to the Committee after giving formal evidence, the Minister for Public Health, Women's Health and Sport outlined some examples, including Chance to Change, MECOPP's Community Health Matters Programme, and the Place and Wellbeing Programme [216] .

370. Professor Sir Michael Marmot highlighted a discrepancy between the positive rhetoric in Scotland about tackling health inequalities and the reality that rates of health inequality in Scotland remain worse than in England. He concluded:

> If you have the right policies, have they just not been applied deeply enough and for long enough, or are there other things that need to be addressed? [217]

371. The Committee also heard evidence during the inquiry that local authority financing and accountability structures can act as barriers to addressing health inequalities.

372. In its recent report examining local authority financing, Audit Scotland found that while there was a significant increase in council funding during the pandemic, core local government funding is lower in real terms in 2022-23 than it was in 2017-18, and there has been an underlying reduction of 4.2 per cent since 2013-14 [218] . The report also found that national priorities are placing additional constraints on councils seeking to prioritise spending on their own local priorities:

> With increasing amounts of money ring-fenced to meet Scottish Government priorities, it means councils must focus on specific policy areas, rather than the urgent, local priorities they have identified. And while councils have rightly shifted their focus to address the immediate impacts of Covid-19, plans to transform services have slowed [219] .

373. In her evidence to the Committee, Professor Petra Meier argued that there was a need for better coordination of policy action across local authorities to maximise its positive impact and avoid wastage and duplication of effort:

> ...the system also introduces a lot of variation and repetition in relation to learning and trying out the same things. Unless there is a really strong evaluation framework and people have the time to do evaluation, a lot of redundancy and extra costs are introduced. Cities and local areas are the way forward, but we need to work in a more systematic way that involves thinking about what we are trying to achieve and trying out the things that everybody can agree on, rather than letting everybody go their own way [220] .

374. During our informal engagement events, many participants emphasised the importance of engaging with local communities to design and deliver public services in a way that reflects their needs and preferences [221] . Dr Cawston highlighted the positive difference community assets can make to individual and community wellbeing but that decreasing budgets, ring-fencing and the extra cost of innovation has undermined their positive impact. Professor Meier argued that attitudes to investment in public services need to change if health and wellbeing outcomes are to be improved:

> We need to ensure that we see public sector investment not as a burden that needs to be minimised, but as an investment that can be optimised to deliver health, wellbeing and sustainability outcomes.

375. While welcoming local innovation, Professor Meier warned that a lack of overall coordination could lead to large discrepancies in the level of effort and resource invested in tackling health inequalities across the country which might ultimately exacerbate inequality:

> Some local authorities have five officers working on economic strategy development and so on, and others have just one person working part time on that. New inequalities are introduced when some areas have larger resources to do evaluation, put in funding bids and so on. In relation to health in place and localism, we need to be careful that we do not make things worse instead of better by having an overarching strategy at the Scottish Government level. I see a lot of really good ideas, with many areas trying out innovative things, but I am a bit worried that that is not well co-ordinated, which can lead to different experiences for people in different areas.

376. Bill Scott argued there is "a need to ensure that every public pound that is spent is, as far as possible, spent on reducing poverty and inequality" [222] . Building on this point, Claire Sweeney highlighted a lack of accountability when it comes to ensuring public services have a specific focus on tackling inequality:

> We hold public bodies to account for financial and access targets, but we do not hold public leaders to account as strongly for reducing inequality. That is something really clear and tangible that could be done. We would like budgets and spend across Scotland to be more closely aligned to impact, which exactly speaks to the point about reducing inequality and child poverty, in particular [223] .

377. The Committee is concerned by evidence that, despite strong rhetoric in support of action to tackle them, the level of health inequalities in Scotland remains higher

than in England.

378. The Committee recognises the benefit of giving local government the autonomy to innovate and to explore new ways of tackling health inequalities. However it also notes evidence as part of the inquiry which suggests a lack of strategic coordination could exacerbate inequality in some instances. We draw this evidence to the attention of colleagues on the Local Government, Housing and Planning Committee.

Scottish Government strategy and action

379. Evidence submitted to this inquiry demonstrates an overwhelming consensus that action to eradicate poverty must be the first priority in tackling health inequalities effectively. Claire Sweeney summed up the sentiment, noting that while there are a wide range of other measures that can mitigate inequalities and support individuals and communities, "giving people more money is absolutely the biggest thing that can be done—for sure, there are reams of public health evidence that say that [224] ."

380. As explored earlier in this report, contributors to the inquiry have suggested various actions to give individuals and families a sustainable source of income. These have included improving employment legislation to ensure workers are adequately supported, ensuring there is a fair, compassionate system of social security that supports, protects and promotes health, and exploring concepts such as a universal basic income, minimum income guarantees or increasing the National Living Wage. The Committee notes that some of the powers to affect change in these areas are reserved while others are devolved.

381. Giving evidence to the inquiry on 28 June, the Minister for Public Health, Women's Health and Sport argued:

> Where potential levers for tackling poverty are reserved, we will continue to put pressure on the UK Government to rethink its social and welfare policies, for example, which absolutely help poverty to persist. We are introducing extra social security programmes that are well beyond anything that the UK Government offers. We know that we have a lot still to do to tackle the determinants of health where we have control of the levers, and we are making progress in a lot of areas.

382. As already outlined, a key focus of the inquiry has been to explore actions the Scottish Government can specifically take to reduce health inequalities and improve health and wellbeing outcomes. While support has been expressed for actions to tackle poverty by boosting the income of those living in poverty and the reform of newly devolved benefits being proposed through Social Security Scotland, evidence has equally highlighted the lack of an overarching strategy for tackling poverty in Scotland as a potential obstacle to progress. Dr David Walsh acknowledged there have been "...big programmes designed to address health inequalities" in Scotland, such as Equally Well, but argued these have been relatively short term in nature and, as a result,"...will not have the necessary traction to make the difference that we know needs to be made [225] ".

383. Giving evidence to the Committee, Claire Stevens argued that, to tackle health inequalities effectively, the voluntary sector would like to see:

> "above all, a cross-Government strategy that is centred on ending poverty [226] ."

384. The Minister set out a range of actions and policy commitments to address health, and wider, inequalities in Scotland, and expressed her view that the goal of tackling health inequalities should run consistently through all areas of public policy:

> I always think of tackling health inequalities as being a golden thread that should run through all our work in the public sector.

385. The inquiry received evidence in support of an overarching strategy to guide collaboration across Scottish Government portfolios to ensure that all policy areas play a role in tackling health inequalities . The Royal Society of Edinburgh submitted:

> A clear strategy should be generated and applied across governmental sectors that have the remit to address the varied factors that result in health inequalities. The strategy should include mutually supportive goals and a monitoring process to evaluate progress. A line of accountability should be established with the Cabinet being responsible for its efforts in reducing health inequalities. The fundamental determinants of health inequalities are social inequalities, so every Cabinet member and their department has a role. Local authorities should also be accountable for their joint efforts. A clear strategy and line of accountability will help bolster awareness of health inequalities across government and deliver more coherent and consistent outcomes [227] .

386. Giving evidence to the Finance and Public Administration Committee on the National Performance Framework on 31 May 2022, the Deputy First Minister and Cabinet Secretary for Covid Recovery outlined how cross-governmental collaboration had contributed to the formulation of the child poverty delivery plan:

> Behind that process was an extensive amount of cross-governmental dialogue, which I chaired, to ensure that the plan would get cross-government intervention and support. What came out of that dialogue was a collection of measures that addressed not only direct financial support to families, but employability support and wider holistic support, drawing on aspects of transport, childcare, early intervention, mental wellbeing and counselling for people who are economically inactive. As a result, the plan was much broader. A lot of cross-ministerial dialogue was involved to get to that point—probably more than should be needed, but it was necessary in order to get across all those compartments. What we produced was a much broader and much more relevant intervention, which was much closer to the aspirations of the national performance framework than it would have been if we had just left the work to the compartment within Government that formally deals with poverty, which is Shona Robison's responsibility [228] .

387. The Deputy First Minister also underlined his commitment to working on a cross-ministerial basis:

> If we are going to tackle poverty, we need to work on education, health, transport and employability—it will not take place in a neat little compartment. I explained to the committee the focus on the big themes of eradicating child poverty, economic recovery from Covid and net zero. Those big issues are all tackled on a cross-ministerial basis to give us some chance of ensuring that our interventions are commensurate with the scale of the challenge [229] .

388. It is notable that the priority aims identified in the foreword to the Scottish Government's Covid Recovery Strategy align quite closely with the priorities for future action to tackle health inequalities identified by this inquiry, namely:

> 1. Address the systemic inequalities made worse by Covid
>
> 2. Make progress towards a wellbeing economy
>
> 3. Accelerate inclusive person-centred public service [230]

389. The Committee notes there is no overarching strategy for tackling health inequalities in Scotland at the current time. However, the Committee believes there needs to be an overarching strategy or set of principles to guide policy-making and foster active collaboration across portfolios to ensure all relevant policy areas and all levels of Government are contributing positively towards tackling health inequalities. The Committee invites the Scottish Government to consider how this might best be achieved and, in responding to this report, to set out what steps it intends to take to improve cross-government and cross-sectoral efforts to tackle health inequalities.

390. As is already implied by the priority objectives the Scottish Government has set for Covid recovery, the Committee believes reducing health inequalities must be a core outcome of the Covid Recovery Strategy published in October 2021. The Committee intends to undertake continued scrutiny and evaluation of the Strategy's implementation with a view to evaluating its performance against that specific outcome. We would equally draw this to the attention of colleagues on the Covid-19 Recovery Committee to consider this as a core element of their ongoing scrutiny of the Strategy and would welcome the opportunity to undertake further joint scrutiny in this area in future years of this session.

391. Given the combination of reserved and devolved policy responsibilities reflected in this report, the Committee calls on the Scottish Government to provide the Committee with regular updates on progress in tackling health inequalities, and refers this report to the UK Government and the Scottish Affairs Select Committee at Westminster.

Annex A - Call for views summary

392. A summary of the responses submitted to the Committee's call for views is available online.

Annexe B - informal engagement events summary

The Committee undertook a series of informal engagement sessions on 20 and 23 May 2022 to help understand people's experiences in relation to health inequalities. A summary of these events is available online.

Annexe C - Minutes of meeting

19th Meeting, 2022 (Session 6) Tuesday, 24 May, 2022

Inquiry on health inequalities:

The Committee took evidence from—

- David Finch, Assistant Director, Healthy Lives Directorate, The Health Foundation
- Gerry McCartney, Professor of Wellbeing Economy, University of Glasgow
- Claire Stevens, Chief Executive, Voluntary Health Scotland
- David Walsh, Public Health Programme Manager, Glasgow Centre for Population Health

20th Meeting, 2022 (Session 6) Tuesday, 31 May, 2022

Inquiry on health inequalities:

The Committee took evidence from—

- Dr Ima Jackson, Scottish Migrant Ethnic Health Research Strategy (SMEHRS) Group
- Ed Pybus, Policy and Parliamentary Officer, Child Poverty Action Group in Scotland
- Bill Scott, Chair, Poverty and Inequality Commission
- Claire Sweeney, Director of Place and Wellbeing, Public Health Scotland

And then from—

- Gill Bhatti, Employee and Diversity Manager, South Lanarkshire Council
- Danny Boyle, BEMIS Scotland Senior Parliamentary and Policy Officer and National Coordinator of the EMNRN, BEMIS and Ethnic Minority National Resilience Network
- Emma Fyvie, Senior Manager (Development), Clackmannanshire Council
- Dr Gillian Purdon, Head of Nutrition, Science and Policy, Food Standards Scotland

22nd Meeting, 2022 (Session 6) Tuesday, 14 June, 2022

Inquiry on health inequalities:

The Committee took evidence from—

- Toni Groundwater, Head of External Engagement, Families Outside
- Karen Lewis, Manager, The Hub, Dumfries and Galloway
- Richard Meade, Director, Carers Scotland
- Dr Sharon Wright, Professor, University of Glasgow

23rd Meeting, 2022 (Session 6) Tuesday, 21 June, 2022

Inquiry on health inequalities:

The Committee took evidence from—

- Dr Peter Cawston, GP Principal, GPs at the Deep End
- Professor Sir Michael Marmot, Professor of Epidemiology, University College London
- Dr Shari McDaid, Head of Evidence and Impact (Scotland and Northern Ireland), Mental Health Foundation
- Professor Petra Meier, Director, UKPRP-funded SIPHER Consortium

24th Meeting, 2022 (Session 6) Tuesday, 28 June, 2022

Inquiry on health inequalities:

The Committee took evidence from—

- Maree Todd MSP, Minister for Public Health, Women's Health and Sport
- Michael Kellet, Director, Population Health, Scottish Government

Annexe D- Evidence

Written evidence

- Responses submitted to the Committee's call for views.

Official reports of meetings

- Tuesday 24 May 2022
- Tuesday 31 May 2022
- Tuesday 14 June 2022
- Tuesday 21 June 2022
- Tuesday 28 June 2022 - evidence from the Scottish Government

1 Scottish Attainment Challenge; Education, Children and Young People Committee report

2 Research Briefing: Public Health (Wales) Act 2017

3 Statement on committee priorities: Covid-19 Recovery Committee

4 Health, Social Care and Sport Committee, Official Report 24 May 2022

5 Health, Social Care and Sport Committee, Official Report 21 June 2022

6 What are health inequalities? - Health inequalities - Public Health Scotland

7 Health and Sport Committee Report on Health Inequalities, 2015

8 Health and Sport Committee Report on Health Inequalities, 2015

9 Scottish Government Response: Health Inequalities

10 Preventative Action and Public Health (parliament.scot)

11 Health inequality and COVID-19 in Scotland: SPICe briefing

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13 Scottish Executive. (1999). *Towards a Healthier Scotland.* Cm 4269 (Edinburgh: The Stationery Office).

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15 Health, Social Care and Sport Committee, Official Report 24 May 2022

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19 Anonymised summary of informal engagement sessions, Scottish Parliament

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21 Health, Social Care and Sport Committee, Official Report 24 May 2022

22 Response 8356358 to Inquiry into health inequalities - Scottish Parliament - Citizen Space

23 Health inequalities: What are they? How do we reduce them? Inequality briefing Housing and health, NHS Health Scotland

24 WHO Housing and Health Guidelines

25 Health, Social Care and Sport Committee, Official Report 14 June 2022

26 Summary of informal engagement events, Health Social Care and Sport Committee

27 Response 343758459 to Inquiry into health inequalities - Scottish Parliament - Citizen Space

28 Response 343758459 to Inquiry into health inequalities - Scottish Parliament - Citizen Space

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31 Health, Social Care and Sport Committee, Official Report 14 June 2022

32 Blog: Influencing the health inequalities inquiry, Voluntary Health Scotland

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34 Health, Social Care and Sport Committee, Official Report 14 June 2022

35 Impact of social and physical environments - Health inequalities - Public Health Scotland

36 Scotland's Wellbeing – Delivering the National Outcomes, Scottish Government

37 Summary of informal engagement events, Health Social Care and Sport Committee

38 Summary of informal engagement events, Health Social Care and Sport Committee

39 Letter from the Convener, Health, Social Care and Sport Committee to the Convener, Local Government, Housing and Planning Committee, 24 February 2022

40 The Zubairi Report, Voluntary Health Scotland, 2018

41 The Zubairi Report, Voluntary Health Scotland, 2018

42 Health, Social Care and Sport Committee, Official Report 31 May 2022

43 Response 189775152 to Inquiry into health inequalities - Scottish Parliament - Citizen Space

44 Health, Social Care and Sport Committee, Official Report 21 June 2022

45 Health, Social Care and Sport Committee, Official Report 21 June 2022

46 Health, Social Care and Sport Committee, Official Report 21 June 2022

47 Health, Social Care and Sport Committee, Official Report 24 May 2022

48 Health, Social Care and Sport Committee, Official Report 24 May 2022

49 Health, Social Care and Sport Committee, Official Report 28 June 2022

50 Education - ScotPHO

51 Health and Sport Committee Report on Health Inequalities, 2015

52 Health, Social Care and Sport Committee, Official Report 18 January 2022

53 Health, Social Care and Sport Committee, Official Report 24 May 2022

54 Formal response to the Committee's report from the Minister for Mental Wellbeing and Social Care and Minister for Children and Young People, 6 July 2022

55 Formal response to the Committee's report from the Minister for Mental Wellbeing and Social Care and Minister for Children and Young People, 6 July 2022

56 Health, Social Care and Sport Committee, Official Report 28 June 2022

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59 Scottish Attainment Challenge; Education, Children and Young People Committee report

60 Health and work strategy: review report - gov.scot

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81 Health and social care integration: Update on progress (audit-scotland.gov.uk)

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