

“

scotland's health is improving rapidly but it is not improving fast enough for the poorest sections of our society. Health inequalities ... remain our major challenge.

”

equally
well

report of the ministerial task force on health inequalities



The Scottish
Government

“

scotland's health is improving rapidly but it is not improving fast enough for the poorest sections of our society. Health inequalities ... remain our major challenge.

”

equally well

report of the ministerial task force on health inequalities

© Crown copyright 2008

ISBN: 978-0-7559-5760-6

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

Produced for the Scottish Government by RR Donnelley B56023 06/08

Published by the Scottish Government, June 2008

Further copies are available from
Blackwell's Bookshop
53 South Bridge
Edinburgh
EH1 1YS

The text pages of this document are printed on recycled paper and are 100% recyclable

CONTENTS

Foreword – First Minister	v
Preface – Scottish Government and COSLA	vi
Executive Summary	1
Introduction	9
The challenge facing the Task Force	9
Key health inequalities	10
What causes health inequalities?	11
The Task Force’s approach	12
Communication and engagement	15
The Task Force’s principles and priorities	15
Action and Recommendations	17
Smarter Scotland: Early years and young people	18
Wealthier and Fairer Scotland: Tackling poverty and increasing employment	23
Greener Scotland: Physical environments and transport	27
Safer and Stronger Scotland: Harms to health and wellbeing: alcohol, drugs and violence	30
Healthier Scotland: Health and wellbeing	35
Delivering Change	43
Public services and client pathways: a step change	43
Workforce	46
Resources	47
Third Sector contribution	50
What will success look like?	51
Limitations of current devolved powers	55
Reviewing progress	56
Annex 1 Key health inequalities in Scotland	57
Annex 2 Previous reviews and reports on health inequalities	63
Annex 3 Illustrative assessment of inequalities in premature mortality from coronary heart disease	65
Annex 4 Recommendations	68

FOREWORD

In Scotland, we can point to good progress in the quality of our health care and in major indications of health outcomes, notably record survival rates from the major “killer diseases” such as cancer, heart disease and strokes. But this progress is not being experienced by everyone yet.

Tackling health inequalities is a matter of social justice. It’s unacceptable in 21st century Scotland that some people can expect to die earlier than others, simply due to an accident of birth or circumstances. For that reason alone, the work of the Task Force, as outlined in this report, is worthwhile. Indeed, it is imperative.

But it goes further than that. Reducing health inequalities is vital to achieving the Scottish Government’s overall purpose: sustainable economic growth. If Scotland is to live up to its potential in terms of economic success, healthy life expectancy must increase – particularly among those whose lives are currently cut short due to deprivation or other inequalities.

I am delighted to see that the Task Force has brought Government Ministers and local government together, with the NHS, Third Sector and research community, to tackle some of these most stubborn of Scotland’s health problems. There has been a great willingness to explore the evidence, think creatively about the action and come up with practical recommendations that all concerned can start to implement now.

The Scottish Government is ready to play our part. I commend this report to every organisation and individual with a contribution to make. We look forward to working with you, towards clear goals and aspirations that will help to make Scotland “Equally Well”.



A handwritten signature in black ink, which appears to read "Alex Salmond". The signature is fluid and cursive.

The Rt Hon Alex Salmond MSP MP
First Minister of Scotland

PREFACE

We are delighted to present the report of the Ministerial Task Force on health inequalities, which is ambitious in scope and based on the principle of opportunity for all. Recommendations are based on the latest international evidence and will put Scotland in the vanguard of countries grappling with these difficult issues. Scotland does face huge challenges, but these can be overcome if we work together.

The Task Force has taken on board the new approach of the Scottish Government to developing policy, which is to unite Ministerial portfolios to address the underlying causes of health inequalities. The Task Force also reflects well on the new relationship between the Scottish Government and local government: COSLA has been fully involved in the development of the report and had given its full commitment to delivering on this agenda.

The report brings together thinking on poverty, lack of employment, children's lives and support for families and physical and social environments, as well as on health and wellbeing. It makes clear that we will not only respond to the consequences of health inequalities, but also tackle its causes. The Task Force recognises that success will be a long-term achievement but that short-term gains can still be made.

Delivering on the Task Force's recommendations will depend on strong joint working between the NHS, local government, the Third Sector and others within community planning partnerships. It is vital that we harness the power and expertise of those delivering services to our most vulnerable citizens.



A handwritten signature in black ink that reads "Shona Robison".

Shona Robison MSP
Minister for Public Health



A handwritten signature in black ink that reads "Ronnie McColl".

Councillor Ronnie McColl
COSLA spokesperson on Health and Wellbeing

EXECUTIVE SUMMARY

KEY POINTS

- Health inequalities remain a significant challenge in Scotland.
- The poorest in our society die earlier and have higher rates of disease, including mental illness.
- Healthy life expectancy needs to be increased across the board to achieve the Scottish Government's overall purpose of sustainable economic growth.
- Tackling health inequalities requires action from national and local government and from other agencies including the NHS, schools, employers and Third Sector.
- Priority areas are children, particularly in the early years, "killer diseases" such as heart disease, mental health and the harm caused by drugs, alcohol and violence.
- Radical cross-cutting action is needed to address Scotland's health gap to benefit its citizens, communities and the country as a whole.

Scotland's health is improving. But there are big differences between rich and poor. In 2006, men could on average expect 67.9 years of healthy life and women 69 years. In the most deprived 15% of areas in Scotland, though, men could only expect 57.3 years of healthy life and women 59 years.

More babies born to mothers living in the most deprived fifth of areas have a low birth weight than those born to mothers living in the most affluent areas: 9% compared to 5%.

People struggling with poverty and low income have poorer mental health and wellbeing than those with higher incomes or who find it easy to manage financially.

There are large and increasing inequalities in deaths amongst young adults due to drugs, alcohol, violence and suicide.

These are just a few examples; there are many others detailed throughout this report.

The Scottish Government believes this situation is unacceptable. And what's more, it's bad for Scotland. That's why the Ministerial Task Force on health inequalities was set up to tackle the inequalities in health that will otherwise prevent Scotland from achieving the Government's overall purpose of sustainable economic growth, supported by increased healthy life expectancy.

Difference in income is not the only factor to blame for inequalities. Health may also vary according to people's age, disability, gender, race, religion or belief, sexual orientation and other individual factors. These interact with socioeconomic status and low income. While the Task Force has been primarily interested in health inequalities that result from socioeconomic circumstances, we have also considered how health and other public services respond to this range of complex factors which affect people's health.

Scientific evidence now helps explain how deprivation and other forms of chronic stress lead to poor health. Children's earliest experiences shape how their brains develop. Very young children need secure and consistent relationships with other people, or else they will not thrive, learn and adapt to their surroundings. People's responses to external stress cause premature ageing and increase risks of dying from the big killer diseases, and of dying early.

There is international agreement that reducing unfair and unjust inequalities in health needs a cross-government approach. It cannot be achieved through health policies and health care systems alone.

The Task Force's new and ambitious approach has been to take our emerging understanding of the underlying causes of health inequalities and turn it into practical and linked action across all of national and local government's key responsibilities: for making Scotland Smarter, Wealthier and Fairer, Greener, Safer and Stronger and, ultimately, Healthier.

The Ministerial members of the Task Force come from right across Government. We have worked together in a new way, in line with the Government's unified approach to its overall purpose of sustainable economic growth. Local government, NHSScotland, the Third (voluntary) Sector and the research community have also participated actively in the Task Force's work. This, too, represents a new approach in which local government and others are equal partners in developing national policy and agreeing how that can be delivered in practice.

Importantly, we have also looked at what's already happening in Scotland. There are many good services which, if rolled out across Scotland, could make a real difference.

The Task Force has discussed its thinking with a range of frontline staff and managers, a wide Third Sector audience, young people and members of the police, the business community, local authorities and NHSScotland.

Much of the change the Task Force recommends can only be generated locally, through the people in public services who work to meet their clients' needs day in and day out. They are critical in determining client pathways or routes into, through, between and eventually out of public services. The Task Force recommends how to support improvements that come from the direct experience of local staff.

- **The Government should provide resources to test and promote the Task Force's approach to redesigning and refocusing public services through health inequalities learning networks. These will operate initially through a small number of test sites within community planning partnerships. Resources will be required to apply continuous improvement techniques locally, as well as to bring together all the evidence available to inform good practice, track progress and spread learning in order to influence change in public services more widely.**

In order to reduce inequalities in healthy life expectancy and wellbeing generally, the Task Force has identified priorities where action is most needed:

- Children's very early years, where inequalities may first arise and influence the rest of people's lives.
- The high economic, social and health burden imposed by mental illness, and the corresponding requirement to improve mental wellbeing.

- The “big killer” diseases: cardiovascular disease and cancer. Some risk factors for these, such as smoking, are strongly linked to deprivation.
- Drug and alcohol problems and links to violence that affect younger men in particular and where inequalities are widening.

In the light of these priorities, and evidence about what causes inequalities in health, the Task Force has agreed key principles to drive our work. These include:

- Improving the whole range of circumstances and environments that offer opportunities to improve people’s life circumstances and hence their health.
- Addressing the inter-generational factors that risk perpetuating Scotland’s health inequalities from parent to child, particularly by supporting the best possible start in life for all children in Scotland.
- Engaging individuals, families and communities most at risk of poor health in services and decisions relevant to their health.
- Delivering health and other public services that are universal, but also targeted and tailored to meet the needs of those most at risk of poor health. We need to prevent problems arising in the future, as well as addressing them if they do.

The Task Force has reviewed what is known about effective action to reduce health inequalities and has assessed what’s already happening in Scotland in the light of this evidence. Our recommendations for action run across Government and local services and that is what makes them new and different.

There is already a lot of good work underway, for example to transform the school curriculum, to improve people’s chances of decent employment, to increase access to green and open spaces, particularly for children and young people in poorer communities, to intervene early in tackling youth violence and anti-social behaviour more generally and for health services to anticipate risks of ill health and support people to reduce those risks.

The Task Force’s recommendations will lead to a step change over and above these developments. They involve public services working together more than they have in the past, in order to make a difference to the complex underlying reasons for inequalities in health.

The recommendations will improve health and other life outcomes for particularly vulnerable groups of people, who need a cross-government and cross-sector approach from the services they rely on. For example, the state must meet its additional responsibility to support and care for looked after children and young people and care leavers, in an effective and joined up way.

Here are our key recommendations. A full list is in Annex 4 at the end of the report.

Early years and young people

Many changes will only happen in the long term, when action to improve educational achievement and skills, employment and income bears fruit. But there will be shorter term, measurable improvements, for example in numbers of women smoking during pregnancy and children’s healthy eating and physical activity levels.

Change that the Task Force recommends goes hand in hand with the early years framework being jointly developed by the Scottish Government and COSLA. Reducing health inequalities will be a key outcome for the framework when it is published in autumn 2008. There should be a continuum of services that identify need and provide support to the most vulnerable children and families across the age range.

The Task Force's key recommendations are:

- **NHS Boards should improve the capacity of ante-natal services to reach higher risk groups and identify and manage risks during pregnancy.**
- **The Government should lead the development of support services for families with very young children at risk of poor health and other poor outcomes.**
- **The Government should develop a community-based integrated school health team approach, increasing the nursing staff and other professionals supporting schools.**
- **The Curriculum for Excellence reforms should continue their strong focus on literacy and numeracy and health and wellbeing.**
- **Curriculum for Excellence should provide continuity and progression through school to post-school and should aim to keep young people in learning after the age of 16.**
- **Physical environments that promote healthy lifestyles for children, including opportunities for play, physical activity and healthy eating, should be a priority for local authorities and other public services.**

Tackling poverty and increasing employment

The Task Force's recommendations are linked to the development of the Government's framework for tackling poverty, inequality and deprivation. This is important because of the strong links between poverty and poor health. There is also a two-way link between health and employment: good quality employment helps physical health and mental health and wellbeing. And people who are currently unable to work may need help to improve their health so that they can get and keep a job.

The Task Force's key recommendations are:

- **Fairer Scotland Fund resources used by community planning partnerships should contribute to health outcomes and help improve healthy life expectancy.**
- **The Government should help people to maximise their income and encourage them to take up means tested benefits, starting with older people and extending activity through intermediary organisations such as Registered Social Landlords and health care services.**
- **The Government should encourage local leadership in activating business participation in the community planning process. New agencies and current statutory partners should be involved in responding to local needs. In particular, NHS Boards should play an active part in employability partnerships across Scotland.**
- **To achieve the potential of business and enterprise in contributing to local community action, the outcome of improving health through work should be integrated with the remit of economic development agencies at national, sectoral and local authority levels including urban regeneration initiatives.**
- **NHS Boards and public sector employers should act as exemplars in increasing and supporting healthy employment for vulnerable groups.**
- **Public sector leaders should promote the evidence on the health benefits of employment with staff, patients and clients.**

Physical environments and transport

The outcomes of these Task Force recommendations will include better opportunities, especially for children and young people, to improve health through enjoying the benefits of safe green and open spaces. Transport recommendations will make public services more accessible, as well as benefiting health through increased walking and cycling.

The Task Force's key recommendations are:

- **Government action on the physical environment should include improvements to promote healthy weight and to the quality of local neighbourhoods through increased community cohesion and preventing risks to community safety.**
- **The Government, NHS Boards and other public sector organisations should take specific steps to encourage the use and enjoyment of green space by all.**
- **Delivering the Government's National Transport Strategy should include specific action likely to improve health and reduce health inequalities. For example, rolling out effective local projects that improve active travel within deprived communities.**
- **New Government whole-community initiatives should be measured on their impact on health and health inequalities.**

Harms to health and wellbeing: alcohol, drugs and violence

The longer-term outcomes of these recommendations will be to reverse the rising inequalities in harm to health from alcohol, drugs and violence. The Government's long-term strategic approaches to both drugs and alcohol will emphasise links to poor health. Prevention is vital, especially among young people, but so is treatment and recovery for people who already have a serious drug or alcohol problem.

The Task Force's key recommendations are:

- **Local authorities, Third Sector organisations and other partners should increase programmes designed to support and engage with young people who have started on the cycle of offending. More support should be provided for parents whose children begin to display violent behaviour; for counselling programmes for victims of violence and for mentoring for young people at risk of damaging, violent or anti-social behaviour.**
- **Local authorities and their partners should provide more positive activities for young people, including improved access to existing facilities.**
- **NHS drug treatment services, which will incorporate the Government's new emphasis on recovery, should link locally to other forms of support that address clients' wider problems and life circumstances.**
- **The Government should ensure more effective local delivery of joined up services for problem drug and alcohol users, through reform of the current Alcohol and Drug Action Team arrangements. Local resources should be more targeted to deprived groups and communities.**

Health and wellbeing

Action here will make an impact on each of the priority inequalities the Task Force has highlighted, through improving people's access to health and social care services and the results those services achieve for them. This is particularly important for the most vulnerable groups of people in the population, and in primary care where the NHS has most contact with the public.

The Task Force's key recommendations are:

- **Keep Well health checks in deprived areas should identify people with depression and anxiety and make sure they get treatment and support.**
- **The Government should create and fund new evidence-based anticipatory care programmes for other groups at high risk of health problems.**
- **The Government should continue to reform the funding of primary care services, to meet the needs of groups and communities most at risk of health inequalities.**
- **The Government should lead development of a framework for regular health assessments for people with learning disabilities in all NHS Board areas.**
- **Offenders who want to tackle their drug problems should be able to get access to addiction and health services within six weeks of release from prison.**
- **NHS Health Scotland should deliver an accessible communication, translation and interpreting strategy.**

Delivering change

To make sure that the Task Force's proposals lead to real and effective action we recommend that:

- **The Government should publish an implementation plan later in 2008, which gives more practical detail about how these recommendations will be turned into action and who will be responsible, at both national and local levels.**

The global sums allocated by the Government to local government and for health and wellbeing include resources for programmes and services that influence the underlying causes of health inequalities, as well as dealing with the consequences for people. Within these sums, the Task Force has identified £586 million in 2008-09 as more directly targeted at addressing both causes and consequences. As a result of the Task Force's work the Government has already agreed to add a further £15 million over three years to support children and families most at risk and to back the Task Force's test sites and health inequalities learning networks.

The Task Force's local test sites will show what changes in public services can be achieved within existing resources, with a view to reducing the key health inequalities in the longer term. Test sites will also provide evidence for future spending decisions, both nationally and locally, to redesign public services and shift the emphasis from dealing with consequences of health inequalities to preventing them in the first place.

The Task Force recommends some new headline measures of health inequalities, to be reported in addition to healthy life expectancy. Measures of people's health are needed so that change can be tracked in the long-term. In the medium-term, the Scottish Government and local authorities and their community planning partners should report progress in tackling the key underlying causes of health inequalities. This must form part of the new relationship between the Scottish Government and local authorities, with their local partner organisations, as embodied in Single Outcome Agreements.

- **The Government itself should review progress in implementing the Task Force's recommendations and publish their review in 2010, together with any further action that is needed.**

The Task Force's recommendations are to be seen as a complete set. They will work together on the most important underlying reasons for Scotland's health inequalities. There are, however, some examples of important policy and action where the Scottish Government does not have enough powers for maximum impact. These should be pursued as part of discussions about Scotland's constitutional future.

Our recommendations have been developed as part of a new approach to policy making that shares understanding and responsibility between the Government, local authorities and other organisations which deliver services locally. Making change happen now requires all these organisations to work together. Above all, the Task Force's understanding of the reasons for health inequalities tells us that services must fit in with what their clients really need, not the other way around.

This is an ambitious and radical programme for change. But without it, Scotland will not make progress towards all of its citizens being "Equally Well".

INTRODUCTION

THE CHALLENGE FACING THE TASK FORCE

"Scotland's health is improving rapidly [but] it is not improving fast enough for the poorest sections of our society. Health inequalities ... remain our major challenge."

Annual Report of the Chief Medical Officer: Health in Scotland 2006.

"There's no room for health inequalities in modern day Scotland."

Young Scot consultation for the Task Force

"We have made tackling health inequalities our top priority."

Nicola Sturgeon, Cabinet Secretary for Health and Wellbeing

Setting up the Ministerial Task Force on health inequalities was one of the earliest acts of the current Scottish Government. The aim is to tackle the inequalities in health which prevent Scotland reaching its potential. It is part of achieving the Government's overall purpose: "a more successful country, with opportunities for all of Scotland to flourish, through increasing sustainable economic growth". Increased healthy life expectancy is an important part of this. It must also be achieved in a way that reduces disparities between richer and poorer and narrows the gap between Scotland's best and worst performing regions.

The Task Force's key contribution to achieving these ambitions is to ensure that improvements in the health of the whole population are shared more equally between rich and poor, between other groups in the community at particular risk of poor health and across both urban and rural areas. Reducing such inequalities in health will play a significant part in creating a skilled, resilient population with the sense of wellbeing and control over their own lives, keen to look after their own health and able to participate in the economy and employment opportunities of the future.

The Task Force identified from the outset that few, if any, other countries have succeeded in reducing socioeconomic inequalities in health. We heard about some of the barriers to progress in other countries at the International Summit on Health Improvement and Health Inequalities in Edinburgh in April 2008. It is clear that governments need a shared purpose if they are to address the underlying causes of inequalities in health. They will need courage to face up to some very difficult challenges, such as the linked problems of violence, substance misuse and poor health. Radical action is needed to achieve success.

There is general, internationally-shared consensus that tackling health inequalities requires a cross-government approach and cannot be achieved through health policies and health care systems alone. International approaches so far, however, have not been driven by a clear understanding of why the whole range of public policies matters in determining the health of individuals and communities, nor of how those public policies need to change and develop, in order to alleviate the consequences of unfair and unjust health inequalities.

The Task Force's job has been to take our emerging understanding of the deep-seated causes of health inequalities and turn it into practical action. This involves working across all of national and local government's key responsibilities – for enterprise and skills, children, justice and the physical environment, as well as health and wellbeing.

This document meets the Task Force's commitment to report on what now needs to be done to tackle health inequalities more effectively. We base our recommendations for action on what is already known about what works and we build on previous experience, both positive and negative. But more dynamic approaches are now needed, based on a better understanding of what the Government and others must do. Action is required nationally and locally, to tackle both the causes and consequences of inequalities in health. That is the ambition the Task Force has set itself. That is what its radical recommendations for change can achieve.

KEY HEALTH INEQUALITIES

There are inequalities in the health of people in Scotland which are unfair and unjust, because they are based on social structures and factors such as how much money people have. These inequalities mean that some people are more likely to be ill or have low levels of wellbeing and to die younger than others.

Annex 1 describes some of the key health inequalities facing Scotland today. It identifies some of the most significant challenges facing the Task Force, which have guided its work and determined its priorities. For example:

- In Scotland in 2006, healthy life expectancy at birth was 67.9 years for men and 69 years for women. In the most deprived 15% of areas in Scotland in 2005-06, healthy life expectancy at birth was considerably lower at 57.3 years for men and 59 years for women.
- A higher proportion of babies born to mothers living in the most deprived fifth of the population have a low birth weight than those born to mothers living in the most affluent areas (9% compared to 5% in 2004-05).
- In Scotland in 2006, people who had a low household income, or reported finding it difficult to manage on their household income, had poorer mental wellbeing than those with a high household income or who reported finding it easy to manage on their income.
- There are large and increasing relative inequalities in deaths amongst young adults due to drugs, alcohol, assault and suicide.
- In Scotland in 2006, more than two thirds of the total alcohol-related deaths were in the most deprived two fifths of areas.
- Those living in the most deprived 10% of areas of Scotland have a suicide risk double that of the Scottish average.
- Adult smoking rates increase with increasing deprivation. In Scotland in 2005-06, smoking rates ranged from 11% in the least deprived 10% of areas to 44% in the most deprived 10%.
- Compared with the non-South Asian population, the incidence of heart attacks in Scottish South Asians is 45% higher in men and 80% higher in women.

- Lesbian/gay/bisexual and transgender people experience lower self-esteem and higher rates of mental health problems and these have an impact on health behaviours, including higher reported rates of smoking, alcohol and drug use.
- Just under a quarter (24%) of all individuals in households with at least one disabled adult or disabled child are living in relative low income, compared to 16% of those in households with no disabled adults or disabled children.

Health inequalities are most often described in terms of socioeconomic status and linked to poverty and deprivation. The data available are generally based on the average circumstances of populations living in particular areas rather than the circumstances of individuals. However, not everyone living in areas defined as deprived is disadvantaged. Also, many disadvantaged people do not live in areas of multiple deprivation. It is therefore important to look at health inequalities across the whole population in different ways wherever this is possible.

Health outcomes and health risks may also vary according to people's age, disability, gender, race, religion or belief, sexual orientation and other individual factors. There is information on health inequalities by gender and age, but much less is available in Scotland for health inequalities by ethnicity, disability, sexual orientation, transgender and religion or belief.

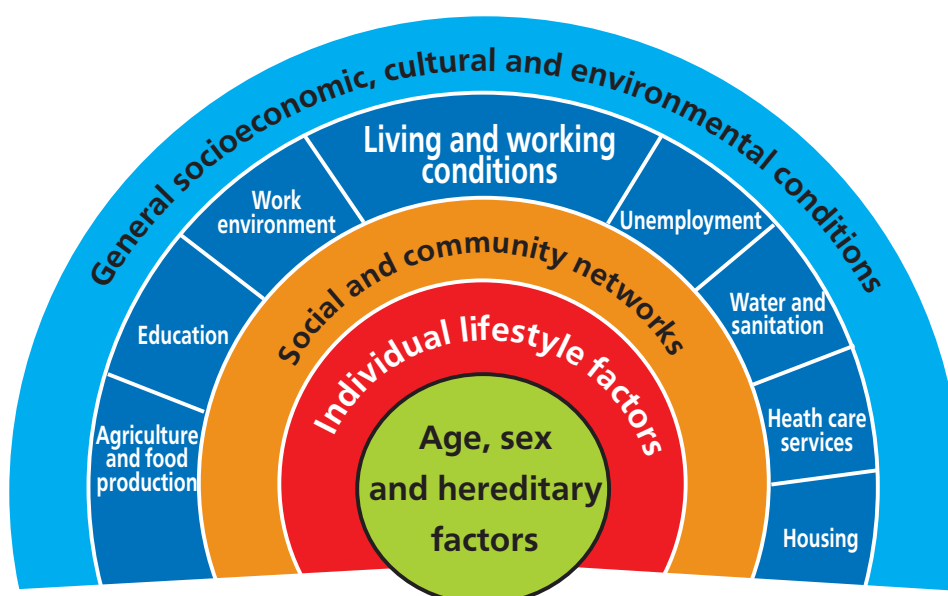
Health outcomes such as life expectancy generally improve with socioeconomic status. This is critical to the Task Force's approach, but we are seeking to address all dimensions of health inequalities, not just to improve the health of people in the most deprived areas. Previous Government targets have focused solely on the latter, however.

WHAT CAUSES HEALTH INEQUALITIES?

The Task Force has adopted the widely accepted definition of health as: "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity". (World Health Organization). Health may also include people's ability to lead a socially and economically productive life.

The Task Force has started its work from a social model of health, describing the factors that influence people's health and wellbeing and that determine inequalities.

Dahlgren G, Whitehead M. Policies and strategies to promote social equity in health. Copenhagen: World Health Organization, 1992.



Individual characteristics, such as gender and hereditary factors are largely fixed. As seen above, diversity (age, disability, gender, race, religion or belief, sexual orientation) can lead to unequal health outcomes for people with particular characteristics, compared to the rest of the population. Working outwards from the centre of the diagram, the layers show determinants (causes) of both health and inequalities in health. These include people's personal strengths and vulnerabilities, their lifestyles and health-related behaviours eg smoking, diet, physical activity. Social and community networks can have an important impact. So may economic, social and environmental factors, which play a large part in causing inequalities in people's health.

Sometimes diversity and life circumstances interact and pose increased risks to health. People do not just live in poverty, they may also be a lone parent, may have a long-term disability that affects the work they can do, or live with discrimination which has an impact on their mental health. Gender, and masculinity in particular, contributes to problems of violence, to the reluctance of men to seek help for problems and may make men more likely to resort to alcohol and drugs than to seek help for a mental health problem.

We have based our approach on emerging scientific evidence of how deprivation and other forms of chronic stress lead to poor health, starting at the very early stages of children's lives. Hopelessness and a sense of lack of control increase people's risk of dying from the big killer diseases and of dying early. There is a biological basis for this in the body's inflammatory system. People's responses to stress of all kinds can become "toxic" rather than positive or tolerable. They fail to adapt to their physical and social environments. They may not interact effectively with the world of work, nor with public and other services that should provide support. They age earlier and are more vulnerable to harm from their health-related behaviours such as smoking, as well as from external stress caused by poverty and deprivation or lack of good employment.

Future health inequalities are, to a large extent, determined from a child's earliest years. This is down to biological factors as well as life circumstances generally. Early responses to what is happening shape future physical and psychological functioning. To help the brain develop children need secure and consistent relationships with others, or else they will not thrive, learn, adapt and form good future relationships.

"Early experiences determine whether a child's brain architecture will provide a strong or weak foundation for all future learning, behaviour, and health. The interaction of genes and experience shapes the architecture of the developing brain, and the active agent is the 'serve and return' nature of children's relationships with the important adults in their lives. Policies that support the ability of parents, providers of early care and education, and other community members to interact positively with children in stable and stimulating environments help create a sturdy foundation for later school achievement, economic productivity, and responsible citizenship."

(Center on the Developing Child, Harvard University, USA.)

Some of the Task Force's most important conclusions are therefore about providing the best possible environment for children's earliest years and ending cycles of poverty and poor health passed down from parent to child.

THE TASK FORCE'S APPROACH

In looking at the factors that bring about inequalities in health, the Task Force has examined underlying causes across the whole range of public policy. The remit with which the Task Force began its work in Autumn 2007 was:

- To agree priorities for cross-cutting government activity that will achieve both short and long-term outcomes in reducing the most significant and widening health inequalities in Scotland.

- To build on existing evidence to identify practical measures to reduce health inequalities whose impact can be assessed effectively.
- To influence emerging Government policies and strategies, including the Better Health, Better Care action plan, the early years framework and Curriculum for Excellence.
- To engage the key sectors and organisations that are involved in delivering action on health inequalities, in order to build up their commitment and support.

Members of the Ministerial Task Force on Health Inequalities

Shona Robison, Minister for Public Health – Chair

Fergus Ewing, Minister for Community Safety

Maureen Watt, Minister for Schools and Skills

Stewart Maxwell, Minister for Communities and Sport

Adam Ingram, Minister for Children and Early Years

Jim Mather, Minister for Enterprise, Energy and Tourism

Mike Russell, Minister for Environment

Dr Harry Burns, Chief Medical Officer for Scotland

Professor Carol Tannahill, Director, Glasgow Centre for Population Health

Councillor Ronnie McColl, COSLA spokesperson on Health & Wellbeing

Ken Corsar, Chair, NHS Lanarkshire

Andrew Muirhead, Chief Executive, Lloyds TSB Foundation for Scotland

Pam Whittle, Director of Public Health and Wellbeing, Scottish Government

The Ministerial members of the Task Force have responsibilities covering a wide spectrum across Government. We have worked together on the Task Force in a new way, embodying the Government's unified approach to its overall purpose of sustainable economic growth and the key factors that will make that a reality. Our recommendations make it clear that working together is essential to deliver change.

COSLA and NHSScotland have also taken an active part in the Task Force's thinking. This, too, represents a new way of working, in which local government is an equal partner in developing national policy and agreeing how that can be delivered in practice. Much of the change we need can only be generated locally, through the people in front-line public services. We will recommend how to foster this evolutionary process and learn from both professionals and those they serve about what really works.

The Task Force has been keen to use experience and evidence from previous strategies and inquiries into health inequalities. Annex 2 summarises the most important of these in Scotland, the UK and internationally.

The Task Force also heard helpful evidence from Professor Sally Macintyre (Director, MRC Social and Public Health Sciences Unit, University of Glasgow) about policies and interventions that are likely to help reduce health inequalities.

Box 1: Characteristics of policies more likely to be effective in reducing inequalities in health

Structural changes in the environment: **(eg installing affordable heating in damp cold houses)**

Legislative and regulatory controls **(eg smoking bans in workplaces)**

Fiscal policies **(eg increase price of tobacco and alcohol products)**

Income support **(eg tax and benefit systems, professional welfare rights advice in health care settings)**

Reducing price barriers **(eg free prescriptions)**

Improving accessibility of services **(eg location and accessibility of primary health care and other core services)**

Prioritising disadvantaged groups **(eg multiply deprived families and communities, the unemployed, fuel poor, rough sleepers and the homeless)**

Offering intensive support **(eg systematic, tailored and intensive approaches involving face to face or group work, home visiting)**

Starting young **(eg pre- and post-natal support and interventions, home visiting in infancy, good quality pre-school day care)**

The Task Force wishes to build its report and recommendations for action on policies and programmes already in place where possible. We have therefore looked to see where current action in Scotland is on the right track. Our recommendations are about what needs to be added to what's already happening.

More work will be needed to turn our recommendations into action. The Task Force therefore recommends that:

- 1. The Government should produce a practical implementation plan by the end of 2008, setting out how the Task Force's recommendations will be turned into action and who will be responsible, at both national and local levels.**

Reducing Scotland's deep-rooted inequalities in health is a long-term task. Significant impact on health outcomes may only be achieved in a generation, or at least on a 10-15 year timescale. The Task Force does, however, want to see improvements in the short to medium-term and recommendations will set out how progress can be assessed within this time frame, as well as in the longer term.

The action that the Task Force recommends in the next three years (2008-09 to 2010-11) can be funded within resources provided by Government, both centrally and locally. Some realignment of current funding may be needed, so that efforts are focused on more effective interventions and targeted on services for people who need them the most.

In the longer term, the Task Force's ambitions for the redesign of public services may require more significant shifts in resources from dealing with consequences of inequalities to prevention and early intervention. Long-term resource implications will be explored locally through the Task Force's learning networks approach. This will inform how public resources can best be deployed in the longer term, in order to contribute to reducing health inequalities.

COMMUNICATION AND ENGAGEMENT

The Task Force itself includes members from local government, NHSScotland, the Third (voluntary) Sector and the research community. At its meetings, the Task Force discussed its work with members of the police, the business community, NHSScotland, local authorities and young people.

The Government-led discussion on Better Health, Better Care in the autumn of 2007 highlighted the importance of inequalities in health and gathered views from a wide range of individuals and groups, including the public, non-NHS organisations and NHS staff and management. These views informed the Task Force's thinking at an early stage.

The Task Force itself has organised three specific consultations:

- We listened to views of young people through Young Scot.
- We heard from a wide Third Sector audience.
- We held a delivery-proofing event, to consult frontline staff and managers from a broad range of sectors and settings about practical aspects of our emerging conclusions.

All of these discussions have been helpful in developing the Task Force's thinking and have provided a welcome reality check on its recommendations. They are reflected in this report. The Task Force is grateful to the many people who have contributed, online, in writing and in person.

THE TASK FORCE'S PRINCIPLES AND PRIORITIES

At the start of its work, the Task Force examined the wide range of inequalities in health in Scotland and the data that are available to describe these. We identified priorities among these health inequalities to guide our assessment of current and future action. The core criteria for deciding priorities were:

- The **importance** of the inequality in health outcomes.
- The **effectiveness** of current activity and potential further action.
- The **feasibility** of delivering such action in Scotland, eg costs, timescale for success, capacity required of delivery organisations.
- Whether we shall be able to **measure and monitor success**.

In the light of these criteria, the Task Force agreed that it should focus on these priority health outcomes:

- Children's very early years, where inequalities may first arise and influence the rest of people's lives.
- The high economic, social and health burden imposed by mental illness, and the corresponding requirement to improve mental wellbeing.
- The "big killer" diseases: cardiovascular disease and cancer. Some risk factors for these, such as smoking, are strongly linked to deprivation.
- Drug and alcohol problems and links to violence that affect younger men in particular and where inequalities are widening.

Given these priorities and evidence about what drives socioeconomic inequalities in health, the Task Force has agreed key principles to underpin our work. These are:

- Improving the whole range of circumstances and environments that offer opportunities to improve people's life circumstances and hence their health.
- Reducing people's exposure to factors in the physical and social environment that cause stress, are damaging to health and wellbeing, and lead to health inequalities.
- Addressing the inter-generational factors that risk perpetuating Scotland's health inequalities, particularly focusing on supporting the best possible start in life for all children in Scotland.
- Engaging individuals, families and communities most at risk of poor health in services and decisions relevant to their health, and promoting clear ownership of the issues by all involved.
- Delivering health and other services that are both universal and appropriately prioritised to meet the needs of those most at risk of poor health, and that seek to prevent problems arising, as well as addressing them if they do.
- Basing current and future action on the available evidence and adding to that evidence for the future, through introducing new policies and interventions in ways which allow for evaluating progress and success.
- Ensuring that the range of actions we take now will achieve both short and long-term impact and will address foreseeable future challenges.

Throughout its work, the Task Force has considered the importance of diversity and of people's individual characteristics in determining both health and health inequalities. This report and recommendations have undergone formal equality impact assessment. This ensures that we meet statutory requirements and get fully to the heart of the complex factors that determine Scotland's health inequalities. To ensure this continues into the action now to follow, the Task Force recommends that:

- 2. Those responsible for implementing the Task Force's recommendations should: carry out equality impact assessments on the action they are taking to ensure this is legally compliant; systematically consider the needs of the diversity of the population; ensure action does not adversely affect any part of the population; and consider how they can promote equality.**

ACTION AND RECOMMENDATIONS

Recommendations for change

The Task Force's recommendations for change in policy, practice and delivery follow in the rest of this report. These start with children's early years and the role of education in determining later health. They include throughout the need to build individual, family and community wellbeing and resilience. The report addresses critical underlying causes of health inequalities such as poverty and lack of employment as well as exposure to physical and social environments that perpetuate poor health and create inequalities. There are links between all of these themes.

The Task Force has examined and discussed the range of key policy responsibilities, corresponding to the Government's five strategic objectives for a Smarter, Wealthier and Fairer, Greener, Safer and Stronger and Healthier Scotland. Each of the following sections looks at one area in more detail, summarising:

- Why this matters for health inequalities.
- What works.
- What's already happening in Scotland.
- What the Task Force recommends.

Volume 2 of this report, available on the Government's web pages, incorporates the discussion papers that the Task Force has commissioned. These provide a more detailed account of the evidence-base and the approach that the Task Force has taken.

Making it happen

This agenda is for the whole of public services and their partners in other sectors. It requires significant refocusing of public services. As COSLA said in their discussion paper for the Task Force: "To address health inequalities it is likely that public sector resources will have to focus on early interventions and prevention, and as part of that develop a more anticipatory and proactive approach to working with disadvantaged groups. If we do not do this, we will merely be falling back on a strategy that addresses the manifestations of disadvantage rather than tackling the source of disadvantage. Consequently, nothing will change: poverty and other social inequalities will continue to place vulnerable families at risk."

The Scottish Government and COSLA are working in partnership to tackle health inequalities. As a key provider of social support, education, regeneration, housing, and green spaces, local government will continue to make an important contribution in tackling health inequalities. Local government is committed to maintaining and improving these crucial services, thus improving the health and wellbeing of all members of the community, but particularly those living in disadvantage.

Delivering action and change on this scale will only be possible with strong leadership and effective community planning partnerships. Local joint planning and working will require the right contribution from each agency involved. Accountability will operate through the Single Outcome Agreement process, acknowledging where arrangements differ across sectors, eg NHSScotland, Third Sector organisations. Staff who have the right skills and who are supported to operate in new ways will be critical. The Task Force will recommend new ways of managing change that take into account the plethora of existing initiatives and developments, but go beyond these to embody a more fundamental understanding of what is required to reduce inequalities in health and wellbeing.

SMARTER SCOTLAND: EARLY YEARS AND YOUNG PEOPLE

“Early intervention is a hallmark of this Government’s approach to improving the lives of Scots and delivering the better Scotland that we all want to see. The early years of a child’s life are a key opportunity to build resilience and reduce the impact of inequalities on health outcomes.”

Adam Ingram, Minister for Children and Early Years

“We have a once in a generation opportunity, with the transformation in the education system under Curriculum for Excellence, to make a lasting difference to our children’s health, wellbeing and life chances. By placing the child at the centre, personalising learning and support, we can tackle underlying poverty and deprivation and take a holistic approach to health and wellbeing for all our children and young people.”

Maureen Watt, Minister for Schools and Skills

Key points:

- Children’s circumstances in the earliest years of life are critical to future health inequalities.
- Action is needed to end the cycle of health inequalities which passes from parent to child.
- A range of services is needed to support and help children and families.
- Vulnerable groups such as looked after children or those who live in a house where alcohol or drugs are misused require particular help.
- Children should be encouraged to enjoy learning and to stay in education beyond the age of 16.

Why this matters

The earliest years of children’s lives are critical to their future development. Scientific evidence tells us how future health and wellbeing are determined by the ways children’s brains develop. Inequalities experienced by parents and their own lifestyles such as drug and alcohol use can harm their children. Support for families that improves children’s mental and physical health and life prospects is needed. This must continue through an education system that develops in young people the qualities of resilience and adaptability, together with aspirations and the capacity to go on learning and developing throughout their lives.

Educational achievement is critically affected by children's home circumstances and influences out of school. A major challenge for Scottish education is to reduce the achievement gap that widens up to around age 15. Children from poorer communities and families are more likely to underachieve. As the OECD Review of Quality and Equity of Schooling in Scotland (2007) found: "Family cultural capital, lifestyle and aspirations influence student outcomes through the nature of the cognitive and cultural demands of the curriculum, teacher values, the programme emphasis in schools and peer effects."

Young people told us the same in Young Scot's consultation for the Task Force:

- Family and friends matter a lot to their health and wellbeing.
- They want to learn more at school about a healthy life.
- But they also need the right choices and chances outwith school: advice on health just for young people, safe places to go and chances to take exercise that they can afford.

What works?

Effective action in the early years to address future inequalities in health, and linked aspects of people's lives, includes:

- High quality ante-natal care that identifies and addresses risks early.
- Improving maternal nutrition during pregnancy.
- Improving the quality of interaction between parents or carers and children in the very early years, for example through high quality home visiting services and parenting programmes.
- Targeted interventions and programmes for children at particularly high risk.
- High quality centre-based pre-school provision and school education.
- Alleviating poverty in families with young children.
- Reducing environmental hazards.

Example: The Nurse Family Partnership Home Visiting Programme targets low-income first time parents and their children. It was set up by Professor David Olds at the University of Colorado, and aims, by an intensive programme of home visits by highly trained nurses, to improve pregnancy outcomes, improve child health and development and importantly improve families' economic self sufficiency by helping parents to see and plan their own future, including continuing their education and finding jobs.

The HMIE report Missing Out has identified characteristics of schools achieving good all round outcomes for their pupils:

- Teaching that provides the highest quality learning experiences.
- Leadership and a shared mission.
- Partnerships including those with parents and families.
- Ethos of ambition/achievement.

What's already happening in Scotland?

The Government and COSLA have recently published a joint policy statement on early years and early intervention (March 2008). This provides the strategic context for the Task Force's work on early years and is an important step on the way to delivering a comprehensive early years framework in the autumn. It marks a shift away from crisis intervention and towards identifying and addressing risks early in life that lead to poor health and other inequalities.

The Task Force supports the statement in the Foreword that: "the biggest gains ... will come from supporting parents – to help them help themselves – and by creating communities which are positive places to grow up".

The policy statement sets out four principles of early intervention which are the same as those behind the Task Force's work.

- Our ambitions are universal ... to have the same outcomes for all and for all to have the same opportunities.
- We take action to identify those at risk of not achieving these outcomes or having these opportunities and take action to prevent that risk materialising.
- We make sustained and effective interventions in cases where these risks have materialised.
- We shift the focus from service provision as the vehicle for delivery of outcomes to building the capacity of individuals, families and communities ... and addressing the external barriers they may face ... making use of high quality, accessible public services as required.

Most services for children and families are delivered through the universal health and education systems. There are also some highly targeted services, such as children and families social work, drug rehabilitation and services for looked after children that focus on families in greatest need. Sure Start Scotland provides a mix of universal and highly targeted services for families.

Example: Special Needs in Pregnancy, Inverclyde. The special needs in pregnancy service (SNIPS) helps pregnant women in Inverclyde to access a range of services. Multi disciplinary assessments are done. The service has two midwives, two family support workers, a homemaker, senior social worker, health visitor, senior nurse from Inverclyde drug services and a community drug team worker. Advice is also available from a consultant psychiatrist. There is strong emphasis on prevention. Women with a range of issues and difficulties are therefore encouraged to use the service. Women who are misusing drugs or alcohol get a response, which is characterised by joint working and early intervention.

The Government will now provide £19 million over three years to improve diet and other healthy living activities for pregnant women and children up to age 5, especially those in deprived groups and communities.

NHS Boards have already been given a target to increase the proportion of new-born children exclusively breastfed at 6-8 weeks from 26.6% in 2006-07 to 33.3% in 2010-11. In order to achieve this they will need to increase breastfeeding rates in deprived areas and among disadvantaged groups.

The Government's Getting It Right For Every Child (GIRFEC) approach is about identifying children's needs at any age and bringing together the agencies that should be involved in their lives.

Within the GIRFEC approach, the reform of Scottish education from age 3 to 18 under Curriculum for Excellence will provide more choices and more chances for all children and young people.

The Additional Support for Learning Act (2004) supports early intervention and a personalised approach to additional support needs, in order to address inequality and promote positive outcomes for children and young people.

The Schools (Health Promotion and Nutrition) (Scotland) 2007 Act places a duty on local authorities to ensure that schools are health promoting. This links with the developments in Curriculum for Excellence.

Example: Pitfour Primary School, Mintlaw, Aberdeenshire. This school is in a village that contains a large housing estate with significant social challenges within its catchment area. The school is aiming to become an accredited health promoting school, involving the parents and other partners from the wider community. They have held evening events on healthy eating and behaviour, bullying and discipline. To encourage positive behaviour by all children a booklet Promoting Positive Behaviour has been issued to all pupils. It is filled in every day and goes home at the end of the week for parents/carers to sign.

Home-school link workers support vulnerable families to engage with education services and there are other initiatives to increase parental and community involvement in school education.

Looked After Children and Young People: We Can and Must Do Better, aims to improve educational and other outcomes for looked after children, who have particularly poor education and other life prospects. "Young people leaving school and leaving care, having to manage their lives as they try to get into the job market, are among the most vulnerable." (Third Sector consultation)

Example: Edinburgh City Council – Corporate Parenting Action. The Reading Champion project run by Edinburgh City Council is a very practical example of corporate parenting in action. The project aims to improve the mental health and wellbeing of looked after children by encouraging reading activities. Reading to or with children is a bonding activity carers can use. Engaging in reading helps relaxation. It helps develop relationships with caregivers and therefore improves mental health and wellbeing. This project also creates opportunities for children to interact with adults and build essential literacy skills to assist in later life.

Example: Children's Learning and Supported Play (CHLASP) – East Ayrshire Council. CHLASP is a multi-agency response to addressing the needs of children who are homeless. It is widely recognised that children who experience homelessness are more likely to encounter physical, mental and emotional ill health. Schooling and opportunities for play and social development are also subsequently affected. CHLASP supports children's access to:

- Transport to school or nursery of origin to ensure stability and consistency in children's education and care.
- Transport to health and dental appointments.
- Funding and support to access out of school care and after school activities to provide social and play opportunities in a safe, stimulating environment.
- Cooking skill training for Tenancy Support Workers who deliver cookery classes within homelessness hostels and individually in furnished accommodation.
- Direct referral to Working for Families to support pre-employment skills development for parents/carers.

Outwith school, there are opportunities for young people to play sport, be physically active and enjoy the outdoor world. But these opportunities are not yet available equally to all, nor to young people in some of the most deprived communities, whose life chances are poorest.

Example: Young Scot is the national youth information charity for Scotland. It provides young people between the ages of 11 and 26 with a mixture of information, ideas and incentives to help them become confident and active citizens. One of these services, the Young Scot card, is carried by over 340,000 young people in Scotland. Promoting healthy and positive active lifestyles is a key element of the card, and there is money off at places such as Virgin Active, Walkabout Scotland, Historic Scotland and Scottish Youth Hostel Association. In many local authority areas the Young Scot card is used by young people to access local authority leisure services.

Task Force recommendations

Many of these are for the long term, and will lead to reduced inequalities in aspects of children's future lives, such as income, employment, and the health they enjoy. In some cases, though, we shall see shorter term improvements, for example in numbers of women smoking during pregnancy and children's healthy eating and physical activity levels.

The policy statement on early years and early intervention sets out a number of tasks that will seek to improve outcomes for children and families, with a particular emphasis on reducing inequalities. These are closely aligned with the Government's Better Health, Better Care action plan (December 2007) which put the best possible start for children at the forefront of the Government's health agenda.

As well as supporting the wider agenda that these policy documents have established, the Task Force has identified a number of specific recommendations where we believe there is an urgent need to test new approaches in Scotland across the age range.

3. **Reducing health inequalities should be a key outcome for the early years framework being developed jointly by the Government and COSLA.** This reflects the joint development across Government and other agencies of policy that links understanding of influences in the early years of life on future health.
4. **NHS Boards should improve the capacity of ante-natal services to reach higher risk groups and identify and manage risks during pregnancy.** This will include, rolling out and evaluating a 3-5 year programme to better identify and support vulnerable women and families, through a number of professionals providing effective care.
5. **The Government should arrange a Scottish survey of the incidence of Foetal Alcohol Syndrome.** This is caused by the mother's harmful drinking during pregnancy and leads to physical and psychological damage to children, unless there is early intervention and treatment.
6. **NHS Boards should improve breastfeeding rates in deprived areas and among disadvantaged groups.** The Government's new infant nutrition co-ordinator will concentrate efforts on reaching these groups.
7. **The Government should lead the development of holistic support services for families with very young children at risk of poor health and other poor outcomes.** This should test how the Nurse Family Partnership approach can work in Scotland. Testing will need to examine how best to target the families most in need, engage them effectively and work alongside them to build up their own capacity. It must ensure fidelity with the strong evidence-based Nurse Family Partnership approach.
8. **There should be a range of services that identify need and provide support to the most vulnerable children and families. As part of that, the Government should develop a community-based integrated school health team approach, targeting children at risk and increasing the nursing staff and other professionals supporting schools.**

9. The Government should continue to improve support for children at risk in households where alcohol or drugs are misused.
10. Curriculum for Excellence should continue its strong focus on literacy and numeracy, with every teacher taking responsibility for delivery across the curriculum.
11. Curriculum for Excellence should take a holistic approach to health and wellbeing outcomes, including active and healthy lifestyles, supported by the new school health team approach. This should cover learning in mental, emotional, social and physical health to promote resilience, confident, independent thinking and positive attitudes.
12. The ethos within which Curriculum for Excellence is implemented should place the child at the centre of the process, so that learning starts from the child's perspective, with different abilities and backgrounds taken into account.
13. Curriculum for Excellence should provide continuity and progression through school to post-school, aimed at keeping young people in learning after the age of 16.
14. Physical environments that promote healthy lifestyles for children, including opportunities for play, physical activity and healthy eating, should be a priority for local authorities and other public services. The Government should support the Third Sector to increase opportunities for play, through investing in an Inspiring Scotland theme, subject to current discussions.
15. Each NHS Board should assess the physical, mental and emotional health needs of looked after children and young people and act on these assessments, with local partner agencies. Boards should ensure that health services are more accessible to looked after children and to those in the transition from care to independence.

WEALTHIER AND FAIRER SCOTLAND: TACKLING POVERTY AND INCREASING EMPLOYMENT

"There is a clear relationship between income inequality and health inequality. Ill health is both a cause and a symptom of poverty. It is critical that the solutions we develop target root causes in all their complexity. Action on inequality must be seen as an investment in the future of our country. Taken with our commitment to tackle income inequality through our Solidarity Target, this report offers genuine opportunity to make real progress at last on Scotland's appalling record of health inequalities."

Stewart Maxwell, Minister for Communities and Sport

"Together with their Government, councils, health services and their local business communities, Unions and the Third Sector, Scotland's people hold the answers to their own problems. Centrally-led, target-driven initiatives have not worked to address the deep-rooted and complex issues of health inequality in Scotland's most vulnerable communities for the past three decades, and there is no reason to suppose they will start to work now.

Excellent examples abound – from Raploch in Stirling to the Bronx in New York City.

The task of Government, therefore, is to activate Scotland's most vulnerable communities, to facilitate and support local people, schools, voluntary agencies, councils, businesses and other players to develop local leadership, and local ideas and programmes to address local issues.

As Enterprise Minister for Scotland, I shall be delighted to commit myself to help make this happen."

Jim Mather, Minister for Enterprise, Energy and Tourism

Key Points:

- Poverty is a key factor in poor health and health inequalities.
- Employment is important to individual and community health and wellbeing, both physical and mental, as well as to the economy.
- Workplaces should be health-promoting and public sector employers should set a good example.

Why this matters

The links between poverty and poor health are central to the Task Force's thinking. Tackling poverty and deprivation will improve health and contribute directly to delivering the Government's overall purpose of sustainable economic growth.

Poverty influences poor health and inequalities in a number of ways. It affects the environment in which children are born and is likely to increase stress on both parents and children which will set patterns for children's future development and life chances. People on low incomes and those living in the most deprived areas are most likely to rate their general health as poor and to be more susceptible to mental illness. Poverty drives much of the inequality in death rates from the big killer diseases. Poverty also worsens the outcomes for individuals with chronic disease: increasing chances of losing employment and shortening life expectancy. Socioeconomic disadvantage underlies the increasing inequalities in the harm caused by drugs, alcohol and violence, particularly among younger adults.

There is strong evidence that work is generally good for physical and mental health and wellbeing and that worklessness is associated with poorer physical and mental health and wellbeing.

A key aspect of the Government economic strategy is to increase the numbers of those participating in the labour market, meeting the target to narrow the gap in participation between Scotland's best and worst performing regions by 2017.

A variety of motivating factors drive employers to adopt safe and healthy working practices, including their statutory duties under the Health and Safety at Work Act. However, the case for workplace health and wellbeing policies to support increased, sustainable employment particularly of vulnerable working age people is less well understood. This is typically viewed as a "health" not a "business" issue. Understanding of the case for good quality work, its impact on reducing health inequalities and therefore its contribution to sustainable economic growth, needs to move beyond the healthcare profession into business and local communities. Laudable attempts to join up local services can only go so far: communities need to be activated to help themselves, tapping into support from relevant local partners and government agencies. This will require local leadership to define common goals and influence community planning. Ministers stand ready to help pump prime this process and help communities engage with each other and with other stakeholders.

What works

Action at a whole population level is one of the most effective ways of tackling health inequalities linked to poverty. This includes, in particular, tax and benefit measures aimed at stopping and reversing trends in income inequalities. Child poverty needs to be addressed through redistributive benefit and tax measures. These remain under the control of the UK Government.

Within Scotland, increasing and improving employment opportunities is a significant means of tackling the root causes of poverty and poor health.

Investing in workplace health and wellbeing also makes sound commercial sense. Evidence shows that immediate benefits include reduced sickness absence, staff turnover and injuries, and increased employee satisfaction, productivity and company profile. Bottom line benefits include reduced staff costs, recruitment costs, legal costs/claims, insurance premiums, health care costs and management time. Studies have shown that every £1 invested can yield as much as £84.

What's already happening in Scotland

The Scottish Government is currently consulting on a framework for tackling poverty, inequality and deprivation to be produced later in 2008. This is within the context of the Government's economic strategy. The Government's discussion paper (January 2008) seeks to build on action tackling poverty in three main ways:

- Prevention of poverty and tackling the root causes.
- Helping to lift people out of poverty.
- Alleviating the impact of poverty on people's lives.

Current action to tackle the root causes of poverty includes the Government's Fairer Scotland Fund (£145m per year for the three years from 2008-09). This is a new fund to be used by community planning partnerships, with a strong emphasis on interventions at an early stage. It aims to help people towards and into employment and also addressing the problems faced by those for whom work is not a realistic option. It is a catalyst, to encourage local agencies to use their mainstream budgets and services to get better outcomes of all kinds for the most deprived people in their area.

Financial inclusion or helping people get access to financial products and services can also help reduce poverty. There are a number of public services which help people deal with debt and manage on a low income. These approaches have a positive impact on mental and physical health related to debt and managing on a low income.

The Scottish and UK Governments have had a range of measures addressing fuel poverty in place for some time. Scottish Government funding is concentrated on the Central Heating Programme which targets older people who do not have a functional central heating system. However, the Scottish Government's review of the programme in its current form shows the programme is not a very effective way of tackling fuel poverty. The Scottish Government has reconvened the Scottish Fuel Poverty Forum with all the key stakeholders and a remit to report to Ministers in the autumn with recommendations on how to use current resources to tackle fuel poverty more effectively.

There are some good examples of corporate responsibility among Scotland's employers, both in increasing employment opportunities for vulnerable people and in promoting healthy workplaces to prevent sickness absence and new cases of incapacity. The benefits do, however, need to be much more systematically spread. Evidence of what works should also inform action both inside and outside government.

Example: Nairn's Oatcakes, a medium-sized independent oatcake and biscuit manufacturer based in Craigmillar, Edinburgh, is making good strides in helping to address many of the employability issues faced by one of Scotland's most deprived communities.

Working in partnership with Haven Products and Jobcentre Plus, the company identifies potential candidates for employment with a learning disability, provides them with work experience and offers training and then a permanent job. It also actively employs and supports members of the community with learning disabilities.

Together with Castlebrae Community High School, Nairn's participates in a series of pupil awareness sessions about the "World of Work". The company has run the Nairn's Challenge to develop a new biscuit with first year pupils in each of the last 12 years. The company also supports the breakfast club, CV preparation advice, mock interviews and work experience for Castlebrae pupils to aid their transition into employment.

Nairn's also tries to ensure that its workforce is as healthy as possible through the Healthy Working Lives award scheme. The company promotes smoking cessation information, provides healthy eating and physical activity advice and offers annual health checks with an occupational health nurse. They also offer a free fruit bowl and subsidised membership of a health club to all staff.

The UK Government's welfare reform arrangements are aiming to encourage more people who can do so to enter employment.

Professor Carol Black's recent review of the health of the working age population has made further recommendations about health, work and wellbeing, including early intervention, GP involvement and expert condition management to prevent health problems escalating.

In Scotland, the Workforce Plus employability framework is delivered through local Workforce Plus partnerships. Healthcare professionals are now becoming more involved in local strategies and the NHS is developing the provision of vocational rehabilitation across Scotland. A pilot project in Dundee is providing faster rehabilitation for employees with work-related health conditions.

A framework for supported employment across Scotland is currently being developed between COSLA and the Scottish Government.

The Scottish Government has signed a Local Employer Partnership with Jobcentre Plus (JCP). NHS Boards are also setting an example to other employers through pre-employment services for people who require support to move from benefits into sustained and good quality work.

GPs are being engaged through dialogue with the Royal College of General Practitioners (RCGP) and through joint events with JCP to promote employability in the primary care sector. The Scottish Government is working with JCP to extend the pilots that have successfully placed employability advisers in GP surgeries.

The Scottish Centre for Healthy Working Lives is a centre of excellence, promoting the health and wellbeing of the working age population of Scotland. The Centre's activities include the Healthy Working Lives Award and the provision of occupational health services, especially to small and medium sized enterprises (SMEs).

The Scottish Action Plan on Health and Safety (March 2007) includes action to improve business access to health and safety advice and expanding occupational health support. Action is also underway to increase workers' involvement in managing health and safety as evidence shows this improves performance.

The Scottish Government and the Scottish Trades Union Congress issued a joint communiqué in January 2008 on action to reduce health inequalities through improving employment opportunities and enhancing health and wellbeing in the workplace.

Task Force recommendations

These recommendations will influence the development of the Government's framework for tackling poverty, inequality and deprivation and help ensure that the link between poverty and poor health is broken. Recommendations on employment will extend responsibility for making sure that people benefit from being in work that is good for their health:

16. Fairer Scotland Fund resources deployed by community planning partnerships should contribute to health outcomes and improving healthy life expectancy.

17. **Universal public services should build on examples of effective financial inclusion activity, to engage people at risk of poverty with the financial advice and services they need. Removing the stress caused by debt will improve people's health and wellbeing.**
18. **The Government should help people to maximise their income and encourage them to take up means-tested benefits, starting with older people and extending activity through intermediary organisations such as Registered Social Landlords and healthcare services.** Extra resources acquired by clients tend to be directed towards spending on fuel, food, education, recreation and transport, with resulting improvements in general health, living standards and economic benefits for the local community.
19. **Any future Government action on fuel poverty should consider explicitly whether improvements in health and reductions in health inequalities can be expected as a result.**
20. **The Government should encourage local leadership in activating business participation in the community planning process. New agencies and current statutory partners should be involved in responding to local needs. In particular, NHS Boards should play an active part in employability partnerships across Scotland.**
21. **To achieve the potential of business and enterprise in contributing to local community action, the outcome of improving health through work should be integrated with the remit of economic development agencies at national, sectoral and local authority levels including urban regeneration initiatives.**
22. **NHS Boards and public sector employers should act as exemplars in increasing and supporting healthy employment for vulnerable groups.**
23. **Public sector leaders should promote the evidence on the health benefits of employment with staff, patients and clients.**
24. **Professional bodies in the field of occupational and public health should be consulted on incorporating the evidence on the health benefits of employment into professional development and practice.**
25. **The Scottish Centre for Healthy Working Lives should refine the Healthy Working Lives Award scheme to make it more flexible and accessible to smaller businesses.**
26. **Public sector organisations should increase the use of community benefits clauses in their contracting processes.**

GREENER SCOTLAND: PHYSICAL ENVIRONMENTS AND TRANSPORT

"The places where we live, work and play, can do so much for our health. What each of us can do matters, not only in terms of the benefits to the environment but also in terms of our own personal wellbeing. I believe that by delivering a Greener Scotland we will also contribute towards a Healthier and Fairer Scotland."

Mike Russell, Minister for Environment

Key points

- Physical environments have an impact on people's mental and physical health and wellbeing.
- Play and recreation areas for children and young people should have high priority.
- Transport and planning policies should include actions to improve health inequalities.

Why this matters

People's physical environment can have a really positive impact on their health and wellbeing. But poor quality surroundings can have the opposite effect.

Health inequalities would be much wider today if it were not for a number of policies that have improved the environment. These include neighbourhood regeneration, housing improvements and controls such as clean air acts. The Task Force wishes to reduce still further people's exposure to factors in their physical and social environments that cause stress, damage health and wellbeing, and lead to health inequalities.

What works?

There is evidence of links between environmental factors and health inequalities. For example, people living in more deprived communities are at greater risk of many of the chronic health conditions associated with obesity; those who report the highest levels of local environmental "bads" are also more likely to suffer from anxiety, depression and poor general health.

Children who have better access to safe green and open places are more likely to be physically active and less likely to be overweight than those living in neighbourhoods with reduced access to such facilities. Access to green space is also associated with greater life expectancy in older people.

Recent briefing by the Glasgow Centre for Population Health on how transport could reduce health inequalities concluded that: "Transport strategies have a vital role to play in improving social inclusion and accessibility through investment in good public transport systems and instituting measures that encourage walking and cycling."

The interactions between individual health and physical and social environment characteristics are complex, however. There is disappointingly little evidence for specific effective action that would achieve measureable reductions in health inequalities in Scotland. In line with the Task Force's thinking about the impact of stress on people's health, it may be more important to ensure that people concerned are fully involved in decisions and policies which affect their lives.

What's already happening in Scotland?

The Government recognises the importance of green space and is committed to the provision of an environment which contributes towards well designed, sustainable places with access to amenities and services. The importance of quality of the environment, nature and green space in promoting mental health and wellbeing is recognised.

Example: The Forestry Commission Scotland's Woods In and Around Towns initiative enhances the contribution of woodland to the quality of life in Scotland's urban and post-industrial areas such as Easterhouse and Castlemilk in Glasgow. Community woodlands are developed by involving local people and also by restoring mineral and derelict sites to woodland. Woods in highly-populated areas provide recreational facilities, contribute to people's wellbeing, benefit the environment and stimulate new economic activity.

Volunteering, and environmental volunteering in particular, can help to improve people's mental and physical health and to engage with some of the disadvantaged groups and individuals mentioned in this report, such as young people, offenders and those experiencing mental health problems.

The high incidence of litter and fly-tipping across many areas of Scotland blights the landscape and depresses the spirit. While long-term change in behaviours leading to a more responsible attitude towards our local environments is the ultimate answer, measures need to be taken now to deter the practice and challenge offenders. The Government intends to hold a national summit on the issue later this year and in the meantime encourages the greater imposition of existing penalties.

Scottish Planning Policy 11: Open Space and Physical Activity (SPP 11) sets out national policy on planning for open space and facilities for sport and recreation. It requires all Scottish local authorities to prepare an open space audit and strategy for their area to help safeguard existing valued open space and identify priorities for future investment. There is a presumption against development on open spaces which are valued and functional, or which are capable of being brought into functional use to meet a need identified in the open space strategy. SPP 11 recognises the health benefits of open space and physical activity, and states that it is particularly important to ensure that disadvantaged communities have accessible open space of good quality. The Scottish Government will shortly be issuing an updated Planning Advice Note 65: Planning and Open Space in support of the new SPP 11.

Scotland's planning system is undergoing significant modernisation. The Planning etc (Scotland) Act 2006 introduced substantial changes and work is underway to implement the provisions of the Planning Act. One key aim of the reforms is to deliver a more inclusive planning system, enabling local people to be more involved in the decisions that shape the development of their communities. The reforms focus on improving involvement during the preparation of development plans, and encouraging greater public participation in the early stages when applications are being considered.

The Government's National Transport and Physical Activity Strategies aim to increase the proportion of short journeys made on foot and on bikes, to improve individual health and also to reduce carbon emissions and improve air quality. There are a number of small scale transport projects that work well in deprived communities. For example, Tri-Cycling runs after school bike clubs in Craigmillar, Edinburgh and the Bike Station in Edinburgh has a small project that teaches young people in deprived areas how to build their own bikes.

The Kerbcraft child pedestrian skills training programme has enhanced pedestrian skills in 5-7 year olds, especially in deprived areas.

The Government is planning a number of whole community developments and demonstration projects. One example is the Smarter Choices, Smarter Places sustainable travel demonstration towns, recently announced in partnership with COSLA. These projects will focus on active travel, building in health outcomes from the outset. Other developments will include a focus on promoting healthy weight and support the creation of sustainable places as beacons of good practice in planning and building.

Long-term Scottish research studies are examining the impact of better quality social housing and neighbourhood transformation (for example through mixed-tenure housing developments) on people's health and other aspects of their lives. For example, the Go Well project in Glasgow is investigating the effects on individuals, families and communities of neighbourhood transformation and of people's moves within or beyond the city, over a 10 year period from 2006.

Task Force recommendations

The outcomes of these recommendations will include better opportunities, especially for children and young people, to improve their health through enjoying the benefits of safe green and open spaces. Transport recommendations will make public services more accessible, as well as benefitting health through increasing walking and cycling.

- 27. Government action on the physical environment should include: evidence-based environmental improvements to promote healthy weight, and improving the quality of local neighbourhoods through providing more environmental "goods" to foster better physical and mental health, improve community cohesion and prevent risks to community safety.**

28. The Government and local agencies and partnerships should apply the “precautionary principle” across policy development affecting greenspace in environment, education and health. It should increase the priority given to the creation, retention and promotion of high quality green spaces as essential for health improvement, especially in communities at risk of poor health.
29. The Government, NHS Boards and other public sector organisations should take specific steps to encourage the use and enjoyment of green space by all, with a view to improving health. Public sector organisations should provide materials, resources and training and evaluation of specific initiatives eg the prescription of “green space use” by GPs and clinical practitioners.
30. Local authorities and others should foster greater public responsibility for maintaining local environments.
31. Children’s play areas and recreation areas for young people generally should have high priority in both planning and subsequent maintenance by the responsible authorities.
32. The National Transport Strategy delivery plan, currently being worked up by the Government, should include specific actions likely to improve health and reduce health inequalities. For example, rolling out effective local projects that improve active travel and increase walking and cycling by deprived communities.
33. Health inequalities should be addressed specifically in the Government’s first formal review of the National Transport Strategy, which will report in 2010.
34. The Government should take forward action targeting children from disadvantaged areas who are at greater risk of injury in road accidents and to encourage local authorities to follow existing good practice in this area.
35. New Government whole-community initiatives should be measured on their impact on health and health inequalities.

SAFER AND STRONGER SCOTLAND: HARMS TO HEALTH AND WELLBEING: ALCOHOL, DRUGS AND VIOLENCE

“Prevention, education and recovery are the keys to reducing health inequalities caused by the linked problems of violence and alcohol and drug misuse.”

Fergus Ewing, Minister for Community Safety

Key points

- Violence, alcohol and drug misuse are often linked and are major factors in health inequalities.
- More effective drug and alcohol treatment are needed, as are better ways of tackling problems at an earlier stage.
- Domestic abuse is a significant problem and affects women and children in particular.

Why this matters

The Task Force is making it a priority to halt the increasing inequalities in death rates, in particular among younger men, caused by problems with alcohol, drugs and violence.

The Task Force heard that violence is a significant problem in Scotland, accounting for 26% of all crime and 40% of the prison population. Violence is often linked with use of alcohol and drugs. Recorded violence is also significantly linked to deprivation. The death rate from assault in the most deprived communities is nearly four times that of the Scottish average and over 10 times that in the least deprived communities.

“Young males are creating their own social constructs of what it is to be male in 21st century Scotland; this is resulting in violence, binge drinking, risky behaviour and lack of aspiration or goals.”

Detective Chief Superintendent John Carnochan, Head of the Violence Reduction Unit.

Example: David was born in one of the most deprived areas of Scotland to a mother who used drugs, drank and smoked throughout the pregnancy. He was brought up in an extended family none of whom have ever worked; three “uncles” have convictions for serious violence. Before he was nine David moved or was rehoused eight times, four times due to domestic abuse. David is one of the smallest boys in his year when he starts high school, in an area with high crime levels. He is soon truanting, involved in gang activity and identified as “outwith parental control”; he is known to various agencies including the police and social work. At fourteen, after a series of exclusions, he has left mainstream education. He drinks, takes drugs and abuses solvents. His family resist offers of help. At fifteen he commits three assaults, theft, breach of the peace, robbery, steals two cars, commits various road traffic offences and is charged with attempted murder. While awaiting action to be taken for these offences, David visits the nearby city centre. David has been drinking and is carrying a knife. David bumps into complete stranger John and stabs him once in the upper torso. John dies fifteen minutes later. David is sentenced to 7 years for culpable homicide.

Domestic abuse is a significant problem in Scotland affecting between one in three and one in five women over their lifetime. 87% of victims of domestic abuse are female. Children living in homes where abuse occurs are often witness to this and can be hurt themselves, either by trying to intervene to protect their mother or being physically abused by the perpetrator.

The experience of domestic abuse is a strong risk factor for poor health for both women and children. It is associated with higher levels of depression, anxiety, suicidal thoughts, and drug and alcohol abuse, whilst the array of physical health problems include gynaecological disorders, adverse pregnancy outcomes, chronic pain, irritable bowel syndrome and injuries.

What works?

We know that alcohol misuse underlies many of the worst symptoms of inequality especially violence. The Task Force heard evidence that regulatory, structural or fiscal interventions affecting the whole population (such as increasing the price of alcohol) can be effective in reducing health inequalities due to alcohol-related harm. Information-based approaches (such as health information campaigns) tend not to influence the most disadvantaged groups and individuals, who often find it harder to change behaviour.

In addition, there is strong evidence that screening and brief interventions help people who are drinking at levels which put them at increased risk, but who are not alcohol dependant. Where people are identified a short, simple advice session has been shown to be effective in helping them to reduce consumption over the medium term. Although there has been little analysis of the effectiveness of brief interventions across different socioeconomic groups, it is thought that these are equally successful across the whole population.

People with drug and alcohol problems need treatment services which are linked with services in housing, training or education to support them to recover from their addiction and to sustain that recovery.

However, we need to look wider than just substance misuse. The Task Force endorses the World Health Organization's (WHO) public health approach to violence which is to work across agencies and focus on prevention, rather than reaction. In the shorter term, innovative approaches to enforcement by the police, local authorities and other criminal justice partners may help. For example, the police, prosecutors and judiciary have worked together on knife crime to establish a much firmer regime built on the foundation of tougher legislation. This has included doubling the maximum sentence for carrying a knife. The long-term solution, however, depends on us looking much earlier to those interventions that are effective in stopping violent behaviour developing in the first place.

What's already happening in Scotland?

The Government is publishing in Summer 2008 a consultation paper on a long-term strategic approach to tackling alcohol-related harm. This will include a mixture of whole population and targeted measures. The final strategy will be cross-Government and will bring all elements of public alcohol policy into a coherent framework.

NHS action is already being focused towards reducing alcohol-related harm, through increased alcohol screening and brief interventions, with efforts being targeted towards A&E Departments, primary care and ante-natal care, and amongst deprived communities. In particular, an alcohol services demonstration project, including alcohol screening and brief interventions, will be piloted within the Scottish Prison Service over a three year period.

Example: the Coal Industry Social Welfare Organisation is being funded to tackle alcohol misuse, smoking and associated health issues in some of the most disadvantaged communities in traditional coal field areas in central Scotland. The project will enable local communities to develop their own networks of support via "buddy systems" and similar mechanisms, so that the objectives of smoking cessation and moderation of alcohol consumption become embedded in the local culture as core values.

The Government is also publishing a new drugs strategy in Summer 2008. A key priority of the strategy is to see more people recover from problem drug use to live longer and healthier lives. The strategy includes action and reform at both national and local levels. It highlights the major contribution of work to tackle drugs in reducing health inequalities, and vice versa.

Example: the Lothian and Edinburgh Abstinence Programme (LEAP) is a three month day programme for people with substance misuse problems. LEAP works closely with the City of Edinburgh Council and other local agencies to deliver a recovery-orientated programme in the community with a focus on abstinence. Patients follow an intensive programme which includes medication and also therapeutic care to address the underlying issues of drug misuse. The programme links up with vocational training and education providers to help equip clients with skills and qualifications to move on with their lives once the programme has finished. Supported housing is provided where required. There is an emphasis on self-help and aftercare.

The Violence Reduction Unit (VRU) with Government support, has been the national centre of expertise on violence reduction in Scotland since April 2006. The VRU launched a comprehensive 10 year action plan in December 2007. This follows the WHO approach to prevention, which can be divided roughly in terms of age groups:

- Primary prevention – preventing violence or other anti-social behaviour from occurring in the first place. Focused on children from pre-birth through to high school age and their parents.
- Secondary prevention – preventing the escalation of violence and anti-social behaviour towards serious criminality. Focussed on children of high school age and including diversion and positive opportunities for young people through to more formal youth justice measures.
- Tertiary prevention – preventing violent offenders reoffending, typically adults within the criminal justice system.

The evidence presented to the Task Force confirms there is a lack of current effective interventions aimed at vulnerable young men in all three categories. There are difficulties in engaging with them and influencing the complex mix of individual behaviours and underlying causes.

Example: Streetbase, aimed at 10 to 18 year old vulnerable males in Lanarkshire, involves street workers who actively engage and develop relationships with young people on the streets who are misusing alcohol or at risk of doing so. Streetbase provides one-to-one counselling on alcohol-related problems for the person concerned and the partners, children, friends and employers. The initiative encourages alternative activities including gorge walking, quad biking and football and has impressive outcomes including reducing alcohol consumption and anti-social behaviour and enhancing community relationships.

To tackle domestic abuse and other forms of violence against women, a cross-Government approach has been adopted, reflecting the need for concerted action across sectors and agencies. The key elements of this approach include prevention through social marketing campaigns and materials in schools, support services for women and children affected by abuse, and challenging perpetrators through the justice system. We shall learn more about what helps children and young people through domestic abuse pathfinder projects within the Government's Getting It Right for Every Child (GIRFEC) approach.

Task Force recommendations

The fundamental causes of violence and drug and alcohol misuse are the same as the causes of other health inequalities: poverty, poor educational attainment and lack of opportunities for young people. The longer term outcomes of the recommendations that follow will be to reverse the rising inequalities in harm to health from alcohol, drugs and violence. Early intervention is key in tackling youth violence and anti-social behaviour more generally. Diversion including providing alternative activities is an effective method of early intervention. But while prevention as a whole is vital, so are treatment and recovery.

- 36. Local authorities, Third Sector organisations and other partners should increase programmes designed to support and engage with those young people who have started on the cycle of offending but not yet escalated to serious violence. For example, more support should be provided for parents whose children begin to display violent behaviour; counselling programmes for victims of violence and mentoring programmes for young people at risk of damaging, violent or anti-social behaviour; appropriate use of campus officers in schools with an extended peripatetic role; increased availability of anger management and cognitive behaviour programmes both in the community and in prison; targeted action to provide routes out of gangs and gang intervention schemes.**

37. **Local authorities and their partners should provide more positive activities for young people including improved access to existing facilities.** The Government will continue to develop its Cash Back for Communities programme to ensure that more “choices and chances” are available to young people to divert them from a life of crime or anti-social behaviour.
38. **NHS drug treatment services, which will incorporate the new emphasis on recovery, should be required to link locally to other forms of support that address clients’ wider problems and life circumstances.**
39. **The Government should ensure more effective local delivery of joined-up services for problem drug and alcohol users, through reform of the current Alcohol and Drug Action Team (ADAT) arrangements. The resources that member agencies contribute to ADAT activities should be more targeted to deprived groups and communities.**
40. **Strong leadership for joint working addressing the underlying causes of violence at local level is required through, for example, greater NHS involvement in local community safety partnerships and police participation in relevant health and education forums. Such partnerships should be built on effective cross-agency information sharing to ensure risk is identified early and managed effectively.**
41. **The Government should support improved data collection, analysis and sharing by all agencies, to ensure that the true level of violence and opportunities for joint solutions are identified. The National Injury Surveillance Model currently being trialled by NHS Lanarkshire should be evaluated and then rolled out, in order that hospital injury data can be shared across agencies, to ensure more effective enforcement and prevention action.** Better data generally will help to develop strategies for individuals and communities where violence is an issue.
42. **NHS Boards should ensure that all women attending key NHS services are asked routinely if they are or have been a victim of domestic abuse.** This will improve detection of abuse and afford women and children the opportunity to access support and services. Enquiries should be targeted at areas where women who are experiencing abuse may be disproportionately represented, mental health, addiction, maternity, sexual and reproductive health, primary and community health services, and A&E departments.
43. **NHS Boards and community health partnerships, with other local organisations, should ensure a swift and effective response to the needs of women and children experiencing abuse.**

HEALTHIER SCOTLAND: HEALTH AND WELLBEING

“Health services need to be part of strong local partnerships dedicated to reducing health inequalities.”

Shona Robison, Minister for Public Health

Key points:

- Health services are important in tackling health inequalities but must act in partnership with other agencies.
- Children’s health, “killer” diseases such as cardiovascular disease and mental health and wellbeing are priority areas for addressing inequalities in healthy life expectancy.
- More needs to be done to help vulnerable people access health services.
- Anticipatory care, particularly targeting deprived communities, should help reduce inequalities.

Why this matters

The Task Force believes that health services make an important contribution to reducing health inequalities, especially in giving children the best start in life and anticipating and preventing health problems that people experience later. The Government’s action plan Better Health, Better Care (December 2007) says NHSScotland should:

- Treat the consequences of health inequalities and minimise their impact.
- Address risks for individuals, including their health-related behaviours such as smoking, which is a major cause of health inequalities.
- Provide a universal gateway to the more targeted support that some people need; for example support to families in children’s early years.
- Play a corporate role in the spectrum of services locally. For example, NHS Boards support schools in delivering health and wellbeing aspects of the curriculum. NHS Boards are also significant local investors through employing people from their community and local purchasing of goods and services.

Local authorities have the power to promote and improve the wellbeing of people in their area, and are key partners locally with health services.

Mental illness and mental wellbeing are specific priorities for the Task Force. People with mental illness are more likely to die earlier from suicide, or illnesses such as cardiovascular disease (CVD) and tend to have generally poorer health through conditions such as diabetes.

Mental wellbeing is associated with good mental health, but is not necessarily the same as absence of mental illness. Much of the Task Force’s work is based on the importance of factors such as resilience, hopefulness and optimism that create mental wellbeing and quality of life. These allow people to deal effectively with life’s problems and normal stresses, to make the most of their abilities and the opportunities available and to play a positive part in their community.

People whose wellbeing is good are more likely to look after their own health. However, depression is closely associated with poor physical health, for example increasing significantly the risks of CVD.

Example: the Royston Stress Centre provides evidence-based smoking cessation interventions as part of a wider stress management programme. The focus of the centre’s work is helping people to acquire and improve personal coping skills through the development of self awareness and to develop new strategies and solutions for dealing with stress. The centre provides a range of one-to-one therapeutic support including therapeutic massage, acupuncture, reiki, relaxation, counselling and group work to adults suffering from the full range of stress-related problems.

There are a number of disadvantaged groups of people whose health is particularly at risk. Health and other services must respond to their specific needs and give them the same quality of service as everyone else.

Example: the Disability Rights Commission (2006) found that people with learning disabilities and mental health problems are much more likely than other citizens to have significant health risks and major health problems. For people with learning disabilities, these include obesity and respiratory disease. For people with mental health problems, problems include obesity, smoking, heart disease, high blood pressure, respiratory disease, diabetes and stroke. However, these groups were less likely to receive some of the standard, evidence-based checks and treatments than other patients, for example cholesterol checks and statins (cholesterol-lowering drugs), measurement of body mass index, blood pressure checks, and cervical and breast cancer screening.

Health services need to respond to inequality and diversity in a range of ways. These include making services more culturally sensitive and accessible, for example through translation and interpreting, and by providing a different level or type of service where needed, such as addressing South Asian people's higher risk of developing diabetes.

Improving the health and wellbeing of offenders will make inroads into the Task Force priority to reduce inequalities associated with violence and alcohol and drug problems. For example around 80% of the prison population have a drug problem; 66% have personality disorders and 70% a mental health problem that requires clinical support.

Women prisoners, who comprise only 5% of the prison population, have exceptionally high levels of health need. For example 98% of the women in Cornton Vale have addiction problems, 80% have mental health problems, 70% have been abused and around 50% self harm.

People with a learning disability make up around 25% of the prison population. Their learning disability is often at the root of their offending and also creates a barrier to getting effective support from services available.

What works?

Anticipating preventable ill-health has been shown to work in primary care, through evidence-based checks and early action for people with either risk factors or early signs of disease.

Psychological therapies can help people with depression and anxiety.

The physical health of those with mental illness can be improved through action on smoking and regular medical reviews and interventions on lifestyle, physical activity and diet.

Promoting access to employment, recreation and social engagement are important in reducing the number of people who develop mental illness and in addressing inequalities in mental health.

Equalities legislation requires organisations to demonstrate that they are tackling discrimination and promoting equity of access and opportunity for all. Within the NHS, the Fair for All agenda aims to ensure that "whatever the individual circumstances of people's lives, including age, gender, ethnicity, disability, religion, sexual orientation, mental health, economic or other circumstances, they have access to the right health services for their needs". Fair for All initiatives have produced a range of tools and guidance to help NHS Boards tackle health inequalities. It is too early, however, to see improved health outcomes or changes in patient experience as a result.

What's already happening in Scotland?

Children and young people

The NHS as a universal service is critical in providing ante-natal care, support for families with young children and school health services. These are already targeted to some extent on families most at risk of poor health.

Example: Childsmile School, the school dental service is targeted at the 20% most deprived areas in Scotland. The school-based service provides a range of preventative care interventions for children in primary 1 and 2 to reduce the risk of dental decay, running in 44 schools in NHS Fife and NHS Tayside.

Primary care

NHS action to reduce health inequalities starts with primary care, where more than 90% of patient contacts take place.

The Government is reviewing how GPs are remunerated, via the GMS (GP) contract, to reflect the additional needs of practices in disadvantaged communities and using the Scottish Enhanced Services Programme (SESP) to provide funding to address local needs. The allocation of resources to NHS Boards for the SESP and to practices through the GMS contract reflects the greater needs of more deprived populations.

Keep Well health checks are operating in the most deprived communities to identify and support people at risk of cardiovascular disease and diabetes, to reduce their risk. The Well North programme starts similar checks in 2008 for more than 45,000 people in the Highlands, Grampian and Island communities.

There is also a range of improvements in NHS dental services, community pharmacy and eye care to improve access and services for deprived groups and communities.

The Government is phasing out prescription charges, to ensure that people are not deterred by cost from getting the medication they need. This will be of particular benefit to those who have long-term conditions.

Mental health and wellbeing

The Government's Delivering for Mental Health Programme is improving care and treatment for people. It covers not only those with severe and enduring illnesses such as schizophrenia, bi-polar disorder and dementia, but also those with a wider range of conditions such as depression, anxiety and stress.

The Government-funded See Me campaign has gone some way to reduce the stigma associated with mental illness and improve people's prospects of recovery. NHS Health Scotland and the National Programme for Improving Mental Health and Wellbeing have also been effective in improving general understanding, for example through mental health literacy training for a wide range of people, not just health professionals.

The Quality and Outcome Framework (QOF) of the GMS contract includes two indicators for depression. We are supporting GPs in implementing these indicators firstly to ensure that new patients presenting with depression have a formal assessment using a standardised tool and matched therapy appropriate to level of need. Secondly, treatment models are being developed for those with CVD and/or diabetes, who are identified as having depression and anxiety under the QOF.

Patients with severe and enduring mental illness should, where possible and appropriate, have a physical health assessment every year. This is also supported by an indicator in the Mental Health area of the QOF.

Example: Living Life to the Full is a project which builds on work done in Glasgow and Clyde which used existing experience of introducing self-help materials for cognitive behaviour therapy (CBT) into the NHS. The Government will be funding the piloting of this approach in three NHS Board areas over the next three years. Targeting people with mild to moderate depression, the programme will offer multiple ways of accessing CBT self-help. Interventions will be provided in a variety of ways, such as one-to-one self-help clinics; using written workbooks or a CD Rom, telephone, group sessions, college courses or using website delivery. The project aims to meet the needs of individuals but also to increase capacity in the NHS to support delivery of CBT and a wide range of other interventions. This work will be evaluated.

Eleven NHS Boards are now taking advantage of enhanced service provision funding to provide health checks for people with learning disabilities.

Vulnerable groups: access to services

Some targeted action seeks to address the particular needs of disadvantaged groups of people. This includes the Government's multiple and complex needs initiative, which has an emphasis on changing staff awareness, attitudes and behaviour. The NHS projects being funded are focusing on factors such as engaging clients, building up trust and finding time and appropriate ways to assess clients' needs fully.

Example: The Prison Leavers Project – Women Centred Space in NHS Lothian is about improving the health outcomes for women leaving Cornton Vale. It provides a "safe place" for women returning to the community or women involved in the criminal justice process to engage in formal and informal learning and to gain support from each other and workers both in the Centre and from other agencies. The activities are centred on providing education and support in the form of courses and educational events. Women using the service are involved in design of the space, planning the programme and management of the project.

The health care needs of people who are homeless or at risk of homelessness have been recognised in comprehensive health and homelessness standards. The Government monitors progress in meeting these standards through the NHS Board annual review process.

Example: NHS Forth Valley seconded a community psychiatric nurse in July 2006, to work in the Falkirk Council housing support team, to provide dedicated support to homeless people. In a 16 month period, 105 homeless people of all ages have been referred to the service. Outcomes for them which the service has helped achieve have included: a more settled housing situation; registration with a local GP; accessing mental health and substance use services; accessing community support and supported accommodation; and improvement in general mental wellbeing.

The Scottish Prison Service (SPS) is already following Government initiatives on alcohol problems, Hepatitis C, drugs, sexual health and healthy food. Continuity of care during the transition between prison and the community is vital. A feasibility study in relation to the transfer of prison medical services to the NHS is currently being considered by the Government.

The SPS also has a number of initiatives in place to improve mental health and wellbeing, support for family relationships and aspects of healthy living.

Example: The Scottish Prison Service is using Scotland's Mental Health First Aid training course for staff and prisoners and is training staff as trainers to deliver the course throughout the service.

Local authorities play a major role in providing services to people in need. They are key partners in shifting the balance of health and social care, to meet the needs of older people, vulnerable groups in the community and those with long-term conditions.

For many people, social care services are critical in sustaining and improving their health. The health of unpaid carers can likewise be improved by supporting them in their caring role. In developing these services, key themes are personalisation, following the recommendations of Changing Lives and shifting the balance of care into the community.

One important way (though not the only one) of providing more personalised services is self-directed support. Local authorities and NHS Boards are able to offer self-directed support which allows disabled people and others to purchase their own social care. Self-directed support improves people's lives and builds their capacity to take care of their own health. Take up is low, however.

Survivor Scotland is a national strategy which provides support for survivors of childhood sexual abuse. If survivors receive the self-care and preventative services they require, they are less likely to present later with serious physical and mental illness. Greater public and professional awareness of the issues surrounding abuse is required, however, as are more specialist abuse services and cost effective therapeutic interventions.

Task Force recommendations

These will make an impact on each of the priority inequalities the Task Force has highlighted, through improving the service people get from health and social care services, especially those in particularly vulnerable groups and at some important life stages. We have already said above what the NHS can do for children and families who need the most support. Outcomes from the action here will include better health for people who use social care services and a better experience of services for people with specific and complex needs.

Children and young people

- 44. Local agencies should provide high quality, consistent information to young people in a whole range of settings, including easily accessible drop-in services, staffed by health professionals and youth workers.** These will support young people to make better decisions about things that affect their health significantly, for example sexual health matters.

Primary care

- 45. Keep Well health checks in deprived areas should identify people with depression and anxiety and make sure they get treatment and support.**
- 46. The Government commitment to health checks for all at age 40 should be implemented in ways that build on the Keep Well programme.**
- 47. The Government should create and fund new evidence-based anticipatory care programmes for other groups at high risk of health problems.**
- 48. The Government should continue to reform the funding of primary care. Service developments through the Scottish Enhanced Services Programme should address the needs of groups and communities most at risk of poor health.**

Mental health and wellbeing

- 49. NHS Board interventions to address depression, stress and anxiety should be increasingly targeted in deprived communities, ensuring that approaches and materials used are appropriate.**

50. **The next phase of Government-led work, following the National Programme for Improving Mental Health and Wellbeing should apply evidence of what works, in particular for those in disadvantaged groups and areas whose future health is most at risk.**

Smoking

51. **It should be a key priority within the Government’s smoking strategy that NHS Boards and their local partners act to prevent young people in deprived communities from smoking, and to provide more effective support to smokers in those communities to quit.**

Vulnerable groups: access to services

52. **NHS Boards should target health promotion and health improvement action better for people with learning disabilities and others who may need support with access to information, in line with statutory disability requirements.**
53. **The Government should lead development of a framework for regular health assessments for people with learning disabilities in all NHS Board areas.**
54. **Each NHS Board should have a designated senior post responsible for ensuring that people with learning disabilities receive fair and equitable treatment from health services.**
55. **The Government should roll out a programme for improving the dental health of vulnerable groups, addressing the needs of, for example, older people, prisoners and homeless people.**
56. **NHS Boards and local authorities should work together to maximise the potential of self-directed support which allows disabled people and others to choose and purchase their own social care.** Action should include publicising self-directed support, ensuring there are user-led support organisations locally and combining health and social care budgets.
57. **Offenders and ex-offenders should have access to the health and other public services they need and benefit from the same quality of service as the rest of the population.** Women offenders’ health needs should have priority. This will require joint action by community health partnerships and community justice authorities.
58. **Criminal justice agencies and NHS Boards should work together to ensure that offenders who have engaged with the Throughcare Addiction Service are assessed for and able to access addiction and health services within six weeks of release from prison.**
59. **Criminal justice services should work with other public and Third Sector organisations and user groups to respond to studies led by the Prison Reform Trust that aim to improve the experience and wellbeing of people with learning disabilities who are in trouble with the law.**
60. **Scottish Prison Service approaches to promoting positive mental health and wellbeing should be extended across all criminal justice settings.**
61. **The Scottish Prison Service should offer family and relationships support from the date of entry to prison.** 51% of men and women in prison had dependent children and approximately 15,500 children in Scotland lose a parent to prison every year. The health, social and educational prospects of these children are affected in turn by their parent’s health and wellbeing.

NHS wider role

- 62. NHS Boards should take opportunities to play a leadership role in promoting good relations within communities, recognising the impact of discrimination and disadvantage on health.** An example of a leadership approach is in NHS Highland, where health service staff are working with community partners to develop a web-based alert/notify/monitor system for hate crimes, linked to anti-racism and anti-discrimination activities.
- 63. All contractors and providers commissioned by the NHS should be explicitly required to monitor their services in accordance with public sector equality duties, ensuring that their analysis uses qualitative and quantitative data to monitor the needs of different groups.**
- 64. NHS Health Scotland should deliver an accessible communication, translation and interpreting strategy and action plan, with clear outcome measures.**

DELIVERING CHANGE

Key points

- Better routes or pathways into and between services and agencies are needed.
- The Third Sector has an important role to play in tackling health inequalities.
- Resources will be required to make change a reality; significant funding has been allocated.
- Staff may need new skills and to work increasingly across organisational boundaries.

PUBLIC SERVICES AND CLIENT PATHWAYS: A STEP CHANGE

The Task Force's recommendations for action cover a wide range of public services which affect people's health and health inequalities, both directly and indirectly. These include support for families, education and training, employment, housing, the physical environment, transport, leisure, policing. The ways in which these services operate and respond to people can be critical to health and wellbeing. This is especially important where people's responses to deprivation or discrimination have already made them feel out of control and unable to cope well with managing their lives.

The Task Force recognises that Third Sector services often play a particularly effective part in supporting people at risk and in disadvantaged communities. "Encouraging the building of self-confidence and self-esteem, raising aspirations and helping people to overcome barriers to services are considered as areas in which the Third Sector excels." (Third Sector consultation)

However, the refocusing and redesign that the Task Force wants to see is mainly about change across the spectrum of public services. The Task Force wants to introduce an understanding of client pathways or routes into, through, between and out of the range of services, particularly those with clients who are more disadvantaged and who rely heavily on support and intervention.

From the client's perspective, services are needed which are high quality, with well trained staff meeting clear public expectations. Services need to meet the key general principles articulated in the Government's early years framework to achieve the same outcomes for all, with more support for those who need it.

As one conclusion from the Task Force's delivery proofing consultation put it: "There should be a shift of emphasis onto those who need it most and access services less."

The Task Force recognises that these statements of good practice are not new to public services and are built in to both aspirations and delivery across the public sector. The principle of personalisation – making services relevant to each individual – is a key pillar of the public service reform agenda, for example in Changing Lives and policy priorities across health and social care.

“Personalisation enables the individual... to find the right solutions for them and to participate in the delivery of a service. From being a recipient, citizens can become actively involved in selecting and shaping the services they receive.” (Changing Lives, service development change programme. 2007)

“For people to perceive that they are part of the solution and not just creators of the problem is likely to be a marker of success” (Third Sector consultation)

Personalisation can be about prevention, maintenance or intensive support – whatever is needed.

There are also widely accepted and helpful standards such as those on equality, Investors in People and the National Standards for Community Engagement.

A client pathway may be a simple one to sort out an immediate and specific need that can be met by one service alone. Or it may reflect more complex circumstances in people’s lives requiring a clear route into and between several services. For example attendance at a hospital out-patient appointment might include people’s experience of transport and the potential to identify further needs for family support, financial advice or lifestyle changes related to risks of ill health.

Making client pathways between services work effectively must be the responsibility of service providers working jointly, within community planning arrangements. This presents a challenge to local authorities and their local community planning partners. Meeting the challenge will contribute significantly to the national outcome target which says that: “Our public services are high quality, continually improving, efficient and responsive to local people’s needs.” How local agencies put this into practice is very much a local matter and effective approaches must emerge from local experience. The Task Force wants to make sure that the best evidence is available to inform local development. This includes a clear understanding of why good practice matters for health and wellbeing and how mainstream public services can help to reduce health inequalities that can be unintended consequences of the way services currently work.

The Task Force wants central support for development of new and better client pathways for public services. It wants to see a small number of local test sites (around 6), where changes to public services are planned with a particular focus on health outcomes and reducing health inequalities.

Test sites might focus on some specific client groups or communities who are most at risk. They will address complex issues such as preventing violence or substance misuse, or meeting the health and other needs of young people.

Test sites will need willing and enthusiastic community planning partners, with senior management buy-in across organisations. They will be selected to cover a mix of areas and topics and will be a vital part of implementing and delivering the changes and priorities that the Task Force recommends.

The approach within test sites must be about the whole system of mainstream services, not about services or projects individually. The purpose will be to improve interactions and relationships between services, from the client's perspective. Some of the support that should be given to the test sites includes:

- Providing existing evidence and knowledge about achieving better health outcomes and reduced health inequalities, from Scotland and further afield.
- Incorporating practice from current strategies, standards and workforce development.
- Supporting test sites to engage communities and individuals, to win their confidence and increase the chances of successful service change.
- Ensuring effective data collection and analysis. This includes promoting the sharing of information across agencies.
- Applying continuous improvement techniques, working with both frontline staff and managers to gain their commitment.
- Evaluating and assessing both the process of service change and the health and other outcomes for clients, with the focus on health inequalities.
- Identifying where wider supporting changes are required for services to achieve the maximum impact eg in initial professional education for staff.

The learning and experience from the test sites must be shared effectively, in order to influence service design elsewhere and delivery. The Task Force wants this sharing of experience to start amongst the test sites themselves. They should form health inequalities learning networks that are supported to exchange experience and share emerging understanding in new and effective ways eg Seeing is Believing-type visits, exchange of key staff, joint training across agencies, action learning and peer support. Learning will also need to be shared more widely in ways that will be likely to influence change nationally. There are existing community planning and other networks and organisations that can help with this. These include the local government Improvement Service, NHS Health Scotland, the Scottish Centre for Regeneration, the Violence Reduction Unit and the Glasgow Centre for Population Health.

New resources will be needed for the health inequalities learning networks, in particular to:

- Support the process of service redesign and transformation. This will likely be through a multi-disciplinary team led by a continuous improvement professional, and providing Scotland-wide input.
- Provide capacity on the ground to bring the relevant organisations together, promote service redesign using continuous improvement techniques and make sure evidence is available to help.
- Commission or support performance reporting, performance management and evaluation.
- Share learning amongst test sites and across Scotland in ways that will influence long-term and sustained change in public services.

Resources for service change itself will be those that are already available locally. The test sites will, however, be able to explore where in the longer term further investment may be needed. This will help to inform longer term resource plans at both local and national levels.

The Task Force's recommendation for action is, therefore:

- 65. The Government should provide resources to test and promote the Task Force's approach to redesigning and refocusing public services through health inequalities learning networks. These will operate initially through a small number of test sites within community planning partnerships. Resources will be required to apply continuous improvement techniques locally, as well as to bring together all the evidence available to inform good practice, track progress and spread learning in order to influence change in public services more widely.**

WORKFORCE

The Task Force's recommendations for action will affect the roles and skills of staff working directly with clients. We also expect to see service redesign in the test sites make some new demands on both frontline staff and their managers. Historically, professionals have been trained to deliver services which focus on a particular speciality. For example, health professionals are accustomed to dealing with health issues, social carers with providing care and teachers with teaching. The effect can be that client pathways between services don't work. Disadvantaged clients may not receive the same quality of service as the rest of the population.

Our recommendations mean that staff in a whole range of public services need some new skills and may work increasingly across organisational boundaries. This may involve a key worker or at least someone in a signposting role, connecting clients with other services, as well as meeting specific needs within their own role and agency.

The Task Force is aware that current strategies such as Changing Lives and the early years framework are already addressing increasingly complex demands on workers and also trying to meet the expectations of clients about quality, flexibility and integration of services. The Task Force wants to build on work already in hand, for example to develop an early years role that can operate across several different services and a para-professional role in social services. The Task Force is also aware that some workforce change will only happen in the long term: for example through influencing organisational cultures and the value base of different professions: altering why professionals do something, not just what they know or how they operate.

In the short term, there is an increasing recognition that staff across professions and disciplines need to do their jobs in a way which is sensitive to inequalities. Some relevant education and training is already taking place, for example equality and diversity training, leadership preparation and partnership working. Much of this education tends to focus on particular practitioner groupings and is sometimes specific to policy areas and types of services. In reality, there are many common aspects where learning could be shared. The Task Force believes that some national direction is required and therefore recommends:

- 66. The Government should establish a short-life, cross-sector working group to enable different sectors and those working within them to recognise and share common values, knowledge and skills and develop a joint educational/training framework to support practice which is sensitive to inequalities.**

The Task Force also wants to see more joined up thinking about key worker roles, based on research and what is already known about effectiveness. The Task Force recommends that:

- 67. The Government should use existing experience in work on Changing Lives, Working for Families and in the early years field to develop a wider concept of a key worker role and the competencies and skills required to carry it out.**

Management arrangements must support services to be sensitive to inequalities and allow for corresponding changes to staff roles.

Example: the goals for an inequalities sensitive health service, as adopted in NHS Greater Glasgow and Clyde, are that it:

- knows and understands its diverse population and the nature of inequality and discrimination it experiences.
- develops and delivers meaningful engagement with those experiencing inequality and discrimination in order to design services and empower patients.
- recognises that positive behaviours for health will be more likely to be enacted if strategies for support are specifically designed to take the experience of social class, gender, race, disability, age, sexual orientation and faith into account.
- understands and removes the obstacles to accessing frontline services and health information.
- creates services that have the ability to support patients in the context of their lives and gives practitioners support to address the causes as well as the consequences of inequality and discrimination.
- recruits and retains a workforce that represents, at all levels of the organisation, the diversity of the population.
- creates a working environment which is responsive to all dimensions of health and social inequalities, and prevents discrimination and prejudice from affecting patient care and staff relations by developing the competency of and support for staff leading and implementing an inequalities sensitive health service.
- reallocates available resources and manages performance in favour of the elements of an inequalities sensitive health service.
- procures its goods and services to impact positively on health and social inequality.
- advocates for and contributes to the implementation of economic and social policy which addresses income inequality, geographic and social class inequality, gender inequality, racism, disability discrimination and homophobia, as pre-requisites for good health.

RESOURCES

Existing allocations

The Task Force's agenda will only be delivered if we use existing resources better. This requires community planning partners to use their funds for shared plans and agreed action locally, as in many of the recommendations above.

There are significant resources allocated to the Government's health and wellbeing portfolio for services that can influence and help reduce health inequalities.

The global amounts made available to health and wellbeing are £11.2 billion in 2008-09, £11.7 billion in 2009-10 and £12.2 billion in 2010-11. These figures include allocations to NHS Boards.

In addition, local authorities will advance the health inequalities agenda from within the current local government settlement. The Concordat indicates that the Scottish Government and local government, through COSLA, will work together to develop policy in areas where local government has a key interest. As part of that agreement both sides will also work together to discuss and agree on resource issues relating to these policy areas.

The funding which the Scottish Government will provide to local government over the period 2008-09 to 2010-11 totals £34.7 billion, split £11.1 billion/£11.6 billion/£12 billion. This settlement represents the total funding provided for all council services.

Within these amounts are more specific sums allocated to action tackling health inequalities and underlying causes directly. In particular, the Fairer Scotland Fund of £145 million a year for 2008-10 is being used by community planning partnerships to address poverty and deprivation, especially helping people towards and into employment. It is a catalyst, to encourage local agencies to use their mainstream budgets and services for these purposes.

The table opposite lists the specific amounts that the Government has already provided for action described in this report. The total is £586 million in 2008-09.

Future resource allocations

The Task Force's work has influenced the Government to allocate new funding for implementing our recommendations, within the overall health and wellbeing budget. This is on top of funds already provided for reducing alcohol problems and smoking, promoting healthy weight and other aspects of health improvement and public health. New spend on Task Force recommendations will be:

- **£7 million** over the period 2008-11 for support services for families with very young children and to increase the healthcare capacity in schools.
- **£4 million** over 3 years to support the Task Force's test sites and health inequalities learning networks and fund the application of continuous improvement techniques in the test site areas.
- The Government is exploring with Inspiring Scotland the possibility of a play theme. Subject to the conclusions of those discussions, the Government is prepared to invest **£4 million** from 2009-11.

In total the global and specific resources above represent significant public sector investment. COSLA has identified the need to invest in capacity both to respond to crises and to stop crises happening in the first place. The Task Force's local test sites will show what changes in public services can be achieved within existing resources, with a view to reducing the key health inequalities in the longer term. Test sites will also provide evidence for future spending decisions, both nationally and locally, to redesign public services and shift the emphasis from dealing with consequences of health inequalities to preventing them in the first place.

68. The Government should protect current resources targeted at reducing health inequalities and consider the need for further investment in its longer term spending plans, based on experience from the Task Force's learning networks about any further resources required for public services to address health inequalities and their underlying causes more effectively.

Programme	2008/09 £m	2009/10 £m	2010/11 £m
Early Years/Young People			
Diet and Physical Activity in pregnancy and early years	5.4	8.4	12.4
Learning Teaching Scotland – Health and Wellbeing outcomes as part of Curriculum for Excellence*	0.6	Not available	Not available
Poverty and Employment			
Benefit take up action	0.5	0.8	1.4
Fairer Scotland Fund (ring-fenced in 08-09 and 09-10 only) [†]	145	145	145
Healthy Working Lives*	2.64	2.64	2.64
Fuel Poverty	45	45	45
Urban Regeneration Companies	26	41	20
Physical Environments and Transport			
Sustainable Development and Climate Change*	13	10.8	11
Smarter Choices, Smarter Places demonstration towns* (future funding potentially available)	4	–	–
Healthy Weight Demonstration Towns*	1	1	1
Keep Scotland Beautiful by Waste and Pollution Reduction*	0.5	0.5	0.5
Woods In and Around Towns*	8	8	8
Environmental Volunteering*	0.25	0.25	–
Harms to health and wellbeing: alcohol, drugs, violence			
Tackling alcohol misuse*	30.5	43.5	48.5
Drugs Misuse*	29.5	32	32.8
Specific drugs related community justice interventions which includes expenditure on Drug Treatment and Testing Orders*	9.1	9.1	9.1
Drugs related throughcare	0.9	–	–
Hepatitis C Action Plan*	5.5	16.2	21.2
Proceeds of crime to fund CashBack for Communities initiative (calculated on annual basis)*	8.0		
Scottish Prison Service Primary Care Medical Services Contract	2.1	2.1	2.2
Scottish Prison Service Enhanced Addiction Casework Services Contract	2.3	2.4	2.4
Health and Wellbeing			
Diet, Physical Activity and Healthy Weight*	9.9	9.9	9.9
Violence against women	14.98	14.98	14.98
Sexual Health Strategy*	5.18	5.18	5.18
Improved access to sexual health information and advice in rural and urban areas	0.5	–	–
Keep Well and anticipatory care	12.5	12.5	12.5
Smoking Cessation*	11	11	11
Abolition of prescription charges	20	32	45
Minor Ailment Service	13.5		
Dental Health Improvement	0.5	0.5	0.4
Bloodborne Virus Prevention Funding*	8.9	8.9	8.9
Scottish Enhanced Services Programme (SESP) for Primary and Community Care*	13	–	–
Work through Quality Outcomes Framework (QOF) and Health Improvement (subject to future GP performance). ^{1*}	130	130	130
National Programme for Mental Health and Wellbeing*	6.3	6.3	6.3
Total	586.05	595.95	607.30

* indicates funding is not all for tackling health inequalities.

[†] Funding from 2010-11 included in general local government finance settlement.

¹ Quality Outcome Framework funding is the payments to GPs for a range of clinical outcomes including reducing rates of CHD, cancer, asthma and mental health.

THIRD SECTOR CONTRIBUTION

The Task Force has noted that Third Sector organisations can be very effective in addressing the wider factors underlying health inequalities. Where Third Sector services demonstrate that they contribute to meeting local outcomes and priorities, they should be given the resources by their funders and commissioners to allow services to be maintained, developed and make more financially sustainable.

Example: Fife Community Food Project

The Fife Community Food Project was launched in November 2006.

It aims to improve access to and take up of a healthy diet by communities within areas of multiple deprivation in Fife. Using work around food, such as workshops, growing projects and training, the project seeks to build individual and community capacity and engage people in practical and sustainable food related projects that inspire health and wellbeing.

The project has four Community Food Development Workers, employed by Fife Council, who work with groups ranging from homeless people to young people with drug and alcohol issues, and from older people to young families.

Examples of current work are:

- co-ordinating the development of fruit and vegetable co-ops in nurseries.
- improving access to affordable, quality fruit and vegetables in regeneration areas.
- engaging with a local retailers to develop healthier sausages that are now available for the local community.
- establishing local weaning groups giving practical advice on healthy eating for babies and toddlers.
- planning, developing and organising cookery classes on a budget for young mothers.
- growing initiatives at primary schools.

Example: Aberdeen Healthy Living Network

Aberdeen is frequently perceived as a wealthy city, with a thriving economic climate. However, a significant number of citizens experience poverty and deprivation.

In 2002, 22 organisations, with specific and broad remits for promoting health and reducing health inequalities, formed a network to take forward a community development approach to health improvement. The universal commitment at the outset was that the network should be a low bureaucracy, "money on the ground" initiative, working with and empowering people experiencing economic disadvantage.

The network provides the vehicle for members to share resources, premises, contacts, information, good practice and ideas. By making these connections the partners involved achieve joined up thinking and working, to generate solutions to often complex problems.

Over the course of the initiative, the scale of support provided to Aberdeen's disadvantaged and vulnerable communities has been significant. More than 62,000 people have used, participated in or been customers of projects such income maximisation campaigns, life skills development programmes, parenting programmes, advice and information services and credit unions.

The Task Force is aware of increased Government investment for the Third Sector, where its activities support the Government's overall purpose. This will include a £30 million Scottish Investment Fund which will support enterprise in the Third Sector through supporting asset and business development. These funds will be for organisations with financially sustainable business plans and from across Scotland. Those working with disadvantaged and remote communities will be particularly encouraged to apply. These organisations are likely to be able to contribute in the Task Force's priority areas for action, such as support for families in children's early years, tackling poverty and improving employment opportunities. The Task Force is aware that details of the criteria and process for organisations to access funding from the Scottish Investment Fund are currently being developed. We would like to see the links between Government investment and health inequalities priorities made explicit, and recommend:

69. Funding for Third Sector organisations through the Government's new Scottish Investment Fund should support Third Sector action in the priority areas identified in the Task Force's recommendations, and this should be contained in criteria for for the Fund.

WHAT WILL SUCCESS LOOK LIKE?

Key points:

- It is important to measure progress in tackling health inequalities in the short, medium and long-term.
- The Task Force has recommended eight headline indicators around its priority areas for long-term change.
- Information and the evidence-base on what works need to be improved.

The Task Force wishes to set out what success in reducing health inequalities will look like in the short, medium and long-term and who is accountable for progress at these stages. The Task Force wishes to have a clear framework for this at both national and local levels, which is in keeping with the new relationship between the Scottish Government and local authorities.

Reporting progress in long-term trends in health inequalities

In the long term, success will be assessed in terms of a decline in inequalities in health outcomes which contributes to achieving the Government's overall purpose, strategic objectives and national outcomes. The Government will track and report progress at a national level.

The Task Force has had advice from a group of Government and external experts on appropriate high level population measures of health inequalities. This will form a new basis for measuring improvement over the longer term. The group has proposed a set of eight headline indicators of health outcomes and three inequalities measures of each. These are closely linked to the Task Force's priorities: early years, mental health and wellbeing, the big killer diseases and the cluster of problems related to drugs, alcohol and violence.

The expert group proposed the following headline indicators of inequalities in health outcomes:

- Healthy life expectancy (at age 25).
- Premature mortality (from all causes, aged under 75).
- Mental wellbeing (adults aged over 16).
- Low birth weight.

The group has also suggested measures of inequalities in morbidity and mortality from specific causes for specific age groups:

- Coronary heart disease (CHD) (first ever emergency admission aged under 75; deaths aged 45-74)
- Cancer (incidence rate aged under 75; deaths aged 45-74)
- Alcohol (first ever hospital admission aged under 75, deaths aged 45-74)
- All-cause mortality (aged 15-44 years)

For each of these headline indicators, the expert group proposed the use of three measurement approaches in order to give a comprehensive picture of inequalities across the whole population. This addresses the problem with previous area-based health inequalities targets that only sought to improve the health of people living in the most deprived areas.

Relative Index of Inequality (RII)	<i>How steep is the inequalities gradient?</i> This measure describes the gradient of health observed across the deprivation scale, relative to the mean health of the whole population
Absolute range	<i>How big is the gap?</i> This measure describes the absolute difference between the extremes of deprivation – the rate in the most deprived minus the rate in least deprived group
Scale	<i>How big is the problem?</i> This measure describes the underlying scale of the problem and past trends

These different measures give insight into different aspects of inequalities. The most fundamental of these differences is between absolute and relative measures of inequality. Where improvement has been seen across the population, the inequality gap might well have narrowed in absolute terms. However, improvements in the most deprived areas may not be as great as overall improvements observed in the population, meaning that the inequality gap has widened in relative terms. To be successful, both absolute and relative dimensions of inequalities should be reduced.

The new measures are illustrated at Annex 3 for premature mortality from CHD.

The Task Force considers that the expert group’s proposals will give a much better basis for Government reporting on long-term success in reducing health inequalities and therefore recommends:

- 70. The Government should adopt the recommended new headline indicators and measures for reporting on long-term progress in reducing health inequalities in Scotland and driving action on the underlying causes of the most important inequalities.**
- 71. The Government should publish in Summer 2008 detailed proposals for the new high level indicators and measures of health inequalities, along with current levels and trends for each measure.**

Managing progress in the shorter term

As well as reporting on long-term, high-level trends in health inequalities, it is important to measure and manage progress in the short and medium-term. Local authorities, NHS Boards and other local partners should be looking at progress in the medium-term in addressing the underlying causes of health inequalities. In line with the Task Force's recommendation for action, agencies should be working separately and jointly to achieve outcomes which can be described as:

- Reduced inequalities in outcomes for children, eg literacy levels, school leaver destinations.
- Reduced inequalities in economic conditions and work environments, eg child poverty, low income, financial exclusion, unemployment.
- More equitable access to basic resources and services, eg adequate and affordable housing, neighbourhood satisfaction, reduced crime rates, opportunities for active travel.
- Reduced inequalities in individual health related behaviours, eg smoking, alcohol and drug misuse, domestic abuse.

Most of these outcomes are included in the National Performance Framework and the Single Outcome Agreement approach, which underpins the new relationship between the Scottish Government and local authorities. As well as contributing to reductions in health inequalities as above, they will also help to meet other Government objectives. These include economic, social and environmental goals.

These measures of underlying causes will therefore assist community planning partnerships and their member organisations to set priorities and plan actions to tackle health inequalities. They will allow agencies to assess the combined success of actions on the ground.

In the light of the Task Force's report, some further analysis is needed of whether the current set of national and local indicators provides enough coverage of the main factors causing health inequalities. We also need analysis of the causal links between these wider factors and influences and the priority health inequalities outcomes.

The Task Force therefore recommends that:

- 72. The Government should arrange for a clear analysis of the medium-term outcome indicators critical to achieving reductions in the key health inequalities outcomes. This analysis should reflect the National Performance Framework and the new relationship between the Scottish Government and local authorities as embodied in the Single Outcome Agreement process. It should be published by autumn 2008, in order to guide community planning partnerships and their constituent organisations in their own planning and performance reporting.**

The Task Force expects this analysis to be tried out in local test sites and through the learning networks.

Within organisations, there are performance management systems, which monitor and manage progress towards longer term outcomes. For example, recent revisions to the NHS performance measures for health improvement in the HEAT targets reflect a re-focusing on the NHS contribution to delivering the relevant national outcomes and indicators. The HEAT targets relating to health inequalities are being further reviewed to ensure they focus on key areas where the NHS can make a critical contribution to long-term reductions in health inequalities.

Improving the evidence base

Throughout its work, the Task Force has found that there is not enough good evidence of what works in reducing health inequalities and influencing underlying causes.

The reasons for a lack of good effectiveness evidence to date were summarised for the Task Force by Professor Sally Macintyre. These include:

- Evaluations focusing on descriptions of the problem and on inputs, throughputs and customer or professional satisfaction, rather than on outcomes.
- When evaluations do look at outcomes, health outcomes are often not studied.
- Where health effects are assessed, the differential effects by socioeconomic status are rarely analysed.
- Interventions do not permit rigorous evaluation. Often they lack clear or measurable goals, baseline information, cost/benefit data and control or comparison groups or areas.
- Policies may take some time to have the desired effects.
- Lack of UK studies. It is not therefore clear whether policies that work within other geographical and cultural settings will also be effective in a UK or Scottish context.

In addition, most of the available evidence of what works comes from evaluating individual services, rather than looking at the results of joint efforts between organisations.

The Task Force therefore recommends that:

- 73. The Government should work with existing and new expert organisations in Scotland to develop a wider range of approaches to outcome and impact evaluation, appropriate for specific interventions and for complex and comprehensive packages of actions designed to reduce health inequalities.**

The Government's support for learning networks and test sites should include approaches and resources for evaluation along these lines. In addition, the policies and actions that the Task Force recommends across the board should be implemented in ways that will allow for proper evaluations of their effectiveness. This should include looking at the differential impacts of policies and actions on different sub-groups in the population (socioeconomic, gender, ethnicity, etc.) and cost effectiveness.

Improving data on inequalities

The Task Force has heard that we do not yet have good enough information on inequalities in health outcomes across different groups in the population. Inequalities monitoring and indicators tend to focus on area deprivation. For example, over 90% of health care is provided through primary care services, yet almost no data are available to help assess whether these services are adequately meeting the specific needs of different groups within the population, which is a requirement of equalities legislation. This means it is not possible to use routine data to identify variations or trends in health and health care, nor to guide quality improvement initiatives. A major effort should be made to develop other appropriate indicators, starting with those areas where good data are available, such as gender and age.

The Task Force therefore recommends:

- 74. The Government should commission a review of health data needs which covers gender, ethnicity, age, disability, religion and belief, sexual orientation and transgender. The review should be published and include a plan of action with milestones to fill information gaps identified.**

75. **NHS targets should be set to support work on patient monitoring and collection of equalities data, led by the Equality and Diversity Information Project at NHS National Services for Scotland (ISD).**
76. **The Government, with advice from relevant experts, should work towards better information to describe health inequalities based on socio-economic status, for example looking at low income of individuals, not just at average income of people living in a small area.**

Assessing impact of policies and programmes

The Task Force has been concerned throughout its discussions to make sure that public sector organisations assess the impact which their policies and programmes have on health inequalities. The purpose of such assessment is to highlight potential health issues at an early stage in decision making. Better Health, Better Care has already recommended a systematic assessment of Government policies for their impact on health and potential contribution to reducing health inequalities. Better Health, Better Care also requires NHS Boards' decisions about service change and investment to be more routinely informed by health impact assessment and work is in hand to implement this.

The Task Force is aware of the multiplicity of impact assessments required of public sector organisations, either through legislation or policy. These include equalities, Strategic Environmental Assessment, carbon impact assessment and others. It acknowledges that an integrated impact assessment process is desirable, in which health issues are included alongside other types of impact. Information, evidence and development of staff skills and capacity are all critical in promoting impact assessment. The Task Force therefore recommends:

77. **Integrated impact assessment processes for public policies and programmes should be developed and implemented at national and local levels, within constraints of the relevant formal systems. Impact on health inequalities should be a clear component. The Government should ensure that there is guidance and support to develop the knowledge and skills to enable impact assessment to be carried out, and health inequalities issues to be incorporated effectively.**

LIMITATIONS OF CURRENT DEVOLVED POWERS

Key points:

- The Task Force has identified areas where the Scottish Government does not presently have the power to make maximum impact on health inequalities.
- Areas include tax and benefits, employment policy and health and safety.

The Task Force has looked mainly at what we can do in Scotland with the powers the Scottish Government currently has. There are, however, some examples of policy and action which are critical to reducing health inequalities, but where the Government does not have sufficient powers for maximum impact. Within its priority areas for action, the Task Force has identified the following issues. These should be pursued through the process set up by the Government's National Conversation about Scotland's constitutional future:

- Tax and benefits issues relevant to tackling poverty and deprivation, including housing benefit and support that allows parents access to childcare.
- Devolution of tax and benefits matters could also have an impact on fuel poverty. More control over energy markets would give the option of a different approach towards influencing customer fuel prices for the most vulnerable.

- Aspects of employment policy and benefits that could create a more seamless set of employment arrangements supporting people to move towards and into the labour market. Education, training and skills, childcare, health and social care all link with improving employability and are already devolved.
- Aspects of health and safety legislation that interact with devolved responsibilities for workplace health and wellbeing.

REVIEWING PROGRESS

The Task Force has recommended a broad spread of action, spanning both central and local responsibilities, with short, medium and long-term targets for progress and success. The Task Force itself has worked in a new, creative and invigorating way to agree jointly its plans for real transformational change. The Task Force anticipates that the Government will accept and implement its recommendations. We have already recommended an implementation plan, giving more detail about who will take action forward, both nationally and locally.

We would like to see progress being reviewed and reported formally. While the Task Force itself was designed as a short life group and has completed this phase of its work, we are keen that its members continue to be involved in delivering change across sectors. The Task Force therefore recommends:

- 78. The Government should review progress in implementing the Task Force's recommendations and publish a report, including any further action required, by summer 2010. As a first step in reviewing progress towards long-term shifts in outcomes, the Task Force should be reconvened to sign off the review of progress.**

ANNEXES

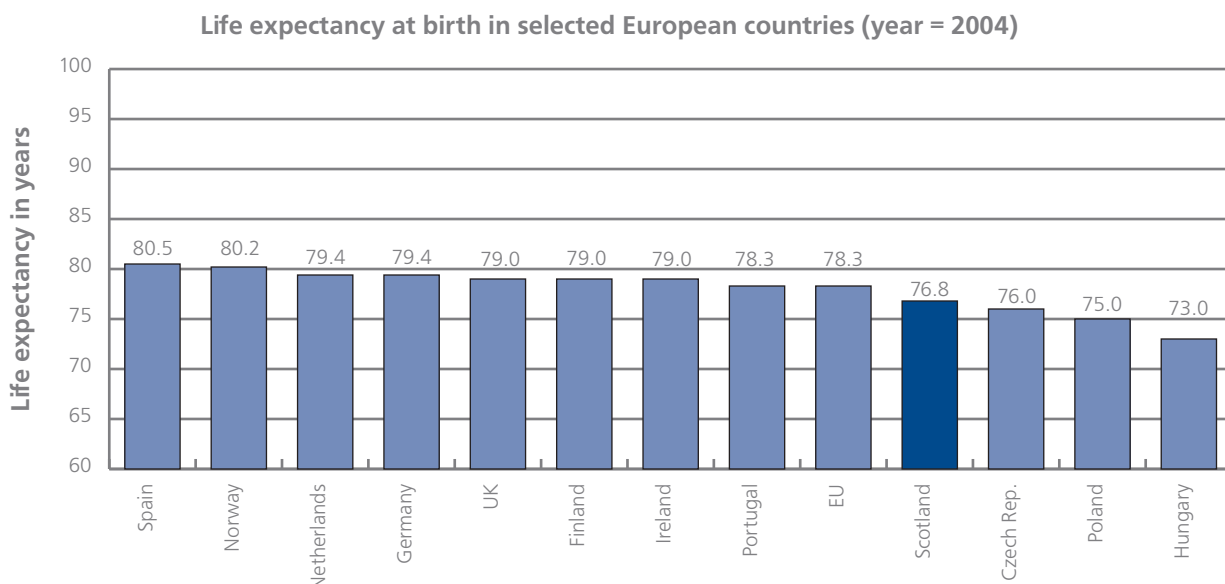
ANNEX 1

KEY HEALTH INEQUALITIES IN SCOTLAND

Life expectancy

In Scotland in 2004-06, male life expectancy in the 10% most deprived areas in Scotland was more than 13.0 years lower than that in the 10% least deprived areas. For females the gap in life expectancy between the most and least deprived was 8.6 years. This inequality gap appears to be widening over time.

Scotland's life expectancy compares unfavourably with the rest of the United Kingdom, and other countries in Europe.



Source: Scotland & European Health for All Database – WHO / ScotPHO
[Based on countries with data for the most recent year available]

Healthy life expectancy

Healthy life expectancy is defined as the number of years a person can expect to live in good health. It is a key measure in the Government's economic strategy, which targets an increase over the period 2007-17.

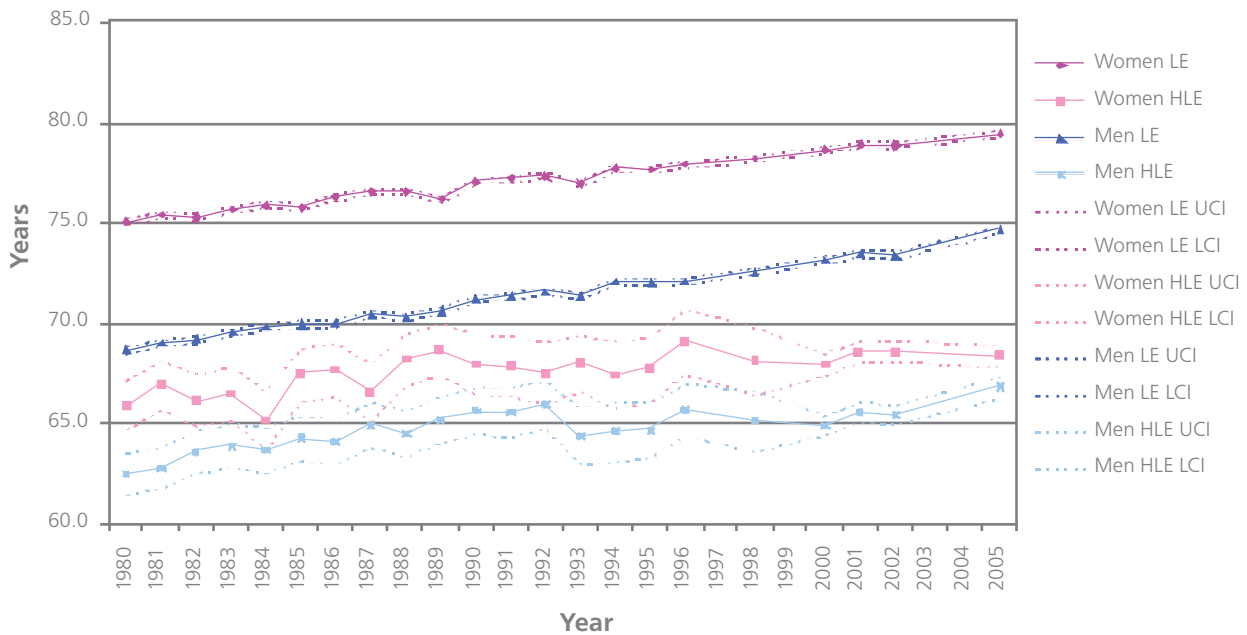
In Scotland in 2006, healthy life expectancy at birth was 67.9 years for men and 69.0 years for women. In the most deprived 15% of areas in Scotland in 2005-06, healthy life expectancy at birth was considerably lower at 57.3 years for males and 59.0 years for females.

Healthy life expectancy in Scotland overall appears to be steadily increasing for men and fluctuating for women. In the 15% most deprived areas in Scotland, healthy life expectancy is increasing for men (at what appears to be a faster rate than for Scotland overall) and fluctuating for women.

It is notable that the long-term life expectancy trend-line for Scotland shows no real decline in the rate of improvement, over the last 25 years in either gender. On the other hand, the rate of improvement of healthy life expectancy has decreased since the late 1980s. This suggests that for both genders the extra years lived since that time have not been spent in good health.

Because of the way data are gathered and the methodology used to calculate estimates, there is a greater degree of uncertainty around the estimates than there is for life expectancy and trends in HLE should be interpreted with caution.

Life/Healthy life expectancy at birth (Scotland 1980-2005)



Healthy life expectancy at birth in deprived areas

Source: ScotPHO/ISD

[LE = Life Expectancy; HLE = Healthy Life Expectancy]

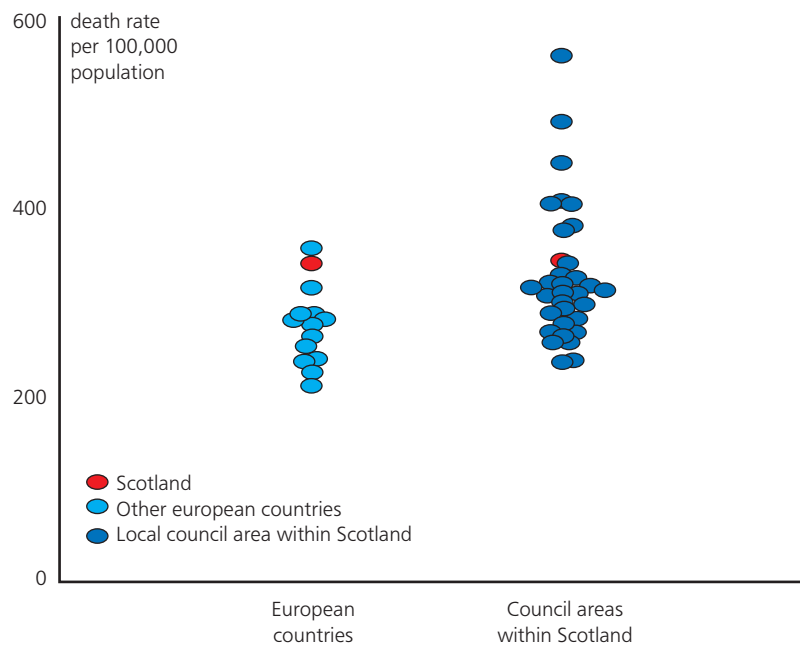
[UCI / LCI = Upper / Lower Confidence Interval - an indication of the uncertainty around the estimates.]

Mortality

In Scotland in 2006, mortality rates for those aged under 75 years in the 15% most deprived areas in Scotland were 1.8 times higher than those in Scotland overall. The difference between the most deprived 15% and Scotland overall seems to be increasing over time (In 1995 and 2000, under 75 mortality rates in the 15% most deprived areas were 1.5 and 1.6 times higher than in Scotland overall).

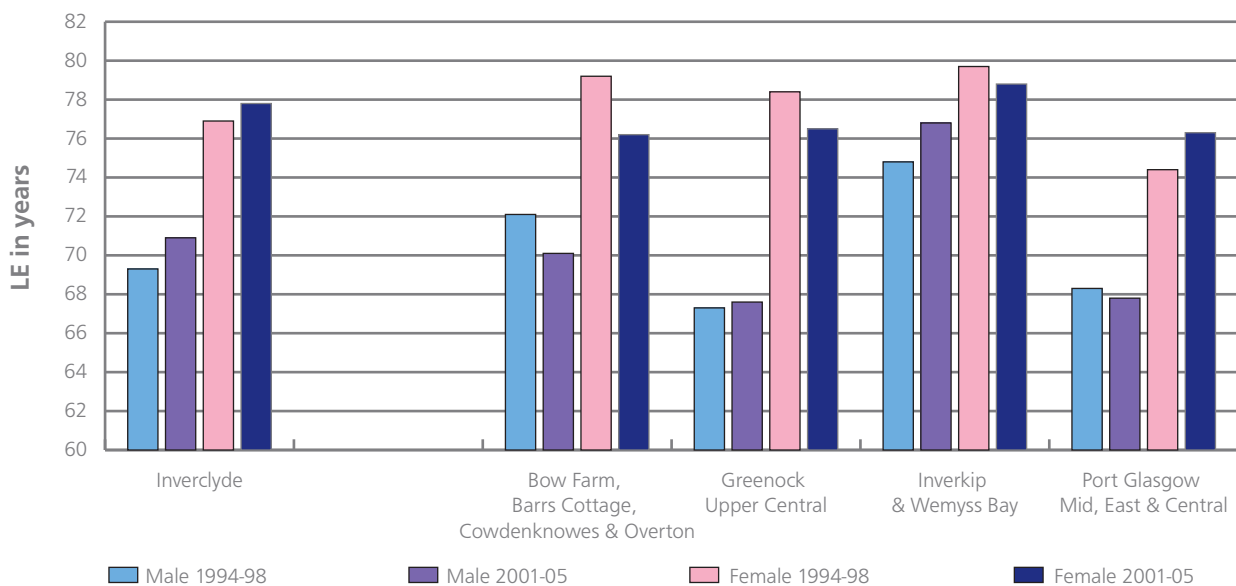
Scotland's mortality rates overall are heavily influenced by the rates in the most deprived areas, in particular because of the poor health of people in the West of Scotland.

Mortality in Scottish Local Authority Areas compared with other European Countries



Life expectancy actually appears to be decreasing in some neighbourhoods, for example within East Glasgow and Inverclyde, although these are relatively small populations and trends should be interpreted with caution.

Life expectancy in local areas within Inverclyde (1994-98 and 2001-05)

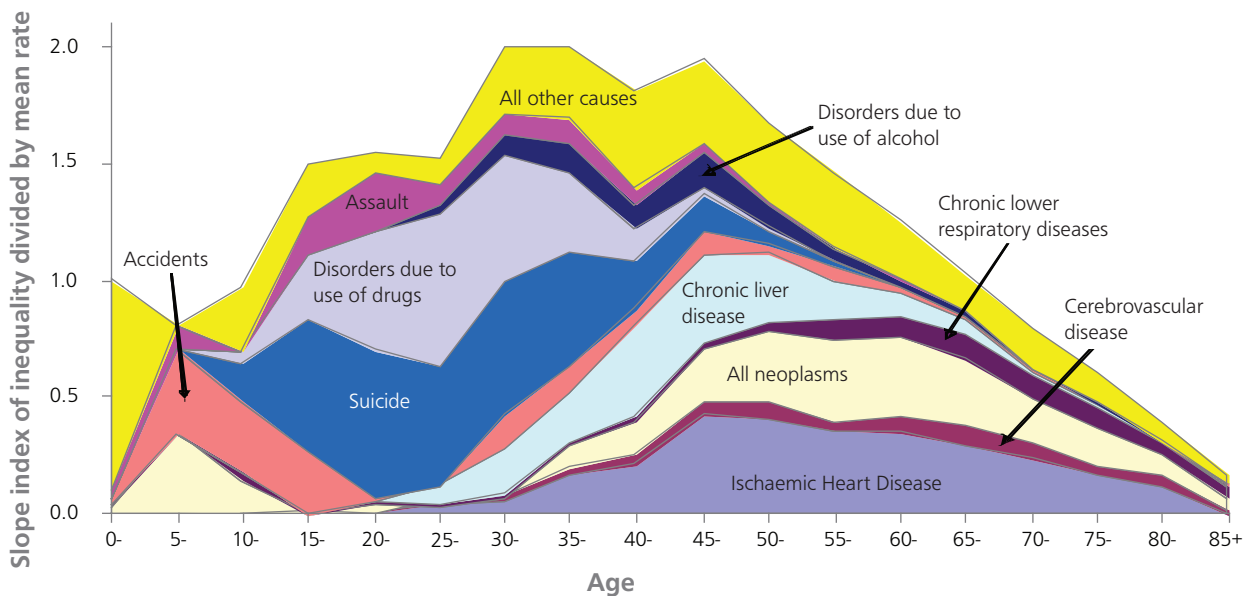


Source: Glasgow Centre For Population Health – Community Profiles

There is also a “Glasgow effect”: inequalities between Glasgow and the rest of Scotland are present, regardless of deprivation or social class.

In Scotland, deaths among men aged 15-44 have increased between 1981 and 2001. They have increased among women aged 15-29 between 1991 and 2001. These increases are due to deaths from suicide, violence, chronic liver disease and mental and behavioural disorders due to the misuse of drugs and alcohol. The increases were restricted to deprived areas and this has led to rising inequalities.

Relative inequalities in mortality by cause, men, Scotland 2001



Source: Inequalities in mortality in Scotland 1981-2001. Leyland et al (2007)

Early years

There are inequalities between rich and poor that have a profound influence on the future health of children now being born in Scotland.

There is marked variation by socioeconomic group and by maternal age at birth in the proportion of pregnant women attending antenatal classes: two thirds of those aged under 20 years (the majority of whom live in deprived areas) did not attend any classes while three quarters of those aged 30-39 years went to most or all.

In addition to this, younger mothers and those from less affluent areas are more likely to find it difficult to know who to ask for help regarding concerns over their children’s health or behavior and are also less likely to ask for help. Younger mothers appear more suspicious of professional help.

A higher proportion of babies born to mothers living in the most deprived fifth of the population have a low birth weight than those born to mothers living in the most affluent areas (9% compared to 5% in 2004-05). In addition to this, older and younger mothers are more likely to have a low birth weight baby. However, a higher number of babies are born to younger mothers living in more deprived areas than to older mothers living in more affluent areas.

Rates of breastfeeding at 6-8 weeks decrease with increasing deprivation and are more than three times lower in the most deprived fifth of areas than in the least deprived areas (18% compared to 57% in 2006). In addition to this, breastfeeding is related to maternal age: only 12% of younger mothers (under 20 age group) in the most deprived fifth of areas are breastfeeding at the health visitor's first visit. This compares with 73% mothers aged 40+ years in the least deprived fifth of areas at first visit.

Mental health and wellbeing

Poor mental health and wellbeing are associated with an increased likelihood of poor physical health.

In Scotland in 2006, people who had a low household income or reported finding it difficult to manage on their household income had on average lower scores on a scale of mental wellbeing than those with a high household income or who reported finding it easy to manage on their income.

Those living in the most deprived areas of Scotland have a suicide risk double that of the Scottish average. During the period 2002-06, there were 4.6 times as many suicides in the most deprived 10% areas as in the least deprived. These inequalities appear to be increasing over time.

The big killer diseases and associated risk factors

Deprived populations have considerably higher levels of mortality from coronary heart disease (CHD). This relationship is evident for all ages, but is strongest in those aged under 75 years for whom mortality rates from CHD in the 10% most deprived areas are 3.5 times higher than in the 10% least deprived areas.

Mortality rates from cancer in the most deprived 10% areas are around 1.5 times those in the least deprived 10% areas.

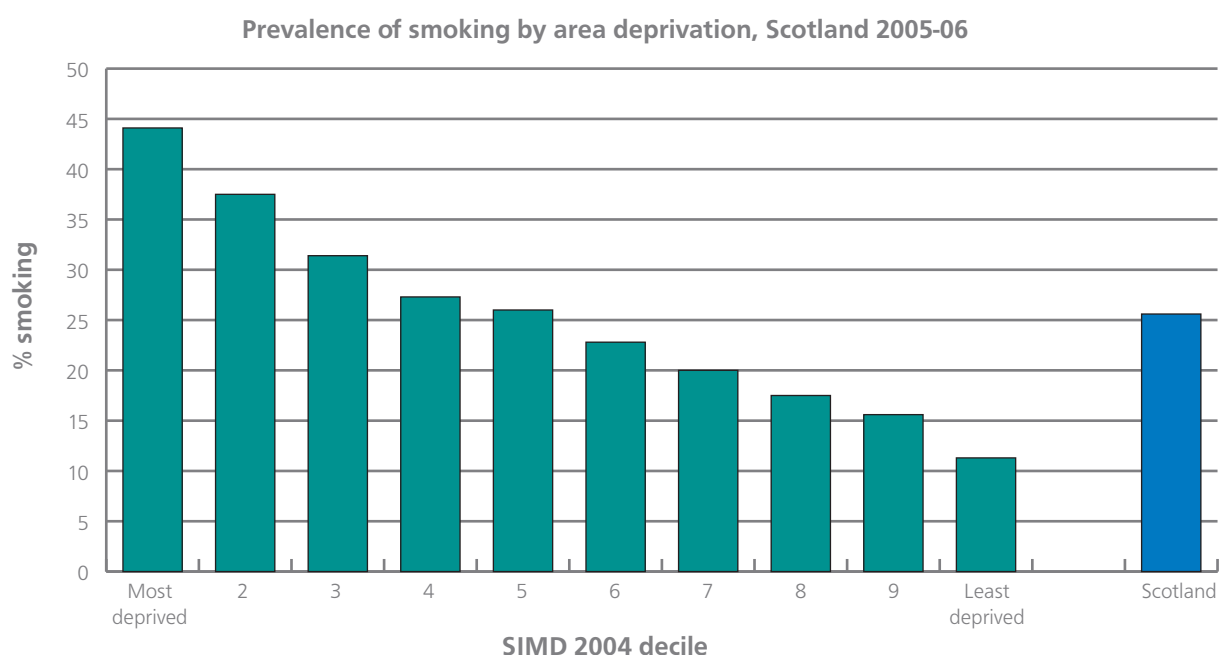
Between 1995 and 2006 the mortality rate amongst those aged under 75 years in the most deprived fifth of the population fell by 16%. The corresponding decrease for those in the most affluent fifth of the population was 20%.

Alcohol-related death rates are increasing in Scotland, whilst they are decreasing in the UK as a whole and in the rest of the European Union. In Scotland in 2006, more than two thirds of the total alcohol-related deaths were in the two most deprived fifths of areas.

People living in the most deprived fifth of areas are around six times more likely to be discharged from a general hospital with an alcohol-related diagnosis than those in the least deprived fifth of areas. This compares with 1.5 times more likely for overall admissions.

Smoking accounts for about 24% of all deaths in Scotland, rising to as much as 34% in some areas. It has been estimated that lifelong smokers die on average about 10 years younger than non-smokers. Smoking also causes a great deal of long-term ill-health due to diseases of the heart, lung and arteries and a long list of cancers and other conditions.

Adult smoking rates increase with increasing deprivation. In Scotland in 2005-06, smoking rates ranged from 11% in the least deprived 10% of areas to 44% in the most deprived 10% of areas.



Source: Scottish Household Survey 2005-06
 Scottish Index of Multiple Deprivation <http://www.scotland.gov.uk/Topics/Statistics/SIMD/Overview>

Other health inequalities

There are important variations in health by ethnic group. For example, Chinese people have better self-reported health and people born in Hong Kong/China but living in Scotland have relatively low mortality rates. Differences in health between different ethnic groups are at least as large as those between rich and poor. Compared with the non-South Asian population, the incidence of heart attacks in Scottish South Asians is 45% higher in men and 80% higher in women. Overall mortality among people living in Scotland but born in India, Pakistan and Bangladesh is lower than among those born in Scotland. On the other hand, mortality from cardiovascular disease is higher among South Asian-born than Scottish-born and the prevalence of diabetes is much higher.

The mental health and wellbeing of some groups is particularly poor:

- Mental health problems affect more women than men. More women experience depressive disorders. However, men are more likely to commit suicide and experience earlier onset of schizophrenia with poorer clinical outcomes than women.
- Teenage mothers suffer from poorer mental health in the first three years after their child's birth than older mothers.
- Lesbian/gay/bisexual and transgender people experience lower self-esteem and higher rates of mental health problems and these have an impact on health behaviours, including higher reported rates of smoking, alcohol and drug use.

ANNEX 2

PREVIOUS REVIEWS AND REPORTS ON HEALTH INEQUALITIES

Inequalities in health: report of a working party. Black D, Morris J, Smith C, Townsend P. London: Department of Health and Social Security, 1980.

www.sochealth.co.uk/history/black10.htm. One of the most influential documents in putting inequalities in health on the agenda. Produced evidence that deprivation and ill-health are inextricably linked and that material deprivation is a major determinant of ill-health and death. Also showed that inequalities in health had worsened in the UK despite the establishment of the NHS in 1948. Inequalities did not result from failures in the health care system, but were due to other social inequalities: income and employment, education, quality of housing, diet and the working environment.

Independent Inquiry into Inequalities in Health: 1998 Acheson report:

www.archive.official-documents.co.uk/document/doh/ih/chair.htm. Review to identify priority areas for future policy development with a very significant evidence base to support recommended action. Report found that although prosperity has increased in England, the health gap between social classes had widened since the 1980's, primarily because of the faster rates of improvement in the more affluent groups. Identified 5 areas for action: breaking the cycle of health inequalities, tackling the major killers, improving access to public services and facilities, strengthening disadvantaged communities and supporting targeted interventions for specific groups.

Towards a Healthier Scotland. Scottish Executive 1999.

www.scotland.gov.uk/library/documents-w7/tahs-00.htm. Calls for coherent attack on health inequalities, a special focus on improving children and young people's health, and major initiatives to drive down cancer and heart disease rates. Overarching aim to tackle inequalities; specified 3 action levels for better health: life circumstances; lifestyles; health topics.

Tackling Health Inequalities 2002 Cross-Cutting Review: Treasury Review

www.hm-treasury.gov.uk/media/B/8/Exec%20sum-Tackling%20Health.pdf. Review to consider how better to match existing resources to health need and to develop a long-term strategy to narrow the health gap. Recommends that tackling health inequalities should be incorporated into priority programmes. Identifies particular groups at risk including: vulnerable older people, vulnerable members of black and minority ethnic communities, people unable to heat their homes, rough sleepers, prisoners and their families, refugees and asylum seekers, looked after children, people with physical or learning disabilities, long-term medical conditions or mental health problems.

Improving Health in Scotland: The Challenge. March 2003.

www.scotland.gov.uk/Publications/2003/03/16747/19929. Endorses previous commitments to tackling health inequalities as an overarching aim of the health improvement agenda. Proposes programme to put health improvement initiatives into the mainstream of action, with a special focus on early years, the teenage transition, the workplace and the community.

Securing Good Health for the Whole Population Wanless Report (commissioned by HM

Treasury) 2004. http://www.hm-treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless04_final.cfm. Review of the cost-effectiveness and consistency of public health spending decisions, in order to improve health outcomes. Focus on prevention and the wider determinants of health in England. Includes an assessment of the evidence on what interventions work, at what stage they work, and the adequacy of the evidence base.

Measuring Inequalities in Health Working Group. Inequalities in Health. Edinburgh, Scottish Parliament, 2003. www.scotland.gov.uk/library5/health/hirnov03.pdf. Group set up to determine the most appropriate indicators to use to monitor progress in tackling health inequalities. Report concentrates on the measurement of health inequalities between socioeconomic groups. Population groups shown as children, young people, adults and older people. Resulted in 23 explicit targets set in 2004 to reduce health inequalities including smoking during pregnancy, breastfeeding, dental health of children, low birth weight babies, accidents in children, teenage pregnancies, suicides by young men and obesity.

Delivering for Health. Scottish Executive 2005. www.scotland.gov.uk/Topics/Health/NHS-Scotland/nursing/review/so-far/deliveringforhealth. Sets out programme of action for the NHS seeking to shift the balance of care towards a system which emphasises a wider effort on improving health and wellbeing through preventative medicine, through support for self care, and through greater targeting of primary care resources on those at greatest risk, with a more proactive approach in the form of anticipatory care services.

Concepts and principles for tackling social inequalities in health: Levelling up Part 1.

World Health Organization. 2006 www.euro.who.int/document/e89383.pdf Concepts and principles for tackling social inequalities in health. European strategies for tackling social inequalities in health: Levelling up Part 2. 2007 www.euro.who.int/document/e89384.pdf

Latest evidence about the nature and extent of the problem in Europe; illustrating an approach and policy options to tackle social inequalities in health.

Health in Scotland 2006 Annual Report of the Chief Medical Officer

www.scotland.gov.uk/Publications/2007/11/15135302/0. Focus on the significance of the first few years of life as a basis for subsequent health and wellbeing in adulthood. Highlights vital role which education within schools and other settings can play. Violence and impact on health also highlighted.

Inequalities in mortality in Scotland 1981-2001. Leyland AH, Dundas R, McLoone P, Boddy FA.

MRC Social and Public Health Sciences Unit Occasional Papers no 16. Glasgow: MRC Social and Public Health Sciences Unit, 2007. www.inequalitiesinhealth.com/. This report combines the use of death records from 1980-2002 with Census data from 1981, 1991 and 2001 to provide a comprehensive picture of the changing patterns of inequalities in mortality in Scotland. It details inequalities by individual socioeconomic circumstances and area deprivation as well as highlighting geographical inequalities. Draws particular attention to widening health inequalities among younger men, due to alcohol, drugs, violence and poor mental health.

ANNEX 3

ILLUSTRATIVE ASSESSMENT OF INEQUALITIES IN PREMATURE MORTALITY FROM CORONARY HEART DISEASE

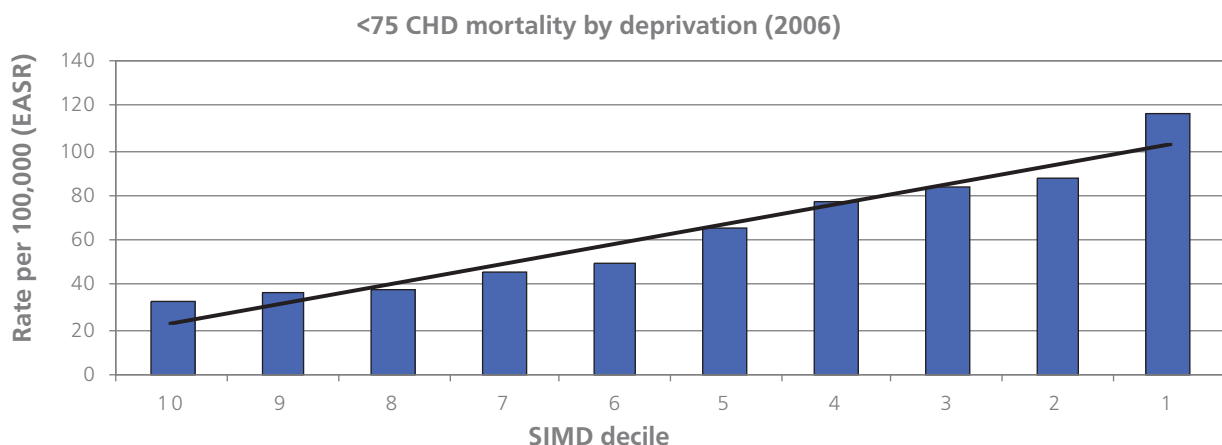
The purpose of this example is to illustrate what the different measures show in terms of explaining inequalities. The detailed definitions of area deprivation to be recommended for use have yet to be finalised, so analyses published at a later date will not match this example exactly. Final analyses will also include estimates of uncertainty around the values, which will highlight whether or not changes over time are statistically significant.

Summary

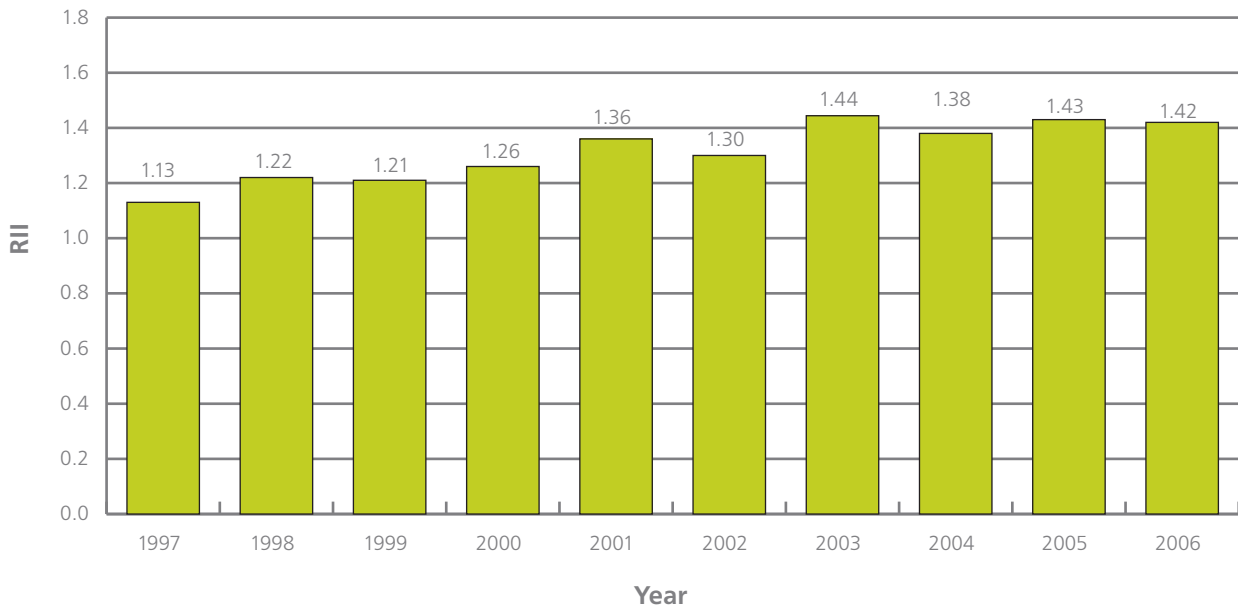
Between 1997 and 2006, there has been a considerable decrease (by 45%) in deaths from coronary heart disease (CHD) in those aged under 75 in the population as a whole. However; CHD remains one of Scotland's biggest causes of premature mortality. Premature death from CHD is more prevalent in deprived areas than in affluent areas. In 2006, adults in the most deprived decile were 3.5 times more likely to die from CHD aged under 75 years than those in the least deprived decile. Recent reductions in CHD mortality have been observed across the population. Whilst the gap between the most and least deprived has narrowed in absolute terms (as demonstrated by the absolute range), improvements observed in deprived areas have not been as great as those observed elsewhere in Scotland resulting in a widening of inequalities in relative terms, as demonstrated by the Relative Index of Inequality (RII).

RII over time

The relative index of inequality describes the gradient of health observed across the deprivation scale, relative to the mean health of the whole population. In the case of premature mortality from coronary heart disease, there is a clear gradient of increasing mortality with increasing deprivation. A horizontal line on the chart below would indicate equality across the deprivation groups. The slope of the best fit line indicates the degree of inequality. A measure of this gradient divided by the population mean rate gives the RII.

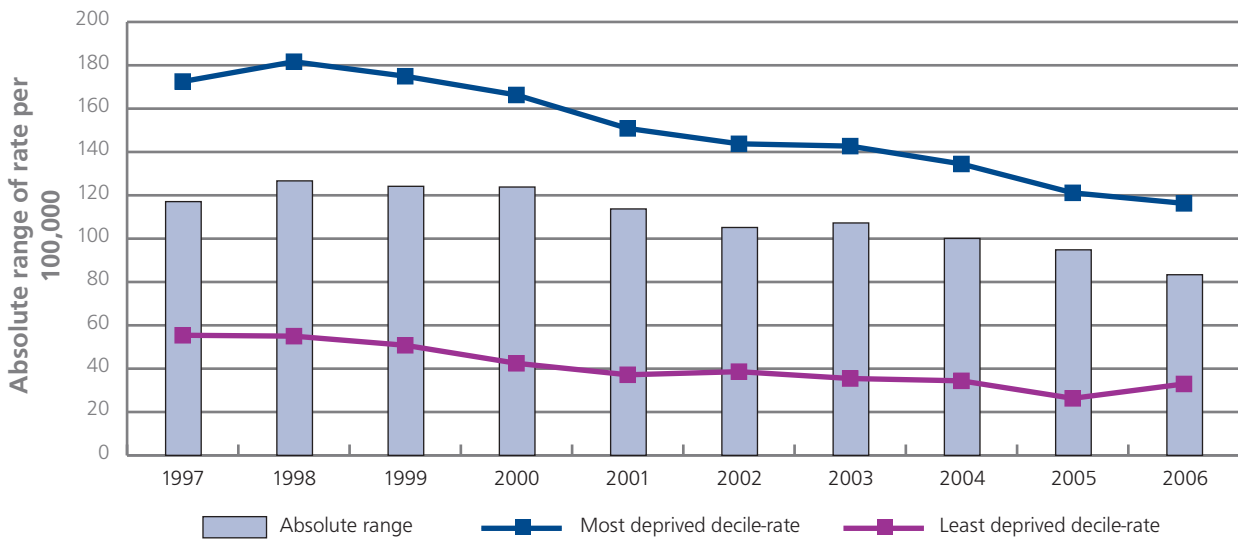


Relative index of inequality (RII): <75 CHD mortality (1997-2006)
 (RII=SII divided by population mean rate)



Absolute range over time

Absolute range: <75 CHD mortality (1997-2006)
 (Absolute range = Rate in most deprived decile-rate in least deprived decile)



Scale

Under 75 CHD mortality rates at Scotland level

Year	Number of deaths	Target population size	Rate per 100,000 (EASR)
1997	6,141	4,740,269	111.6
1998	5,901	4,729,975	106.5
1999	5,605	4,721,298	100.8
2000	5,104	4,708,667	91.7
2001	4,711	4,703,144	83.8
2002	4,537	4,690,508	80.3
2003	4,434	4,690,603	77.6
2004	4,055	4,706,922	70.3
2005	3,929	4,718,403	67.5
2006	3,589	4,734,676	61.8

ANNEX 4

RECOMMENDATIONS

No.	Recommendation
1.	The Government should produce a practical implementation plan by the end of 2008, setting out how the Task Force's recommendations will be turned into action and who will be responsible, at both national and local levels.
2.	Those responsible for implementing the Task Force's recommendations should carry out equality impact assessments on the action they are taking to ensure this is legally compliant; systematically consider the needs of the diversity of the population; ensure action does not adversely affect any part of the population; and consider how they can promote equality.
Early years and young people	
3.	Reducing health inequalities should be a key outcome for the early years framework being developed jointly by the Government and COSLA.
4.	NHS Boards should improve the capacity of ante-natal services to reach higher risk groups and identify and manage risks during pregnancy.
5.	The Government should arrange a Scottish survey of the incidence of Foetal Alcohol Syndrome.
6.	NHS Boards should improve breastfeeding rates in deprived areas and among disadvantaged groups.
7.	The Government should lead the development of holistic support services for families with very young children at risk of poor health and other poor outcomes.
8.	There should be a range of services that identify need and provide support to the most vulnerable children and families. As part of that, the Government should develop a community-based integrated school health team approach, targeting children at risk and increasing the nursing staff and other professionals supporting schools.
9.	The Government should continue to improve support for children at risk in households where alcohol or drugs are misused.
10.	Curriculum for Excellence should continue its strong focus on literacy and numeracy, with every teacher taking responsibility for delivery across the curriculum.
11.	Curriculum for Excellence should take a holistic approach to health and wellbeing outcomes, including active and healthy lifestyles, supported by the new school health team approach.
12.	The ethos within which Curriculum for Excellence is implemented should place the child at the centre of the process.
13.	Curriculum for Excellence should provide continuity and progression through school to post-school, aimed at retaining young people in learning after the age of 16.
14.	Physical environments that promote healthy lifestyles for young children, including opportunities for play, physical activity and healthy eating, should be a priority for local authorities and other public services.
15.	Each NHS Board should assess the physical, mental and emotional health needs of looked after children and young people and act on these assessments, with local partner agencies.

Tackling poverty and increasing employment	
16.	Fairer Scotland Fund resources deployed by community planning partnerships should contribute to health outcomes and improving healthy life expectancy.
17.	Universal public services should build on the examples of effective financial inclusion activity, to engage people at risk of poverty with the financial advice and services they need.
18.	The Government should help people to maximise their income and encourage them to take up means-tested benefits, starting with older people and extending activity through intermediary organisations such as Registered Social Landlords and healthcare services.
19.	Any future Government action on fuel poverty should consider explicitly whether improvements in health and reductions in health inequalities can be expected as a result.
20.	The Government should encourage local leadership in activating business participation in the community planning process. New agencies and current statutory partners should be involved in responding to local needs. In particular, NHS Boards should play an active part in employability partnerships across Scotland.
21.	To achieve the potential of business and enterprise in contributing to local community action, the outcome of improving health through work should be integrated with the remit of economic development agencies at national, sectoral and local authority levels including urban regeneration initiatives.
22.	NHS Boards and public sector employers should act as exemplars in increasing and supporting healthy employment for vulnerable groups.
23.	Public sector leaders should promote the evidence on the health benefits of employment with staff, patients and clients.
24.	Professional bodies in the field of occupational and public health should be consulted on incorporating the evidence on the health benefits of employment into professional development and practice.
25.	The Scottish Centre for Healthy Working Lives should refine the Healthy Working Lives Award scheme to make it more flexible and accessible to smaller businesses.
26.	Public sector organisations should increase the use of community benefits clauses in their contracting processes.

RECOMMENDATIONS – continued

Physical environments and transport	
27.	Government action on the physical environment should include: evidence-based environmental improvements to promote healthy weight, and improving the quality of local neighbourhoods through providing more environmental “goods” to foster better physical and mental health, improve community cohesion and prevent risks to community safety.
28.	The Government and local agencies and partnerships should apply the “precautionary principle” across policy development affecting greenspace in environment, education and health.
29.	The Government, NHS Boards and other public sector organisations should take specific steps to encourage the use and enjoyment of greenspace by all, with a view to improving health. Public sector organisations should provide materials, resources and training and evaluation of specific initiatives eg the prescription of “greenspace use” by GPs and clinical practitioners.
30.	Local authorities and others should foster greater public responsibility for maintaining local environments.
31.	Children’s play areas and recreation areas for young people generally should have high priority in both planning and subsequent maintenance by the responsible authorities.
32.	The National Transport Strategy delivery plan, currently being worked up by the Government, should include specific actions likely to improve health and reduce health inequalities.
33.	Health inequalities should be addressed specifically in the Government’s first formal review of the National Transport Strategy, which will report in 2010.
34.	The Government should take forward action targeting children from disadvantaged areas who are at greater risk of injury in road accidents and to encourage local authorities to follow existing good practice in this area.
35.	New Government whole-community demonstration initiatives should be measured on their impact on health and health inequalities outcomes.

Harms to health and wellbeing: alcohol, drugs and violence	
36.	Local authorities, Third Sector organisations and other partners should increase programmes designed to support and engage with those young people who have started on the cycle of offending but not yet escalated to serious violence.
37.	Local authorities and their partners should provide more positive activities for young people including improved access to existing facilities.
38.	NHS drug treatment services, which will incorporate the new emphasis on recovery, should be required to link locally to other forms of support that address clients' wider problems and life circumstances.
39.	The Government should ensure more effective local delivery of joined-up services for problem drug and alcohol users, through reform of the current Alcohol and Drug Action Team (ADAT) arrangements. The resources that member agencies contribute to ADAT activities should be more targeted to deprived groups and communities.
40.	Strong leadership for joint working addressing the underlying causes of violence at local level is required through, for example, greater NHS involvement in local community safety partnerships and police participation in relevant health and education forums. Such partnerships should be built on effective cross-agency information sharing to ensure risk is identified early and managed effectively.
41.	The Government should support improved data collection, analysis and sharing by all agencies, to ensure that the true level of violence and opportunities for joint solutions are identified. The National Injury Surveillance Model currently being trialled by NHS Lanarkshire should be evaluated and then rolled out, in order that hospital injury data can be shared across agencies, to ensure more effective enforcement and prevention action.
42.	NHS Boards should ensure that all women attending key NHS services are asked routinely if they are or have been a victim of domestic abuse.
43.	NHS Boards and community health partnerships, with other local organisations, should ensure a swift and effective response to the needs of women and children experiencing abuse.

RECOMMENDATIONS – continued

Health and wellbeing	
Children and Young People	
44.	Local agencies should provide high quality, consistent information to young people in a whole range of settings, including easily accessible drop-in services, staffed by health professionals and youth workers.
Primary Care	
45.	Keep Well health checks in deprived areas should identify people with depression and anxiety and make sure they get treatment and support.
46.	The Government commitment to health checks for all at age 40 should be implemented in ways that build on the Keep Well programme.
47.	The Government should create and fund new evidence-based anticipatory care programmes for other groups at high risk of health problems.
48.	The Government should continue to reform the funding of primary care. Service developments through the Scottish Enhanced Services Programme should address the needs of groups and communities most at risk of health inequalities.
Mental Health and Wellbeing	
49.	NHS Board interventions to address depression, stress and anxiety should be increasingly targeted in deprived communities, ensuring that approaches and materials used are appropriate.
50.	The next phase of Government-led work, following the National Programme for Improving Mental Health and Wellbeing should apply evidence of what works, in particular for those in disadvantaged groups and areas whose future health is most at risk.
Smoking	
51.	It should be a key priority within the Government’s smoking strategy that NHS Boards and their local partners act to prevent young people in deprived communities from smoking, and to provide more effective support to smokers in those communities to quit.

Health and wellbeing – continued	
Vulnerable Groups: access to services	
52.	NHS Boards should target health promotion and health improvement action better for people with learning disabilities and others who may need support with access to information, in line with statutory disability requirements.
53.	The Government should lead development of a framework for regular health assessments for people with learning disabilities in all NHS Board areas.
54.	Each NHS Board should have a designated senior post responsible for ensuring that people with learning disabilities receive fair and equitable treatment from health services.
55.	The Government should roll out a programme for improving the dental health of vulnerable groups, addressing the needs of, for example, older people, prisoners and homeless people.
56.	NHS Boards and local authorities should work together to maximise the potential of self directed support which allows disabled people and others to buy their own social care.
57.	Offenders and ex-offenders should have access to the health and other public services they need and benefit from the same quality of service as the rest of the population.
58.	Criminal justice agencies and NHS Boards should work together to ensure that offenders who have engaged with the Throughcare Addiction Service are assessed for and able to access addiction and health services within six weeks of release from prison.
59.	Criminal justice services should work with other public and Third Sector organisations and user groups to respond to studies led by the Prison Reform Trust that aim to improve the experience and wellbeing of people with learning disabilities who are in trouble with the law.
60.	Scottish Prison Service approaches to promoting positive mental health and wellbeing should be extended across all criminal justice settings.
61.	The Scottish Prison Service should offer family and relationships support from the date of entry to prison.
NHS Wider Role	
62.	NHS Boards should take opportunities to play a leadership role in promoting good relations within communities, recognising the impact of discrimination and disadvantage on health.
63.	All contractors and providers commissioned by the NHS should be explicitly required to monitor their services in accordance with public sector equality duties, ensuring that their analysis uses qualitative and quantitative data to monitor the needs of different groups.
64.	NHS Health Scotland should deliver an accessible communication, translation and interpreting strategy and action plan, with clear outcome measures.

RECOMMENDATIONS – continued

Delivering change	
65.	The Government should provide resources to test and promote the Task Force's approach to redesigning and refocusing public services through health inequalities learning networks. These will operate initially through a small number of test sites within community planning partnerships. Resources will be required to apply continuous improvement techniques locally, as well as to bring together all the evidence available to inform good practice, track progress and spread learning in order to influence change in public services more widely.
66.	The Government should establish a short-life, cross-sector working group to enable different sectors and those working within them to recognise and share common values, knowledge and skills and develop a joint educational/training framework to support practice which is sensitive to inequalities.
67.	Government should use existing experience in work on Changing Lives, Working for Families and in the early years field to develop a wider concept of a key worker role and the competencies and skills required to carry it out.
68.	The Government should protect current resources targeted at reducing health inequalities and consider the need for further investment in its longer term spending plans, based on experience from the Task Force's learning networks about any further resources required for public services to address health inequalities and their underlying causes more effectively.
69.	Funding for Third Sector organisations through the Government's new Scottish Investment Fund should support Third Sector action in the priority areas identified in the Task Force's recommendations, and this should be contained in criteria for the Fund.
70.	The Government should adopt the recommended new headline indicators and measures for reporting on long-term progress in reducing health inequalities in Scotland and driving action on the underlying causes of the most important inequalities.
71.	The Government should publish in Summer 2008 detailed proposals for the new high level indicators and measures of health inequalities, along with current levels and trends for each measure.
72.	The Government should arrange for a clear analysis of the medium-term outcome indicators critical to achieving reductions in the key health inequalities outcomes. This analysis should reflect the National Performance Framework and the new relationship between the Scottish Government and local authorities as embodied in the Single Outcome Agreement process. It should be published by autumn 2008, in order to guide community planning partnerships and their constituent organisations in their own planning and performance reporting.
73.	The Government should work with existing and new expert organisations in Scotland to develop a wider repertoire of approaches to outcome and impact evaluation, appropriate for specific interventions and complex and comprehensive packages of actions designed to reduce health inequalities.
74.	The Government should commission a review of health data needs that covers gender, ethnicity, age, disability, religion and belief, sexual orientation and transgender. The review should be published and include a plan of action with milestones to fill information gaps identified.

Delivering change – continued	
75.	NHS targets should be set to support work on patient monitoring and collection of equalities data, led by the Equality and Diversity Information Project at NHS National Services for Scotland (ISD).
76.	The Government, with advice from relevant experts, should work towards better information to describe health inequalities based on socio-economic status, for example looking at low income of individuals, not just at average income of people living in a small area.
77.	Integrated impact assessment processes for public policies and programmes should be developed and implemented at national and local levels, within constraints of the relevant formal systems. Impact on health inequalities should be a clear component. The Government should ensure that there is guidance and support to develop the knowledge and skills to enable impact assessment to be carried out, and health inequalities issues to be incorporated effectively.
78.	The Government should review progress in implementing the Task Force's recommendations and publish a report, including any further action required, by summer 2010. The Task Force should be reconvened to sign off the review of progress.



**The Scottish
Government**

© Crown copyright 2008

This document is also available on the Scottish Government website:
www.scotland.gov.uk

RR Donnelley B56023 06/08

Further copies are available from
Blackwell's Bookshop
53 South Bridge
Edinburgh
EH1 1YS

Telephone orders and enquiries
0131 622 8283 or 0131 622 8258

Fax orders
0131 557 8149

Email orders
business.edinburgh@blackwell.co.uk

ISBN 978-0-7559-5760-6



9 780755 957606