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Health and Sport Committee

Report on Health Inequalities





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Health and Sport Committee

To consider and report on health policy, the NHS in Scotland, anti poverty measures, equalities, sport and other matters falling within the responsibility of the Cabinet Secretary for Health and Wellbeing apart from those covered by the remit of the Economy, Energy and Tourism Committee.



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Note: The membership of the Committee changed during the period covered by this report, as follows:

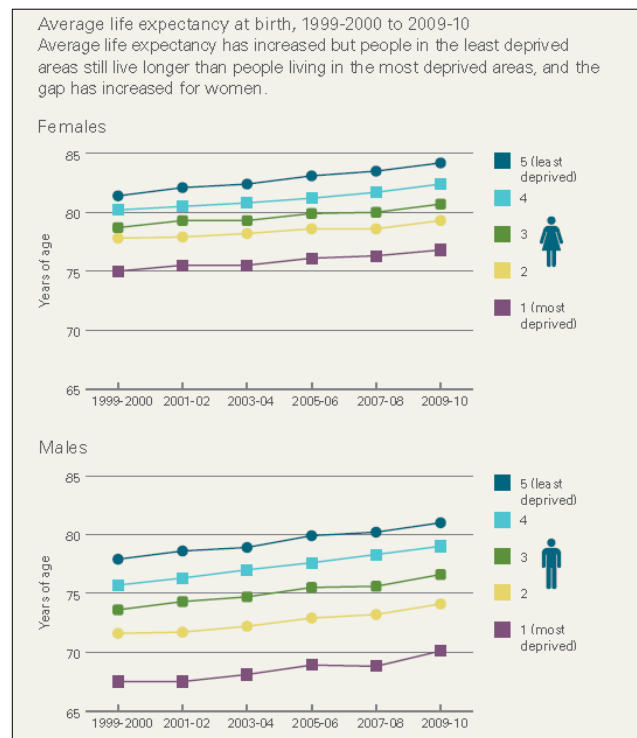
Mike MacKenzie and Dennis Robertson joined the Committee on 27 November 2014, replacing Aileen McLeod (Scottish National Party, South Scotland) and Gil Paterson (Scottish National Party, Clydebank and Milngavie).

Introduction

1. A boy born today in Lenzie, East Dunbartonshire, can expect to live until he is 82. Yet for a boy born only eight miles away in Carlton, in the east end of Glasgow, life expectancy may be as low as 54 years, a difference of 28 years or almost half as long again as his whole life.¹

2. These kind of stark illustrations of health inequalities are not new. The divisions in health expectations and outcomes between the most and least wealthy, powerful, educated and housed have existed and been acknowledged for a long time, and are well-documented.

3. Addressing such inequalities and reducing the differences between those with the best outcomes and those with the poorest has been a priority for every Scottish administration since devolution. Yet, despite many well-intended initiatives, none has made any significant difference. Indeed, although health is improving, it is doing so less rapidly than in other European countries and although the latest figures are a little more encouraging, health inequalities remain persistently wide.



Life expectancy in Scotland
Source: Audit Scotland

4. The Committee carried out a “scoping exercise” intended to help define the remit and terms of reference for a possible full-scale inquiry into health inequalities. Having carried out the initial exercise, however, we have concluded that most of the primary causes of health inequalities are rooted in wider social and income inequalities, many of which lie outside our remit (and indeed that of the NHS). There would, therefore, be little to be gained in practical terms by embarking on a lengthy inquiry, which might reveal little, if any, more than had been found by previous studies.
5. While there is no doubt that the NHS has a key role to play in tackling health inequalities and in measuring progress against the broad objectives of reducing health inequalities, it is clear that it cannot do so successfully entirely on its own,

and the efforts to address the issue need to be made on a much wider number of fronts.

6. In this preliminary report to the Parliament, therefore, we seek to widen the debate on inequalities, and through that debate challenge the Parliament and its committees to consider what action they can and should take in order to help to develop policy and scrutinise government activity across a range of portfolios to that should be active in reduce these wider inequalities. That challenge will involve a parliamentary debate, and an engagement with individual relevant parliamentary committees.
7. At the same time, we will continue our agreed approach of directing our efforts towards shorter, focussed inquiries on health inequalities-related issues that sit mainly within our remit (albeit some of the work that we are doing is cross-cutting, for example some the early years work relates to the Education and Culture Committee remit) and broadly within the portfolio of Ministers and Cabinet Secretaries who are directly accountable to us.
8. We have already reported (in 2013) on our short inquiry into teenage pregnancy, following our short inquiry that had been intentionally linked to the health inequalities scoping exercise.
9. We also scrutinised the Scottish Government's annual report for the child poverty strategy taking evidence from Scottish Government and UK government ministers and officials and visiting the Children's Inclusion Partnership in Glasgow's Possilpark to see projects managed by One Parent Families Scotland and Children 1st. We will continue to scrutinise reports on progress against child poverty on an annual basis.
10. In 2014, we have continued to develop this focussed inquiry model, inquiring into early years, and taking evidence on access to primary care services. Much of our ongoing work – for example in relation to access, integration, medicines and scrutiny of the Scottish Government annual budget – also has a health inequalities aspect.
11. We will also consider whether there is a need for investigation of any other topic by the Committee in the remainder of the parliamentary session or, indeed, whether there is further specific work that we wish to ask the Scottish Government to undertake in relation to health inequalities. This report will also pull together the various strands of work that we have carried out on health inequalities over the last two years.



Pushchairs at Smithycroft Secondary School,
Glasgow

12. In each section of this interim report, we have drawn some initial conclusions about the nature of the issues under consideration and given some commentary on the Scottish Government's activity and action in the area. We also draw the Scottish Government's attention to the body of evidence that we have collected during the scoping exercise, the early years and teenage pregnancy inquiries and the access to services sessions. We also, intend, over the remainder of this session, to invite it to give evidence from time to time on its progress on the health inequalities agenda. We will keep that work under scrutiny, with the expectation of longer-term and determined policy and action across the Scottish Government, other public bodies and beyond.
13. We offer this cross-party report, therefore, as an introductory backdrop to help support the participation of all parties, parliamentary committees and government in the forthcoming parliamentary debate and to stimulate wider discussion on health inequalities amongst our stakeholder organisation.

Background

14. We agreed, on 4 October 2012, that the area of health inequalities would be a major priority for our inquiry work for the middle part of session 4 of the Parliament. On 19 December 2012, we considered our approach to the inquiry and agreed to hold a "scoping exercise", involving evidence-taking from the [Chief Medical Officer and the Chief Executive of NHS Scotland](#), a roundtable evidence session involving a [range of academics](#) and a stakeholder event involving keynote speakers and key contributors.



Stakeholder event

15. We organised a stakeholder conference, *Mind the 28 year gap: Health inequalities in Scotland*, which took place in the Parliament on 18 February 2013. This was attended by about 80 delegates from local authorities, health boards and third sector organisations from around Scotland. Professor Clare Bamba and Professor Kate Pickett were the keynote speakers.



Stirling visit

16. We visited Stirling on Friday 21 June 2013, and spoke to people involved in measures to combat health inequalities in the Culterhove area of the city. We also visited Stirling Community Hospital, where we saw a performance of *Max in the Middle*, an integrated drama, dance and multimedia project intended to promote healthy eating and nutritional awareness, that had been developed in

Professors Kate Pickett and (top) Clare Bamba, keynote speakers at the Committee's stakeholder event on 18 February 2013

primary schools in the Stirling area, and met older people involved in the Town Break project. We also held a formal committee meeting on the same day in the Stirling Council chamber and [took evidence](#) from Stirling Council, NHS Forth Valley and others on the approach being taken to tackle health inequalities locally.

Conclusion of scoping exercise

17. We concluded our scoping exercise on 10 June 2014, when we took [evidence](#) from the Minister for Public Health on *Equally Well* and the findings of the Ministerial taskforce on health inequalities.

Parallel inquiry into teenage pregnancy

18. We also agreed to hold a short, parallel inquiry into teenage pregnancy. We were aware of the links between health inequalities and high rates of teenage pregnancy. This inquiry gave the Committee an opportunity to examine this important topic and provided a model that could be used in future inquiries on specific topics linked to health inequalities.

The Committee's health inequalities work to date: issues

Scene-setting in the scoping exercise

Historical context

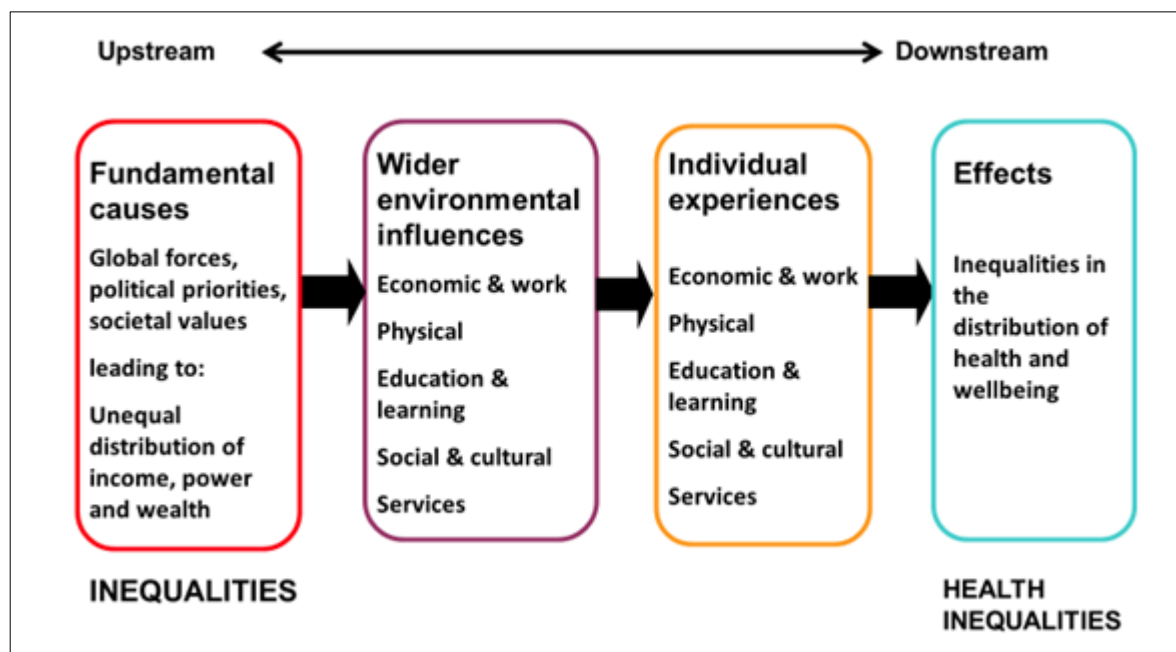
19. Sir Harry Burns (Chief Medical Officer at the time) told us that trends in life expectancy in 16 western European countries going back 160 years showed that for most of that time, Scotland had “pretty much the average life expectancy in western Europe”. It had only fallen behind in the past 40 or 50 years “because the gap between rich and poor has widened”. He explained that affluent people in Scotland had a life expectancy “better than the western European average”, but the gap in life expectancy between the extremes of rich and poor in Scotland was 14 or 15 years. He said that if poor people’s life expectancy had improved at the same rate as it did until the 1950s or 1960s, average life expectancy would be what it had been for most of the past 150 years—the western European average or slightly better than that. There was, he said, nothing intrinsically unhealthy about Scotland or the Scots. What had happened in the past 40 or 50 years was that a large part of the population has failed to improve its health at the same rate as the more affluent in the population had. Understanding that, he said, was the key to doing something about it².

Views on causes of health inequalities

20. The most striking thing about the evidence that emerged during our early evidence-taking in the scoping exercise was the degree of unanimity regarding the

high level causes of health inequalities, such as low income and poverty, economic disadvantage, poor housing, low educational attainment and industrial decline. There was also agreement that some interventions, for example public health messages in relation to risky behaviours such as alcohol abuse, tobacco use, diet and exercise had been shown to have had little or no impact on health inequalities or, indeed, to have exacerbated them.

21. Dr Gerry McCartney, a consultant on public health and head of the public health observatory team at NHS Health Scotland, told us that there was “fairly good evidence that income, power and wealth inequalities drive health inequalities”. He mentioned that in the UK and US inequalities dramatically reduced between 1920 and the mid-1970s, during a time when income, wealth and power inequalities, as measured by the rise of the welfare state, declined. Later, there was a reverse as income inequalities and wealth inequalities rose.³
22. Professor Sally McIntyre, director of the institute of health and wellbeing at the University of Glasgow, told us that the three key issues were employment, income and education. She said it was important to note that policies in those “three key domains” would help to reduce social inequalities in relation to health and other things.⁴
23. Professor Carol Tannahill told us that we should also think about the changing nature of work. She said that the evidence on work and health inequalities was developed at a time when employment was very different from what it is today. We should be concerned, she said, about “the changing nature of work and the consequence of people being in and out of poor-quality work on short-term contracts for their health, which seems from some recent evidence to be even more detrimental than long-term unemployment”⁵.



Health Scotland theory of causation of health inequalities.⁶

24. The Chief Executive of NHS Scotland (at the time, Derek Feeley) told us that the problem of health inequalities was **“probably the most complex that we face and there is no simple solution.”**⁷ Sir Harry Burns noted that the problem of health inequalities was “much more complex than you think”, and that the whole story had “been bedevilled by people who knew the answer”. It was, he said, “much more complicated than anyone ever assumed”.⁸
25. The main thrust of Sir Harry Burns’ contribution during his evidence was that “the notion of family support and consistent parenting that allows young people to develop a sense of being in control of their lives and allows them to make choices—not to get involved in difficult behaviour but to succeed at school and see that as a way of emerging—is the key to all this”⁹. He also told us that



Members met users at Stirling Townbreak during the Parliament day visit in June 2013

evidence showed that adverse and chaotic environments in childhood led to a number of problems later in life and that children who experienced adverse environments faced a range of biological consequences that lead on to behavioural consequences. Children who experience adverse events in early life, he said, were far more likely to have mental health problems and were far less likely to succeed at school. This created “a generational cycle of failure in a number of domains of living”¹⁰.

26. Sir Harry Burns told us that, while there were things that could be done, for children and later on in life, that could ameliorate the problems of early life, **“unless we break the intergenerational cycle by radically changing conditions of nurture, attachment and support for babies and their families, we will not be as effective as we can be”**¹¹.

Consensus on structural view of health inequalities

27. Most of the witnesses at our roundtable of academics promoted a largely structural view of health inequalities, which was perhaps a little different in emphasis from some of the views expressed by the Chief Medical Officer (CMO). Professor Sally McIntyre, for example, told us, “when we talk about social inequalities, we are talking about socially structured inequalities that mean that, on average, people from poorer backgrounds have poorer outcomes across many domains of life, such as health or crime.” Noting that the CMO was “keen on parenting” she remarked that, “we all know that good parents can help to ameliorate problems and provide more resilience, but health inequalities are not about parenting; they are about the socially structured issues that cause those inequalities, such as poverty, unemployment and living in terrible places”.¹²
28. Social inequalities, Professor McIntyre went on to argue, were not about random variation and why some people did better than others in health but about broad generalisations that life expectancy and healthy life expectancy were systematically different between social groups. The issue with the CMO’s remarks to the Committee, she said, was that “he implied that, if you have good parents, it is fine, but if you have bad parents, it is bad”¹³.

Impact of initiatives and lifestyle drift

29. Graeme Watt noted that many health improvement initiatives could “have perverse effects, given where they are taken up and where they are not.” He also suggested that it was necessary to extend that argument and “recognise that the health service as a whole has the potential to achieve the same perverse effects unless we make it our business to identify and address them”. He also noted that an advantage of general practice was that GPs were independent practitioners, so could speak independently about policies and their consequences. Health services, he argued, were therefore “very much better described, analysed and commented on than other services”¹⁴.
30. It was also noted by Dr Gerry McCartney that, in discussions of health inequalities, there was a danger of drifting from the importance of poverty and inequality in society to discussion about parenting or individualised interventions and health services. This has become known as “the lifestyle drift”. He also spoke of a “service drift”, where discussion of the societal determinants of health rapidly gives way to discussion about health services.¹⁵
31. There was agreement in the roundtable that although health inequalities had been a stated priority of every Scottish administration since devolution, they would not be reduced without action to reduce inequalities in every other policy area and across every portfolio.
32. A picture similar to that which we discovered during our two evidence sessions on [22 January](#) and [5 February](#) 2013 emerged from the stakeholder event, held on 18 February 2013. Clare Bambra, Professor of Public Health Policy, Department of

Geography and Director of the Wolfson Research Institute for Health and Wellbeing at the University of Durham, in her keynote speech, highlighted the links between worklessness or low quality work and poor health. Professor Bambra's presentation concluded that reducing health inequalities in the UK required "the creation of good quality, secure jobs alongside a more supportive social security system"

33. Kate Pickett, Professor of Inequalities in Health at the University of York and co-author of *The Spirit Level: Why Equality is Better for Everyone*, in the second keynote speech of the day, gave evidence of how the **citizens of more equal societies have better health outcomes**.

34. We note the evidence we received on the primary causes of health inequalities. In particular, we note the strong links between low educational attainment, poverty, worklessness or low economic activity, poor quality work and poor quality housing on the one hand, and higher levels of morbidity, reduced life expectancy and poor health outcomes generally. We also recognise that while economic growth brings the potential for increased levels of employment, which may help to reduce economic inequality, modern patterns of employment can be characterised by temporary or sporadic work, short term or zero-hours contracts or work that is poorly paid, stressful, low-status and with little autonomy. In the poorest communities, it may also be the case that many people's health may render them unable to take up what employment opportunities exist currently or in the future. Economic growth alone, therefore, will not be sufficient to address structural health inequalities. Moreover, the implementation of welfare reform is reducing the income available to the poorest and most vulnerable individuals and families, potentially further impacting on health and wellbeing inequalities.
35. We draw this evidence to the attention of the Parliament. In particular, we draw it to the attention of the Education and Culture Committee, the Economy, Enterprise and Tourism Committee, the Infrastructure and Capital Investment Committee, the Equal Opportunities Committee, the Finance Committee and the Welfare Reform Committee.
36. In drawing this report to the attention of these parliamentary committees, we are not seeking to abdicate our own responsibility in relation to health inequalities. Nor are we saying that the issue is too difficult and complex for us to investigate; indeed, later in the report we will set out what our next steps will be. What we are saying is that the Parliament needs a joined-up approach across a raft of policy areas, and a recognition that impacts of specific policy choices across these areas may be felt more across certain social groups and may have impact most severely on the least advantaged, potentially further exacerbating health inequalities. While we hesitate to add

another topic to the list of issues that committees have already been asked to “mainstream”, we believe that wider social and income inequalities and their impact on the health and wellbeing of the people of Scotland need to be considered and debated more widely in the Parliament and beyond the confines of the Scottish Government health directorate and the Health and Sport Committee. We will be happy to move forward on this agenda in partnership with our colleagues on other committees.

- 37. We acknowledge that the Welfare Reform Committee and others have already undertaken significant pieces of work in relevant areas. Nevertheless, we invite these committees to consider the extent to which they could hold their own inquiries, or hold Ministers and Cabinet Secretaries to account for their actions, in ways that could help address wider inequalities and in turn health and wellbeing inequalities.**

Teenage pregnancy inquiry

38. The Committee reported specifically on teenage pregnancy in its fifth report 2013¹⁶ ([SP Paper 355](#)). The report noted strong linkages between health inequalities and high incidences of teenage pregnancy. It also noted that many of the factors associated with a high risk of early pregnancy – deprivation, being a member of a vulnerable group (for example living in care, suffering from abuse, having low self-esteem, being a child of a teenage mother, being homeless or being excluded, truanting or under-performing at school) – were also closely associated with health inequalities more widely.
39. We concluded that that any action taken to reduce teenage pregnancy, for example to address any of the individual contributory factors to teenage pregnancy, also needed to recognise the fundamental structural issues and the need for broader, cross-cutting efforts to address them.



The Committee visited Smithycroft Secondary School in Glasgow at the start of its teenage pregnancy inquiry.

Themes from access to services evidence sessions

40. We decided not to hold a short inquiry into access to services, as it was something that had previously been investigated, for example in the Session 3 Health and Sport Committee inquiry into health inequalities. However, we felt it would be useful to hold two roundtable sessions in order to gain a “snapshot” view of the relationship between access to primary care health services and inequality. These sessions took place on [25 March](#) and [1 April 2014](#).
41. This section of the report will be a little more detailed than some of the others, as we have no plans to report formally on this aspect of health inequalities.

Impact of poverty

42. We heard that poverty and deprivation could have multiple and multi-faceted effects on the health of individuals and families. Hanna McCulloch of Child Poverty Action Group told us that the relationship between poverty and health in the early years was “extremely complex” and that in some cases it was a “cyclical relationship”. She said that part of the relationship was “fairly direct”, in that low incomes had a direct negative impact on health through things such as dietary issues. There was, she said, a fairly direct link between poverty and obesity. In other circumstances, however, the relationship was much more complex. Poverty caused “stress in a household”, which could impact on a child’s mental health and cognitive development, in turn reinforcing poverty and ill health. She said that while increasing household income would not, in itself, eradicate health inequalities, it was unlikely that inequalities would be tackled meaningfully until every family had an income that was sufficient to meet their most basic needs.¹⁷

People with disabilities

43. Pam Duncan of the Independent Living in Scotland Project told us that disabled people experienced health inequalities in two ways – by living in poverty and through the discrimination that exists in access to health services. She said they faced “an intricate, multi-layered problem when they encounter health inequalities in accessing health”. She also said that disabled people were “hugely impacted by welfare reforms”. Many lived in poverty and fewer of them than non-disabled people were in work. This meant that they had to make “very difficult choices around food, heating and, in some cases, social care”. Many disabled people also found it difficult to access mainstream transport so often needed to rely on more expensive forms of transport, such as taxis, so it could be difficult to get to appointments. Flexible systems such as phone appointments, she said, were often not available to disabled people, either because they were not accessible options for them or because surgeries did not use them.¹⁸
44. We also heard that disabled people found that poverty was a huge barrier to their participation in sport and physical activity, which had an impact on their general health.

Carers

45. A similar picture was painted regarding the access inequalities experienced by carers. We heard from Fiona Collie of Carers Scotland that levels of debt for carers were very high and they were less likely to be working and more likely to be living in deprived areas. While there were carers who had adequate amounts of money, they faced difficulties in accessing support for their own health, for example being able to access GP appointments and to attend hospital. If the lack of services were to be tackled, more carers would perhaps be able to work, but the current level of services meant that many people could not do so. She said that older carers might have access to more income but also had significant health problems of their own and the same problems accessing services.¹⁹

Inverse care law

46. We noted the “inverse care law”, first described by Tudor Hart, in 1971, to describe the relationship whereby the availability of good medical care tends to vary conversely with the need for it in the population served²⁰. This was built upon in the roundtable session by many of the witnesses. Professor Graham Watt, for example, told us that it was a “historical issue that continues in good and bad times”. He said it was “a question of whether the NHS, in addition to providing universal coverage and access, provides the means for front-line practitioners to deal proportionately with the problems that patients present”²¹.

Access, funding and need

47. Professor Watt also remarked on the “ability of some social groups to access and use the service more effectively than others” and told us that, in the most deprived quintile of the population (approximately a million people) the average practice spending per patient in the most recent year for which data were available was £118 per patient per annum. In the most affluent fifth of the population (also around a million people) the average spend was £123. Therefore, he said, about 5% more was being spent on the most affluent fifth than on the most deprived fifth. He concluded: “we cannot address health inequalities on that basis”²².
48. Dr Andrew Buist of the British Medical Association Scotland (BMA) explained that the difference in funding might be “due to the rural effect”. On an island, for example, he said there could be one GP for 150 patients whereas in an urban area, a GP could have 1,600 patients, leading to economies of scale that would probably account for the £5 difference. He also explained the “global sum” which is divided up by the Scottish allocation formula based on the amount of work in looking after patients. He noted that the biggest determinant of work needed in primary care was patient age, though “some damping down of the age factor” had been required in the formula because practices in more deprived areas were, paradoxically, “protected from that in some ways” because the biggest indicator of health inequalities was “people dying early”²³. This chimed with what Graham Watt had told us about the challenges in defining the extent of unmet need within the primary care system. He said that using activity as a proxy for need took no

account of unmet need. As the deep-end practices²⁴ were “unable to generate activity that reflects need”, he said, it “goes unrecorded”²⁵.

“Did not attends” and Accident and Emergency use

49. Dr Pauline Craig of NHS Health Scotland told us that the organisation had carried out some analyses of DNAs (did not attends), which showed that DNAs were “socially patterned”. People from deprived areas were more likely not to turn up at services, or to turn up late. This was confirmed by Lorna Kelly of NHS Greater Glasgow and Clyde, who said that analysis in Glasgow showed that the DNA rate for the most deprived quintile was “much higher than that for the most affluent quintile”.²⁶
50. Lorna Kelly also pointed out that hospital-based services were disproportionately used by people from deprived areas. She said this was particularly the case in NHSGG&C with accident and emergency services, where nearly 50 per cent of A and E attendances were from the most deprived populations, compared with a spread of around 34 per cent across the population. She noted that it was “a challenge” to respond appropriately to that, because A and E facilities were “set up to treat a presenting issue and then send people away”. However, in the case of people who made multiple presentations, usually with underlying chronic disease, mental health or addictions issues, a better way to connect from A and E back to primary care community services was needed so that an on-going relationship with the person could be developed, in order to have “some chance of dealing with their underlying issues”.²⁷

Resourcing primary care teams

51. There was wide agreement that more needs to be done to better resource primary care teams to improve access for vulnerable patients. However, we noted that much of the momentum in recent years seems to have been in the other direction. Lorna Kelly of NHSGG&C told us that it was clear to boards that there were “a number of drivers that push resources in the opposite direction”. She said that many of the targets applied largely to hospital-based services and there were “lots of pressures that push boards towards investing more in hospital services”. The money that was available for primary care and community-based services, she said, was limited.²⁸
52. Lorna Kelly also told us that, particularly in relation to children in vulnerable families, there were “opportunities to improve vastly the relationship between secondary care and primary care” so that there was “much better knowledge about when patients do not turn up. Not turning up for appointments, she said, could be a symptom of much wider problems in a family”.²⁹
53. Dr John Budd of Lothian Deprivation Interest Group told us that, in the most deprived communities, people are known to develop multiple morbidities 10 to 15 years earlier than in the least deprived. He said that most of those patients do not have care workers or home helps. However, they may “come into contact with

GPs and the people who run the practices, such as district nurses—the same people who are under most pressure in providing general services to communities”³⁰.

54. This was backed up by Andrew Buist of the BMA, who told us—

“unless we resource the primary care teams, not just GPs, to improve access for vulnerable patients with multiple morbidities, we will not be able to do that. I believe that we need to shift more money from other parts of the system into primary care, to provide services more locally and to keep people in their communities, so that they do not need to get two buses to hospital.”³¹

55. Dr Buist concluded that the key was “to crack healthcare and social care integration”. He said it was “essential that we involve general practitioners from all types of practices” looking at services and how they were provided, at patient pathways and “at getting social care and healthcare working more closely together”. In order to achieve that, he said, it was necessary to “make it possible for GPs to get away from their practices for an afternoon a month in order to get involved in that”³².

56. However, he went on to tell us that it “will be difficult”. He said that there were early signs of a “workforce crisis appearing in general practice”. This was because general practice had lost popularity with young doctors coming into the profession, older doctors were leaving earlier and women who had left to have their families were not coming back into the profession. He said that these doctors were “burnt out” and “battle weary” because the workload was “becoming intolerable”³³.

57. We note the evidence we received during our two sessions on access to services and we draw it to the attention of the Scottish Government.

58. It is clear to us from the two sessions that the most disadvantaged people, with the most complex problems and the fewest resources, also face significant barriers in accessing services. Unless addressed comprehensively, this can only compound the difficulties faced by people in the more deprived and challenged communities.

59. That said, we acknowledge that steps are being taken both by central government and by NHS boards to improve access to services, particularly primary care services, in the most deprived communities. We also accept that integration of health and social care, currently being taken forward under the Public Bodies (Joint Working) (Scotland) Act 2013, may help to bring improved services that will, potentially, improve access.

Themes from early years evidence sessions

60. At the time of writing, we have not completed our evidence taking on this short inquiry. We also intend to report formally to the Parliament at the conclusion of the inquiry. This section of the report, therefore, will be general and interim in nature.
61. In addition to the formal evidence-taking sessions described below, we visited Pilton in North Edinburgh, where we met young parents and heard about the joint early years work being undertaken by NHS Lothian and The City of Edinburgh Council, including the Family Nurse Partnership (FNP). We also visited Paisley, where we were able to talk to young people benefitting from the Barnardo's Threads project, and Glasgow where we visited Westerhouse Nursery and Family Learning Centre and Bridgeton Family Learning Centre.

Context

62. We held an [evidence-taking](#) session with Sir Michael Marmot, Professor of Epidemiology and Public Health at University College London and Professor Sir Harry Burns, professor of global public health at the University of Strathclyde and former Scottish Government Chief Medical Officer. We followed this up with a roundtable of academic early years experts.
63. Sir Michael Marmot explained that, when people think about health inequalities, they commonly think about the health of the poor. He said that while the poor did indeed have poor health, the real challenge was “the gradient”. People “near the top” have worse health than those at the top, people in the middle have worse health than those near the top and so on. The same applied to children, in relation to physical development and growth, cognitive, linguistic, social and emotional development, performance in school and the socioeconomic characteristics of their parents or the area in which they lived. The lower the socioeconomic level, he said, the worse the performance.³⁴
64. Professor Marmot therefore argued that if we are to do better globally, we “must address not just the poor performance of those at the bottom, but the gradient”. He suggested that the gradient implied a need for “proportionate universalism” because “a health service for the poor is a poor health service, and an education system for the poor is a poor education system”. He said that he wanted people to “have the entitlement to be part of the mainstream”, and “to bring them into universalist systems in education, healthcare or society in general”.³⁵



Members met young parents who use the Barnardo's Threads service in Paisley

65. Sir Harry Burns was in general accord with Professor Marmot. He told us that, if we really wanted a future generation to deliver intellectually and to be innovative and creative, we must “give them the best start in life”. He said there was “powerful evidence” from studies in Glasgow and internationally that the physical damage done by poverty limited the capacity of young children to learn and behave appropriately in complex situations. The more adversity that young children experience in early life, he said, the more likely they would be to become alcoholics, drug addicts, violent and so on.³⁶
66. Sir Harry also noted that Glasgow Centre for Population Health’s comparative analysis of Glasgow, Liverpool and Manchester showed that although the three cities are the same in terms of inequality and average income, they differ significantly in their causes of premature death. He said that what was different between the three cities was “related to empathy and connectedness”. He also said that studies had shown that people in Glasgow were “far less likely to trust their neighbours” and “far less likely to be members of clubs, to volunteer, to go to church or to be part of a definable community”³⁷. Part of the challenge, he said, was “about not just pulling a set of policy levers, but creating a sense of community and of compassion for people”³⁸.

Good services can make a difference

67. Many of these themes were echoed in the roundtable of academics. While there was wide agreement on the need for measures to reduce poverty and increase income (for example through the living wage) there was also agreement that services could play a key role in making a difference. Dr Sarah Hill, Senior Lecturer in Global Public Health at the University of Edinburgh, for example, emphasised the role of early childhood education as an ameliorating influence for children who came from disadvantaged backgrounds. She welcomed steps taken by the Scottish Government to improve access to early childcare, but said that if this were to lead to improvements in educational and health outcomes, “stronger investment” was needed in the educational aspects of early childhood care. Remarking that it was “not just childcare” that was important she suggested that the provision of well-supported early childhood education by qualified staff offered “a huge opportunity to ameliorate some of the more negative impacts of cuts in benefits”³⁹.



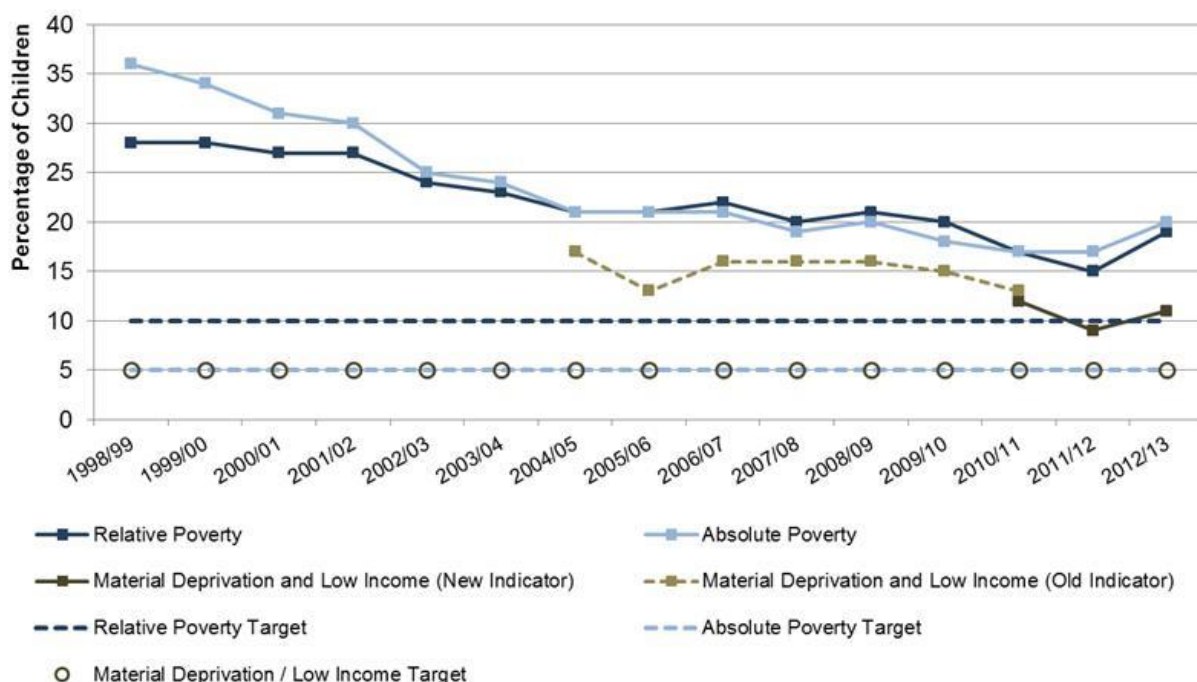
Demi Baker, 16, with daughter Kayla (7 months) at the Committee’s launch of its teenage pregnancy report at Wester Hailes Education Centre Young Mums Unit.

68. Sir Harry Burns and Sir Michael Marmot agreed that good services could make a difference. Sir Michael highlighted the difference made by Birmingham City Council, which had succeeded in closing the gap between the city and the English average in early child development. He also said that there were “good evaluated programmes that really improve early child development, and we should be taking the best of them”.⁴⁰
69. Sir Harry mentioned the work that was being carried out through the early Early Years Collaborative, the Family Nurse Partnership and the Positive Parenting Plan. However, he also said that, in working with local authorities across Scotland, he could “see great differences in capacity and willingness to act”.⁴¹

Scottish Government early years policy

70. We took [evidence](#) from Scottish Government officials. They explained that the early years framework had been co-produced with COSLA and was published in 2008. This set out the “transformational aims” for children and young people. In 2011, the early years task force, which brought together early years experts from around Scotland, was established.
71. In March 2012, the Scottish Government published *The Early Years Taskforce—Shared Vision and Priorities*. The officials told us that although the publication “took us quite a way down the journey” they “continued to grapple with delivery”. It was not, at that stage, clear how improvements that would have an impact and improve outcomes for children and families could be made or pockets of good practice throughout Scotland could be scaled up to a national level.
72. The next development was the establishment of the early years collaborative in October 2012. The collaborative brings together early years experts and closely involves community planning partnerships, which have been chosen as the multi-agency delivery vehicle. To date, five meetings, or “learning sessions” of the Collaborative have taken place, with another due to be held at the end of October 2014. Aims have been developed and are being taken forward in four workstreams, leading to “key changes”. It is expected that, over the next year, this thinking and learning will continue, along with further development work with CPPs. CPPs were invited to come forward with examples of improvement work aligned to a Key Change that could be used as a ‘Pioneer Site’, which would focus on improvement activity in a particular geographic location with a view to “scaling up” the activity across the community planning partnership and the rest of the country. At present, 16 of the 32 community planning partnerships have come forward with a total of 40 pioneer sites.⁴²

Child Poverty in Scotland - 1998/99 to 2012/13



Annual Report for the Child Poverty Strategy for Scotland 2014.⁴³

73. We note the developing work of the Early Years Collaborative and the learning and projects that are taking place around the country under the Collaborative. This work is clearly at an early stage, and is not equally well developed in all parts of the country, but has the potential to be innovative and groundbreaking as it develops. We also note the ongoing roll-out of the Family Nurse Partnership. We will continue to observe and monitor these programmes with interest as they develop over the remainder of the session.
74. We also note that our own work on early years (themed under health inequalities) continues, building on the roundtable sessions and visits that were conducted during spring and early summer 2014. During autumn 2014, a roundtable of health professionals will be held and we shall conclude this work by taking evidence from the relevant Scottish Ministers, before reporting to the Parliament on this topic.
75. Finally, we draw the Parliament's attention to our ongoing scrutiny of the Scottish Government's annual reports on its performance in relation to its child poverty strategy. Relative child poverty decreased from 21 per cent in 2008/09 to 15 per cent in 2011/12 before increasing to 19 per cent in 2012/13 (see chart). The combined impact of further welfare reform, sluggish economic growth and continuing public expenditure cuts as a result of the UK government's austerity measures to tackle the budget deficit has led to fears of worsening conditions towards 2020. That said, however, we recognise that child poverty is unlikely ever to be eliminated without a step change in the

way that administrations at all levels, including local government, prioritise their spending.

Scottish Government's Ministerial Taskforce on health inequalities

76. Shortly after we began the scoping exercise in 2013, the Scottish Government announced that it was to re-convene its ministerial taskforce on health inequalities, which had originally been established in 2008. We decided that it would be helpful to hear [evidence](#) from the Scottish Government on progress that had been made with regard to health inequalities since the taskforce had been established, and on what future action was planned in order to make further progress.
77. The Minister for Public Health gave the Committee a comprehensive update on the work of the Ministerial taskforce. He told us that it had been re-established to build on the previous work, to consider changes in how people and communities were being engaged in decisions that affected them and to consider the implications of the work of the Christie commission and how “place” has an impact on people’s lives.



Members watch a performance of Max in the middle, a multimedia drama and dance project to promote healthy eating in Stirling primary schools, during their visit to Stirling in June 2013.

78. He told us that although Scotland's health continued to improve, that improvement was taking place more slowly than in other European countries. Conventional approaches to the problem that involved attempting to modify people's health-related behaviour had not had a significant impact. Moreover, the level of deaths in the 15 to 44 age group was a significant factor in contributing to Scotland's relatively poor position on health in a European context.
79. The issue of health inequalities, he said, despite the significant effort that the present and previous administrations had made to tackle them, remained "a blight on our society". He told us that the complexities of health inequalities meant that they were not a problem to be solved solely by the national health service and that all parts of government and the wider public sector had a role to play. The Scottish Government, he said, remained "determined to address the social inequalities that lead to health inequalities across the country".
80. The Minister told us that the challenge has been that health inequalities had, in the past, been seen "largely as requiring a health response", and the barrier had been the tendency to "look for a health-based approach to tackling deeply ingrained social inequalities". If we were to challenge that principal barrier more effectively, he said, we must "ensure that all aspects of government and the public sector see tackling inequality in society as a priority for them, as it is social inequalities that drive the health inequalities".
81. We heard that the principal success of *Equally Well* had been the focus it had provided on health inequalities, which had not existed at a strategic level in the past. The Minister told us that a key factor in achieving that was securing the necessary support at a senior enough level within all aspects of government and the public sector, so that they saw it as part of their day-to-day business to tackle inequality in whatever form it presented itself in the work that they undertook.⁴⁴

Social capital

82. Much of what the Minister told us was concerned with the need to focus on "social capital and related issues" in communities where there were individuals and families who had become "isolated and excluded from the main stream". Those individuals and families, he said, did not engage in the same way that more resilient individuals and communities did, and did not take advantage of the services that were provided. This, he said, had been widely recognised by the Christie commission, which had argued that building personal and community capacity, resilience and autonomy should be a key objective of future public service reform.⁴⁵
83. Coupled with this focus on the development of social capital was a recognition of the importance of "place" and the emerging evidence of the impact that the immediate environment could have on people's health.⁴⁶

84. We noted that this chimes with much of what Sir Harry Burns told us during our early years work (mentioned earlier in the report) about “connectedness” and sense of community.

Future policy direction on health inequalities

85. In terms of the strategic governance arrangements required to take forward these and other measures to tackle health inequalities, the Minister told us that it had become clear that the current regular two-yearly review by the task force was “not the best way to drive forward delivery”. He said that he was therefore replacing that arrangement with an alternative one that would bring “sharper and more frequent focus on the problems that we face” in this area while also “supporting our Community Planning Partnerships”.⁴⁷
86. The new arrangement will involve the Health and Community Care Delivery Group, which has been working on the development of the integration agenda over the last two years, and which brings together a range of different organisations from local government, health, the third sector, Government and other interested parties. It will meet at least four times a year and will be the lead group to take forward the approach to tackling health inequality.
87. The Minister said that it was expected that the group would be supported by several sub-groups, which would have specialties and would submit evidence-based papers to the delivery group on areas they considered to be priorities. One of these sub-groups would be the inequalities action group, which would be responsible for undertaking research-based work and submitting it to the delivery group, with recommendations on areas to be taken forward. The delivery group, the Minister said, would then “look at taking that forward on a continuous basis”.
88. The Minister also advised us that changes had been made to community planning partnerships to “embed them more effectively in how planning takes place at local level and in delivery of services”. Health Scotland is to be given the role of supporting and advising community planning partnerships on that agenda, and of providing them with materials to support their work. He added that the Health and Community Care Delivery Group would also support community planning partnerships to work more effectively in their local areas.⁴⁸
89. The Minister also indicated that, in the evidence the task force had received, the issue of place in the local environment had been highlighted as “a significant factor”. This had led, he said, to the task force’s recommendation on the need for a place standard that reflected thinking on that area of policy. He said that designing and planning areas in a much more effective way could have a positive impact on people’s health and create a different type of community. Work had begun by the architecture and design section in the Scottish Government to review the existing place standard guidance and to examine how that work could be developed in the light of the evidence received by the taskforce. It was hoped that a new place standard would be agreed by the end of 2014 and that it could then be rolled out to local authority colleagues.⁴⁹

90. We note with interest the Minister's remarks and his update on the work of the Ministerial taskforce.
91. We were interested to hear from the Minister that, following the report of the Ministerial taskforce, it was now being explicitly recognised that if action to address health inequalities were to have any impact, it would need to address wider social inequalities and involve a range of partners across central and local government and the wider public sector and the third sector. We think the proposals set out by the Minister in his evidence – for example to establish the Health and Community Care Delivery Group and the inequalities action group, to support changes in community planning partnerships to embed them more effectively in planning and delivery of local services and to establish place standards – are to be welcomed as positive steps.
92. Throughout this report, we have emphasised the importance of action across a range of portfolios, joined-up-working, inter-agency collaboration and “getting out of silos”. We see some evidence that the Ministerial taskforce and some of the initiatives that it is supporting are helping to promote such working practices and we hope this initiative will continue to do so till the end of and indeed beyond the current parliamentary session.

Conclusions

Primary causes of health inequalities

93. The scoping exercise has, perhaps unsurprisingly, told us that the primary causes of health inequalities are complex and, although Scotland's health is improving, attempts to address inequalities in our health and wellbeing have, so far, met with only limited success. The latest figures (2009-10), for example, show that in relation to “all-cause mortality” in people under 75, the absolute gap between most and least deprived areas is now smaller than in any other year covered by this report. However, on the same measure, relative inequality has been stable since 2006 and increased over the longer term. The death rate for coronary heart disease among those aged 45 to 74 years has declined considerably since 1997, but the reduction has been slower in the most deprived areas of Scotland than elsewhere, resulting in increased relative inequality over the long term. Readers are referred to the Scottish Government's evaluation of the *Keep Well* programme for more information.⁵⁰
94. Healthy life expectancy remains lower in Glasgow and the west of Scotland than in comparable post-industrial areas like the north east and north west of England.

95. It is also clear from the evidence that, while health inequalities receive high levels of public policy attention and media coverage, many of their primary causes lie outside the health field. All the evidence pointed to very clear linkages between socio-economic deprivation and poverty and poor health and wellbeing, raised morbidity levels and lower life expectancy. The Committee's witnesses during its scoping exercise agreed that if health inequalities were to be reduced the primary social and economic causes would need to be addressed, although this would not, in itself, be sufficient to make the required difference
96. We start from the position, therefore, that health inequalities reflect wider inequalities that stem from the divisions present in our society. Setting aside the constitutional question, we recognise that while there are things that can be done that are within the powers of the Scottish Parliament and the UK Parliament to help reduce inequalities, some aspects of inequality are, arguably, bi-products of the nature of the globalised systems of production and exchange, over which national legislatures and governments probably have only limited degrees of influence.
97. Nevertheless, there are measures that could be taken through the taxation and benefits systems to help reduce income inequalities, which in turn would, over time, have an impact on health inequalities. Other policy measures within the Parliament's devolved powers, for example in education and housing, could have an impact. These, of course, represent political choices that must be made by politicians in the appropriate place at the relevant time. We have, however, drawn the attention of the Parliament and some of its committees to these areas in the report.

Role of health services

98. The traditional response of the NHS has been to treat diseases and other medical conditions once they have arisen – referred to in the evidence as “downstream” – or to seek to change behaviours that are known to give rise to ill-health, like smoking, alcohol and drug misuse, poor diet, lack of exercise and so on. The Committee heard repeatedly during the scoping exercise that the effect of these “lifestyle” public health campaigns was to widen inequalities rather than to narrow them. If real progress is to be made, significant efforts will, as we have stressed throughout the report, have to be made across a raft of policy areas and by different agencies collaborating and working more effectively together.

99. This is not to suggest that we think that health services do not have an important role to play in reducing health inequalities. As we have indicated in the report, the least well-off and most vulnerable individuals and communities often have the poorest access to primary health services and this remains an issue that the NHS will need to make efforts to improve, by whatever means. The health service also has a clear role in preventing ill-health through education and awareness-raising, notwithstanding what we have said in the report about the tendency for public health campaigns to widen health inequalities rather than narrow them. The health agencies are also where data are collected and analysed and progress is measured. Health service initiatives like the Early Years Collaborative and the Family Nurse Partnership (and the activities stemming from them) are also reported to be making a difference. More widely, we have seen developments like self-directed support, the integration agenda and moves towards preventative spending, all of which can play some role in helping to reduce health inequalities.

What next?

Parliamentary debate

100. We have been successful in securing a parliamentary debate. In advance of that, we will be writing to the relevant subject committee conveners, inviting them to consider what their committees can do regarding reducing wider inequalities, which, as we have seen, will have a corresponding impact on health and wellbeing inequalities.
101. Progress towards significant reductions in health inequalities will be an ongoing matter for scrutiny by the Parliament, its committees and others as emerging policies and initiatives are initiated, developed and evaluated over time.

Future action by the Health and Sport Committee

102. We will continue our early years inquiry, reporting to the Parliament in spring 2015.
103. We will consider our work programme for the remainder of the parliamentary session at the end of 2014. We intend to undertake further work under the health inequalities theme, which we hope will take account of issues raised in the parliamentary debate. We would also invite suggestions from readers of this report and from wider civic society.

104. We would expect scrutiny of the Scottish Government's continuing actions to address health and wellbeing inequalities to be ongoing. We will also consider, however, in the light of our inquiry activity over the last two years, whether it is appropriate to ask the Scottish Government to take any other specific actions

¹ World Health Organization. (2008) *Closing the gap in a generation - Health equity through action on the social determinants of health*. Available at

http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf?ua=1 [Accessed 24 September 2014].

² Scottish Parliament Health and Sport Committee. *Official Report*, 22 January 2013. Col 3152

³ Scottish Parliament Health and Sport Committee. *Official Report*, 5 February 2013. Col 3268-69

⁴ Scottish Parliament Health and Sport Committee. *Official Report*, 5 February 2013. Col 3268-69

⁵ Scottish Parliament Health and Sport Committee. *Official Report*, 5 February 2013.. Col 3270

⁶ Scottish Government. (2013) [Report of the Ministerial Task Force on Health Inequalities](#).

⁷ Scottish Parliament Health and Sport Committee. *Official Report*, 22 January 2013. Col 3149.

⁸ Scottish Parliament Health and Sport Committee. *Official Report*, 22 January 2013. Col 3156

⁹ Scottish Parliament Health and Sport Committee. *Official Report*, 22 January 2013. Col 3152.

¹⁰ Scottish Parliament Health and Sport Committee. *Official Report*, 22 January 2013. Col 3151.

¹¹ Scottish Parliament Health and Sport Committee. *Official Report*, 22 January 2013. Col 3151.

¹² Scottish Parliament Health and Sport Committee. *Official Report*, 5 February 2013. Col 3273.

¹³ Scottish Parliament Health and Sport Committee. *Official Report*, 5 February 2013. Col 3273.

¹⁴ Scottish Parliament Health and Sport Committee. *Official Report*, 5 February 2013. Col 3276.

¹⁵ Scottish Parliament Health and Sport Committee. *Official Report*, 5 February 2013. Col 3272.

¹⁶ Scottish Parliament Health and Sport Committee. 5th Report 2013. *Report on inquiry into teenage pregnancy*. (SP paper 355)

¹⁷ Scottish Parliament Health and Sport Committee. *Official Report*, 25 March 2014. Col 5117.

¹⁸ Scottish Parliament Health and Sport Committee. *Official Report*, 25 March 2014. Cols 5119-20.

¹⁹ Scottish Parliament Health and Sport Committee. *Official Report*, 25 March 2014. Col 5118.

²⁰ Watt, G. (2002) [The inverse care law today](#). *The Lancet* 360 (252-254)

²¹ Scottish Parliament Health and Sport Committee. *Official Report*, 1 April 2014. Col 5162.

²² Scottish Parliament Health and Sport Committee. *Official Report*, 1 April 2014. Col 5164.

²³ Scottish Parliament Health and Sport Committee. *Official Report*, 1 April 2014. Col 5169.

²⁴ The Deep End project is the 100 GP practices that work in the most socio-economically deprived populations in Scotland (a high proportion of which are in Glasgow).

²⁵ Scottish Parliament Health and Sport Committee. *Official Report*, 1 April 2014. Col 5182.

²⁶ Scottish Parliament Health and Sport Committee. *Official Report*, 1 April 2014. Col 5171.

²⁷ Scottish Parliament Health and Sport Committee. *Official Report*, 1 April 2014. Col 5171-72.

²⁸ Scottish Parliament Health and Sport Committee. *Official Report*, 1 April 2014. Col 5166.

²⁹ Scottish Parliament Health and Sport Committee. *Official Report*, 1 April 2014. Col 5171.

³⁰ Scottish Parliament Health and Sport Committee. *Official Report*, 1 April 2014. Col 5184.

³¹ Scottish Parliament Health and Sport Committee. *Official Report*, 1 April 2014. Col 5173.

³² Scottish Parliament Health and Sport Committee. *Official Report*, 1 April 2014. Col 5174.

³³ Scottish Parliament Health and Sport Committee. *Official Report*, 1 April 2014. Col 5174.

³⁴ Scottish Parliament Health and Sport Committee. *Official Report*, 13 May 2014. Col 5369.

³⁵ Scottish Parliament Health and Sport Committee. *Official Report*, 13 May 2014. Col 5370.

³⁶ Scottish Parliament Health and Sport Committee. *Official Report*, 13 May 2014. Col 5376.

³⁷ Scottish Parliament Health and Sport Committee. *Official Report*, 13 May 2014. Col 5378.

³⁸ Scottish Parliament Health and Sport Committee. *Official Report*, 13 May 2014. Col 5379.

³⁹ Scottish Parliament Health and Sport Committee. *Official Report*, 13 May 2014. Col 5404.

⁴⁰ Scottish Parliament Health and Sport Committee. *Official Report*, 13 May 2014. Col 5377.

⁴¹ Scottish Parliament Health and Sport Committee. *Official Report*, 13 May 2014. Col 5395

⁴² Scottish Parliament Health and Sport Committee. *Official Report*, 6 May 2014. Col 5328-30.

⁴³ Scottish Government (2014). [Annual Report for the Child Poverty Strategy for Scotland 2014](#)

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- ⁴⁴ Scottish Parliament Health and Sport Committee. *Official Report*, 10 June 2014. Col 5617.
⁴⁵ Scottish Parliament Health and Sport Committee. *Official Report*, 10 June 2014. Col 5615.
⁴⁶ Scottish Parliament Health and Sport Committee. *Official Report*, 10 June 2014. Col 5616.
⁴⁷ Scottish Parliament Health and Sport Committee. *Official Report*, 10 June 2014. Col 5621.
⁴⁸ Scottish Parliament Health and Sport Committee. *Official Report*, 10 June 2014. Col 5617-18.
⁴⁹ Scottish Parliament Health and Sport Committee. *Official Report*, 10 June 2014. Col 5619.
⁵⁰ Scottish Government (2014) [Keep Well Impact Evaluation](#)

Appendix A

Extracts from the minutes of the Health and Sport Committee and associated written and supplementary evidence

2nd Meeting, 2013 (Session 4), Tuesday 22 January 2013

Health inequalities in Scotland: The Committee took evidence from—
Derek Feeley, Director General Health and Social Care, and Sir Harry Burns, Chief Medical Officer, Scottish Government.

Health inequalities in Scotland - witness expenses: The Committee agreed to delegate to the Convener responsibility for arranging for the SPCB to pay, under Rule 12.4.3, any expenses of witnesses in the inquiry.

4th Meeting, 2013 (Session 4), Tuesday 5 February 2013

Health inequalities: The Committee took evidence, in round table format, from—
Professor Carol Tannahill, Director, Glasgow Centre for Population Health;
Graham Watt, Professor of General Practice;
Sally McIntyre, Director of Social and Public Health Sciences Unit, University of Glasgow;
Dave Liddell, Board Member, Poverty Alliance;
Erica Wimbush, Head of Evaluation;
Dr Gerry McCartney, Head of Public Health Observatory, NHS Health Scotland.

Written Evidence

 **NHS Health Scotland**

10th Meeting, 2013 (Session 4), Tuesday 26 March 2013

1. **Decision on taking business in private:** The Committee agreed to take items 5 and 6 in private.
5. **Health inequalities:** The Committee considered and agreed its approach to the next phase of the inquiry.

21st Meeting, 2013 (Session 4), Friday 21 June 2013

Health inequalities: The Committee took evidence from—
Kathy O'Neil, General Manager, Dr Anne Maree Wallace, Director of Public Health, Joe Hamill, Senior Health Promotion Officer(Community), and Johnny

Keenan, Head of Health Improvement and CHP (Corporate) Services, NHS Forth Valley;
Paul Davison, Senior Research Officer, Chief Executive's Office, and Lynne McKinley, Team Leader – Capacity Building, Stirling Council;
Elaine Lawlor, FVADP Co-ordinator, Forth Valley Alcohol and Drug Partnership;
Alasdair Tollemache, Chief Executive, and Anne Knox, Change Fund Engagement Officer, Stirlingshire Voluntary Enterprise;
Dr Ken Thomson, Depute Principal – Principal Designate, Forth Valley College;
Elaine Brown, Substance Development Office, Stirling Alcohol and Drug Partnership.

Written Evidence

 **Forth Valley Health Improvement/Health Inequalities Group**

10th Meeting, 2014 (Session 4), Tuesday 25 March 2014

Health Inequalities - Access to Services: The Committee took evidence from—

Dr Ima Jackson, School of Health and Life Sciences, Glasgow Caledonian University/ GRAMNET Glasgow Refugee Asylum and Migration Network, University of Glasgow;

Nina Murray, Women's Policy Development Officer, Scottish Refugee Council;
Hanna McCulloch, Policy and Parliamentary Officer, Child Poverty Action Group in Scotland;

Fiona Collie, Policy and Public Affairs Manager, Carers Scotland;

Lexi Parfitt, Campaigns Officer, SAMH;

Derek Young, Policy Officer, Age Scotland;

Pam Duncan, Policy Officer, Independent Living in Scotland (ILiS).

Written Evidence

 **Glasgow Refugee Asylum and Migration Network**

 **Scottish Refugee Council**

 **SAMH**

 **Age Scotland**

 **Independent Living in Scotland (ILiS)**

11th Meeting, 2014 (Session 4), Tuesday 1 April 2014

Health Inequalities - Access to Services: The Committee took evidence from—

Graham Watt, Professor of General Practice, General Practitioners at the Deep End;

Dr Pauline Craig, Head of Equality, NHS Health Scotland;

Dr Andrew Buist, Deputy Chair of the BMA's Scottish GP Committee, British Medical Association (Scotland);

John Budd, GP Edinburgh Access Practice Coordinator, Lothian Deprivation Interest Group;
Lorna Kelly, Head of Policy, NHS Greater Glasgow and Clyde Health Board, Greater Glasgow and Clyde Primary Care Deprivation Group.

Written Evidence

-  **General Practitioners at the Deep End**
-  **NHS Health Scotland**
-  **British Medical Association (Scotland)**
-  **Lothian Deprivation Interest Group**
-  **Greater Glasgow and Clyde Primary Care Deprivation Group**

16th Meeting, 2014 (Session 4), Tuesday 20 May 2014

Health Inequalities: Equally Well: The Committee agreed to defer consideration of this item.

19th Meeting, 2014 (Session 4), Tuesday 10 June 2014

Health Inequalities: Equally Well: The Committee took evidence from—
Michael Matheson, Minister for Public Health, Donald Henderson, Head of Public Health Division, and Dr Fergus Millan, Head of Creating Health Team, Public Health Division, Scottish Government.

26th Meeting, 2014 (Session 4), Tuesday 7 October 2014

1. Decision on taking business in private: The Committee agreed to take item 3 in private and agreed that its consideration of the draft report would be taken in private at future meetings.

3. Health Inequalities: The Committee considered a draft report. Various changes were agreed to, and the Committee agreed to consider a revised draft, in private, at a future meeting.

27th Meeting, 2014 (Session 4), Tuesday 28 October 2014

Health Inequalities (in private): The Committee agreed to defer consideration of this item.

28th Meeting, 2014 (Session 4), Tuesday 4 November 2014

Health Inequalities (in private): The Committee considered a draft report. Various changes were agreed to, and the Committee agreed to consider a revised draft, in private, at its meeting on 11 November.

29th Meeting, 2014 (Session 4), Tuesday 11 November 2014

Health Inequalities (in private): The Committee agreed to defer consideration of this item.

30th Meeting, 2014 (Session 4), Tuesday 18 November 2014

Health Inequalities (in private): The Committee considered and agreed a draft report on its inquiry into Health Inequalities.

