



INSTITUTE *of*
HEALTH EQUITY



A FAIRER, HEALTHIER SCOTLAND: THE COLLABORATION FOR HEALTH EQUITY

CONTENTS

FOREWORD	5
ACKNOWLEDGEMENTS	6
CHAPTER 1. INTRODUCTION	7
THE CHES FRAMEWORK	10
Inequities in power, money and resources	10
Health equity and new and emerging threats	10
Health equity and the conditions of daily life	11
Delivering for health equity	11
CHES AND THE MARMOT FRAMEWORK	12
Work in the three collaborating places	12
THE CHES PROGRAMME	13
THE POLICY CONTEXT	15
REPORT METHODOLOGY	16
Data analysis	16
SUMMARY AND RECOMMENDATIONS	17
CHAPTER 2. HEALTH INEQUITIES IN SCOTLAND	18
LIFE EXPECTANCY IN SCOTLAND	19
INEQUITIES IN LIFE EXPECTANCY IN SCOTLAND	22
HEALTHY LIFE EXPECTANCY IN SCOTLAND	26
YEARS SPENT IN ILL HEALTH	31
PHYSICAL DISABILITIES	33
DESPAIR, ILL HEALTH AND DEATHS	34
Mental health	34
Suicides	35
Harm from alcohol use	36
Drug misuse	38
Smoking	39
Obesity	41
SUMMARY AND RECOMMENDATION 1	43
SECTION 1: ACT ON THE STRUCTURAL DRIVERS OF HEALTH INEQUITY	44
CHAPTER 3. HEALTH EQUITY AND INEQUITIES IN POWER, MONEY AND RESOURCES	45
NATIONAL POLITICAL LEADERSHIP FOR ACTION ON INEQUITIES IN POWER MONEY AND RESOURCES	47
INEQUITIES IN POWER	49
National and local power imbalances	49
Community power	49
Strengthening Third Sector organisations	51

INEQUITIES IN MONEY AND RESOURCES	52
Inequities in wealth	52
Tackling child and family poverty	54
SUFFICIENCY OF FUNDING ALLOCATIONS TO REDUCE INEQUITIES IN HEALTH AND THE SOCIAL DETERMINANTS OF HEALTH	59
Equitably investing for children and young people	59
Sufficiency of funding to Councils to reduce inequities in health and the social determinants of health	60
Investing at scale	62
Investments in prevention	64
SUMMARY AND RECOMMENDATION 2	66
CHAPTER 4. HEALTH EQUITY AND EMERGING CHALLENGES	67
CHANGING DEMOGRAPHICS IN SCOTLAND	68
Age structure	68
Ethnic diversity	71
DEEPENING INEQUITIES POST-COVID	73
School absence	73
Economic inactivity due to ill health	74
Loss of trust	75
AI AND DIGITALISATION AND HEALTH EQUITY	77
Digitalisation of services	77
Social media	77
Artificial intelligence	78
ENVIRONMENTAL AND CLIMATE CRISES AND HEALTH EQUITY	79
SUMMARY AND RECOMMENDATION 3	82
SECTION 2: DELIVER HEALTH EQUITY	83
CHAPTER 5. THE DESIGN AND DELIVERY OF PROGRAMMES	84
HEALTH EQUITY AND PROPORTIONATE UNIVERSALISM	85
THE FUNDING AND DELIVERY LANDSCAPE	94
National and local priorities	94
Total place approaches	94
Short-term funding and programme cycles	98
Commissioning and procurement for health equity	98
SUMMARY AND RECOMMENDATIONS 4	100
CHAPTER 6. PRIORITISING HEALTH EQUITY	101
GOVERNMENT DUTIES AND ACCOUNTABILITIES FOR HEALTH EQUITY	102
Legislation and cross-government action	102
Accountabilities for health equity	103
A national target for greater health equity	103
LEADERSHIP AND CAPACITY FOR HEALTH EQUITY	104
Training and capacity building	110
Political leadership	110

BUSINESSES FOR HEALTH EQUITY	111
HEALTHCARE FOR HEALTH EQUITY	113
NHS investments in prevention	113
Social value procurement	114
Healthcare and anchor organisations and population health approaches	115
SUMMARY AND RECOMMENDATION 5	118
CHAPTER 7. EVIDENCE AND DATA FOR HEALTH EQUITY	119
DATA ABOUT WITHIN AREA INEQUITIES IN HEALTH AND SOCIAL DETERMINANTS OF HEALTH	121
The local data	121
ASSESSING WHETHER RESOURCE ALLOCATIONS ARE APPROPRIATE FOR ACTION TO TACKLE INEQUITIES	126
DATA AND EVIDENCE FOR COMMUNICATION	126
Continuing data needs identified in CHES	129
COMMUNITY ENGAGEMENT AND PERSPECTIVES AND INSIGHTS	130
EVIDENCE FOR HEALTH EQUITY AND THE SOCIAL DETERMINANTS OF HEALTH	132
Evidence to build the case for investment in prevention and the social determinants	134
EVIDENCE GAPS IN MARMOT 8 PRINCIPLES	135
Evidence to tackle racism, discrimination and impacts on health	135
Pursue environmental sustainability and health equity together	136
SUMMARY AND RECOMMENDATION 6	137
CONCLUSIONS	138
RECOMMENDATIONS	140
RECOMMENDATIONS SUMMARY	141
REFERENCES	146

FOREWORD

Scotland is unhealthy compared with the rest of the UK and has wide inequities in health. That is the first salient fact that infuses CHES, the Collaboration for Health Equity Scotland. The second is a strong desire to change this picture. The first is depressing, the second inspiring. Our challenge in CHES is to move from the first to the second.

There are at least four major problems leading to ill-health in the UK in general and Scotland in particular. The first is a remarkably sluggish recovery from the global financial crisis of 2007/08. Real salaries have barely recovered, and people's living conditions have suffered. Second is the high levels of inequities in income, wealth and social conditions. These play a major role in generating health inequities. Third is the climate crisis. The challenge to achieve a sustainable future has to be managed if it is not to increase inequalities. Fourth is political instability. Given the importance of long-term planning and commitment to achieve greater health equity the rapid turnover of UK prime ministers adds to the challenge.

These four countervailing influences may go some way to answering the question of why Scotland has the lowest life expectancy of the four countries within the UK, and among the lowest in Western Europe. We call them 'countervailing' because Scotland has progressive policies, excellent public health scholars and practitioners, collaborative planning, a focus on community empowerment and high quality data that bear on the problems of health equity. CHES set out to examine the barriers to improved health equity and make recommendations for improvement.

It is here that grounds for hope abound. We at the Institute of Health Equity have a productive and, dare I say, enjoyable partnership with Public Health Scotland and three Scottish places: Aberdeen City, North Ayrshire and South Lanarkshire. A clear lesson from this partnership is that there is no problem too difficult. Improving social determinants of health is possible and, say our partners, we will do it. It is inspiring. Some problems are out of the control of Public Health Scotland and local places. There is maldistribution of wealth in Scotland and the UK in general. A new kind of political and economic settlement will be needed if a child growing up in a poor part of Scotland is to have the same life opportunities, and possibility for good health, as a child growing up in a wealthy part.

One hopes that a new kind of UK political settlement, emphasising devolution, will be beneficial for Scotland.

Recognising the need for macro economic and social change is not a recipe for despair. Our three places show that there is much that can and must be done at local level. Based on our work across the UK, the Institute of Health Equity has the ambition of creating a social movement for fairer societies and greater health equity. What could be more important than to create a fairer distribution of the social conditions for good health? CHES is ambitious, but also concrete and pragmatic in its recommendations, in the context of being a vital contributor to this social movement. Social justice requires it.



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With acknowledgement and thanks to many colleagues from the three CHES areas - Aberdeen City, North Ayrshire, and South Lanarkshire, for their contributions, input, and support throughout.

Thanks also to the numerous stakeholders and community event attendees who joined launch events, community events and participated in meetings – all provided valuable insights.

Thank you to the CHES Strategic Advisory Board for their insight and expertise.

CHES SAG Membership:

- Sir Michael Marmot, Director of the Institute of Health Equity (Co-Chair)
- Paul Johnston, Chief Executive, PHS (Co-Chair)
- Jessica Allen, Deputy Director of the Institute of Health Equity
- Linda Bauld, Chief Social Policy Adviser, Scottish Government, and Bruce and John Usher Chair in Public Health, University of Edinburgh
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- Jo Bibby, former Director of Health, The Health Foundation
- Susan Webb, former Director of Public Health, NHS Grampian

In addition to the CHES SAG membership, contributions to the SAG meetings were made by representatives from each of the three CHES areas. The recommendations contained in this report are those of the IHE and are not endorsed by any of the CHES Strategic Advisory Group member organisations.

CASE STUDIES

Source materials used in the case studies presented in the report were collated by Jessica Allen and Benjamin Viles. Material for the case studies was provided by the three collaborating places, The East London Foundation Trust, Richmond, California, Birmingham and Solihull Integrated Care Board, Deep End Health Care, Wellcome Trust.

CHAPTER 1

INTRODUCTION

The health of the Scottish population is stubbornly poor and unequal. In fact, life expectancy in Scotland is the lowest in the UK and lower than other countries in Western Europe. Widening health inequities across Scotland are unfair and remediable; they blight the lives and wellbeing of residents and limit Scotland's economic and social progress and place unsustainable demand on services.

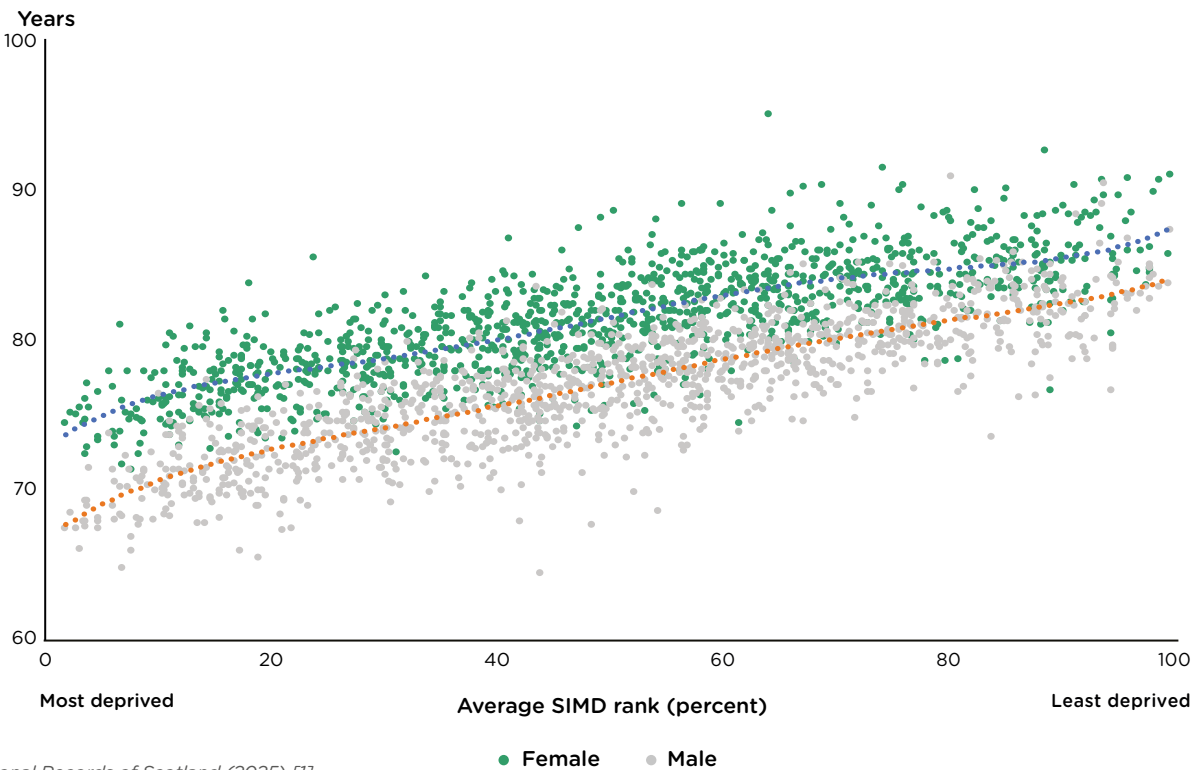
The Collaboration for Health Equity in Scotland (CHES) is a partnership between Public Health Scotland (PHS), the UCL Institute of Health Equity (IHE) and three collaborating places; Aberdeen City, North Ayrshire and South Lanarkshire. It was established in 2024 to explore routes forward to tackle health inequities.

Figure 1 provides a picture, at small area level, of health inequities within Scotland. Each dot in Figure 1 represents a small area in Scotland, known as an Intermediate Zone (IZ), which typically contain a population of between 2,500-6,000 people. These areas are ranked based on the Scottish Index of Multiple Deprivation (SIMD). There is a systematic and graded relationship between level of deprivation and life expectancy across Scotland; the greater the average deprivation rank, the lower the life expectancy. And, as across the UK, everyone in Scotland, aside from those living in the least deprived areas are experiencing lower life expectancy than if they were in the least deprived area.

This gradient in health shows firstly, that everyone is affected, to some degree, by the conditions in which they

are born, grown, live, work and age, conditions which relate to underpinning inequities in power, money and resources – the structural drivers of health. Secondly the gradient is steeper at the extremes, indicating a life expectancy inequity gap of 13.6 years for females and 16.3 years for males based on the average levels (regression line) between the most and least deprived IZs. When described in other summaries, for example in comparisons of life expectancy by SIMD quintile, the inequity gap in life expectancy between the averages of the most and least deprived 20 percent of the population is less; shown as a difference of 8.9 years for females and 11.5 years for males [1]. In Figure 1, the gap between IZs at the midpoint of the most and least deprived quintiles (i.e. the inequity gap between IZs at the 10th and 90th percentiles) is 9.1 for females and 11.7 for males, similar to the quintile averages. Thirdly, the gradient shows that action must be proportionate to the level of poor health and disadvantage but universal to improve everyone’s health and raise and flatten the gradient. Proportionate universalism is a key principle for the CHES.

Figure 1. Female and male life expectancy by average SIMD rank, Scottish Intermediate Zones, 2020-2024



Source: National Records of Scotland (2025) [1]

Other evidence, classifying individuals according to years of education or occupational status, similarly shows a gradient in health: the higher the socioeconomic position the better the health. Life expectancy, or mortality, by deprivation of area is readily available. We use it not only as a proxy for individual characteristics of people, but because characteristics of places may contribute to the health of residents, and it shows how health inequities are distributed in the population.

Further analysis of inequities in health are set out in Chapter 2, including some data indicating potential successes and ways forward.

The previous two CHES reports overviewed inequities in health and the social determinants of health in Scotland and within the three collaborating places [2, 3].

This report, based on the first phase of the CHES sets out how these inequities in health are driven by inequities in power, money and resources and in the conditions of daily life, further challenged by new and emerging threats. The report makes recommendations to address these structural drivers of ill health in Section 1 of this report; ‘act on the structural drivers of health equity’. The CHES also recognises that many of the challenges in addressing health inequities lie in implementation, with recommendations in Section 2; ‘deliver for health equity’.

The implementation gap, the difference between policy intent and impact, has also been demonstrated in other analyses in Scotland in recent years [4-7]. The CHES differs from these analyses because it learns from the three collaborating places, who have tested new ways of doing things locally, and from the strong emphasis on inequities within these and other Council areas in Scotland. The implementation challenges across Scotland relate to broader societal inequities in power, money and resources and that is the overriding context within which all places must try to take action.

Many of the barriers identified by places relate to national and indeed international challenges. Despite structural inequities which limit the possibilities for greater health equity in Scotland, the CHES has demonstrated that there is much that local areas can achieve, with support from the national system, to deliver more effective action for health equity. But there is far more for the national system to do in the face of widening structural inequities and new and emerging threats.

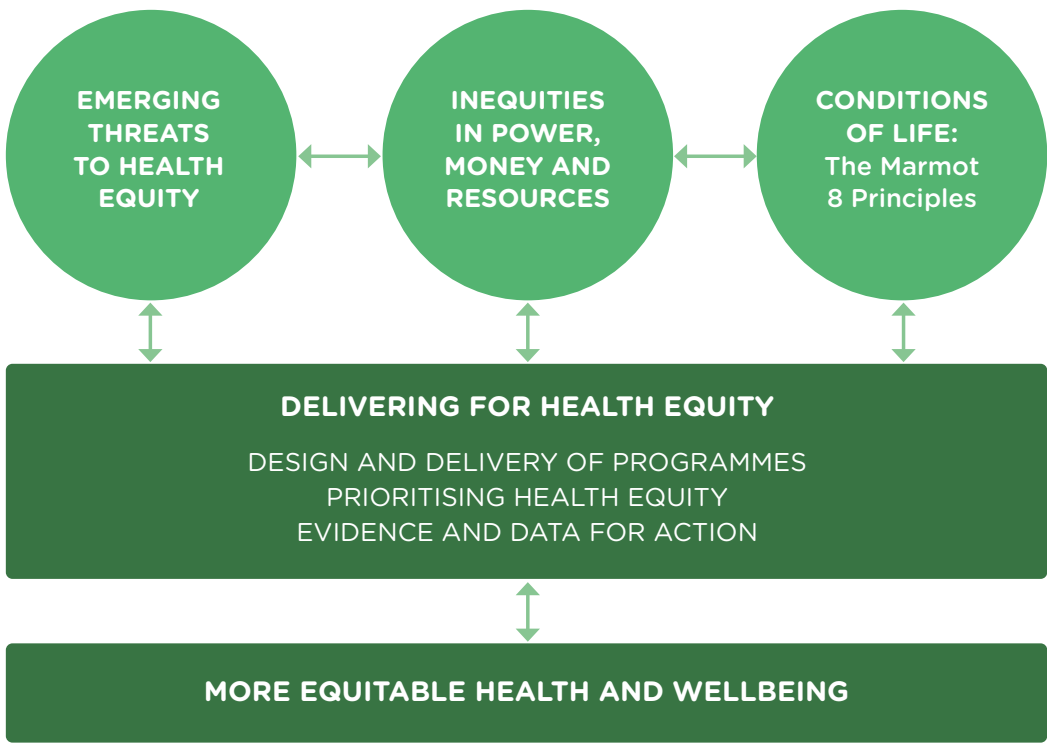
Public Health Scotland (PHS) have committed to continue CHES involving other places in Scotland to develop and deliver more effective implementation and action for health equity. Phase 2 of the programme will build on the learning from the first phase of the programme and tackle other identified challenges and effective national support for places across Scotland.



THE CHES FRAMEWORK

Based on learning from CHES, IHE have developed a framework to represent the drivers of health inequities and the challenges and opportunities in delivering greater health equity in Scotland. The recommendations in this report follow the areas of this framework, Figure 2.

Figure 2. The Health Equity Framework



INEQUITIES IN POWER, MONEY AND RESOURCES

At the centre of the framework are inequities in power, money and resources which structure inequities in the conditions in which people are born, grow, live work and age and resulting inequities in health. Structural inequities loom large through the CHES and are evident nationally and locally. They also underpin many of the delivery and implementation challenges in Scotland. These ‘fundamental causes’ of ill health have been evident and set out in Scotland over many years [8].

In an economic and political context where resources are under huge pressure, politicians and service providers are often unwilling to make the difficult decisions needed to support better health and greater equity. We stress that the public and political case for change needs to be made more strongly with a national discussion on the extent and drivers of health inequities alongside an agenda for fairer resources and programmes.

Inequities in power, money and resources limit many places and communities’ ability to shape the conditions for health. Despite significant national and local efforts to involve communities in the design and delivery

of programmes they continue to lack power and the ability to shape programmes and access resources to make the changes which they would wish to see.

Across Scotland inequities in wealth have widened in recent years and there are fewer resources available for public investments. While the levers for changing these distributions do not lie solely with the Scottish Government, there are ways to reduce structural inequities which are not currently being sufficiently utilised. In Chapter 3 we highlight the need for more equitable allocations of resources from national to local places and within places to reduce inequities, to scale up investments in effective programmes, to increase prevention spend and support commissioning for health equity.

HEALTH EQUITY AND NEW AND EMERGING THREATS

We identify emerging threats to health equity including ongoing inequitable impacts from the COVID pandemic, demographic changes, social media and AI and climate and environmental crises. All have the potential to harm health and widen health inequities but

are infrequently seen through this perspective, instead they are mostly assessed through an economic lens. In Chapter 4 we set out some of the developing evidence of health equity impacts from these emergent threats and recommend that all are considered explicitly and principally through a health equity lens.

HEALTH EQUITY AND THE CONDITIONS OF DAILY LIFE

The ways in which people experience their daily lives profoundly shape their health and differences in these experiences lead to inequities in health. The conditions of daily life are underpinned by structural inequalities. The IHE developed the Marmot 8 Principles to reduce

inequities in daily life, based on robust evidence and presented in the 2010 and 2020 Marmot reviews [9, 10]. The Principles provide an important agenda for action and a lens to assess progress on the social determinants of health and have been adopted widely across the UK and globally. In Scotland the Marmot 8 were the focus of the second CHES report which reported inequities in these areas across Scotland and within the three collaborating places [3]. The Marmot Principles have provided the entry points to embed action for health equity within the CHES collaborating places and have informed understandings about the blockers and enablers to more effective implementation and delivery [11].

Box 1. The Marmot 8 Principles

1

Give every child the best start in life

2

Enable all children, young people and adults to maximise their capabilities and have control over their lives

3

Create fair employment and good work for all

4

Ensure a healthy standard of living for all

5

Create and develop healthy and sustainable places and communities

6

Strengthen the role and impact of ill-health prevention

7

Tackle racism, discrimination and their outcomes

8

Pursue environmental sustainability and health equity together

In this report we do not overview conditions of daily life again and the Marmot 8, nor make recommendations for actions in these areas. Scotland has a relatively progressive policy environment and many of the 8 Principles are already focus for national policy. Therefore, the focus of this report is on inequities in power, money and resources and the blockers and enablers in delivery and implementation mechanisms which the CHES has sought to address, rather than specific Marmot 8 policy areas.

We do set out that equity of health and wellbeing must be at the heart of national Government and that the 8 Principles are the most effective route to ensure that. The same applies locally and as shown through the work of the CHES. Adopting the health equity Marmot 8 Principles nationally and locally would provide the needed framework and coherence for action.

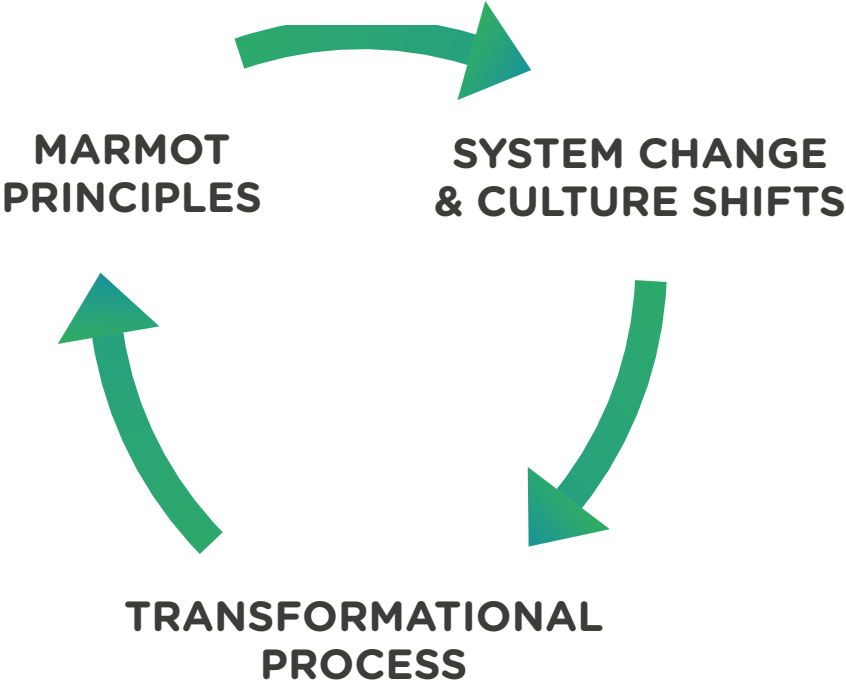
DELIVERING FOR HEALTH EQUITY

Much of CHES has been oriented around understanding and developing more effective and equitable delivery and implementation approaches to reduce health inequities. These are important enablers to more effective action nationally and locally, covered in Chapters 5-7, through the design and delivery of programmes, further prioritising health equity and the evidence and data needed to support delivery for health equity and to monitor impacts.

CHES AND THE MARMOT FRAMEWORK

From work with nearly 70 local authorities across the UK, IHE have identified areas where health equity can be strengthened and change is possible. These are summarised in Figure 3 below as action on the social determinants of health, described as the Marmot 8 Principles, systems change and culture shifts and transformational processes. The work by the three collaborating places has covered all three of these interrelated elements.

Figure 3. Impacts in Marmot Places



WORK IN THE THREE COLLABORATING PLACES

Two of the three places, in collaboration with communities, prioritised particular Marmot Principles and set out ways of strengthening implementation and delivery in these areas of focus; South Lanarkshire on ‘Give Every Child the Best Start in Life’ and North Ayrshire Principles 1; Give Every Child the Best Start in Life, 3; Create Fair Employment and Good Work for All and 6; Strengthen the Role and Impact of Ill Health Prevention in three geographic areas. Aberdeen City focussed on health equity in all policies and

proportionate universalism, building these into the new strategic approaches and strengthening commissioning for health equity.

All three places have identified important barriers and enablers which inform our understanding about routes to more effective delivery and implementation. The work within the three collaborating places is summarised in case study examples in this report and in Boxes 2 and 3.

Box 2. Summary of the CHES collaborating places and action in Marmot places

Action on the Marmot Principles	
South Lanarkshire	Principle 1
North Ayrshire	Principles 1 (Irvine), 3 (Three Towns) and 6 (Garnock Valley)
Aberdeen City	Input into in the Local Outcome Improvement Plan 2026-36 [12]
System change and culture shifts	
All places, PHS	Partnership working
All places	Health equity in all policies
All places, PHS	Leadership and capacity building
Aberdeen City	Proportionate universalism
PHS and all places	Governance
All places	Public and political shifts
All places	Community involvement
Transformational processes	
All especially North Ayrshire and South Lanarkshire, PHS	Data and evidence
Especially South Lanarkshire	Resources
Especially Aberdeen City	Commissioning
All places, PHS	Monitoring
All places, PHS	Accountability

THE CHES PROGRAMME

The CHES programme has comprised outputs principally based on the three approaches developed in Aberdeen City, North Ayrshire and South Lanarkshire and the support and learning within Public Health Scotland. The programme was overseen by a Strategic Advisory Group (membership listed in the acknowledgements) and by PHS and IHE. A data advisory group was convened to support the development and use of data nationally and within the three collaborating places (Chapter 7).

All three places took action through the CHES, summarised in Box 3 and in case studies throughout the report.

Box 3. Summary of CHES in three collaborating places

Aberdeen City

- Developed a commissioning approach and tools for proportionate universal investments and strategies
- Strengthened strategic focus on health equity through the Local Outcome Improvement Plans and Community Planning Partnership
- Built leadership, accountability and a system-wide approach for health equity and proportionate universalism and developed tools to support this

North Ayrshire

- Built systemwide leadership and capacity for health equity
- Undertook a North Ayrshire wide data assessment, alongside stakeholder engagement, which contributed to prioritisation of three Marmot Principles in three places
- Developed local actions based on evidence and community feedback, in Marmot Principles and built capacity for action
- Built system change across North Ayrshire

South Lanarkshire

- Undertook detailed analysis of health inequities across all 8 Marmot Principles and prioritised Marmot Principle 1
- Built system-wide leadership, including training
- Developed communication tools about health equity and the determinants of health
- Developed a pilot around Marmot Principle 1 in an area spanning four communities
- Developed an approach for embedding Marmot within the Community Planning Partnership
- Leveraged in several million pounds in funding from the IJB, the Council and NHS Lanarkshire to develop preventative and proportionate models of service and take forward place-based transformation programmes

Additionally, there have been specific outputs from CHES which include national approaches developed by PHS with input from IHE and the three collaborating places:

- Two interim reports, firstly an overview of health inequities and secondly an overview of the social determinants of health across Scotland and within the three collaborating places [2, 3].
- Analysis of the scale of change required in key social determinants of health [13].
- The CHES learning system which has shared the experience and learnings from CHES with a range of stakeholders and other places in Scotland [14].
- A national business roundtable to explore how businesses can support greater equity of health and wellbeing in Scotland, led by PHS.

An evaluation of the programme from PHS will be available in 2027.

THE POLICY CONTEXT

In Scotland there has been a longstanding focus on reducing health inequities through action on the social determinants of health. In many ways Scotland has led the way in recognising the social, economic, environmental and cultural drivers of poor health. The CHES programme builds on this expertise and momentum in Scotland. Tackling inequities in health continues to be a stated priority, evident in national and local policies, strategies and frameworks across a range of policy areas.

Addressing the determinants of health is highlighted in the Programme for Government 2025 to 2026, which is structured around the four priorities of eradicating child poverty, growing the economy, tackling the climate emergency and improving public services [15]. Health is referred to through the NHS, but making progress on the 4 priorities has the potential to improve health and reduce health inequities. There is a proposal to move to 6 national outcomes, one of which is ‘healthy: we live, longer, healthier and more fulfilling lives’ [16].

The National Strategy for Economic Transformation 2022-2032 set out building a fairer, more equal society, in which health is highlighted [17]. One of the 11 outcome measures in the National Performance Framework relates specifically to health, with an emphasis on inequalities [18].

The Scottish Government and the Convention of Scottish Local Authorities (COSLA) set out ambitions for Scotland’s health in ‘Scotland’s Population Health Framework 2025-2035’ [19]. The framework provides an important agenda to reduce health inequities and improve health by addressing the determinants of health over ten years, recognising that without fundamental shifts to prevention there will be unsustainable pressure on services. A ‘deliberate shift to prioritise upstream actions to support the building blocks of health, especially for those who are most likely to experience ill health’ is outlined. In recognising the social determinants, or building blocks of health as they are described in the framework, the approach is explicitly aligned to the Marmot Principles and with the ambitions of the CHES; many of the recommended actions are also in this report and the work of CHES is highlighted in the framework.



REPORT METHODOLOGY

Analysis in this report has been made by the IHE. All three collaborating places, Public Health Scotland and the Strategic Advisory Group have provided input and advice, but the assessments and recommendations are the responsibility of IHE and as such are independent and advisory. That said the ambition is that the analysis and recommendations be taken up by relevant stakeholders in Scotland.

All three collaborating places established leadership and steering groups and held community events, which have fed into the learning and evidence presented in this report.

DATA ANALYSIS

Much of the data presented in this, and the previous 2 CHES reports, relies on analysis developed through CHES [2, 3]. In the first CHES report we noted that health data are not routinely available below Intermediate Zone level. Assessing deprivation-related health inequalities at local authority level can, to some extent, be done using the Scottish Index of Multiple Deprivation (SIMD) local share which is calculated by the proportion of Data Zones in a local authority which are among the 20 percent (or other threshold) most deprived in Scotland. Although, it would be better to frame this in terms of Data Zones containing 20 percent of the most deprived populations.

In order to look at differences within Council areas at Intermediate Zone level we constructed a deprivation indicator based on the population weighted average rank of the Data Zones in each Intermediate Zone [20]. To quantify the extent of health inequalities

within the three CHES places, we derived an average deprivation rank for each Intermediate Zone. This was calculated using the population weighted average of the SIMD ranks of the Data Zones that comprise the Intermediate Zones. The weighted average is scaled to the number of Data Zones in Scotland (6,976 in 2020) rather than the number of Intermediate Zones. This average is therefore divided by the total number of Data Zones in Scotland in 2020 and multiplied by 100 to express the figure as a percent of the largest rank possible in Scotland. An Intermediate Zone with a higher weighted average SIMD rank (expressed as a percent), predominantly comprises some of the least deprived Data Zones in Scotland and an Intermediate Zone predominantly made up of more deprived Data Zones will have a lower weighted average SIMD rank (expressed as a percent). Further methodological and technical detail on the construction of this deprivation indicator is provided in the technical annex in the second CHES report, An Overview of the Social Determinants of Health in Scotland [3].

Local areas have also undertaken their own analyses, some with IHE advice, and this work has been a major contribution to understanding health inequalities nationally and locally, further set out in Chapter 7.



SUMMARY AND RECOMMENDATIONS

In order to address inequities in health in Scotland there needs to be a fundamental rethink of priorities across the UK. For that to happen equity of health and wellbeing need to be at the heart of government to address inequities in power, money and resources.

While national ambition and action is urgently needed across Scotland and the UK, there is still a great deal that can be achieved to strengthen health equity. Local areas can mitigate the impacts of national and international structural conditions on peoples lives and to some extent improve local structural conditions for health. Places and organisations can also make strong representation to national governments and decision makers about the need for structural changes. The recommendations in this report set out an agenda to do this.

The six overarching recommendations, summarised below, are based on learning from the CHES and on existing evidence and analyses. They have been developed by IHE for consideration and are independent and advisory. The recommendations relate to each part of the CHES framework and chapters in this report, with more detailed recommendations under each heading, set out in each chapter and the conclusions of this report. As the recommendations are considered and implementation plans developed, lead organisations

will be identified and short, medium and long term trajectories to realising them will be developed. Improving health equity is an agenda for the whole of society and the recommendations are necessarily broad and encompass many sectors and types of organisations. There are actions which can be prioritised immediately and are relatively straightforward to implement. Others require structural shifts which may take longer to show impact, but it is urgent to initiate the needed changes.

Many of these recommendations will be familiar and similar recommendations have been made in other analyses but have not been implemented. Putting equity of health and wellbeing at the centre of the national endeavour is needed to overcome this failure to implement repeatedly made recommendations. The health equity agenda can help coalesce many different, and sometimes competing priorities, increasing equity in educational attainment for instance will be a win for health, a win for education and a win for employers and the economy among other positive outcomes.

SUMMARY RECOMMENDATIONS

ACT ON THE STRUCTURAL DRIVERS OF HEALTH INEQUITIES

1

→

PUT EQUITY OF HEALTH AND WELLBEING AT THE HEART OF GOVERNMENT

2

→

REDUCE INEQUITIES IN POWER, MONEY AND RESOURCES

3

→

ADDRESS EMERGING THREATS TO HEALTH EQUITY

DELIVER FOR HEALTH EQUITY

4

→

STRENGTHEN THE DESIGN AND DELIVERY OF POLICIES AND PROGRAMMES

5

→

PRIORITISE HEALTH EQUITY

6

→

BUILD THE EVIDENCE AND DATA NEEDED TO ADDRESS AND MONITOR HEALTH EQUITY

CHAPTER 2

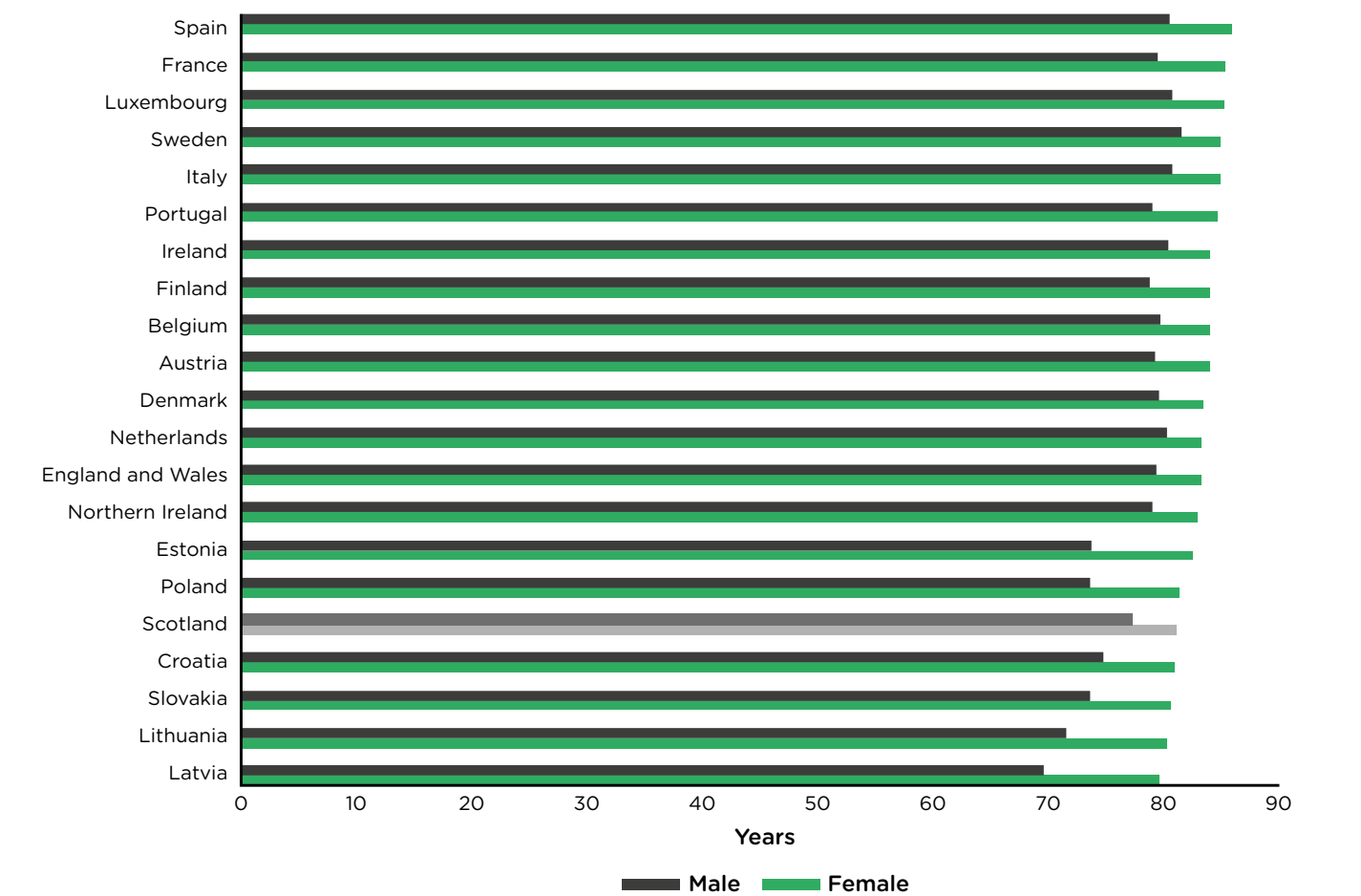
HEALTH INEQUITIES IN SCOTLAND

Throughout the CHES programme we have overviewed inequities in health and the social determinants of health at national and local level and provided additional analyses based on new methodologies which can be used to show inequalities within small areas. The data is set out in two CHES reports published in 2025. Below we include some figures based on new analysis or updated data from the previous reports.

LIFE EXPECTANCY IN SCOTLAND

Compared to many other European Countries, Scotland had relatively low male and female life expectancy in 2022 ranking 17th out of the 21 European countries listed in Figure 4. Life expectancy in Scotland is similar to that of Eastern Europe and below other countries in Western and Northern Europe. Note that the life expectancy figures in 2022 will have been affected by the impacts of the COVID pandemic.

Figure 4. Female and male life expectancy at birth, EU27* and UK countries, 2022



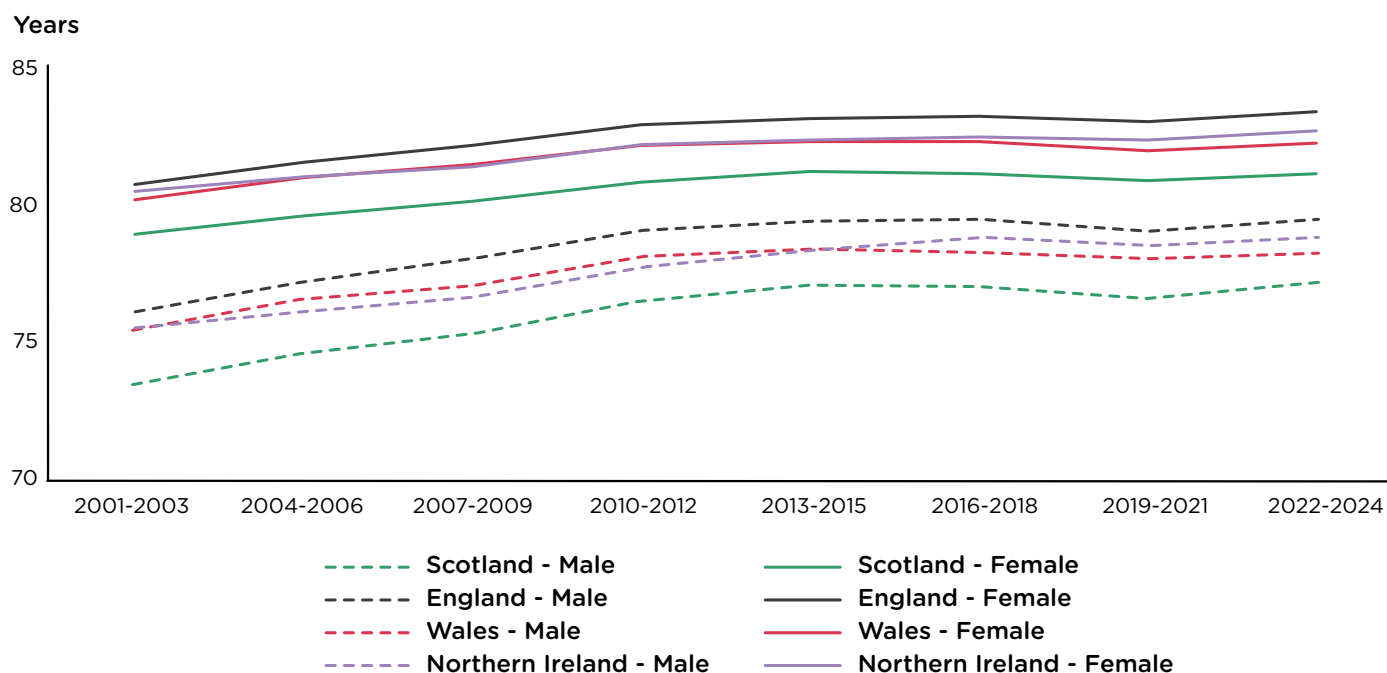
Source: Human Mortality Database (2026) [21]

Notes: 1) Differential impacts of COVID

2) *Missing data for Bulgaria, Hungary, Czech Republic, Germany, Slovenia, Greece, Cyprus, Malta, and Romania

In Scotland life expectancy is lower for both men and women than other UK nations, Figure 5. All four nations experienced a stalling in life expectancy from 2010 and then declines during COVID. Recent increases in life expectancy indicate recovery to pre-COVID levels.

Figure 5. Female and male life expectancy, UK Nations, 2001-2003 to 2022-2024



Source: ONS (2025) [23]

Between 2019-2021 and 2022-2024 male life expectancy increased more in Scotland than other parts of the UK, however, female life expectancy in Scotland increased

by only 0.26 years, the lowest rate compared with other parts of the UK, Table 1.

Table 1. Changes in female and male life expectancy in years between consecutive time periods, UK Nations, 2010-2012 to 2022-2024

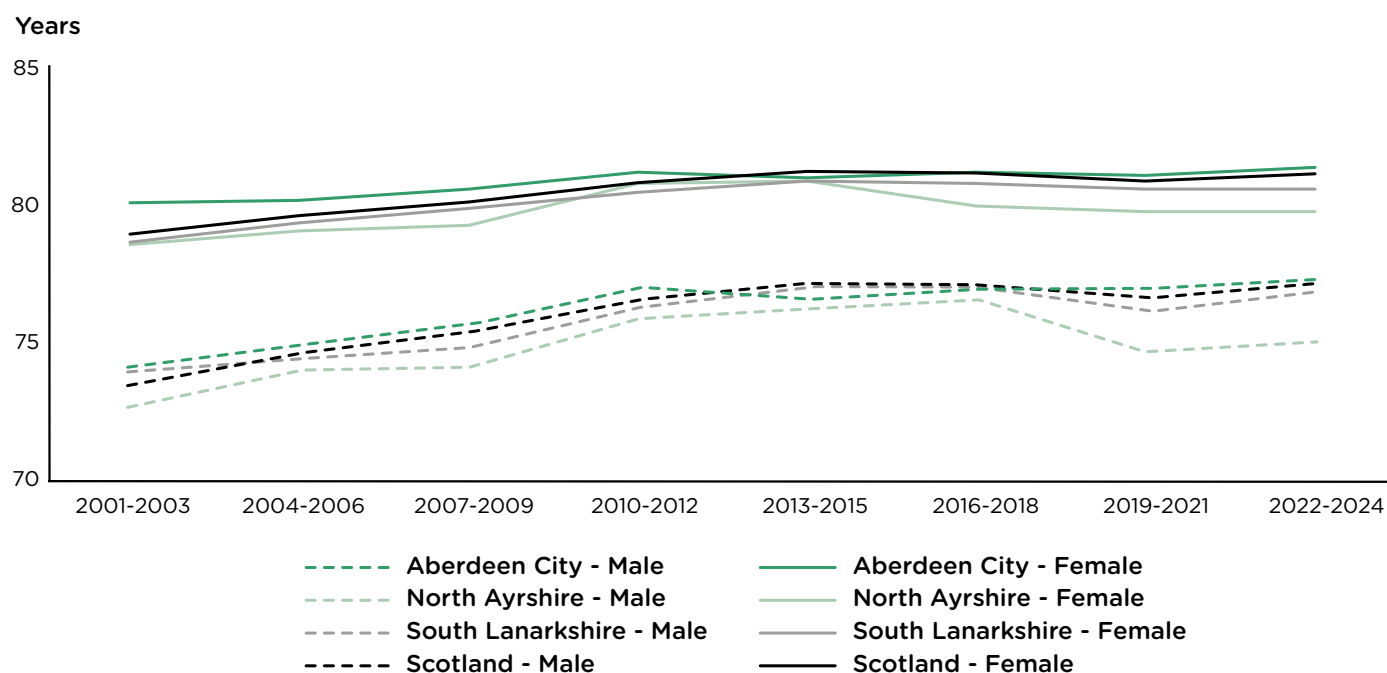
Place	Sex	2010-12 to 2013-15	2013-15 to 2016-18	2016-18 to 2019-21	2019-21 to 2022-24	Overall Change (2010-12 to 2022-24)
Scotland	Male	+0.61	-0.06	-0.49	+0.56	+0.61
	Female	+0.38	-0.06	-0.26	+0.26	+0.32
England	Male	+0.33	+0.14	-0.49	+0.40	+0.38
	Female	+0.22	+0.10	-0.20	+0.36	+0.48
Wales	Male	+0.29	-0.19	-0.19	+0.27	+0.18
	Female	+0.13	+0.00	-0.34	+0.29	+0.08
Northern Ireland	Male	+0.62	+0.39	-0.23	+0.31	+1.09
	Female	+0.16	+0.12	-0.12	+0.33	+0.49

Source: ONS (2025) [23]

Within the three CHES collaborating places life expectancy for males increased between 2001-2003 and 2010-2012, before stalling and then falling in South Lanarkshire and North Ayrshire during the COVID pandemic. In North Ayrshire male life expectancy has not recovered post-pandemic and is well below the high of 2013-2015. Male life expectancy continued to increase in Aberdeen City through and post-pandemic. Among

females in Aberdeen City life expectancy has mostly stalled since 2010-2012, with a slight increase since the pandemic. In South Lanarkshire, female life expectancy gradually declined between 2013-15 and 2022-24. In North Ayrshire however, female life expectancy began declining in 2013-2015 and has failed to recover and the differences in life expectancy for both men and women between North Ayrshire and the rest of Scotland are widening, Figure 6 and Table 2.

Figure 6. Female and male life expectancy, by three collaborating areas and Scotland, 2001-2003 to 2022-2024



Source: National Records of Scotland (2025) [22]

Table 2. Changes in female and male life expectancy in years between consecutive time periods, Aberdeen City, North Ayrshire, South Lanarkshire, and Scotland, 2010-2012 to 2022-2024

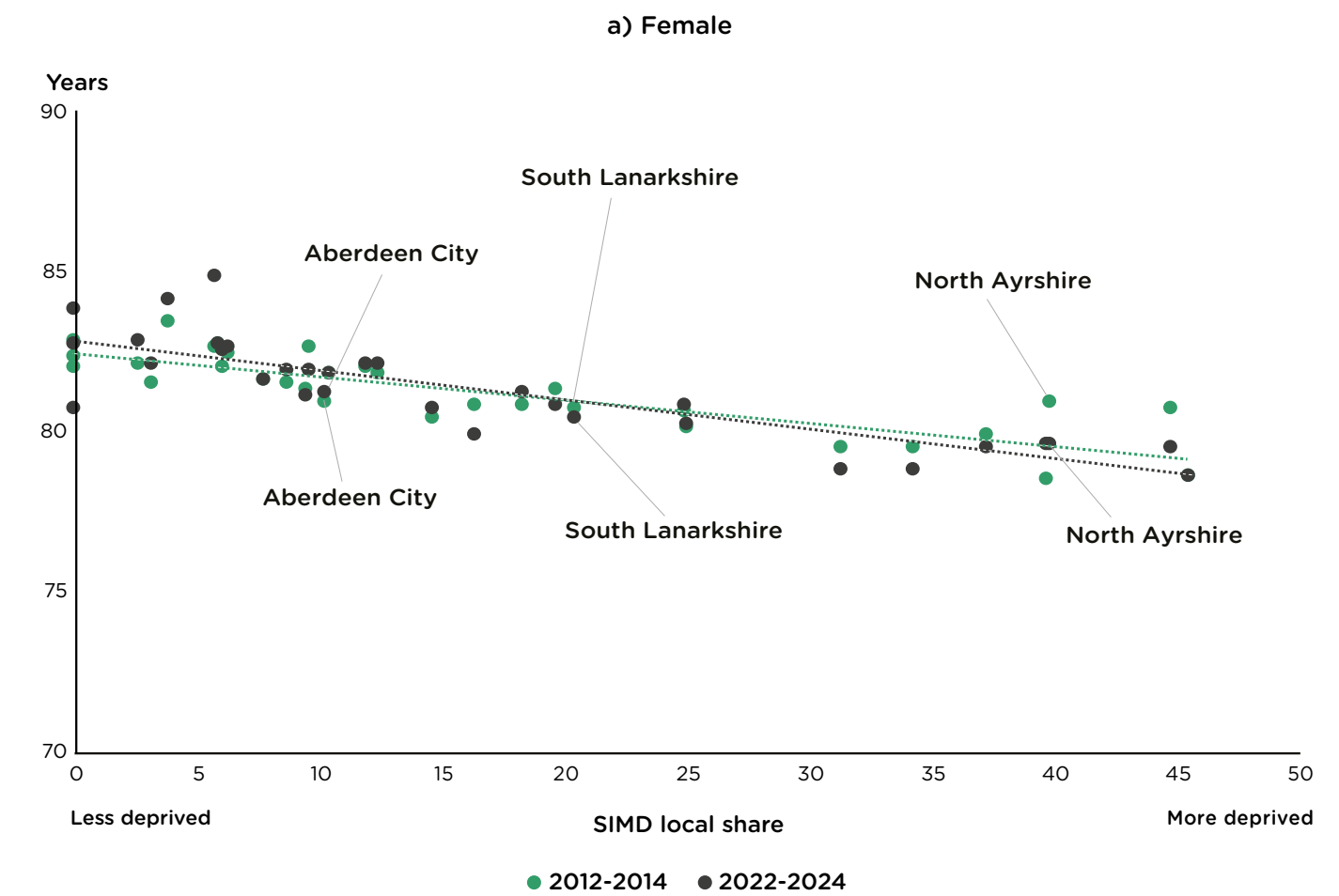
Place	Sex	2010-12 to 2013-15	2013-15 to 2016-18	2016-18 to 2019-21	2019-21 to 2022-24	Overall Change (2010-12 to 2022-24)
Aberdeen City	Male	-0.4	+0.3	0	+0.4	+0.3
	Female	-0.2	+0.2	-0.1	+0.3	+0.2
North Ayrshire	Male	+0.3	+0.3	-1.8	+0.3	-0.9
	Female	+0.1	-0.9	-0.2	0	-1
South Lanarkshire	Male	+0.7	-0.10	-0.8	+0.7	+0.5
	Female	+0.4	-0.1	-0.2	0	+0.1
Scotland	Male	+0.61	-0.06	-0.49	+0.55	+0.61
	Female	+0.38	-0.06	-0.26	+0.25	+0.32

Source: National Records of Scotland (2025) [22]

INEQUITIES IN LIFE EXPECTANCY IN SCOTLAND

Figures below show inequities in life expectancy between Councils in Scotland in two time periods, 2012-2014 and 2022-24. In both there is a clear gradient in life expectancy across Scotland which is closely related to level of deprivation of the Council (SIMD local share). For females the gradient has steepened between the two time points and inequities between less and more deprived Councils have widened, Figure 7a.

Figure 7. Female and male life expectancy (SIMD Local Share), Scottish Council Areas, 2012-2014 and 2022-2024

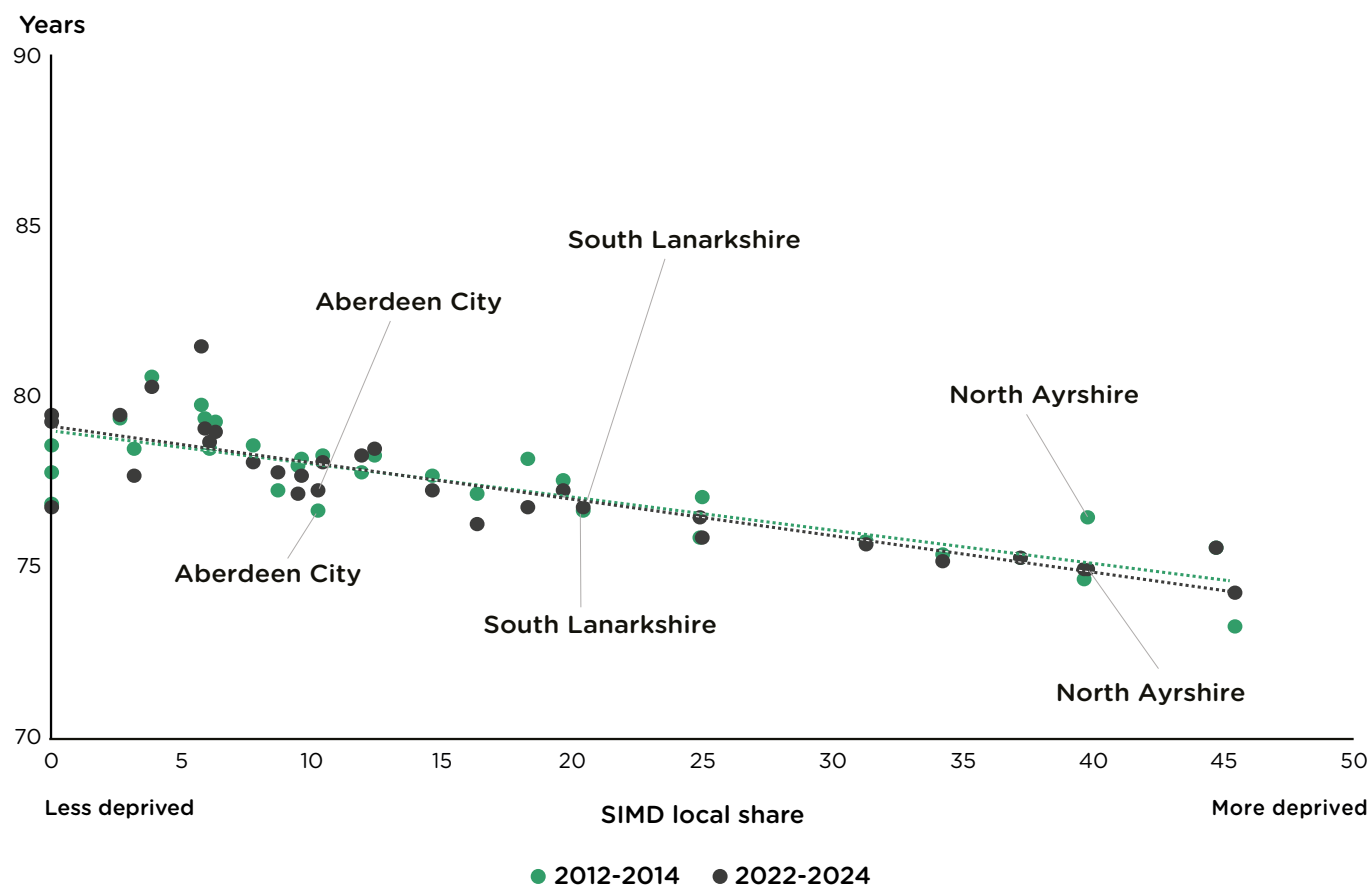


Source: National Records of Scotland (2025) [22]
Note: Glasgow values in 2012-2014 and 2022-2024 are the same and therefore overlap on this chart.

Among males, there is a similar gradient in life expectancy with lower life expectancy in more deprived Council areas, Figure 7b. Between 2012-14 and 2022-24,

as for women, life expectancy deteriorated slightly in more deprived Council areas, and increased, slightly in less deprived areas, widening inequities somewhat.

b) Male



Source: National Records of Scotland (2025) [22]

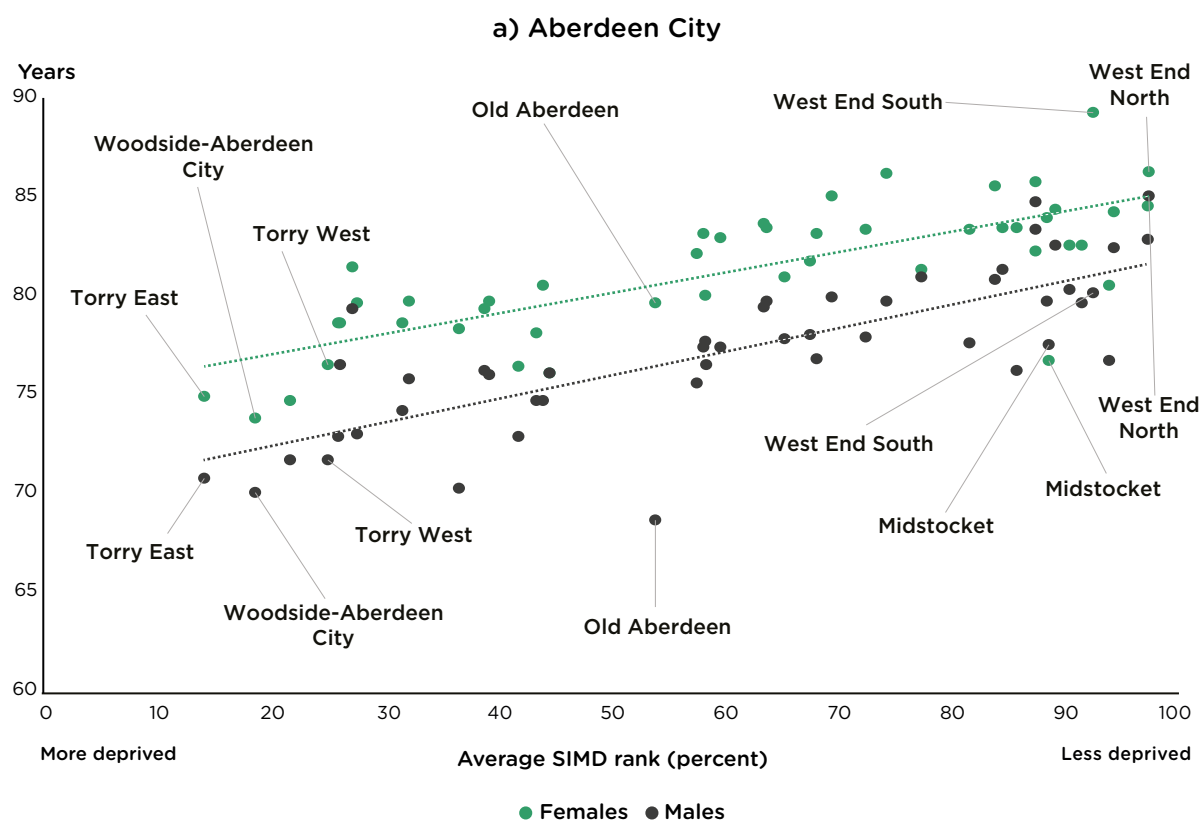
Note: Inverclyde and Dundee City values in 2012-2014 and 2022-2024 are the same and therefore overlap on this chart.

Within the three collaborating places, there are also marked gradients in life expectancy for men and women, with lower life expectancy in more deprived areas and, as across Scotland, a systematic relationship between

health and level of deprivation of each Intermediate Zone, Figures 8a-c. Within each place there is a more than 10 year difference in life expectancy for men and women between more and less deprived areas.

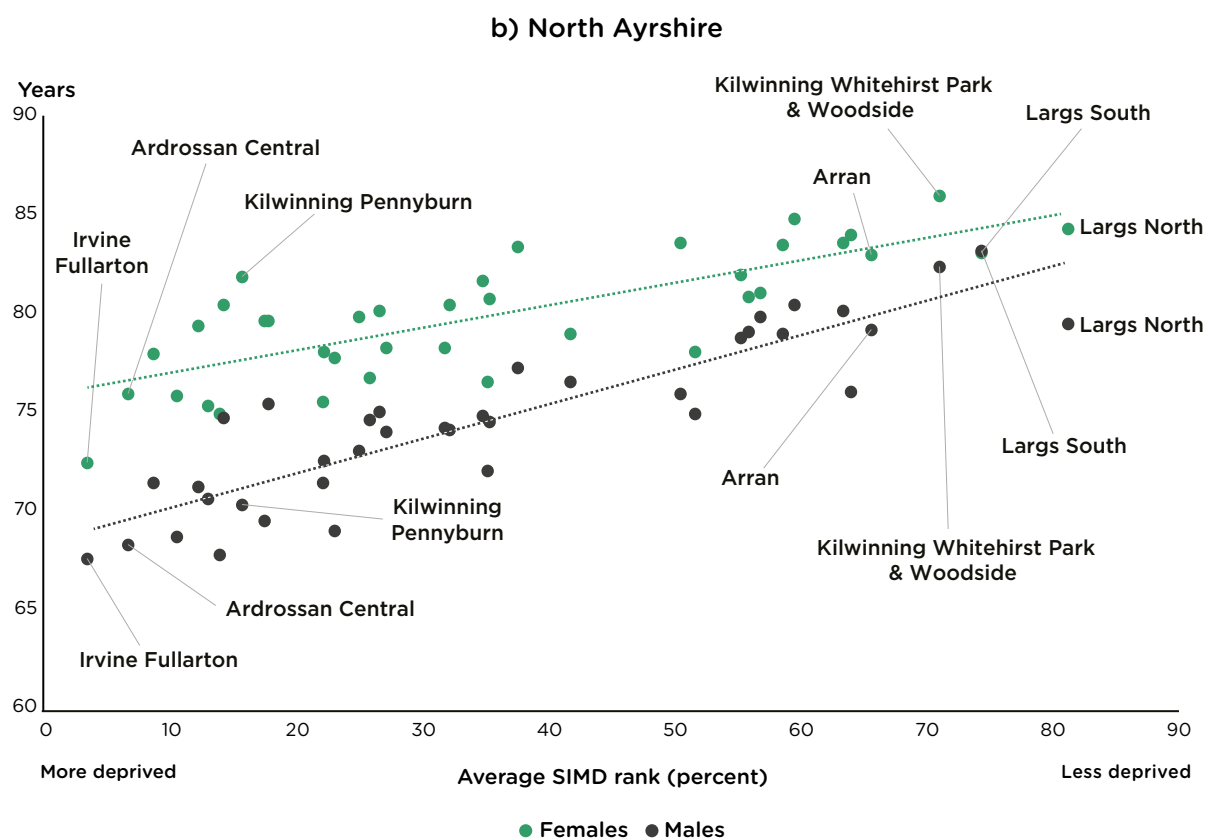


Figure 8. Female and male life expectancy at birth (Average SIMD rank), Three collaborating areas and their Intermediate Zones, 2020-2024



Source: National Records of Scotland (2025) [22]

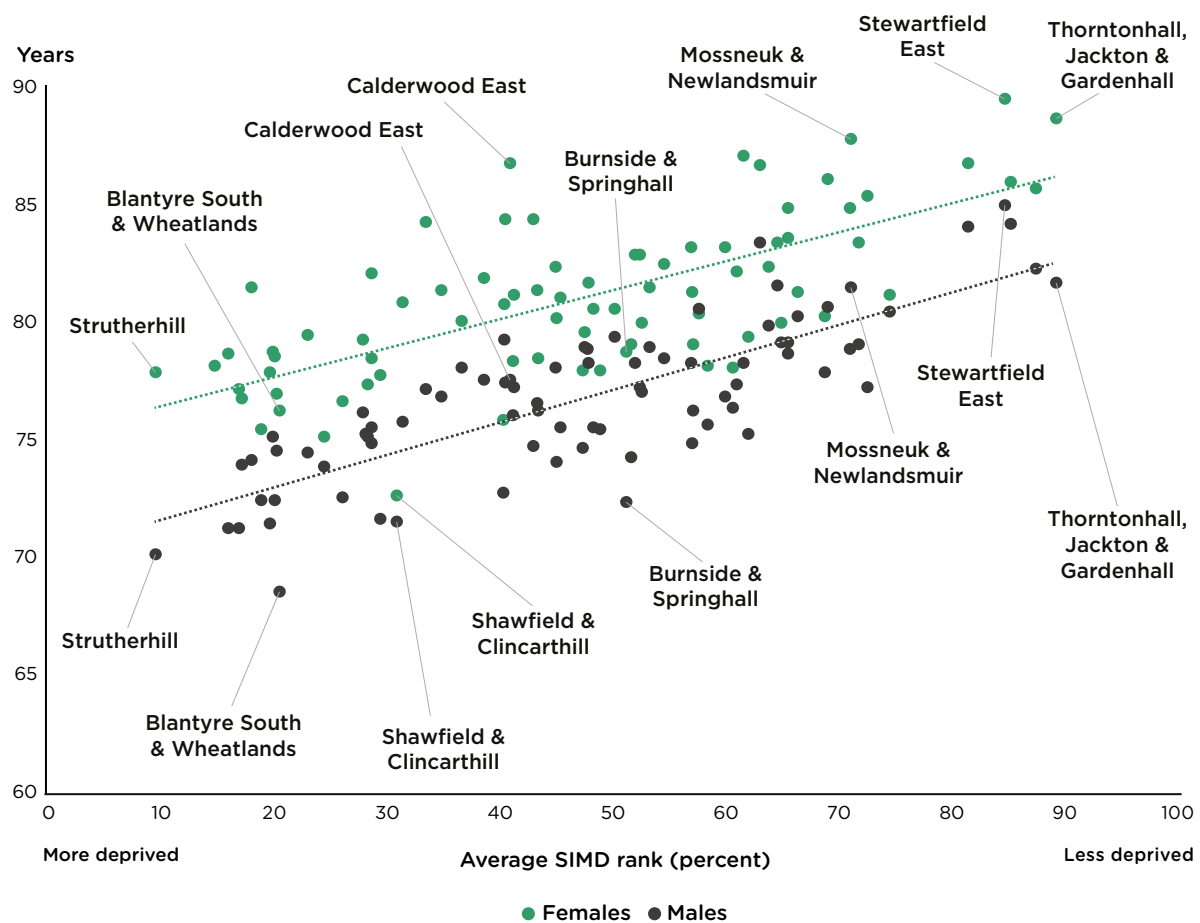
Note: No Data for City Centre East-Aberdeen City for both sexes, and no data for females in Hanover North.



Source: National Records of Scotland (2025) [22]

Note: Largs South figures overlap.

c) South Lanarkshire



Source: National Records of Scotland (2025) [22]

Note: Male life expectancy data is missing for Fairhill, Female life expectancy data is missing from Clydesdale South.

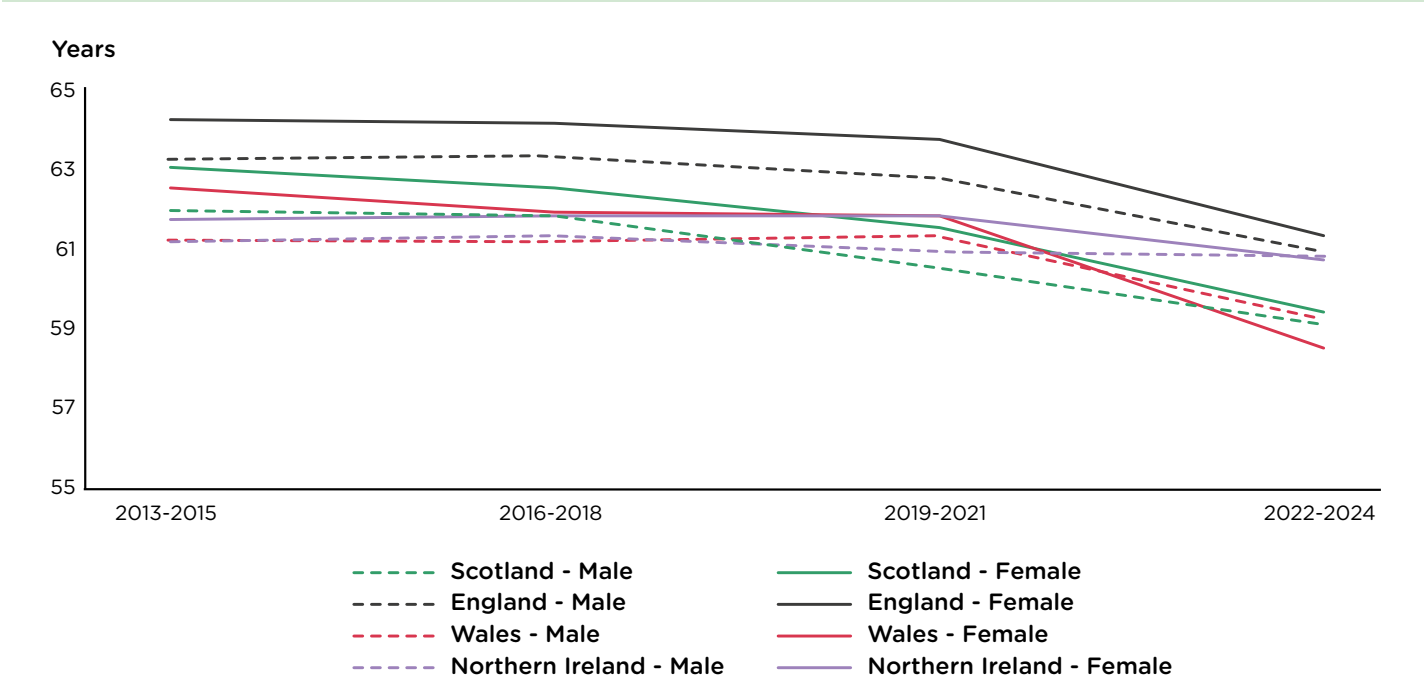
The ambition of the CHES is to raise and flatten gradients in life expectancy and health within places and across Scotland.



HEALTHY LIFE EXPECTANCY IN SCOTLAND

Healthy life expectancy refers to the average number of years people can expect to live in good or very good health. Across the UK healthy life expectancy has declined with particularly steep declines in Scotland and among men in Wales. In Scotland declines in healthy life expectancy are evident from 2013-2015, between 2013-2015 and 2022-2024 there was a decline of 3.6 years in healthy life expectancy among women, Figure 9, and among men a decline of 2.8 years. These are the largest declines compared with other UK nations, except among women in Wales where declines were steeper. Declines in healthy life expectancy have accelerated since the pandemic, Figure 9 and Table 3.

Figure 9. Female and male healthy life expectancy, by UK Nations, 2013-2015 to 2022-2024



Source: ONS (2026) [24]

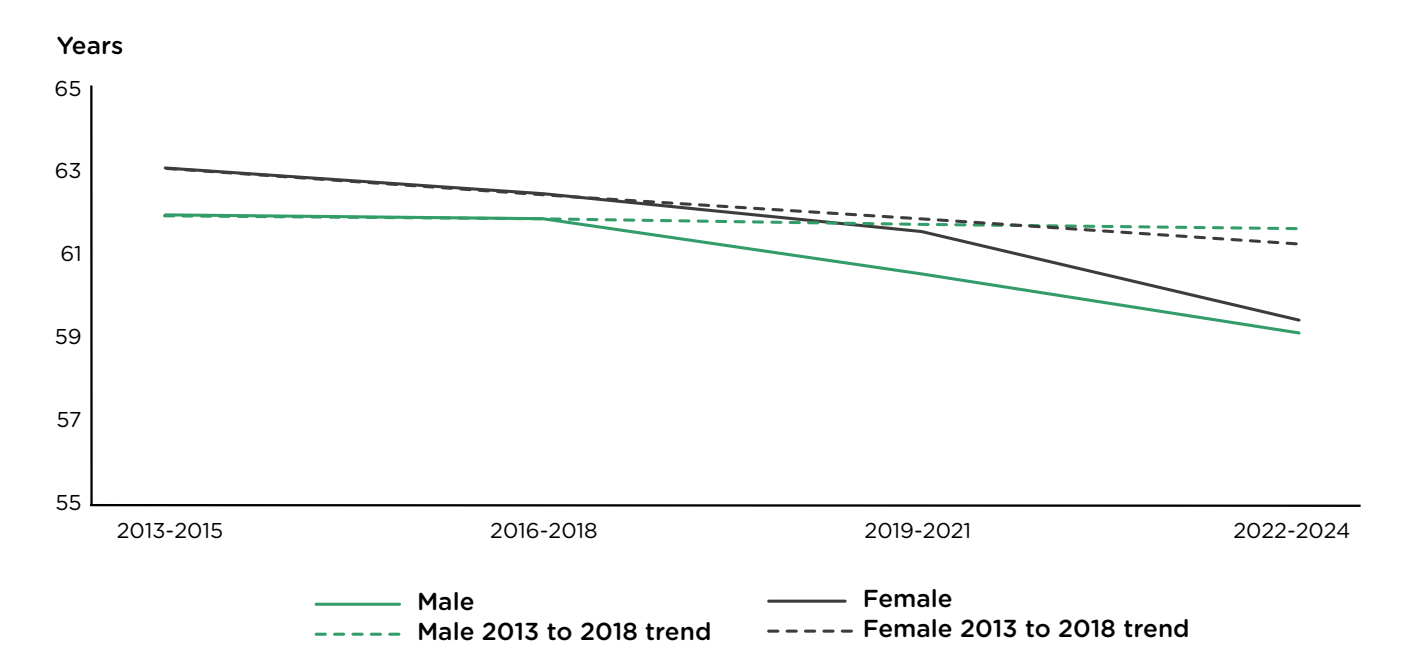
Table 3. Changes in female and male healthy life expectancy in years between consecutive time periods, UK nations, 2013-2015 to 2022-2024

Place	Sex	2013-15 to 2016-18	2016-18 to 2019-21	2019-21 to 2022-24	Overall Change (2013-15 to 2022-24)
Scotland	Male	-0.1	-1.3	-1.4	-2.8
	Female	-0.5	-1.0	-2.1	-3.6
England	Male	+0.1	-0.6	-1.8	-2.3
	Female	-0.1	-0.4	-2.4	-2.9
Wales	Male	0	+0.1	-2.1	-2.0
	Female	-0.6	-0.1	-3.3	-4.0
Northern Ireland	Male	+0.1	-0.4	-0.1	-0.4
	Female	+0.1	+0.0	-1.1	-1.0

Source: ONS (2026) [24]

Figure 10 below shows the sharp decline in healthy life expectancy in Scotland from 2016-2018, and projected trends had healthy life expectancy stayed on the same trajectory as during the period 2013-15 to 2016-18.

Figure 10. Female and male healthy life expectancy, Scotland, 2013-15 to 2022-24

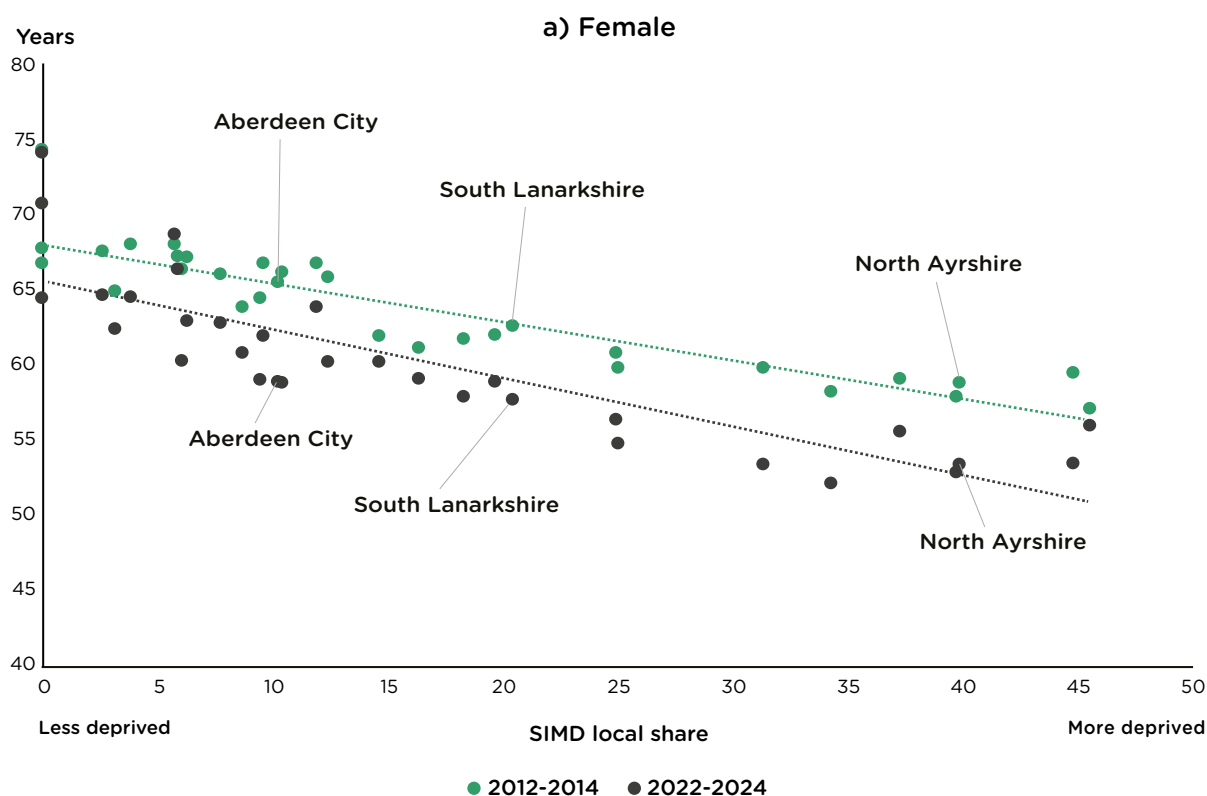


Source: ONS (2026) [24]

As with life expectancy, declines in healthy life expectancy have not been experienced equally across Scotland, leading to widening inequities in health. Figure 11a below shows that the declines in healthy life expectancy for females between 2012-2014 and 2022-2024 have been greater in more deprived Councils and the gradient in health steepened. For women there is now a more than 22 year difference in healthy life expectancy between Councils and for men a difference of 20 years.

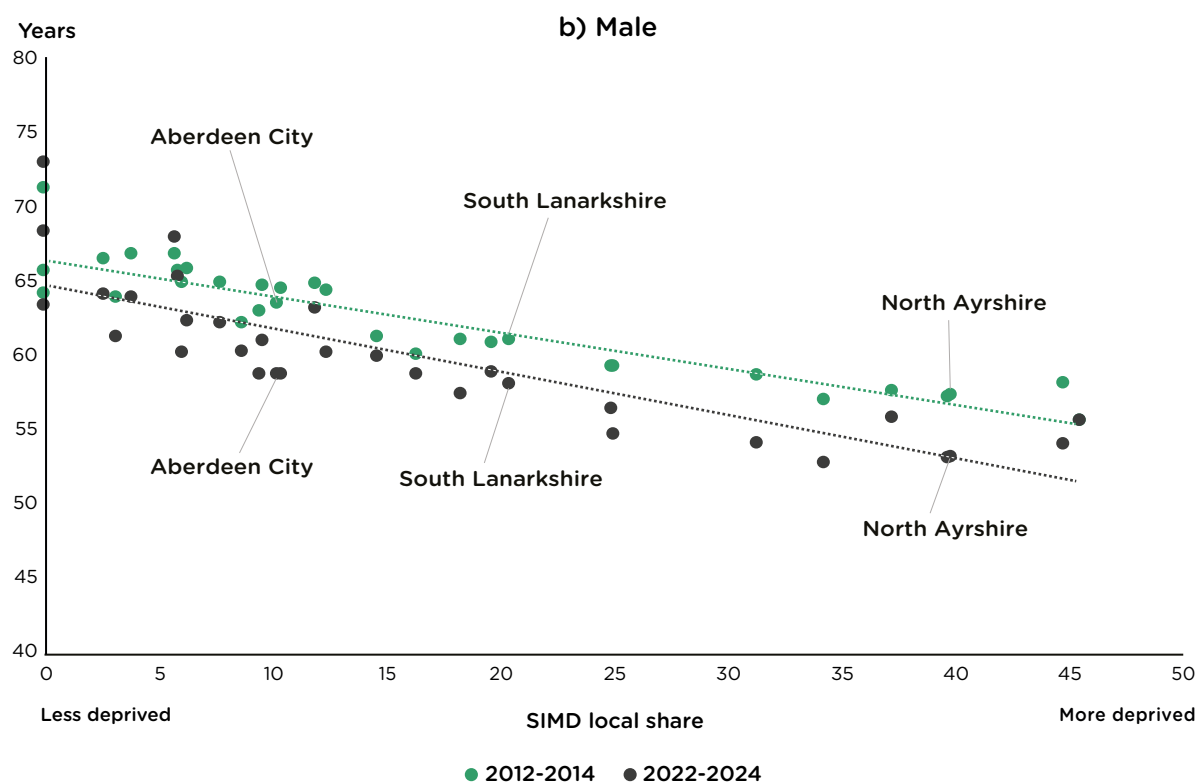


Figure 11. Female and male healthy life expectancy (SIMD Local Share), Scottish Council Areas, 2012-2014 and 2022-2024



Source: National Records of Scotland (2026) [25]

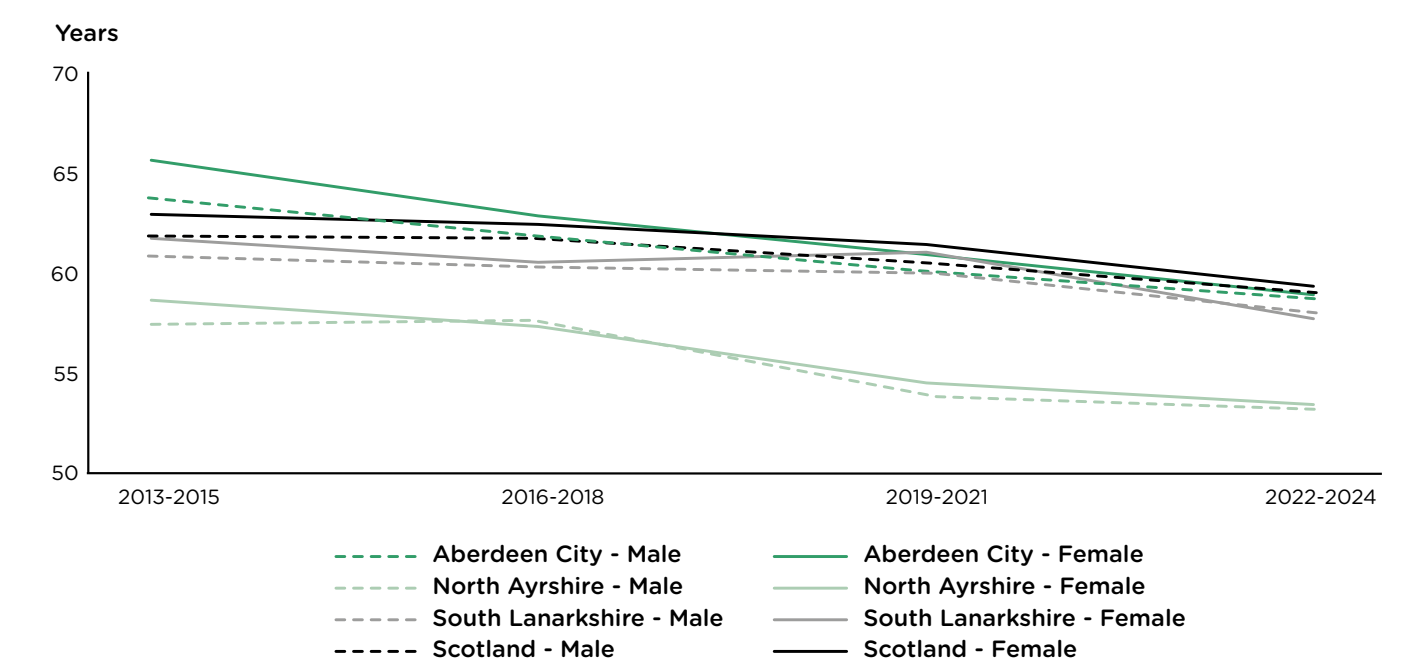
A similar picture of widening inequity is evident among males, with declines in healthy life expectancy being greater in more deprived than less deprived Councils between 2012-2014 and 2022-2024.



Source: National Records of Scotland (2026) [25]

Within the three CHES collaborating places there have also been marked declines in healthy life expectancy and all three places experienced steeper declines in healthy life expectancy than Scotland as a whole, other than men in South Lanarkshire where the declines are in line with the Scottish average. The steepest declines have been among men and women in Aberdeen City, Figure 12 and Table 4.

Figure 12. Female and male healthy life expectancy, Three collaborating areas and Scotland, 2013-2015 to 2022-2024



Source: ONS and National Records of Scotland (2025 and 2026) [25]

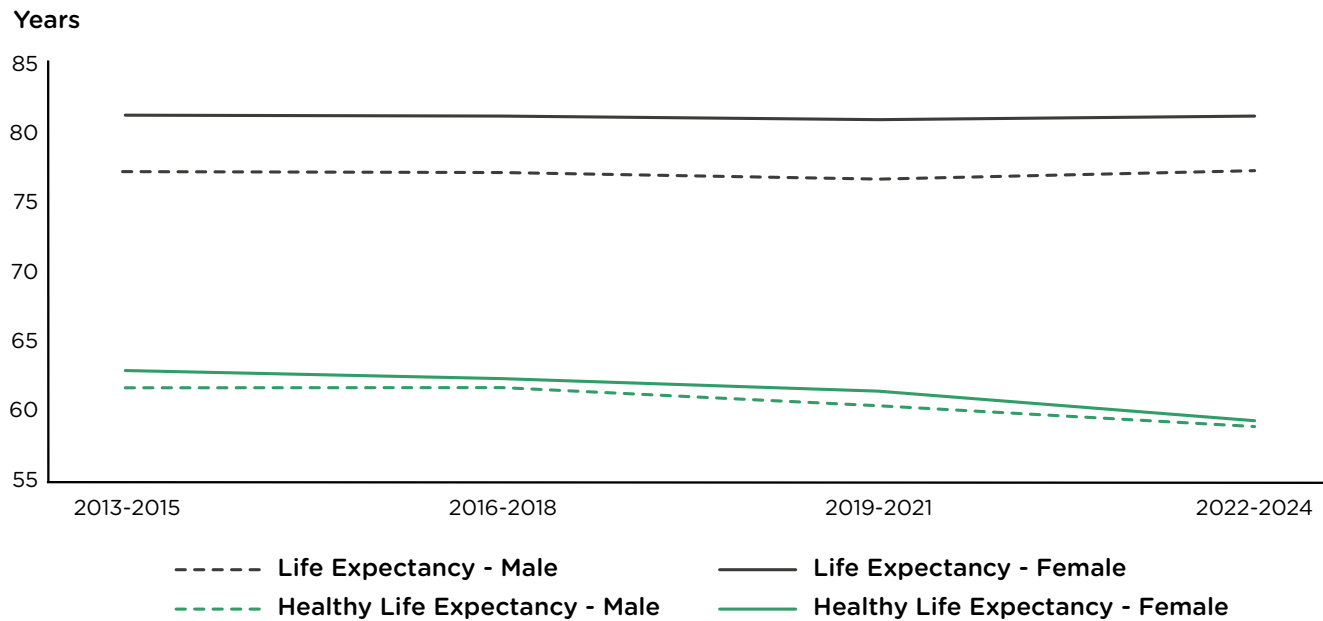
Table 4. Changes in female and male healthy life expectancy in years between consecutive time periods, Aberdeen City, North Ayrshire, South Lanarkshire and Scotland, 2013-2015 to 2022-2024

Place	Sex	2013-15 to 2016-18	2016-18 to 2019-21	2019-21 to 2022-24	Overall Change (2013-15 to 2022-24)
Aberdeen City	Male	-1.8	-1.8	-1.4	-5
	Female	-2.8	-1.9	-2	-6.7
North Ayrshire	Male	+0.1	-3.7	-0.7	-4.3
	Female	-1.3	-2.8	-1.1	-5.2
South Lanarkshire	Male	-0.5	-0.3	-2	-2.8
	Female	-1.2	+0.5	-3	-4
Scotland	Male	-0.1	-1.3	-1.4	-2.8
	Female	-0.5	-1	-2.1	-3.6

Source: National Records of Scotland (2026) [25]

As evident in Figure 13 below, healthy life expectancy has declined more steeply than life expectancy in Scotland, meaning that people can expect to spend longer periods of their life in ill health. This will likely increase rates of economic inactivity and poverty and place more strain on already stretched services, Table 5.

Figure 13. Female and male life expectancy and healthy life expectancy, Scotland, 2013-2015 to 2022-2024



Source: National Records of Scotland (2025 & 2026) [22, 25]

Table 5. Changes in female and male healthy life expectancy and life expectancy in years, Aberdeen City, North Ayrshire, South Lanarkshire and Scotland, 2013-2015 and 2022-2024

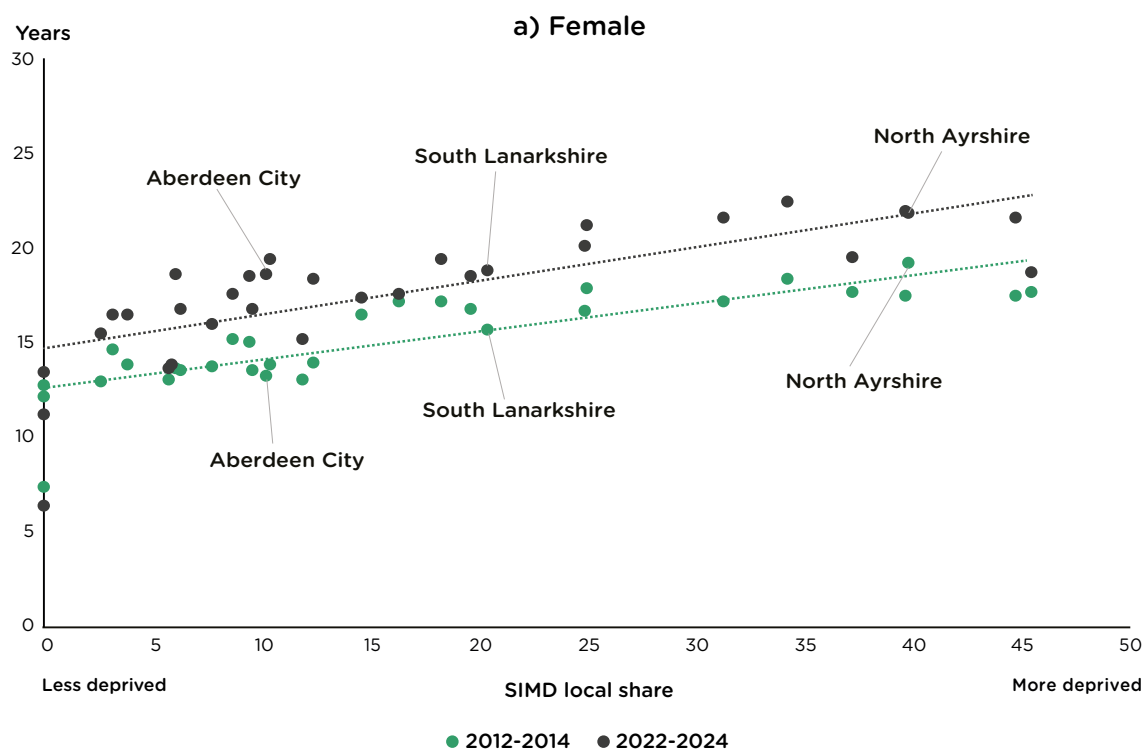
Place	Sex	Healthy life expectancy	Life expectancy
Aberdeen City	Male	-5	+0.3
	Female	-6.7	+0.2
North Ayrshire	Male	-4.3	-0.9
	Female	-5.2	-1.0
South Lanarkshire	Male	-2.8	+0.5
	Female	-4	+0.1
Scotland	Male	-2.8	+0.6
	Female	-3.6	+0.3

Source: National Records of Scotland (2025 and 2026) [22, 25]

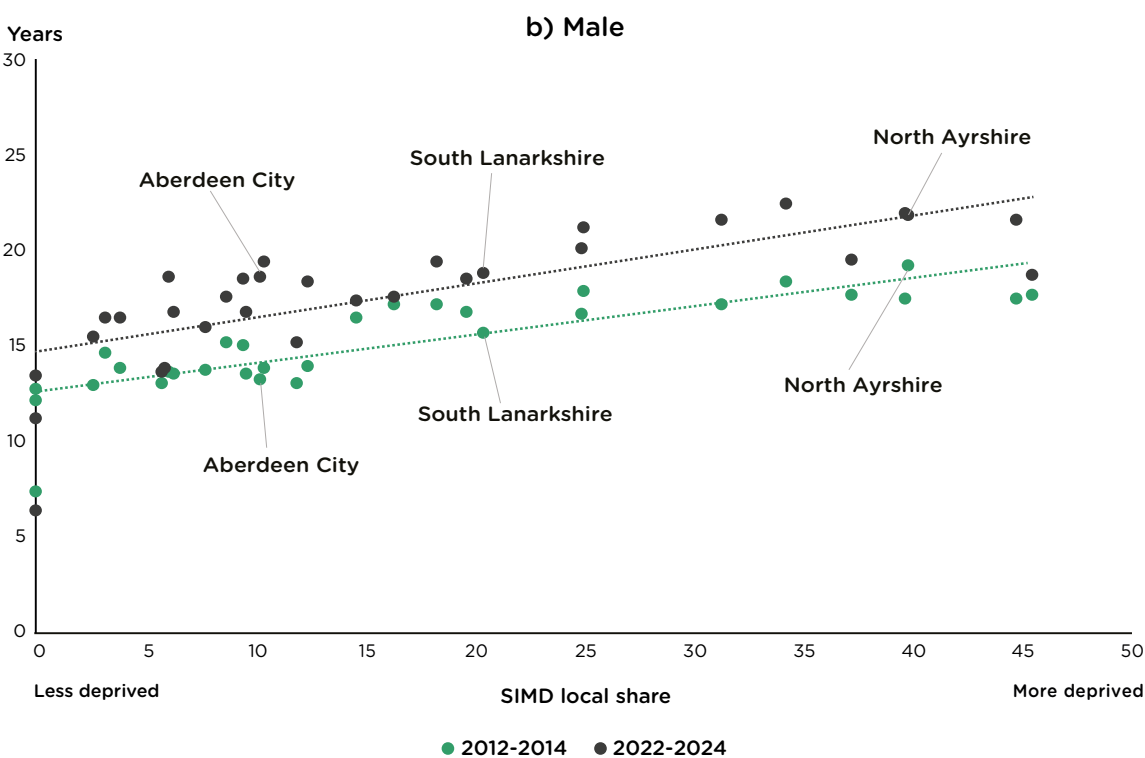
YEARS SPENT IN ILL HEALTH

The larger decreases in healthy life expectancy than life expectancy are reflected in the increases in years spent in ill health across Scotland between 2012-2014 and 2022-2024. These are not distributed equally and there have been greater increases in more deprived Councils, particularly among women, and the gradient is steepening, Figure 14a-b.

Figure 14. Female and male years spent in ill health (SIMD Local Share), Scottish Council Areas, 2012-2014 and 2022-2024



Source: National Records of Scotland (2025 & 2026) [22, 25]



Source: National Records of Scotland (2025 & 2026) [22, 25]

In each of the three collaborating places there have also been increases in the average numbers of years spent in ill health, with associated impacts on services and welfare, communities and families and on economic activity. Increases in years spent in ill health have been particularly steep in Aberdeen City, related to the declines in healthy life expectancy noted above.

Table 6. Changes in female and male years spent in ill health in years between consecutive time periods, Aberdeen City, North Ayrshire, South Lanarkshire and Scotland, 2013-2015 to 2022-2024

Place	Sex	2013-15 to 2016-18	2016-18 to 2019-21	2019-21 to 2022-24	Overall Change (2013-15 to 2022-24)
Aberdeen City	Male	+2.1	+1.8	+1.8	+5.7
	Female	+3.0	+1.8	+2.3	+7.1
North Ayrshire	Male	+0.2	+1.9	+1	+3.1
	Female	+0.4	+2.6	+1.1	+4.1
South Lanarkshire	Male	+0.4	-0.5	+2.7	+2.6
	Female	+1.1	-0.7	+3.3	+3.7
Scotland	Male	+0.1	+0.8	+1.9	+2.8
	Female	+0.5	+0.7	+2.4	+3.6

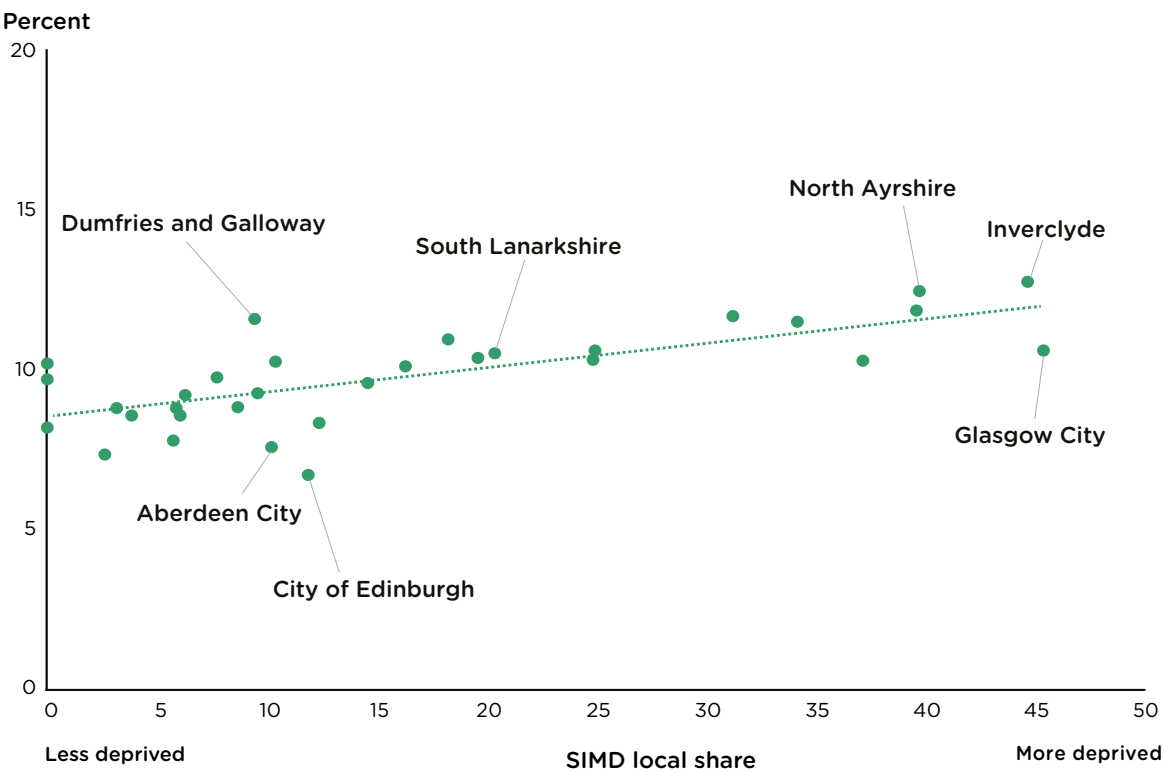
Source: National Records of Scotland (2025 & 2026) [22, 25]



PHYSICAL DISABILITIES

There are large differences in the percentage of people with physical disabilities between Councils, Figure 15, with the highest rates in Inverclyde and lowest rates in the City of Edinburgh. These differences are related to level of deprivation and also age profiles of Councils.

Figure 15. Percentage of people with a physical disability* (SIMD Local Share), Scottish Council Areas, 2022



Source: Scotland Census (2022) [26]
Note: *Physical disability is defined in this context as: A condition that substantially limits one or more basic physical activities such as walking, climbing stairs, lifting or carrying [27].



DESPAIR, ILL HEALTH AND DEATHS

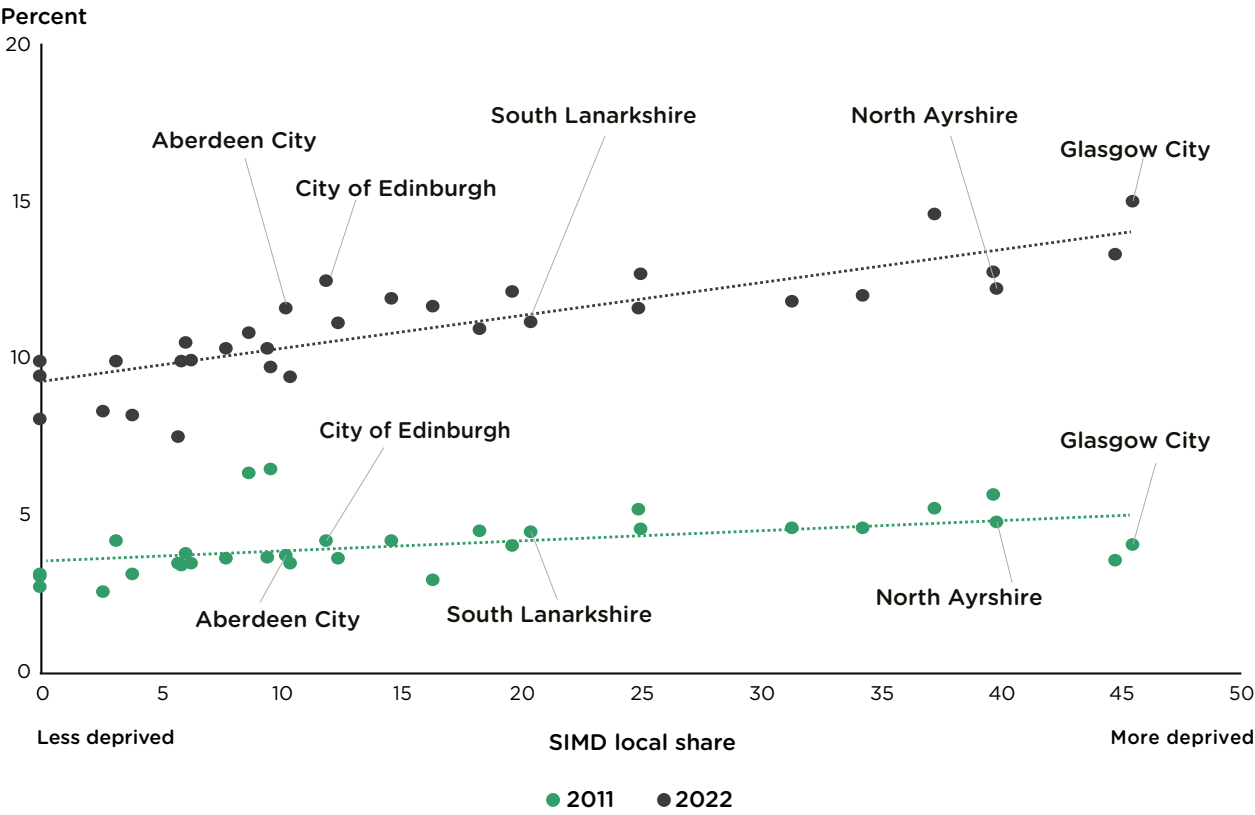
More deprived areas, particularly those which have experienced deindustrialisation and associated significant economic and social decline and entrenched intergenerational inequality, lead to communities experiencing a sense of hopelessness and exclusion. Associated with this are ‘deaths of despair’ and associated poor health including high rates of alcohol consumption, smoking, drug use and suicide [28]. Evidence shows, and highlighted throughout the CHES, that new routes to economic and social investment are required and services and support much more oriented towards prevention of poor outcomes in the social determinants of ill health supporting families and communities, rather than predominantly being offered to individuals during crises.

MENTAL HEALTH

Across Scotland, the proportion of people in each Council who have been diagnosed with a mental health condition is related to level of deprivation of the Council. While diagnoses reflect, to some extent health service activity and practice rather than actual prevalence. Figure 16 below shows that there have been sizeable

increases in diagnoses of mental health conditions between 2011 and 2022. Inequities, related to level of deprivation have intensified and widened over the period, with an increasingly close association between levels of deprivation of Councils and likelihood of being diagnosed with a mental health condition.

Figure 16. Percentage of people with a mental health condition* (SIMD Local Share), Scottish Council Areas, 2011 and 2022



Source: Scotland Censuses (2011 and 2022) [26, 29]

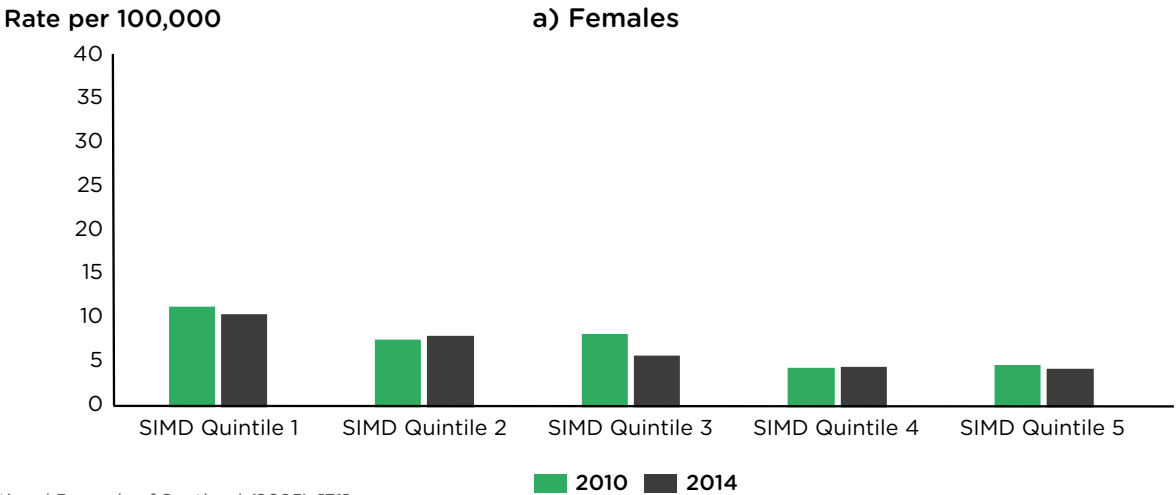
Note: *Mental health condition is defined in this context as: A condition that affects emotional, physical and mental wellbeing in the Scottish Census [30].

SUICIDES

There have been declines in deaths recorded as probable suicides between 2010-2014 and 2020-2024 in Scotland, and inequities in probable suicide by area deprivation are reducing, indicated in Figure 17a-b. While positive, overall rates remain high at 12.7

per 100,000 people and higher than England (10.9 per 100,000) in 2022-24 and there are still marked inequities in probable suicides among men. Rates are higher among men (19.3 per 100,000) than women (6.6 per 100,000).

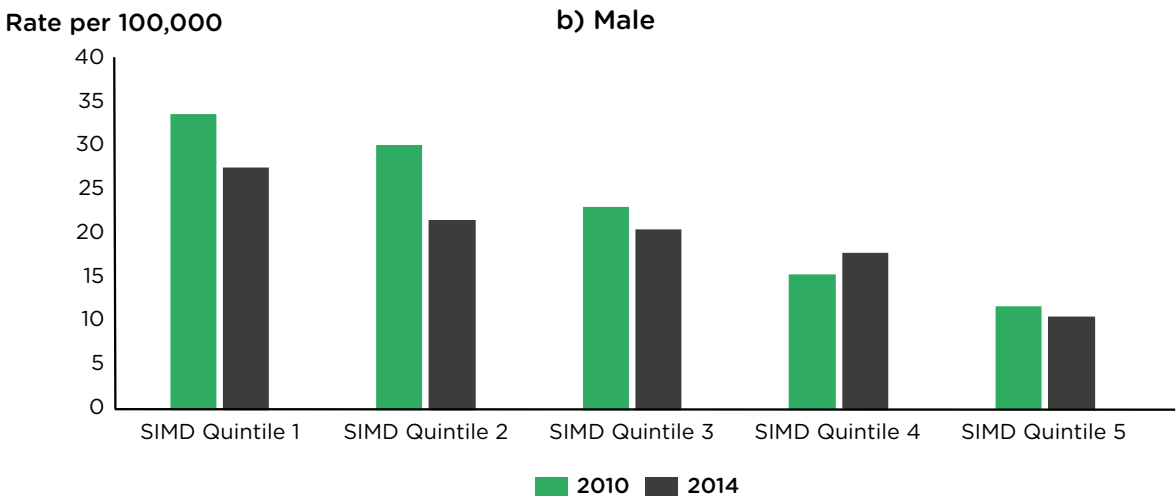
Figure 17. Female and male probable suicides aged 16+*, by SIMD Quintile, Age-standardised rate of mortality per 100,000, Scotland, 2010 and 2024



Source: National Records of Scotland (2025) [31]

Note: *Deaths with an underlying cause of one of the following categories are counted as probable suicides:

- Intentional self-harm
- Events of undetermined intent
- Sequelae of intentional self-harm
- Sequelae of events of undetermined intent [31]



Source: National Records of Scotland (2025) [31]

Note: *Deaths with an underlying cause of one of the following categories are counted as probable suicides:

- Intentional self-harm
- Events of undetermined intent
- Sequelae of intentional self-harm
- Sequelae of events of undetermined intent [31]

At Council level there is no significant relation between probable suicides and level of deprivation; this association may be more apparent at smaller area level although data is not reliable at this level due to low numbers.

While rates of probable suicides among males are decreasing in Scotland, they have increased slightly in Aberdeen City and significantly increased in North Ayrshire, where there have also been increases in probable suicides among women. In South Lanarkshire and Scotland there have been declines.

Table 7. Changes in female and male rates of probable suicides* Aberdeen City, North Ayrshire, South Lanarkshire, and Scotland, 2010-2014 and 2020-2024

Place	Sex	2010-2014	2020-2024	Absolute change in (rate per 100,000)
Aberdeen City	Male	18.3	18.4	+0.1
	Female	6.5	5.9	-0.6
North Ayrshire	Male	19.9	25.9	+6.0
	Female	5.8	9.6	+3.8
South Lanarkshire	Male	20.8	20.2	-0.6
	Female	7	6.8	-0.2
Scotland	Male	22.8	21.3	-1.5
	Female	7.7	7.2	-0.5
	Both combined	15	14	-1.0

Source: National Records of Scotland (2025) [31]

Note: *Deaths with an underlying cause of one of the following categories are counted as probable suicides:

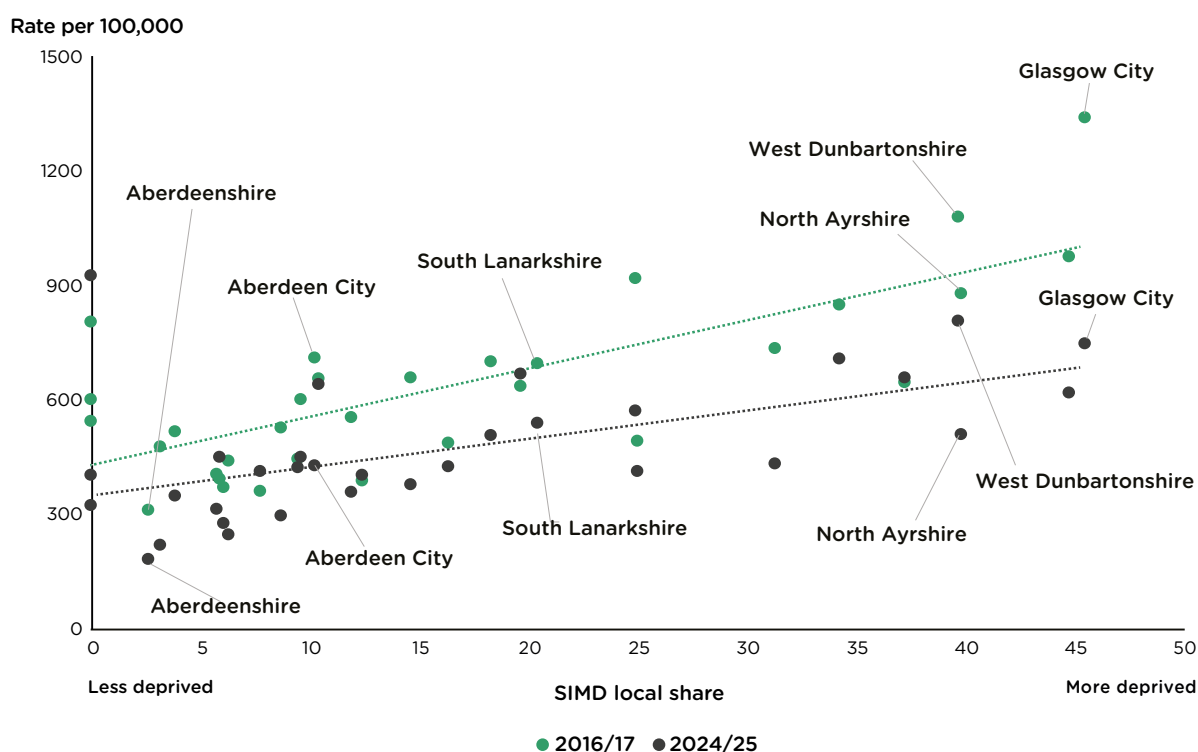
- Intentional self-harm
- Events of undetermined intent
- Sequelae of intentional self-harm
- Sequelae of events of undetermined intent [31]

HARM FROM ALCOHOL USE

In 2018, minimum unit pricing for alcohol was introduced in Scotland, which increased the cost of alcohol. Positively, between 2016/17 and 2024/25, rates of alcohol related hospital admissions declined across Scotland and the inequities related to level of Council deprivation have declined, Figure 18. In all three collaborating places there have been marked declines,

Table 8. Hospital admission practices may play a role in these recorded reductions and surveys indicate that young people are drinking less but that said, it is likely that minimum unit pricing for alcohol has played a role in these important health and equity impacts, showing what is possible through major national programmes.

Figure 18. Alcohol-related hospital admissions (SIMD Local Share), Age- and sex-standardised rate per 100,000, Scottish Council Areas, 2016/17 and 2024/25



Source: Public Health Scotland (2026) [32]

Table 8. Changes in alcohol-related hospital admissions (rates and percentages), Aberdeen City, North Ayrshire, South Lanarkshire, and Scotland, 2016/17 and 2024/25

	Absolute change in rates per 100,000	Percentage change
Scotland	-189.8	-27.7
Aberdeen City	-283.1	-39.6
North Ayrshire	-368.4	-41.7
South Lanarkshire	-154.4	-22.1

Source: Public Health Scotland (2026) [32]

Box 4. Minimum Unit Pricing

Minimum Unit Pricing (MUP) for alcohol is a population-level preventative intervention introduced by the Scottish Government in 2018 to reduce alcohol-related harm and tackle health inequalities [33]. By setting a minimum price of 50p per unit (increased to 65p in 2024), the policy aimed to reduce the availability of cheap, high-strength alcohol. People who drink at hazardous and harmful levels in lower socio-economic groups also tend to suffer greater alcohol-related health problems than those who drink at similar levels in higher socio-economic groups [34]. This is sometimes referred to as the ‘Alcohol Harm Paradox’, and can be attributed to in part to the multiple drivers of health inequality and how they impact people differently depending on their socioeconomic status [35].

The intervention was developed in response to Scotland’s high rates of alcohol consumption, alcohol-related hospital admissions and deaths and the significant social and economic costs associated with alcohol misuse. Importantly, the burden of alcohol-related harm falls disproportionately on the most deprived communities, making MUP an example of a preventative policy which reduces inequalities as well as improving population health.

The policy was underpinned by strong evidence and extensive modelling before implementation and has since become one of the most comprehensively evaluated public health interventions in Scotland. A multi-component evaluation coordinated by Public Health Scotland drew on more than 40 studies examining changes in alcohol purchasing, health outcomes, social impacts and economic effects [36]. The evidence showed that overall alcohol sales fell by around 3 percent and the largest reductions occurring among households that had previously purchased the greatest quantities of alcohol.

The evaluation found that Minimum Unit Pricing was associated with an estimated 13.4 percent reduction in alcohol-attributable deaths, equivalent to around 156 fewer deaths each year, together with reductions in alcohol-related hospital admissions, particularly for chronic conditions. The greatest improvements were observed among men and people living in Scotland’s most deprived communities, demonstrating the policy’s contribution to reducing health inequalities.

Economic analysis also identified substantial societal benefits, including an estimated £215 million from deaths prevented and reductions in NHS treatment costs [33]. Scotland’s experience has since influenced policy internationally, with the World Health Organisation and other countries recognising MUP as an effective example of preventative public health policy demonstrating that sustained investment in evidence-based prevention can improve population health, reduce inequalities and lessen demand on health services.

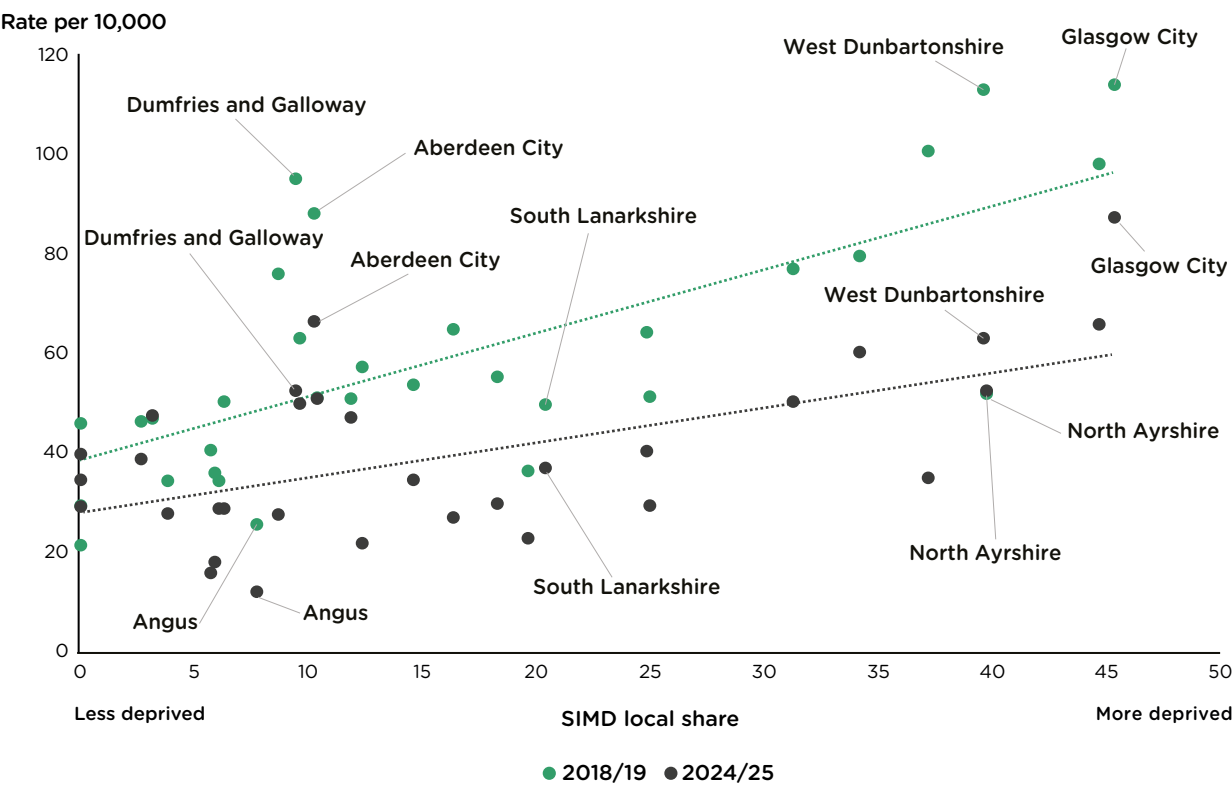


DRUG MISUSE

Over the last 6 years, data show decreasing rates and inequities in drug-recorded crimes in Scotland. Recorded crime data is provided by the police and may reflect policing practices and changes in recording rather than reduced prevalence of drug use and

associated crimes and practices may differ between police divisions across Police Scotland. Nonetheless the falling rates and decreasing inequities are encouraging, Figure 19.

Figure 19. Drug-recorded crimes (SIMD Local Share), Rate per 10,000 population, Scottish Council Areas, 2018/19 and 2024/25



Source: Scottish Government (2026) [37]
Note: North Ayrshire figures are almost identical for different time points and therefore overlap on the graph.

Among the three collaborating places there have been sizeable declines in drug recorded crimes in both Aberdeen City and South Lanarkshire, but not in North Ayrshire, between 2018/19 and 2024/25.

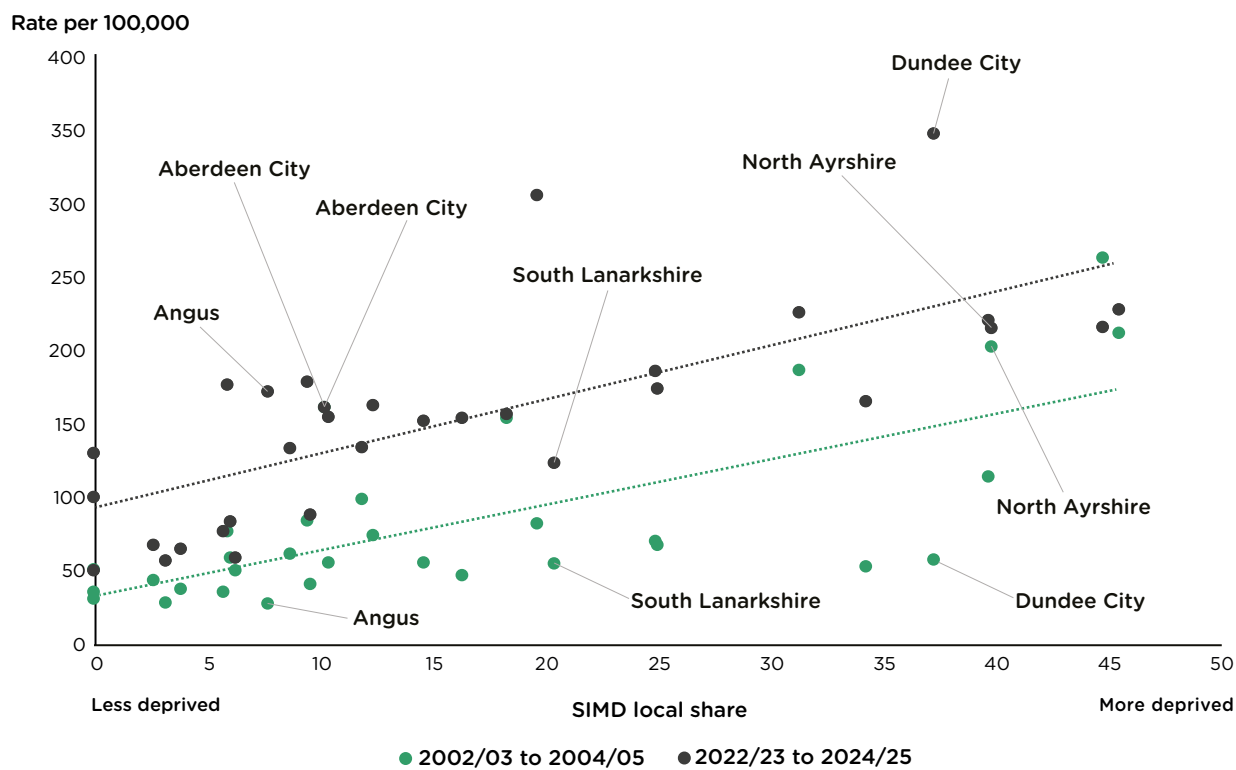
Table 9. Changes in drug-recorded crimes (rates and percentages), Aberdeen City, North Ayrshire, South Lanarkshire, and Scotland, 2018/19 and 2024/25

	Absolute change in rates per 100,000	Percentage change
Scotland	+0.1	+0.08
Aberdeen City	-21.5	-24.5
North Ayrshire	+0.5	+0.96
South Lanarkshire	-12.6	-25.5

Source: Scottish Government (2026) [37]

Despite the positive decline in drug recorded crimes recently, there have been increases in drug-related hospital admissions over the longer time period between 2002/03 to 2024/25, with persisting inequities related to level of Council deprivation, Figure 20.

Figure 20. Drug-related hospital admissions (SIMD Local Share), Sex-standardised rate per 100,000 population, Scottish Council Areas, 2002/03 to 2004/05 and 2022/23 to 2024/25



Source: Public Health Scotland (2026) [32]
Note: Aberdeen City 2002/03 to 2004/05 and 2022/23 to 2024/25 values overlap

In South Lanarkshire there was a marked increase of 120 percent in rates of drug related hospital admissions between 2002/03-2004/05 and 2022/23-2024/25, nearly double the percentage increase in Scotland overall. There has been a slight increase in North Ayrshire, but much less than in Scotland, Table 10.

Table 10. Changes in drug-related hospital admissions (rates and percentages), Aberdeen City, North Ayrshire, South Lanarkshire, and Scotland, 2002/03 to 2004/05 and 2022/23 to 2024/25

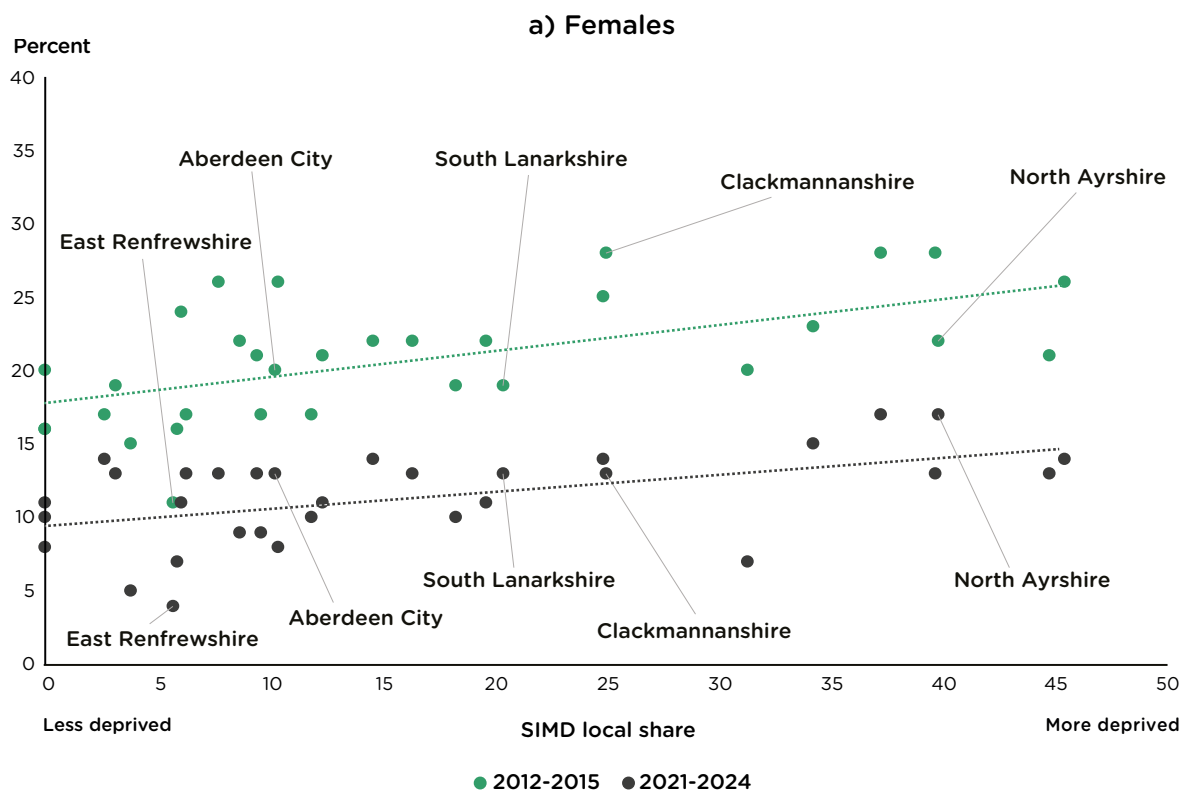
	Absolute change in rates per 100,000	Percentage change
Scotland	+66.2	+67.5
Aberdeen City	-0.2	-0.12
North Ayrshire	+12.4	+6.1
South Lanarkshire	+68	+120.3

Source: Public Health Scotland (2026) [32]

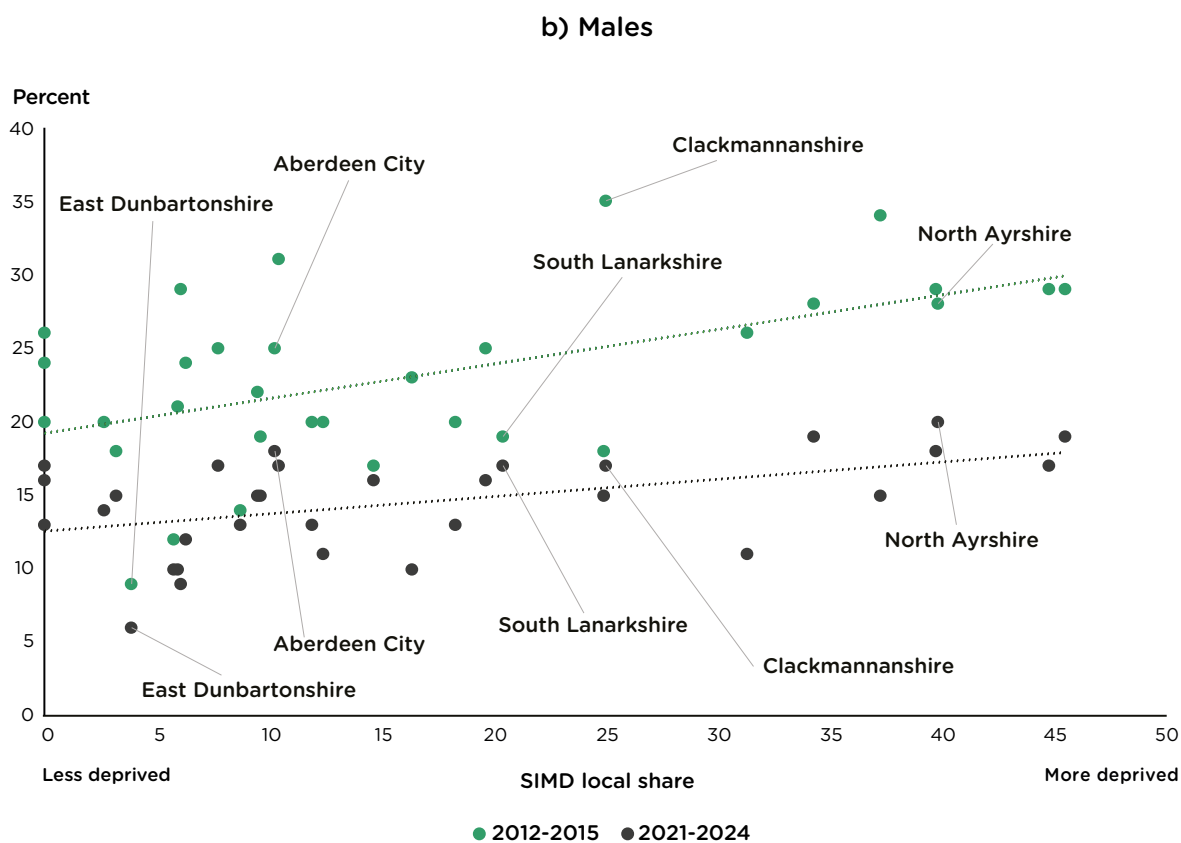
SMOKING

Across Scotland there have been large declines, recorded by the Scottish Health Survey, in smoking prevalence among both men and women including in the three collaborating places between 2012-2015 and 2021-2024. Notably there has been a reduction and flattening of the gradient in smoking prevalence, with more deprived Councils experiencing greater reductions, although the association between the level of deprivation of Councils and smoking is relatively weak.

Figure 21. Female and male smoking prevalence aged 16+ (SIMD Local Share), Scottish Council Areas, 2012-2015 and 2021-2024



Source: Scottish Health Survey (2024) [38]



Source: Scottish Health Survey (2024) [38]

Surveys suggest that there have been reductions in rates of smoking in all three places and across Scotland between 2012-15 and 2021-24, Table 11.

Table 11. Changes in smoking prevalence rates, Aberdeen City, North Ayrshire, South Lanarkshire, and Scotland, 2012-2015 and 2021-2024

Place	Sex	2012-2015 (percent)	2021-2024 (percent)	Absolute Change (percentage points)
Aberdeen City	Male	25	18	-7
	Female	20	13	-7
North Ayrshire	Male	28	20	-8
	Female	22	17	-5
South Lanarkshire	Male	19	17	-2
	Female	19	13	-6
Scotland	Male	23	15	-8
	Female	21	12	-9

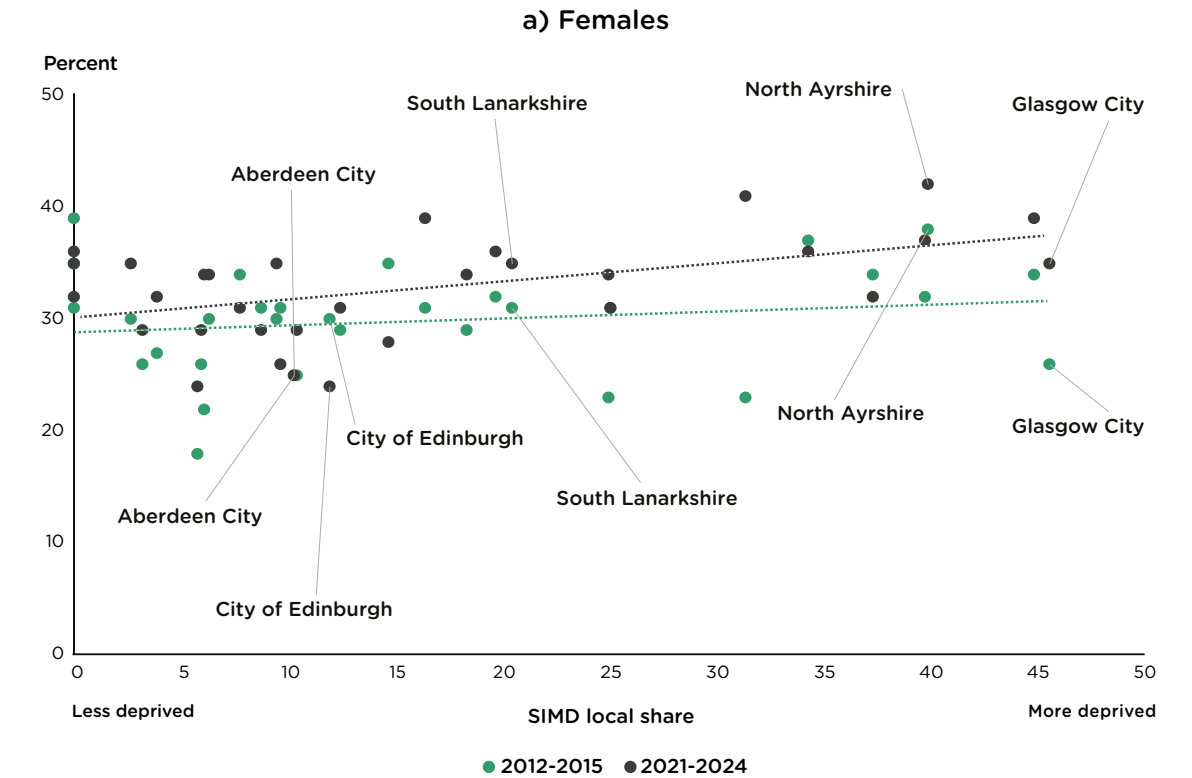
Source: Scottish Health Survey (2024) [38]

OBESITY

Overall levels of obesity for both men and women are high and increasing in Scotland, as elsewhere in the UK. Surveys indicate that between 2012-2015 and 2021-2024 there has been a slight increase in inequities in rates of obesity between Councils for both men and women,

although there is no meaningful association with levels of deprivation of Councils. Notably, in Aberdeen City, there are indications, that there have not been increases in obesity, figures 22a-b and Table 12.

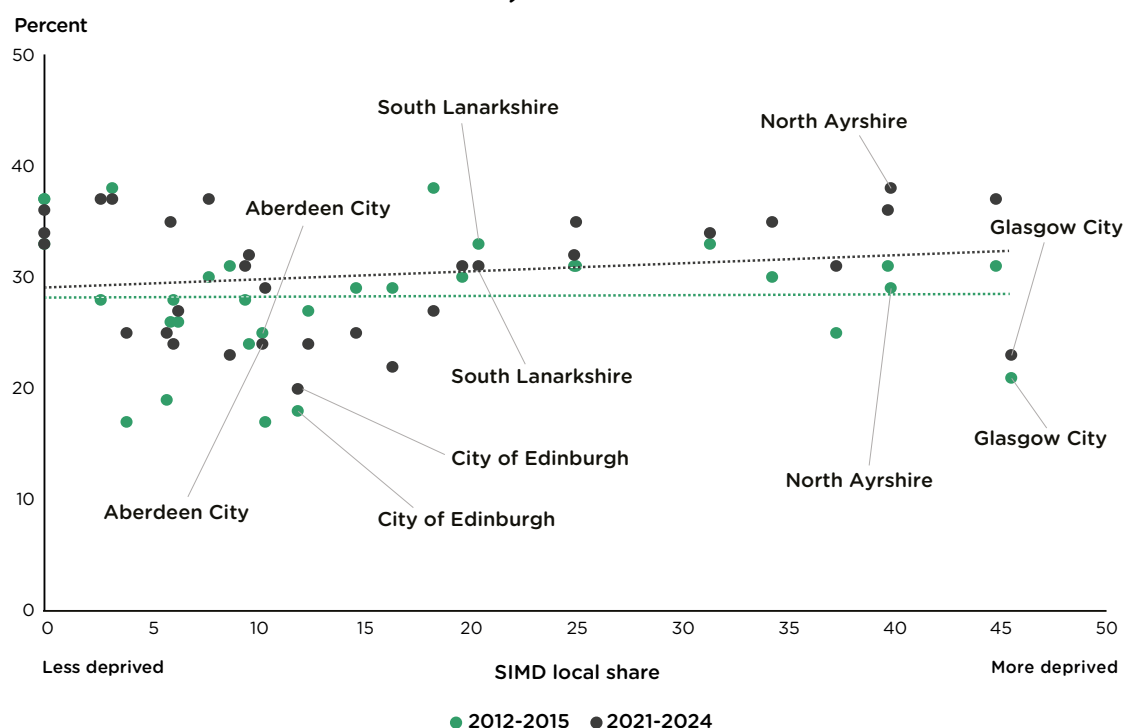
Figure 22. Percentage of females and males who are classified as obese* (SIMD Local Share), Scottish Council Areas, 2012-2015 and 2021-2024



Source: Scottish Health Survey (2024) [38]

Note: *Obesity is defined as over 30 BMI

b) Males



Source: Scottish Health Survey (2024) [38]

Note: *Obesity is defined as over 30 BMI

Table 12, from the Scottish Health Survey suggest that there have been increases in rates of obesity for men and women in Scotland and North Ayrshire and among

females in South Lanarkshire. There have not been increases in Aberdeen City and a slight decline among males in South Lanarkshire.

Table 12. Changes in obesity rates, Aberdeen City, North Ayrshire, South Lanarkshire, and Scotland, 2012-15 and 2021-24

Place	Sex	2012-2015 (percent)	2021-2024 (percent)	Absolute Change (percentage points)
Aberdeen City	Male	25	24	-1
North Ayrshire		29	38	+9
South Lanarkshire		33	31	-2
Scotland		27	29	+2
Aberdeen City	Female	25	25	0
North Ayrshire		38	42	+4
South Lanarkshire		31	35	+4
Scotland		29	33	+4

Source: Scottish Health Survey (2024) [38]

Note: *Obesity is defined as over 30 BMI

SUMMARY

Many people, particularly those living in deprived areas in Scotland are unhealthy compared with other parts of the UK and compared with people living in less deprived areas in Scotland. Life expectancy and health continues to deteriorate with people spending longer periods of their lives in ill health.

There are wide and increasing inequities in life expectancy and healthy life expectancy between and within Councils and clear gradients in health across Scotland and within Councils related to an areas level of deprivation. There also indications of substantial increases in poor mental health and rising levels and inequities in rates of people living with obesity. The deteriorations in healthy life expectancy are harming individuals, families, communities and limiting the potential for economic and social development in Scotland.

Despite these concerning trends, there are also improvements which give encouragement and make a positive case for strong public health policies and interventions. Improvements include lower rates and reduced inequities in admission to hospital as a result of alcohol misuse, reduced rates of smoking and declines in suicide. As set out in Chapter 1 health inequities relate to inequities in the conditions of daily life, which are shaped by inequities in power, money and resources, the focus of the next Chapter.

RECOMMENDATION 1:

PUT EQUITY OF HEALTH AND WELLBEING AT THE HEART OF GOVERNMENT

ENSURE THAT HEALTH EQUITY CONSIDERATIONS ARE AT THE HEART OF SOCIAL AND ECONOMIC POLICIES

SECTION 1: ACTION ON THE STRUCTURAL DRIVERS OF HEALTH INEQUITY IN SCOTLAND

CHAPTER 3

HEALTH EQUITY AND INEQUITIES IN POWER, MONEY AND RESOURCES

In Scotland there have been many strategies and policies aimed at reducing health inequities and many recommendations made for stronger action. The question for CHES has been why these have not delivered and how to strengthen implementation.

This Chapter takes a step back and overviews inequities in power, money and resources in Scotland; these structural drivers shape peoples’ health and they also influence the capacity of the system to respond and reduce health inequities.

The structural drivers affect communities’ resources and capacity to be healthy and they often reinforce significant limits in communities’ power to influence the design and delivery of programmes and approaches which affect them. The structural drivers also affect levels of funding and whether the funding and resources which are available are allocated in ways which enable inequities to be addressed. We outline the national context of decreasing public wealth and assets and inequities in personal wealth which diminish peoples’ capacity to be healthy and reduce what is available for investments to support health. We highlight that funding allocations between national and local places are not set up to reduce inequities and that allocations within public services are also not sufficiently oriented towards equity.

Given the entrenched, intergenerational nature of the structural drivers it can seem that there is little that local places and individual organisations can do and efforts are principally directed towards mitigation rather than reducing inequities in the structural drivers. This is not the case. While local places operate within the context of national and indeed international structural inequities, the delivery and implementation of programmes and policies can be more equity enhancing and the three places within CHES have developed routes to do this. The CHES has also built the evidence and strengthened momentum for action on the structural drivers of health inequities locally and nationally, while more advocacy and stronger political leadership is required.



NATIONAL POLITICAL LEADERSHIP FOR ACTION ON INEQUITIES IN POWER MONEY AND RESOURCES

Tackling inequities in power, money and resources requires bold political leadership and a reconfiguration of the national purpose to ensure greater equity of health and wellbeing. Fundamental changes in the distributions of power, money and resources are needed and the Scottish Government must be leading transformation in these areas.

Political and commercial interests can weaken and undermine ambitions for health equity, or support them. Reducing health inequities requires legislation and strong regulation and enforcement to reduce exposure to harmful practices, to ensure safe environments, to set a minimum wage, to ensure basic provision of services for instance [39, 40]. In Chapter 5, we highlight the positive contributions that businesses can make. Commercial practices which can harm health are significant and widespread, including poor working conditions, the supply and marketing of unhealthy goods and services. The commercial interests of businesses are often at odds with the health of the public and there are many efforts to promote unhealthy goods and services and advocate against further regulation and to dismantle what is in place [40]. Nonetheless there are opportunities to strengthen the positive impacts businesses can have on health. As the Lancet sets out.

“Commercial actors can contribute positively to health and society, and many do, providing essential products and services. However, a substantial group of commercial actors are escalating avoidable levels of ill health, planetary damage, and inequity - the commercial determinants of health. While policy solutions are available, they are not currently being implemented, and the costs of harm caused by some products and practices are coming at a great cost to individuals and society.” [41]

Equity approaches can require moving resources from one sector or geographic area or population group to another. Opposition to shifting resources may be expressed by communities, commercial interests,

different sectors and by political representatives as they understand that their residents and geographic area might be diminished by the proposed changes. Local communities frequently respond by campaigning against any proposed changes which see their resources and services being cut or diminished leading to political opposition to changes. Strong public health and political leadership and public support is needed. Commercial interests and associated marketing and lobbying can weaken public and political demand for action and support for needed changes, as well as influencing behaviour and consumption patterns [39, 40]. Building greater momentum to tackle health inequities and inequities in the social determinants within places, however, when framed around health and equity and fairness can be highly motivating and can bring support for the needed action and investments.

Nationally, there needs to be stronger and more ambitious political leadership and campaigns to build public awareness about the extent of health inequities and the need for greater action on key social determinants of health. It is important to emphasise that the message must be orientated around the strong moral and social case for action on the social determinants of health, although the economic case is also strong. The evidence supporting the economic case is available in this and many other analyses and reports in Scotland.

Strengthening the case for change and highlighting the universally beneficial impacts of more equitable approaches can strengthen leadership, build resolve and the appetite for change. Through the CHES, evidence, strong leadership, community engagement and cross-sector buy-in have helped places strengthen their case for change, Box 5.

Box 5. Building the case for action through CHES

North Ayrshire

North Ayrshire identified that through the CHES there has been a greater awareness and understanding of health inequalities and the social determinants of health across the local system. The programme has brought together organisations that may not traditionally work closely on health inequalities and has fostered stronger relationships, shared ownership and collective leadership. This has helped shape wider strategic partnerships and created new opportunities for collaborative action across North Ayrshire.

The data and evidence developed through the programme helped support a successful Pride in Place funding application for the Three Towns area with analysis clearly showing the relationship between deprivation, health inequalities and economic inactivity as a compelling case for investment.

A suite of reports and evidence products has been developed through the programme. These articulate the context, scale and complexity of local health inequalities whilst highlighting opportunities for system-wide action. The work is helping to raise the profile of health inequalities both within North Ayrshire and across Scotland to demonstrate how innovative partnership working can support meaningful action on the social determinants of health.

Aberdeen City

Aberdeen City have identified that the CHES programme has played an important role in ensuring that health and equity are at the heart of Aberdeen City's strategic planning processes and in population health plans set out by NHS Grampian. This includes providing direct input into the Aberdeen City Local Outcome Improvement Plan (LOIP), Local Housing Strategy, Children's Services Plan, Community Learning and Development Plan, Aberdeen City Health and Care Strategic Plan and population health plans. Influenced by the CHES and the City's NIHR funded Health Determinants Research Collaboration (HDRC), the Council's Strategy Framework has been designed to explicitly address health equity.

CHES also informed development of the Population Needs Assessment (PNA), helping to strengthen the evidence base underpinning these plans and strategies and improve understanding of the social determinants of health through learning from other areas of Scotland and the wider Marmot network.

South Lanarkshire

The CHES has supported local partners in South Lanarkshire's Community Planning Partnership, to elevate inequality and the social determinants of health from thematic topics to key strategic drivers.

The CHES worked with the partnership's data group to develop a new, place based, inequalities evidence base for South Lanarkshire. The new approach to data unmasked the variation of inequality across places that were hidden in pockets of urban and rural data boundaries, providing a powerful evidence base for action.

The partnership decided early on that child poverty and the early years would be the focus of their prevention approach. Partners collaborated to take action to improve whole systems service models that support local children and families, proportionate to needs, identified by the evidence base.

NHS Lanarkshire, South Lanarkshire IJB and South Lanarkshire Council jointly contributed £8 million of funding to developing the new preventative, and proportionate models of services and to take forward a place based transformation programme for South Lanarkshire Council.

A further barrier to understanding health inequities and social determinants of health is the lack of a shared narrative and terminology around health inequity and the social determinants of health. Prevention, upstream action, social determinants of health, building blocks of health, population health and other phrases, are at times used interchangeably, but have different meanings

within different sectors. None necessarily resonate with the public, among whom such terms are not commonly used. Building a shared language on health equity and the social determinants of health across organisations and with the public will help build understanding and the case for action.

INEQUITIES IN POWER

Inequities in power between national and local organisations, between sectors and between decision-makers, services and residents perpetuate the conditions which lead to inequities in health. Despite strong efforts to engage communities in decision making processes and to deliver services and support with residents and Third Sector organisations, there are ongoing issues with levels of engagement, trust and support. As wealth inequities widen within Scotland and globally, the wealthiest individuals and businesses accrue more power, generating wider inequities and limiting the resources which are available for investments in public goods and assets, which are needed to build health.

Analysis of how inequities in power are sustained or disrupted have been summarised in 3 dimensions, below [42, 43]. These areas suggest routes to address inequities in ways which would enhance the power of excluded and deprived residents and communities and support better health:

- **Procedural equity:** Fair, transparent and inclusive decision making processes that acknowledge power imbalances and value lived experience as expertise.
- **Distributional equity:** Fair allocation of resources, services, opportunities and protections, prioritising communities most impacted by structural injustice.
- **Structural equity:** Addressing root causes: structural economic disadvantage, historic discrimination, institutional cultures, policies, practices and norms that continue to produce unequal outcomes today.

All of these forms of power inequities were evident and acknowledged through the work of the CHES.

NATIONAL AND LOCAL POWER IMBALANCES

National systems and organisations tend to have greater power to make decisions than local systems and organisations. They set policy direction, including priorities, ambitions, targets and accountabilities, ways of working, regulatory frameworks, and eligibility for services. While there may be some local flexibility in delivering these policies and services, the capacity of local areas to influence the programmes and delivery mechanisms can be quite weak.

During the CHES a range of programmes were introduced by the UK and Scottish Governments with set priority issues, geographic reach or other eligibility criteria, with limited capacity for local direction. There were also many, at times competing or conflicting programmes and policies which were nationally set, but expected to be delivered locally, often on a short time scale.

Based on this, the case for local places to have much greater flexibility and control over what services and

programmes are available in their areas, for whom and how they are delivered has been made. In Chapter 5 we make the recommendation that a health equity 'total place' approach is developed, with resources allocated locally to disburse, potentially through a health equity and prevention fund, rather than being allocated programmatically by the Scottish and UK Governments. The intention is that such a place-based approach will simplify delivery, reducing fragmentation and significantly empower communities in decisions about where resources are allocated and the types of services and support available.

COMMUNITY POWER

Evidence shows how transferring power and resources to communities is possible and impactful; strengthening individual and community resources and improving the design and delivery of services and policies [44]. Scotland has a longstanding and strong focus on community participation. The 2015 Community Empowerment (Scotland) Act empowers community bodies through the ownership or control of land and buildings and by strengthening their voices in decisions about public services [45]. These statutory routes include participation requests, asset transfers and Community Planning Partnerships (CPPs). The CPPs have been particularly important through the CHES in the three collaborating places, overviewed in case studies in this report.

While not a CHES programme, participatory budgeting in North Ayrshire has been used to help address the social determinants of health by devolving decision-making power to communities themselves. Local residents exercised budgetary authority over the conditions of their own lives, which has contributed to building a sense of control that is central to health equity. The process of participatory budgeting brought residents together to debate and vote on community priorities, and this also supported social cohesion and reduced isolation. North Ayrshire's and South Lanarkshire's ambition to mainstream participatory budgeting into core public budgets, rather than treating it as a discrete

funding pot, signals a commitment to community power as a long-term driver of health improvement, closely aligned with the goals of the CHES programme. While the amount of money available is relatively small,

there has been widespread interest and involvement from many organisations, indicating that the process of participatory budgeting is important and there is demand for it. More investment is of course needed.

Box 6. North Ayrshire and South Lanarkshire - Participatory Budgeting

Outside the CHES, **North Ayrshire** Community Planning Partnership developed participatory budgeting programmes, giving local people control over how public funds are spent in their communities. Operating across North Ayrshire's six localities, Arran; Garnock Valley; Irvine; Kilwinning; North Coast & Cumbraes; and Three Towns, the programme offers multiple funding streams. In 2024/25 £204,159 was made available for locality projects, Community Wealth Building initiatives, and youth-led grants. Applications are tied to priorities identified through Locality Partnerships, ensuring funded projects are responsive to the specific challenges of each community rather than generic service provision.

Themed participatory budgeting rounds have directed funding toward specific health and social challenges. Dedicated mental health events, co-funded by the Health and Social Care Partnership, have supported locally designed wellbeing projects across the area. The 'Substance of our Communities' round, run by North Ayrshire Alcohol and Drugs Partnership, funded six projects with grants of £8,000 – £10,000 to reduce drug-related deaths using a whole family approach, recognising that addiction is rooted in social conditions rather than individual behaviour. The youth participatory budgeting stream goes further, young people aged 8–25 act as the sole decision-makers, and in 2022, 4,131 young people voted to distribute £56,000 across almost 100 projects [46, 47].

Participatory budgeting in **South Lanarkshire** has become integral to supporting the delivery of locally identified priority actions within the CPP's statutory Locality Plans which have been co-produced with communities to improve socio-economic outcomes in some of the most deprived communities. The allocation of participatory budgeting funds is aligned with local priorities and is decided through a public vote, promoting community empowerment through participatory democracy.

In 2025/26, £160,000 was distributed through place-based participatory budgeting and demand significantly exceeded available funding. Participation levels were high, 10,975 local votes were cast, and 83 local projects were fully/partially funded. Evaluation findings were positive, demonstrating that participatory budgeting acts as a catalyst for community engagement and action while providing residents with a meaningful role in local decision-making.

While there are some important and positive community empowerment processes, many deprived areas and lower-income households are unable, or feel unable or unwilling, to influence local decision-making processes. The reasons for this relate to structural drivers and include lack of time, caring roles, lacking agency, stresses related to financial precarity, cultures of non-participation, experiences of exclusion and discrimination and low levels of trust which result. All of which frequently lead to inadequate representation of residents' priorities and needs and diminishes provision of the type of support or the investments which are needed to improve lives.

Given ongoing legacies of low participation and mistrust, long term effective engagement, access to resources and demonstrably positive impacts are needed. The CHES involved community engagement and consultation in all three places, overviewed in Chapter 7. It should be noted, however, that engagement, while important in shaping priorities and services does not necessarily lead to community empowerment and some community consultations can actively undermine empowerment if the findings are then overlooked and no positive impacts are evident.



STRENGTHENING THIRD SECTOR ORGANISATIONS

Third Sector organisations provide essential support for health and the social determinants of health, including for the most excluded residents and areas, without which inequities in health would be wider and the burden on public services much higher. However, many local Third Sector organisations are beset with inadequate and fragmented funding and a declining donor base. Across Scotland the Third Sector is recognised as an important collaborating partner and there are statutory mechanisms to ensure this participation [48, 49]. Within the three collaborating places the Third Sector were recognised as important partners in providing representation of disadvantaged communities and inputting advice. However, there are

persisting power imbalances in relationships, with Third Sector organisations reporting that at times they are treated as junior partners, that engagement can be tokenistic and that resources are woefully inadequate to ensure parity with public and statutory sectors.

During CHES it was highlighted that one of the main challenges has been that while communities and the Third Sector were recognised as trusted partners locally, current commissioning and funding arrangements were limiting genuine collaboration. Nationally, the role of the Third Sector can be further strengthened and was not a central feature of CHES, although there was representation through the Strategic Advisory Group.

INEQUITIES IN MONEY AND RESOURCES

Inequities in power are closely related and shaped by inequities in money and resources. Across Scotland low-income households and more deprived areas have insufficient resources to prevent or address the resulting poor health. These resource and financial limitations relate to distributional and structural inequities highlighted above. There are a number of ways in which inequalities in resources were evident during the CHES.

Structural drivers, including poverty and deprivation continues to blight the lives and health of lower income households despite important policies to reduce poverty in Scotland. We note that globally and in Scotland inequities in wealth are increasing and a greater proportion of resources are in private, rather than public hands. To significantly improve health and reduce inequities the proportion of wealth which is available for public assets and investments needs to be increased.

Investments in the social determinants of health are often insufficient and on timescales which are too short to be effective. However, this can change. Recent investments have reduced child poverty and will be beneficial to health equity in the long run, although there are still persistently high rates in many areas.

We show inequities in the distribution and allocation of resources through two examples. Firstly, investments in the early years and in spending on healthcare among children are not allocated in ways to reduce inequities. Secondly, allocations of resources are insufficient to reduce inequities in more deprived Councils and do not sufficiently take account of deprivation.

Evidence shows that many policies have potential to reduce health inequities, provided they are at scale. We model policy scenarios showing that reductions in health inequities are entirely possible through investments in housing insulation, early years provision and poverty reduction.

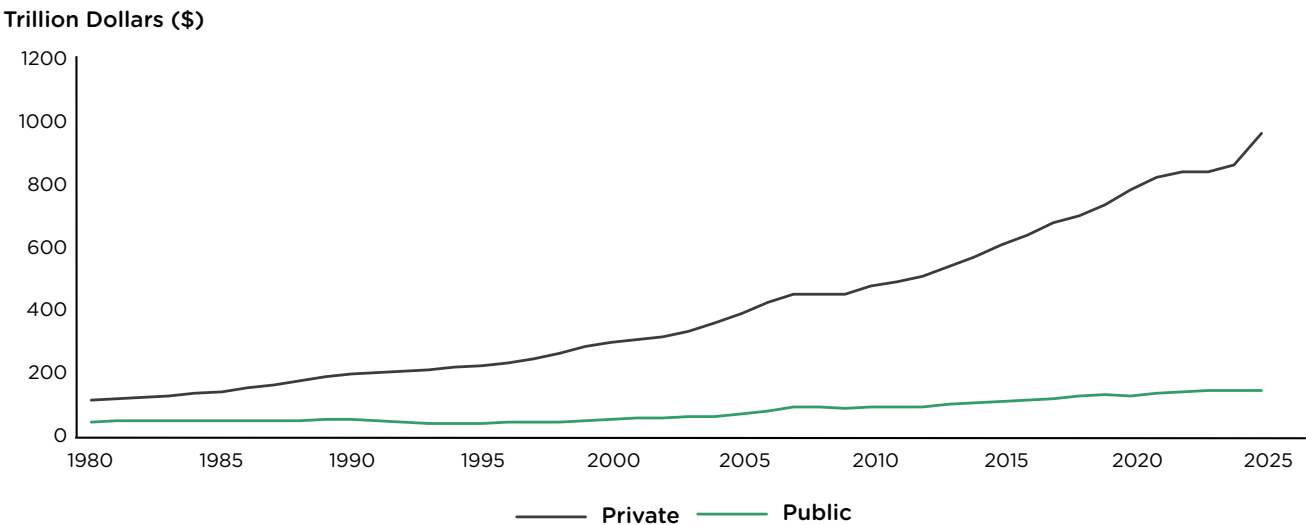
Investing in prevention is a well established principle in Scotland. However, recent analyses show that prevention is mostly delivered in relatively downstream routes, which do not address longstanding structural inequities and inequities in the social determinants of health and comprise a very small proportion of overall funding.

INEQUITIES IN WEALTH

Globally there have been huge increases in inequities in wealth and increasing private wealth and assets, with resulting reductions in public wealth. Both these trends contribute to widening health inequities within countries and undermine the capacity of governments, services and other stakeholders to address them [40].

Figure 23 shows that globally public wealth has increased only slightly since 1980 while private wealth has increased at considerable rate.

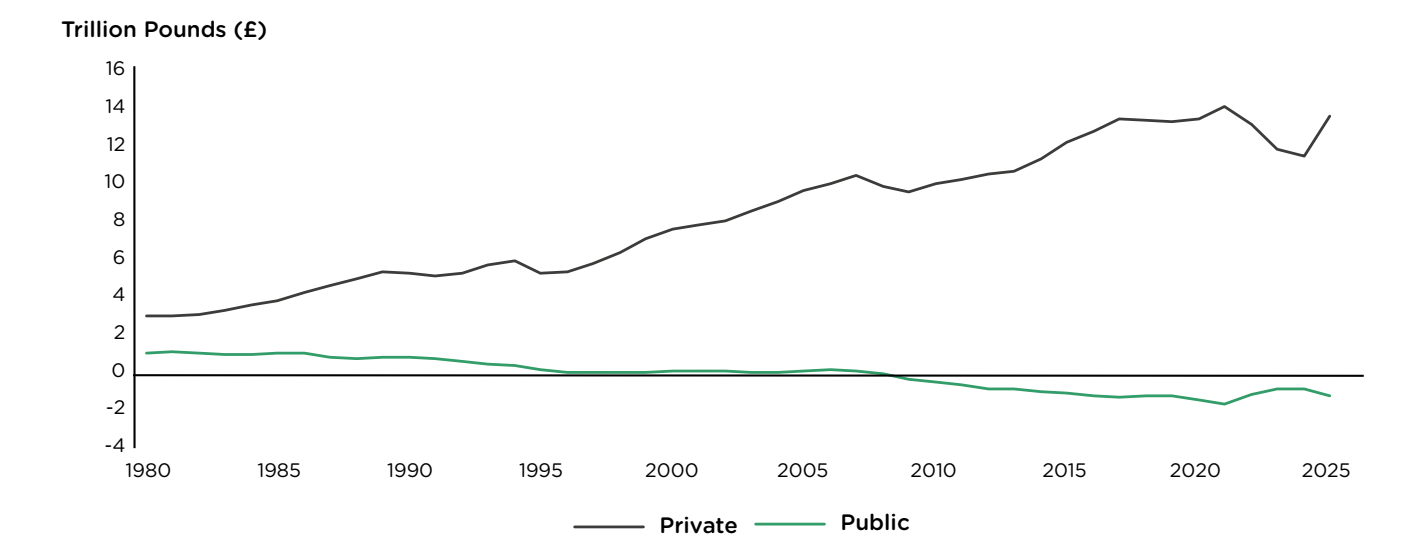
Figure 23. Global net public and private wealth, 1980 to 2025



Source: World Inequality Database (2026) [50]

In the UK net public wealth has decreased markedly, and is now negative, leading to large public debt, while private wealth has increased rapidly since 1980.

Figure 24. United Kingdom net public and private wealth, 1980 to 2025

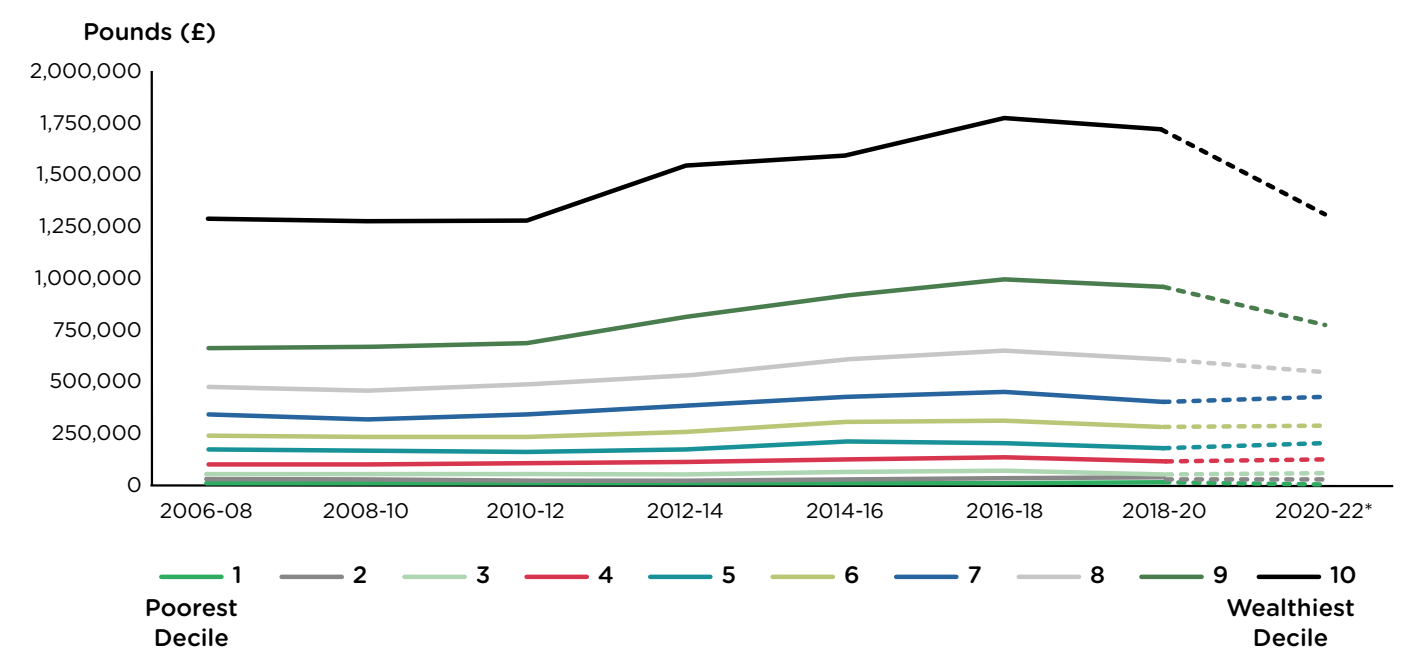


Source: World Inequality Database (2026) [50]

Across the world, wealth inequalities have increased markedly, with enormous increases in the wealth held by the top 1 percent, and among the top 0.1 percent. For instance in the United States the wealth of the top 0.1 percent has increased from around 6 percent of total wealth in the 1970's to nearly 20 percent by 2016 [51].

In Scotland inequities in wealth have also increased since 2006-08. Figure 25 shows changes in levels of wealth (after inflation) by decile over the period 2006-08 and 2020-22 in Scotland. Although the average wealth of the wealthiest 3 deciles declined in the latest period, there have also been declines in the wealth of the lower wealth deciles.

Figure 25. Median household wealth by wealth decile, adjusted for inflation, Scotland, 2006-08 to 2020-22



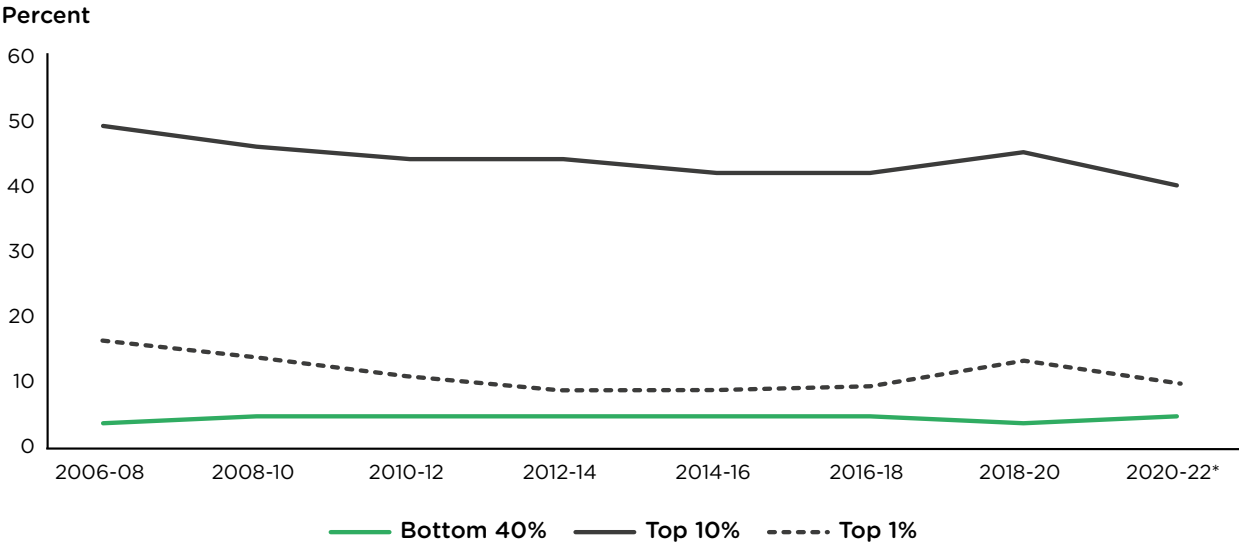
Source: Scottish Government [52]

Note: 2020-22 survey was carried it with different methods due to the COVID-19 pandemic. Caution should be taken when comparing to previous years.

There were declines in wealth in every decile between 2016-18 and 2018-20, likely due to the pandemic. The wealth of the top 3 deciles continued to decline in 2020-22 having grown significantly up until 2018-2020 and the wealth of the lower two deciles also declined. In the lowest wealth decile the proportion of wealth held doubled between 2006-2008 to 2020-2022, rising from £3,600 to £7,600. However, the amount has declined since a high of £8,400 in 2014-2016 and recent declines are evident among the lowest 4 deciles.

Figure 26 shows the proportion of wealth held by the lowest 40 percent, the top 10 percent and the top 1 percent. While the proportion of wealth held by the top 10 percent has declined from 49 percent to 40 percent and the top 1 percent from 17 percent to 10 percent, these have not led to a greater share among the lowest 40 percent, who have not seen an increase in the proportion of wealth they hold, which has stayed at around 4 to 5 percent between 2006-08 and 2020-22.

Figure 26. Total wealth by wealth distribution, Scotland, 2006-08 to 2020-22



Source: Source: Scottish Government (2025) [53]

The wealth data is important context to understanding and taking action on health inequities in Scotland. Despite Scotland’s relatively progressive policies and impacts on reducing poverty, less wealthy residents in Scotland are now experiencing declining wealth and the proportion of wealth they have not changed since 2006-2008. This affects the capacity of people to access the resources and services to be healthy, and also continues to perpetuate inequities in power which shape attitudes and action for health equity.

TACKLING CHILD AND FAMILY POVERTY

Rates of poverty relate to structural economic conditions and to economic and social policies. In Scotland, there have been positive efforts to reduce child poverty and support children and young people. The Scottish Parliament set targets on reducing absolute and relative child poverty and established approaches to do this including through the Scottish child payment [54].

These important policies have reduced the child poverty rate such that Scotland now has the lowest rate of poverty in the UK. These reductions will contribute to greater health equity. Figure 27 and Table 13 show the relatively low rate of child poverty before housing costs are taken into account in Scotland compared with England and Wales.



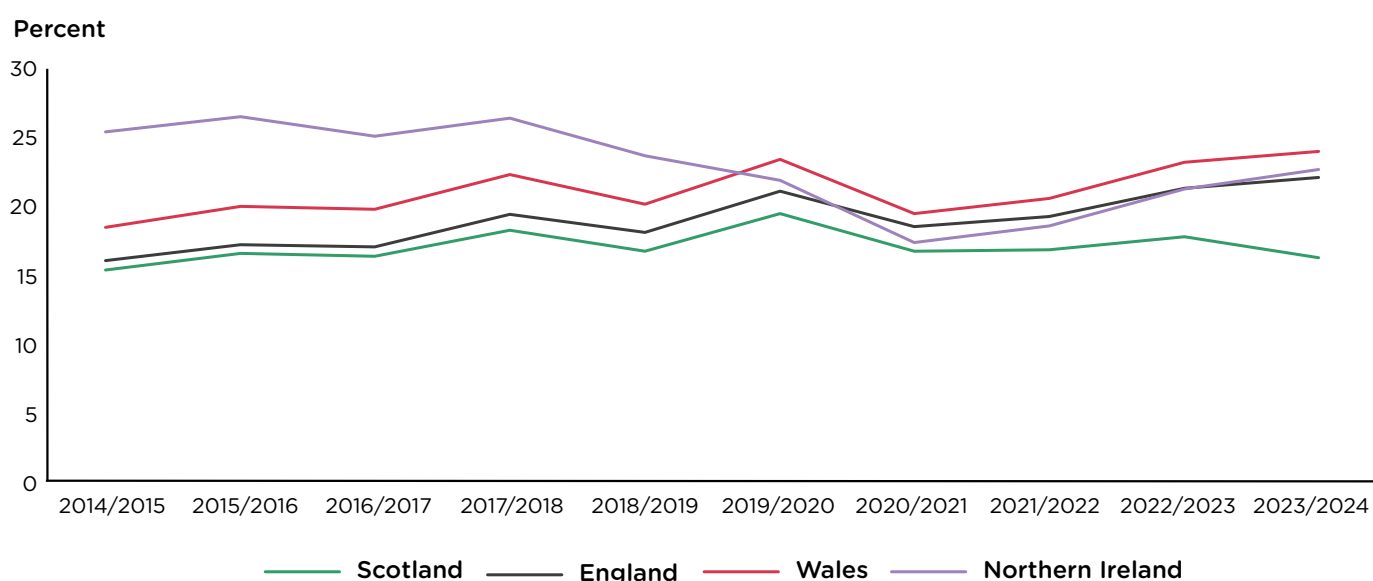
Table 13. Changes in children in relative low-income families, Before Housing Costs, UK Nations, 2014/15 and 2023/24

UK Nations	2014/15 (percent)	2023/24 (percent)	Absolute change (percentage points)
Scotland	15.4	16.3	+0.9
England	16.1	22.1	+6
Wales	18.5	24	+5.5
Northern Ireland	25.4	22.7	-2.7

Source: Department for Work and Pensions (2024) [55]

Importantly Scotland has not seen the large post-pandemic increases in child poverty which are apparent in the rest of the UK, Figure 27.

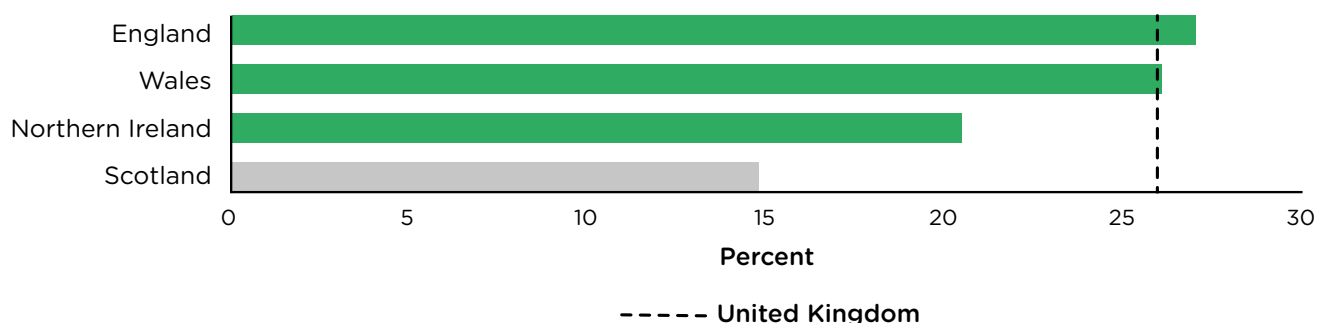
Figure 27. Children living in relative low-income families, Before Housing Costs, UK Nations, 2014/15 to 2023/24



Source: Department for Work and Pensions (2024) [55]

After housing costs are taken into account the average rate of relative child poverty in Scotland was 14.8 percent in 2025, well below the average in the UK of 26 percent.

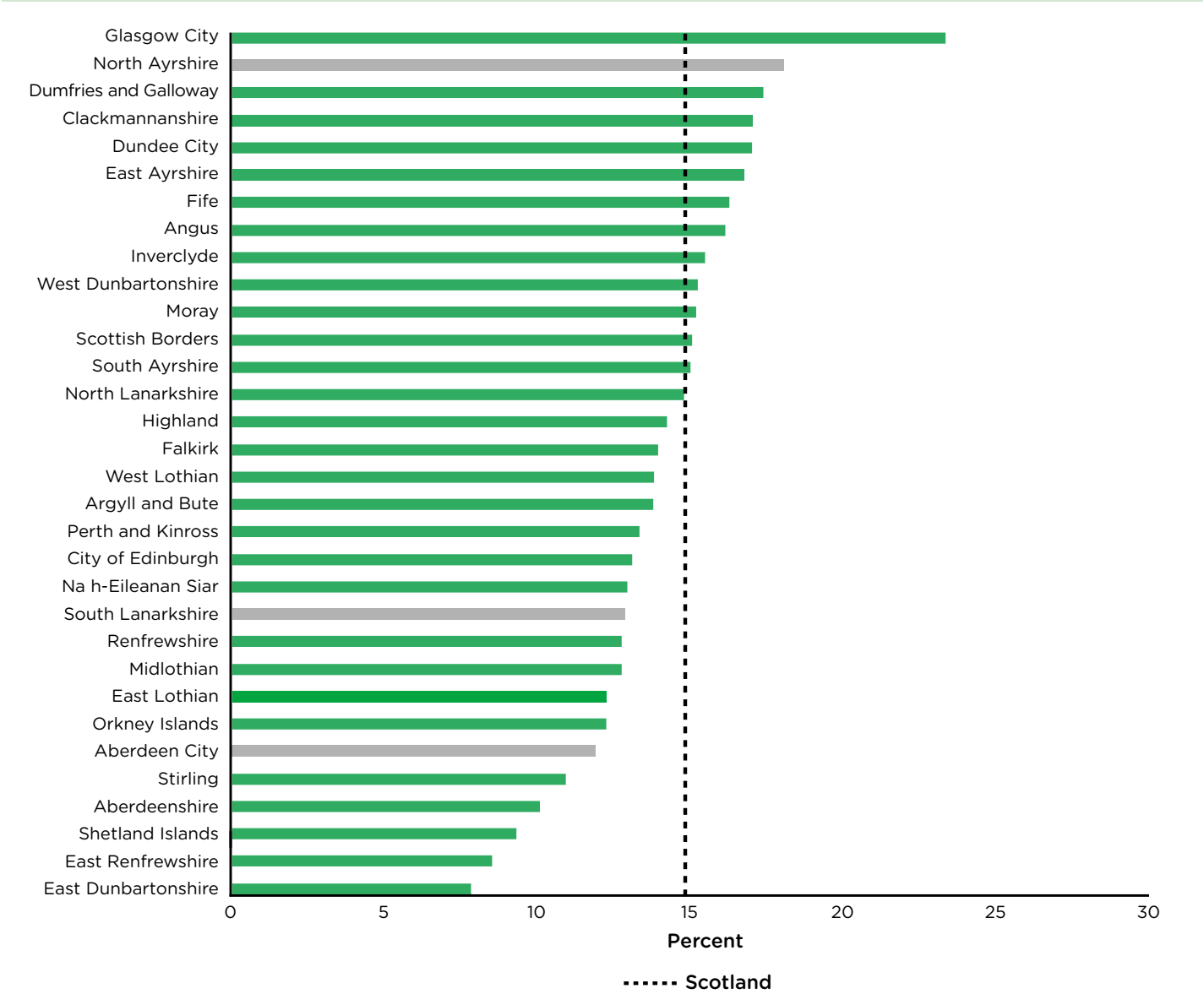
Figure 28. Children in relative low-income families, After Housing Costs, UK Nations and the UK, 2024/25



Source: Department for Work and Pensions (2024) [56]

However, more deprived Councils in Scotland have much higher rates of child poverty, and in Glasgow City nearly 25 percent or 1 in 4 children still grow up in relative child poverty after housing costs. Further support and reductions are required in areas with these higher rates.

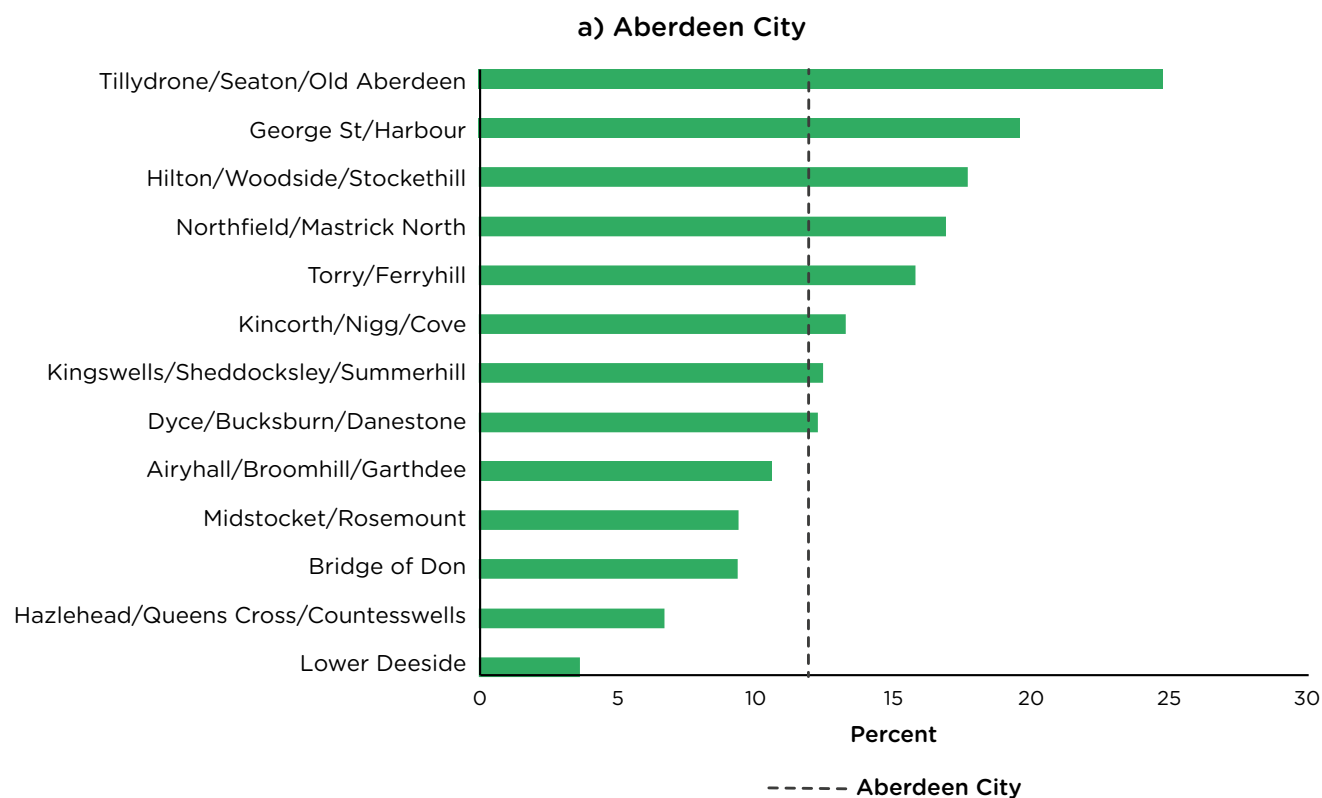
Figure 29. Percentage of children in relative poverty, After Housing Costs, Scottish Council Areas, 2024/25



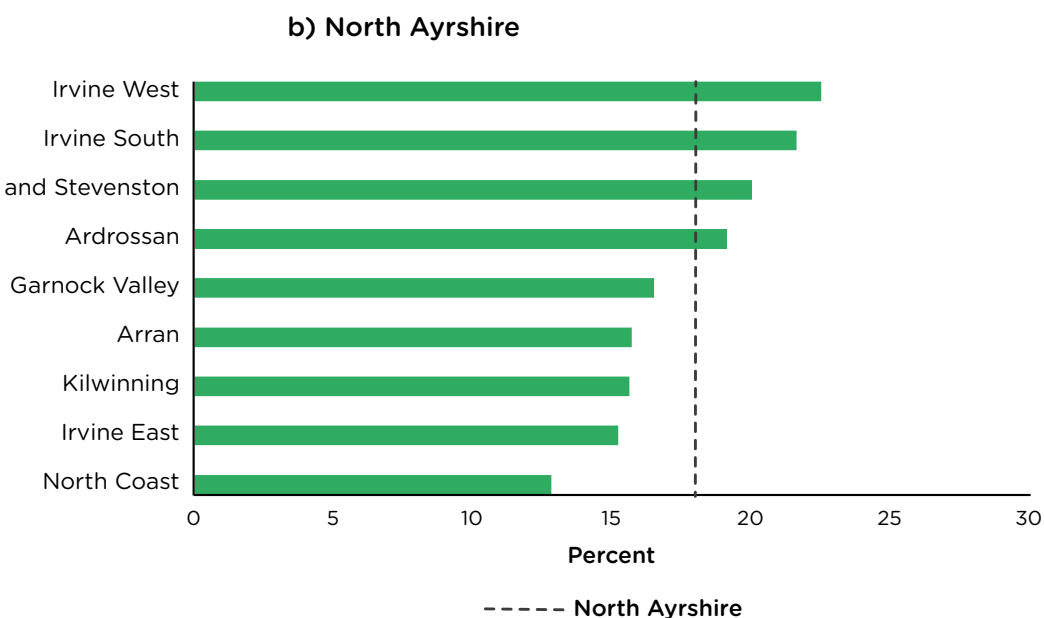
Source: UK Government Department for Work and Pensions (2025) [36]

All three of the collaborating places in CHES prioritised reducing and mitigating the impacts of child poverty and there are many ongoing efforts within the Councils to this end. Figures 30a-c below show rates of poverty within the three collaborating places in 2024/25. The percentage of children in relative poverty after housing costs was lowest in Aberdeen City, 11.9 percent and North Ayrshire the highest at 18 percent, with South Lanarkshire at 12.8 percent. However, there are wide differences within each place, ranging between 4 and 25 percent in Aberdeen City, between 13 and 24 percent in North Ayrshire and between 7 and 21 percent in South Lanarkshire in 2025. All recognise that efforts to reduce and mitigate the impacts of child poverty must be universal and proportionate to the scale of need which varies widely within the Councils.

Figure 30. Percentage of children in relative poverty, After Housing Costs, Three collaborating areas and their wards, 2024/25

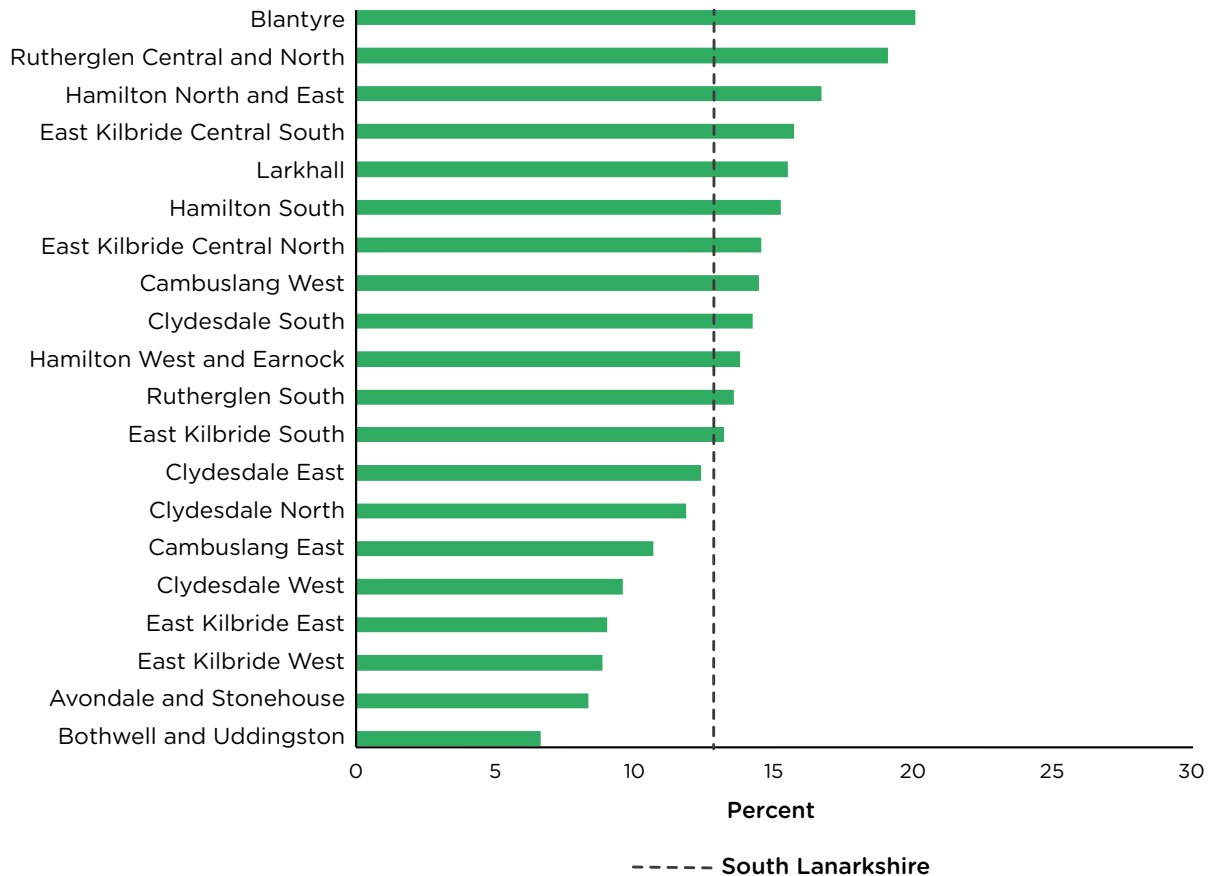


Source: Department for Work and Pensions (2026) [56]



Source: Department for Work and Pensions (2026) [56]

c) South Lanarkshire

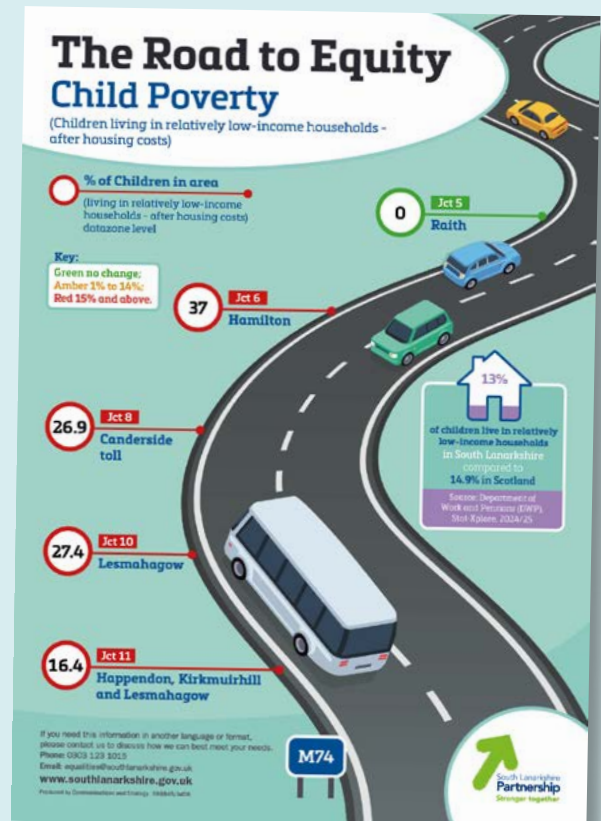


Source: Department for Work and Pensions (2026) [56]

Through the CHES South Lanarkshire developed a child poverty map, based on a journey along the M74 to communicate the wide differences in child poverty rates, Box 7.

Box 7. South Lanarkshire - Child poverty map

Child poverty rates range from 0 percent in Raith to well over a third of children in Hamilton. The high child poverty rates in some areas are hidden when only considering the average rate in South Lanarkshire. The infographic below provides a clear message that proportionately greater efforts are needed in some places.



SUFFICIENCY OF FUNDING ALLOCATIONS TO REDUCE INEQUITIES IN HEALTH AND THE SOCIAL DETERMINANTS OF HEALTH

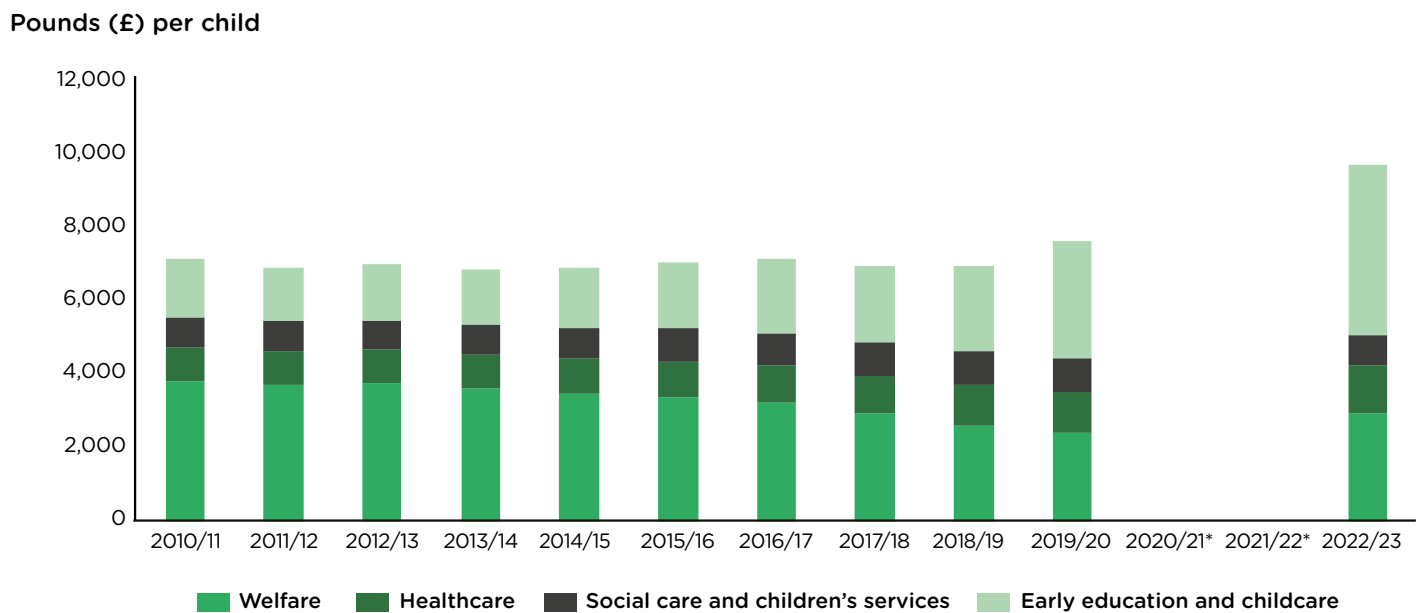
Even with increasing demand and declining public resources, there are many opportunities for better health and greater health equity through resource allocations.

EQUITABLY INVESTING FOR CHILDREN AND YOUNG PEOPLE

Investments in services for young people have not been oriented towards more deprived households and children. Rebalancing these investments in a more proportionate, equitable way would help to reduce inequities further.

Positively, cuts in welfare introduced by the UK Government from 2010, have been offset in Scotland through increases in investments in early education and childcare, Figure 31. Spending per child through welfare, healthcare, social care and children’s services and early years and education was assessed by Alma Economics to be nearly £10,000 in 2022/23 [57].

Figure 31. Early years spending per child, Pounds (£), Scotland, 2010/11 to 2022/23



Source: Alma Economics (2025) [57]
Note: * No data available for 2020/21 and 2021/22.

The funding increases in early education and childcare are mostly available for 2-4 year olds, and not 0-2 year olds. Evidence shows that investments for 0-2 year olds are essential for supporting good early years development. Alma Economics also assess that overall early years support in Scotland has shifted away from lower income households [57]. Table 14 below shows that average spending on early learning and childcare

per child is almost the same within each quartile of share of children in relative poverty. To help reduce inequalities at this crucial stage of life proportionately greater increases in spending are needed where children are more likely to experience poverty. Such equity focussed investments would help reduce inequities in early years development and in the long term reduce inequities in health.

Table 14. Average spending on early learning and childcare per child 0-4 years, by quartile of the share of children in relative poverty, 2016/17 and 2023/24

Share of children in relative poverty, quartile	Spending per Child (2016/17)	Spending per Child (2023/24)	Percentage Change in spending per child from 2016/17 to 2023/24
Q1 (Highest poverty)	£2,210	£5,000	+126%
Q2	£1,800	£4,090	+127%
Q3	£2,170	£4,940	+127%
Q4 (Lowest poverty)	£2,140	£4,840	+126%

Source: Alma Economics (2025) [57]

Note: Presents average per-child spending on early education and childcare spending in different local authorities, grouped into quartiles according to their levels of relative child poverty, for 2016/17 and 2023/24.

Healthcare spending for babies and young children also increased by 20 percent between 2016/17 and 2023/24. However, as shown in Table 15 spending on healthcare per child was lower in the lowest 2 income quartiles in 2016/17, increasing by 2023/24, but still

lower compared with the lowest child poverty quartile. In order to support greater health equity investments must be proportionately higher among children and young people living in poverty.

Table 15. Average spending on healthcare per child, by quartile of the share of children in relative poverty, 2016/17 and 2023/24

Income quartile	Spending per Child (2016/17)	Spending per Child (2023/24)	Percentage Change in spending per child from 2016/17 to 2023/24
Q1 (Highest poverty)	£1,000	£1,400	+37%
Q2	£1,000	£1,700	+73%
Q3	£1,100	£1,300	+17%
Q4 (Lowest poverty)	£1,300	£1,600	+23%

Source: Alma Economics (2025) [57]

The two examples of spending distributions indicate that funding allocations need to be further assessed to create more equitable outcomes across Scotland, further illustrated below.

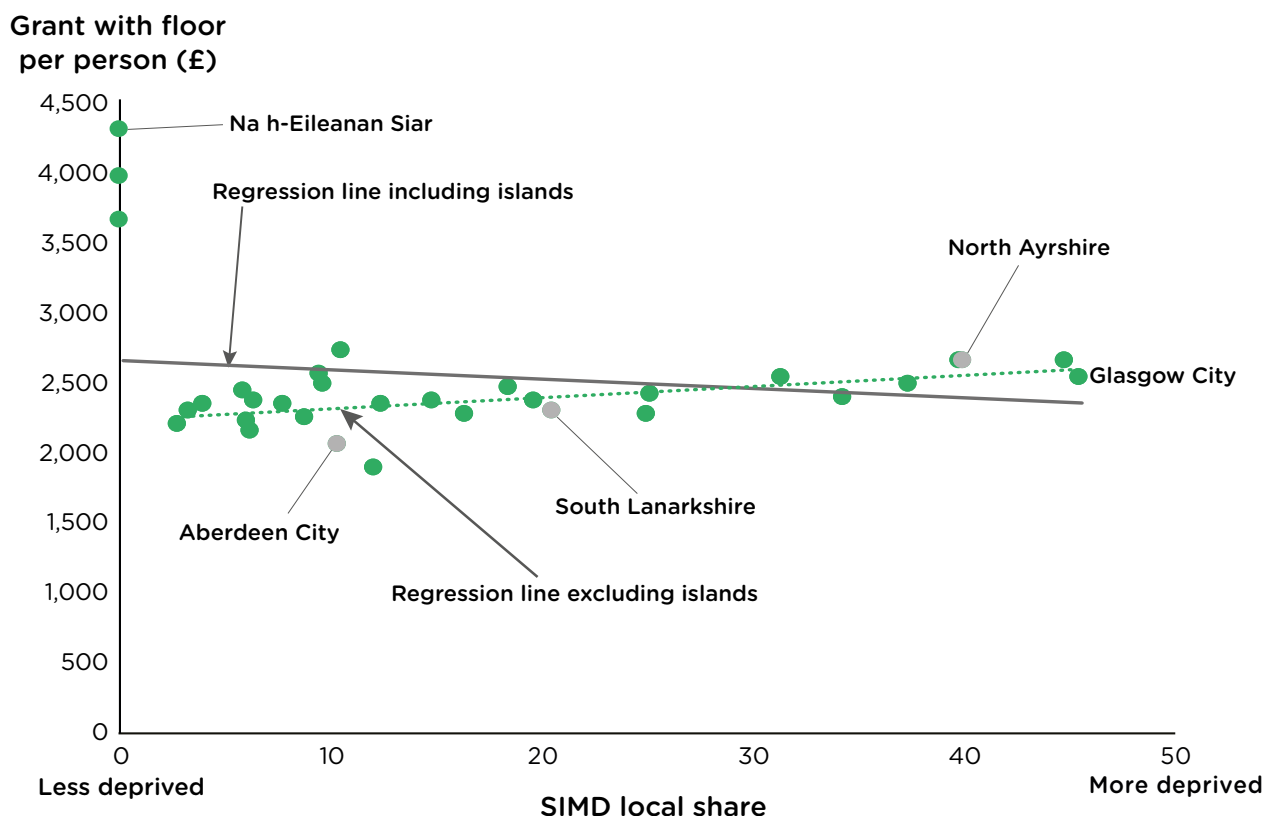
SUFFICIENCY OF FUNDING TO COUNCILS TO REDUCE INEQUITIES IN HEALTH AND THE SOCIAL DETERMINANTS OF HEALTH

In the second CHES report we highlighted that the funding formula underpinning the General Revenue Funding Grant allocations from the Scottish Government to local governments reflect deprivation to some extent [3]. The analysis provides context around individual Councils' capacity to take action on health inequities and the social determinants of health. By looking at the level of deprivation of Councils and the funding available through the Grant, we assessed that the additional funding related to deprivation is insufficient to enable them to reduce deprivation and disadvantage, Figure 32. In the earlier report we did not make specific recommendations as to how to increase or redistribute

available funds. Here we propose that the criteria and methodology underpinning the General Revenue Funding allocations from the Scottish Government to local government are assessed and modified to ensure that the funding is sufficient to tackle and mitigate inequities related to level of deprivation.



Figure 32. General Revenue Funding Grants (per person) to local authorities (SIMD Local Share), Scotland, 2025-26



Source: Scottish Government & Institute of Health Equity (2025) [3, 58, 59]

Note: SIMD local share used here is the proportion of data zones in a local authority which are among the 20 percent most deprived in Scotland (see Technical Annex from the CHES Overview of the Social Determinants of Health in Scotland report for more details [3]).

Of course, Councils also receive funds through property and business tax, but both tend to be lower in more deprived areas and therefore increase inequities in available resources. Funding for public services such as education may have explicit weighting for low income households, although as indicated above, this is not necessarily the case. Other sources of funding which may reduce inequities include programme funding from the UK and Scottish Government, which tends to be directed towards more deprived places and low-income households. Similarly philanthropic organisations, Third Sector organisations, business grants and giving may be directed more towards lower income households and deprived places, although there is no guarantee of that as these grants are usually at the discretion of the donors.

There are no assessments of the total funding available in each Council area in Scotland per head of population nor how that might relate to level of deprivation. While complex, estimates of total

funding available by level of deprivation would assist in planning resource allocations nationally and within areas. Ensuring that resources are weighted towards more deprived areas and households would support action to reduce health inequities and inequities in the social determinants of health.

More deprived areas have experienced deteriorations in many key social determinants of health and health since the pandemic, Chapter 4. These findings should be incorporated into spending allocation decisions which currently do not sufficiently take account of deepening disadvantage and widening inequity. Also highlighted in the following Chapter are rapidly changing demographics in Scotland. Some funding to local areas is allocated by population size which is decreasing in some areas while aging populations in many areas leads both to increased demand on services, especially health and care and reduced capacity to raise local taxes. Both levels of disadvantage and demographic changes need to be taken into account in funding decisions.

INVESTING AT SCALE

While there are programmes to reduce poverty and deprivation and mitigate their impacts many of these are not at sufficient scale to be effective to tackle health inequities. Reducing poverty, improving housing and reducing fuel deprivation and increasing educational outcomes are three important routes to reduce health inequities in the long term. Analysis indicates that, together, these factors could explain up to 70 percent of the difference in self-rated health within countries in Europe [40].

To assess the potential health equity impacts of these approaches, three hypothetical scenarios in Scotland have been analysed by the IHE. Using the best available evidence, potential health gains and reductions in health inequity have been calculated. These scenarios suggest that significant reductions in deprivation related health inequity are possible, through large scale, bold and long-term policies and investments. The scenarios are summarised in Box 8 and outlined in more detail in a short accompanying report for the CHES [13].

Box 8. Scale of change and reductions in health inequities

Three example interventions were selected to illustrate how reducing poverty, improving housing and increasing educational attainment may impact on health and health inequities. The three specific policy approaches were:

- An expansion of income security measures (such as increased welfare payments) to reduce poverty, ensuring that all households in Scotland receive at least the Joseph Rowntree Minimum Income Standard.
- The provision of energy efficiency retrofits for low-income, low-energy efficiency households in Scotland, such as insulation or new boilers, to improve temperature control and air quality.
- An expansion/consolidation of early childhood interventions in low-income communities in Scotland, such as childcare and health visits, to reduce inequalities in educational outcomes.

The scenarios, based on existing evidence about the impacts of such interventions, were used to explore the potential subsequent changes in life expectancy or healthy life expectancy by Scottish Index of Multiple Deprivation. A new slope index of inequality (showing the extent of inequality) was calculated for each scenario and compared to the status quo.

While the scenarios indicate large potential reductions in health inequity, the evidence of intervention impacts is only robust enough to indicate plausible reductions in health inequities and are not exact predictions of impact.

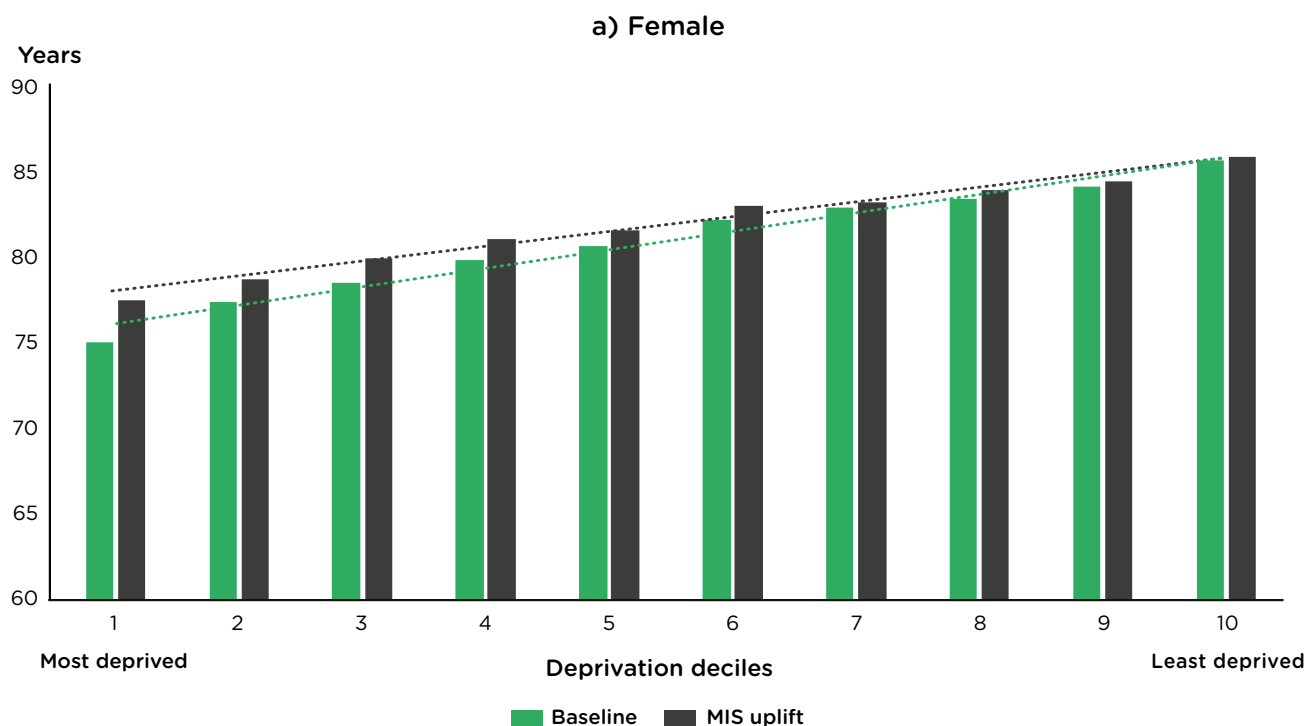
1. Increasing income of low-income households through increased pay or cash benefits.

We estimated that in 2023/24, 28.8 percent of the Scottish population, living in approximately 790,000 households lived below the JRF MIS. Direct financial transfers to bring these household up to the MIS would cost around £1.5 billion per annum (based on 2023 population estimates)

If low-income households were brought up to the Minimum Income Standard proposed by the Joseph Rowntree Foundation, overall life expectancy may increase by as much as one year for women (1.2 percent increase) and 1.1 years for men (1.5 percent increase.). The predicted increases are greater in more deprived areas (around 2.5 years in the most deprived decile) with smaller average increases in less deprived areas (1-2 months in the least deprived decile), leading to reduced health inequities between areas although with improvements in health for everyone. **There would be a 22 percent reduction in overall inequity in life expectancy among women, and a 19 percent reduction among men.**

Figures 33a-b below show the estimated flattening gradient in life expectancy as a result of increasing everyone's income up to JRF Minimum Income Standard for both women and men.

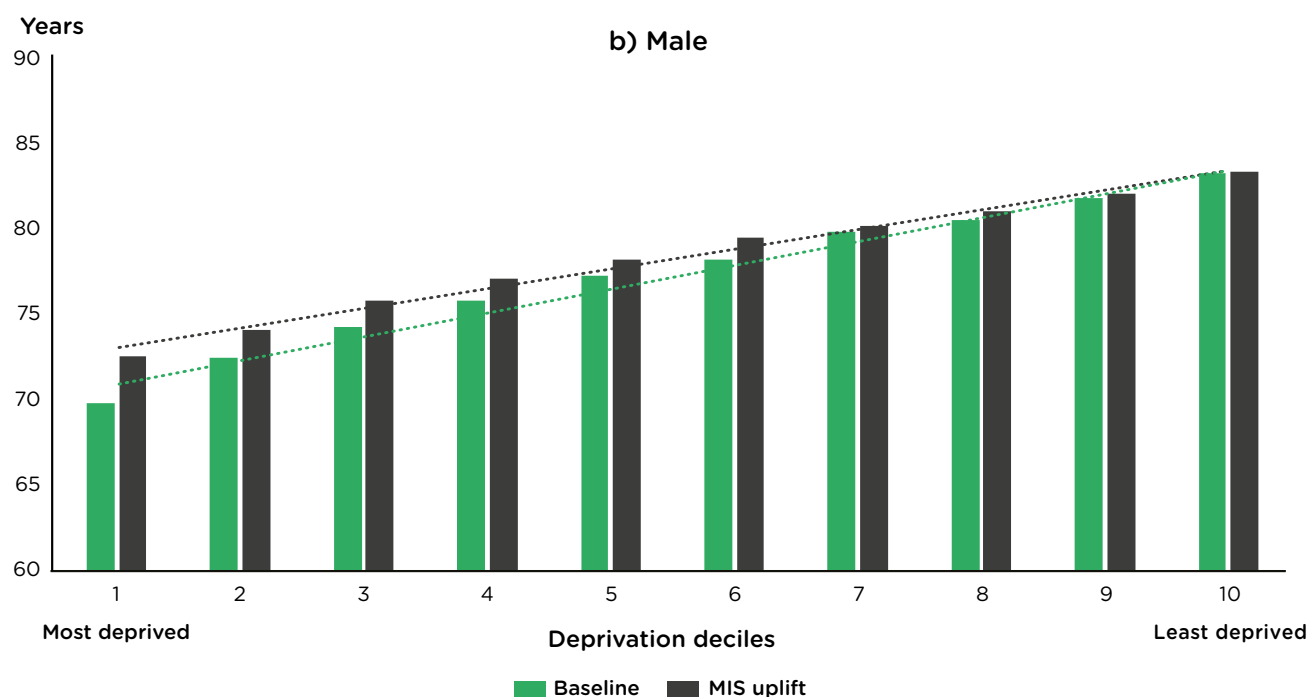
Figure 33. Potential change in female and male life expectancy with MIS uplift, Scotland



Source: Estimates taken from supplementary analysis carried out for CHES [13]

Notes: 1) Dotted lines show a linear line of best fit pre- and post-MIS income uplift

2) The MIS is an independent annual estimate of the income required to live a dignified life, given the cost of living. It is higher than the absolute or relative poverty lines



Source: Estimates taken from supplementary analysis carried out for CHES [13]

Notes: 1) Dotted lines show a linear line of best fit pre- and post-MIS income uplift

2) The MIS is an independent annual estimate of the income required to live a dignified life, given the cost of living. It is higher than the absolute or relative poverty lines

2. Improving the energy efficiency of housing among low-income households

Improving the energy efficiency of dwellings reduces incidence of mould and damp and improves the overall air quality, all of which are highly beneficial for the health of inhabitants. It also decreases energy bills, which would impact on health by freeing up resources for other necessities.

In 2022, 791,000 households in Scotland (31 percent) were in fuel poverty, of which 530,000 households were also income poor [60].

Clinical modelling data suggests that insulating 500,000 dwellings could generate around 235,000 healthy life years for the current cohort of beneficiaries. If targeted at low-income households living in energy inefficient dwellings, this would translate into 0.7 percent (female) and 1 percent (male) reductions in inequalities in healthy life expectancy. This is a highly conservative estimate, based on evidence that does not break down by either fuel or income poverty, and that focuses on cardiovascular and respiratory health. It is plausible that the total health gains (including physical and mental health) and reductions in inequality would be larger if targeted at low income, energy inefficient households. The clinical model reflects average households in average dwellings. Health benefits could plausibly be as high as 1.05 million healthy life years for the current cohort of beneficiaries, **with 3.5 percent (female) and 3.7 percent (male) reductions in inequality of healthy life expectancy. If achieved, the social value of these healthy life years could reach £26.2 billion.**

3. Increasing access to family support and early childhood interventions

There are around 250,000 children aged zero to four in Scotland (2025 population estimates). As a conservative estimate, just under 100,000 children live in households that are below the MIS.

Early childhood interventions (such as care, health and nutrition check-ups, and family visits) in deprived communities have long lasting impacts on educational attainment, income, crime and health. The Scottish government recently expanded access to early learning and childcare, as well as a range of child support payments and community services such as health visitors and community midwives.

It will take time for the benefits of these policies to materialise (as the beneficiaries grow into adulthood). There are also opportunities for the government to expand services further (for example by opening access to early learning and childcare to all pre-school age children.) Expanded and maintained provision of early childhood interventions (such as early learning and childcare, home visits, health and nutritional checks, nutritional support) **could generate four to six million additional healthy life years with a 10-15 percent reduction in inequality of healthy life expectancy over a 70-year period. The social value of the extra healthy life years lived could range from £100 billion to £150 billion over a generation (80 years).**

The scenarios above show that reductions in health inequities in Scotland are entirely possible and there is evidence to indicate how and where investments can be made to realise them. But the analysis also shows the scale of investment needed. While the outlays and investments required are large, the health and equity benefits are significant. Moreover, as a secondary benefit, health improvements and reductions in health inequities will support economic and social development, including through increased education and employment productivity and tax revenue as well lower demand for (and costs of) a range of health and social care services.

INVESTMENTS IN PREVENTION

Cuts to public services and local government funding across the UK have led to increasing ill health and crises which lead to a greater need for crisis support and

intervention. The cycle then continues as prevention focussed support is cut or underfunded in order to fund crisis-related services, which then leads to an increased need for crisis-related services. Evidence has shown that as well as being equitable and effective in the long term, investments in prevention through the social determinants of health can also be cost-effective, reducing demand on a range of services [61-63]. However, as these investments take time to have impacts, the level of demand for services does not decrease immediately and investments for double running crisis and prevention services are needed, a further barrier to increasing prevention spend.

CHES is based on evidence that investments and action on the social determinants of health are the most effective and equitable route to prevent ill health and lead to greater health equity. The point is important. Prevention is often seen as involving activities such

as equitable access to services, screening, identifying individual risk factors for disease, and vaccination. All have an important part to play. Childhood immunisation is vital and we know that vaccination helped reduce mortality from COVID. But it is also important to prevent inequities in power, money and resources that lead to inequities in the conditions of daily life and health inequities.

Developing prevention oriented services and investing in prevention is a well established priority in Scotland, building on the 2011 Christie Commission which set out that public services must be preventative rather than reactive [64]. This principle is represented in the National Performance Framework outcomes and the recent Population Health Framework for Scotland (2025-2035) [65].

The Scottish Government have committed to tracking prevention spend and ensuring that the proportion increases, previously the proportion of spend on prevention has not been known [66, 67]. The Scottish Government Prevention Unit have developed a tool to do this and in the first pilot assessed the proportion of prevention spend in just over 40 percent of the total spend covered in the Scottish budget [68]. There are questions about the definitions of prevention used in the tool, much is focussed on upstream activity and not prevention the way Christie set out [69].

The Prevention Unit tool tagged that 15 percent of spend was directed towards prevention, with an additional 4 percent tagged as spend that enables delivery of prevention activity. Prevention was defined at 3 levels; as primary prevention, which is population level action to build resilience and stop problems developing; secondary prevention which is targeted action to respond to early problems and tertiary prevention identified as spend once problems have manifested to stop them getting worse. Forty percent of the spend that was assessed as prevention was classified as tertiary, 42 percent classified as secondary those at risk of crisis, with only 18 percent assessed as spend on primary, upstream prevention, representing less than 3 percent of the overall Scottish Budget spend [68]. Of that primary prevention, NHS Board activity around vaccinations and immunisations were included, which while vitally important for health and equity are not social determinants of health. In Chapter 6 we overview how the healthcare system can strengthen its ambitions and impacts on the social determinants of health.

The assessment is an important step in building the case for increasing prevention spend and activity. However, the process has demonstrated that prevention spend as a proportion of the Scottish budget is low and reveals a narrow understanding of prevention, much of what is defined as prevention relates to intervening once problems manifest. While important, and may prevent the development of further crises, this does not prevent problems and resulting ill health from developing.

A recent report from the Scottish think tank 'Enlighten' on Prevention in Scottish Public Service Reform warns that implementing the Scottish Government's Preventative Spend Guidance risks undermining efforts to reduce inequities and *"have the effect of mitigatory and reactive spending being labelled preventative without requiring the structural transformation Christie deemed necessary"* [69]. The report recommends a Structural Prevention Test for major spending decisions and a Christie-Aligned Indicators Framework to sit alongside the budget.

A further obstacle to investing in upstream prevention is the need for additional funding during transition phases as crisis funding reduces and before the increasing prevention funding helps reduce demand on the crisis service. These double running costs have not been addressed and continue to block further investments in upstream prevention and investment in the social determinants of health.

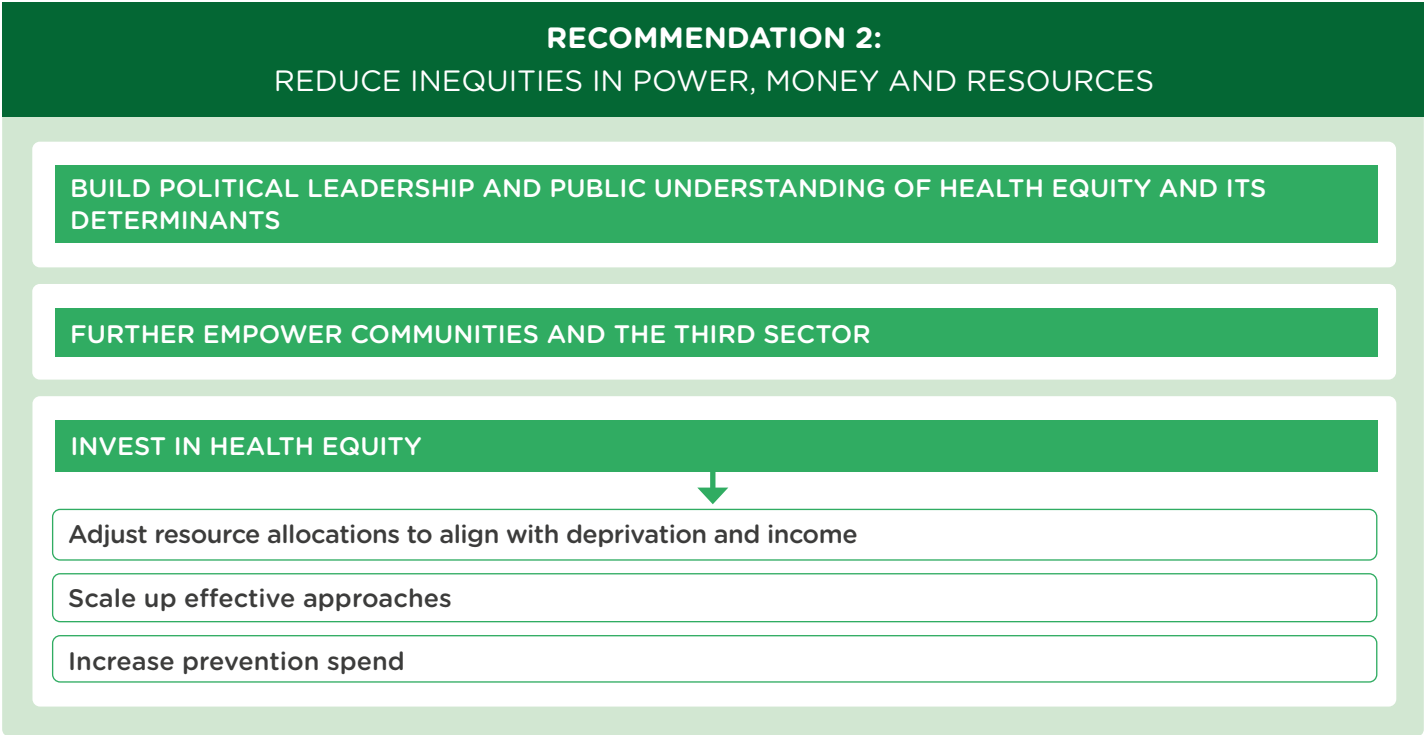
While the financial case for investments in reducing health inequalities can, and should be made more explicit, the real case for investment in health inequalities is a moral case – health inequities which are the result of inequitable policies and distributions of power, money and resources are simply unfair and damaging to individuals, families, communities and society as a whole.



SUMMARY AND RECOMMENDATIONS

Inequities in power, money and resources and their impacts on health have profound impacts on health throughout people’s lives. They also impact on delivery and implementation; influencing which organisations, sectors, places and communities have greater power, who is represented and where money and assets are allocated. Health equity must be at the heart of decisions about distributions of wealth and resources and assets.

As wealth inequalities increase and public resources and investments shrink, it is even more important for the impacts on health and longevity to be articulated and acted on. Politicians have an important advocacy and leadership role in championing the conditions for better health. The public and political case needs to be made more strongly with a national discussion on the extent and drivers of health inequities alongside an agenda for fairer allocation of resources, with resources matched to levels of deprivation and disadvantage, greater scale of investment for health equity, with recognition of the win-wins and much increased spend on upstream prevention.



CHAPTER 4

HEALTH EQUITY AND EMERGING CHALLENGES

This Chapter identifies new and emerging threats to health and health equity: demographic change, accelerating post-pandemic inequities, AI and digitalisation and the climate and biodiversity crises. Most analyses of the impacts of these profound societal changes focus on their likely economic and social impacts without reference to health. Impacts on health equity must be at the heart of understanding and acting on these threats, with an enhanced role for PHS to expand awareness and ensure mitigating actions.

CHANGING DEMOGRAPHICS IN SCOTLAND

The population of Scotland is becoming more ethnically diverse and older. There are important social, economic and health equity implications from these changes, which are not always well understood or factored into decision making, resource allocations and the design and delivery of appropriate services and support. Many of the demographic changes evident in Scotland are being experienced, to varying extents, across the UK and indeed globally.

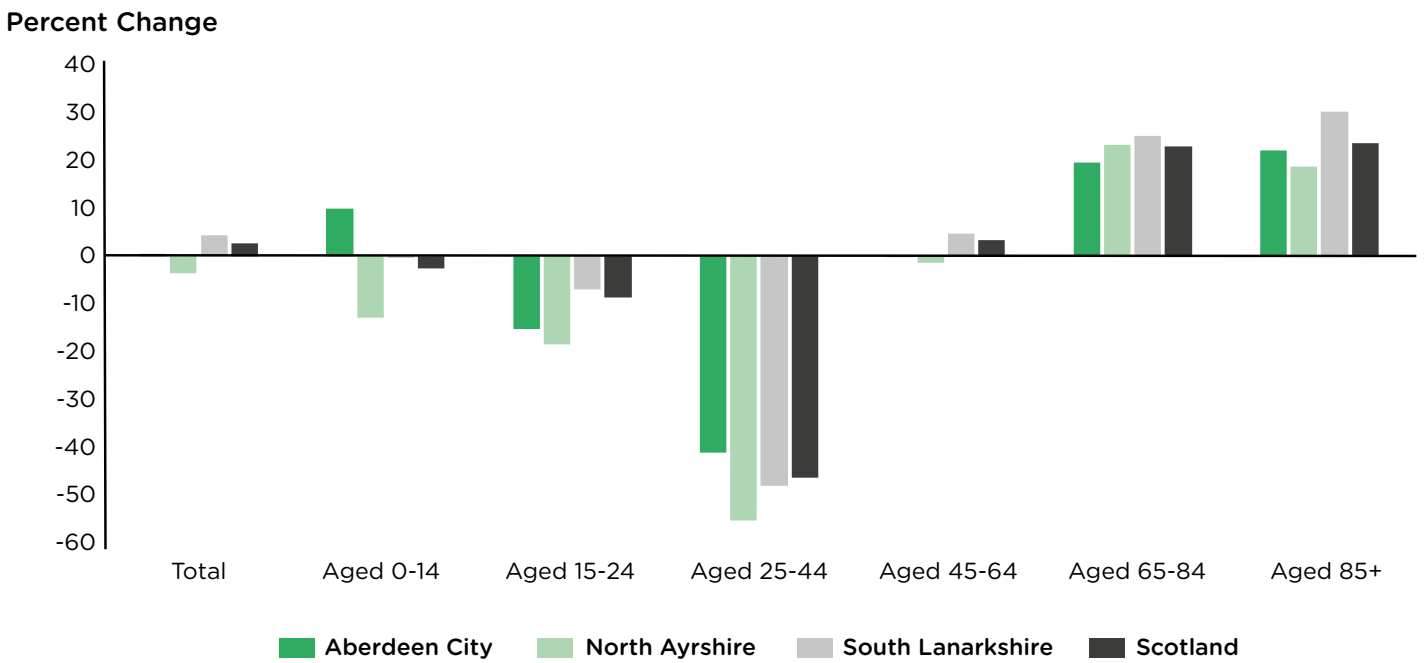
AGE STRUCTURE

The population in Scotland is aging and fertility rates are falling. Older populations require specific health, social care and support services. Meanwhile the needs of babies, children and young people must not be overlooked in places with a relatively high proportions of older people.

Figure 34 shows population changes in Scotland in the three CHES collaborating places at the time of the two latest Censuses, 2011 and 2022 [26, 29]. Of particular note are the large declines in the proportion

of the population who are aged 25-44 across Scotland and the slightly lower, although still fairly sizeable, declines in the proportion of the population who are aged 15-24. In North Ayrshire the proportion of the population aged under 65 has declined, with increases of over 20 percent in the proportion of the population aged 65 and over. Clearly, these demographic trends are likely to persist and accelerate with significant impacts for health, for services and for the tax base and productivity in the area.

Figure 34. Percent change in population by age group, Aberdeen City, North Ayrshire, South Lanarkshire, and Scotland, 2011 to 2022

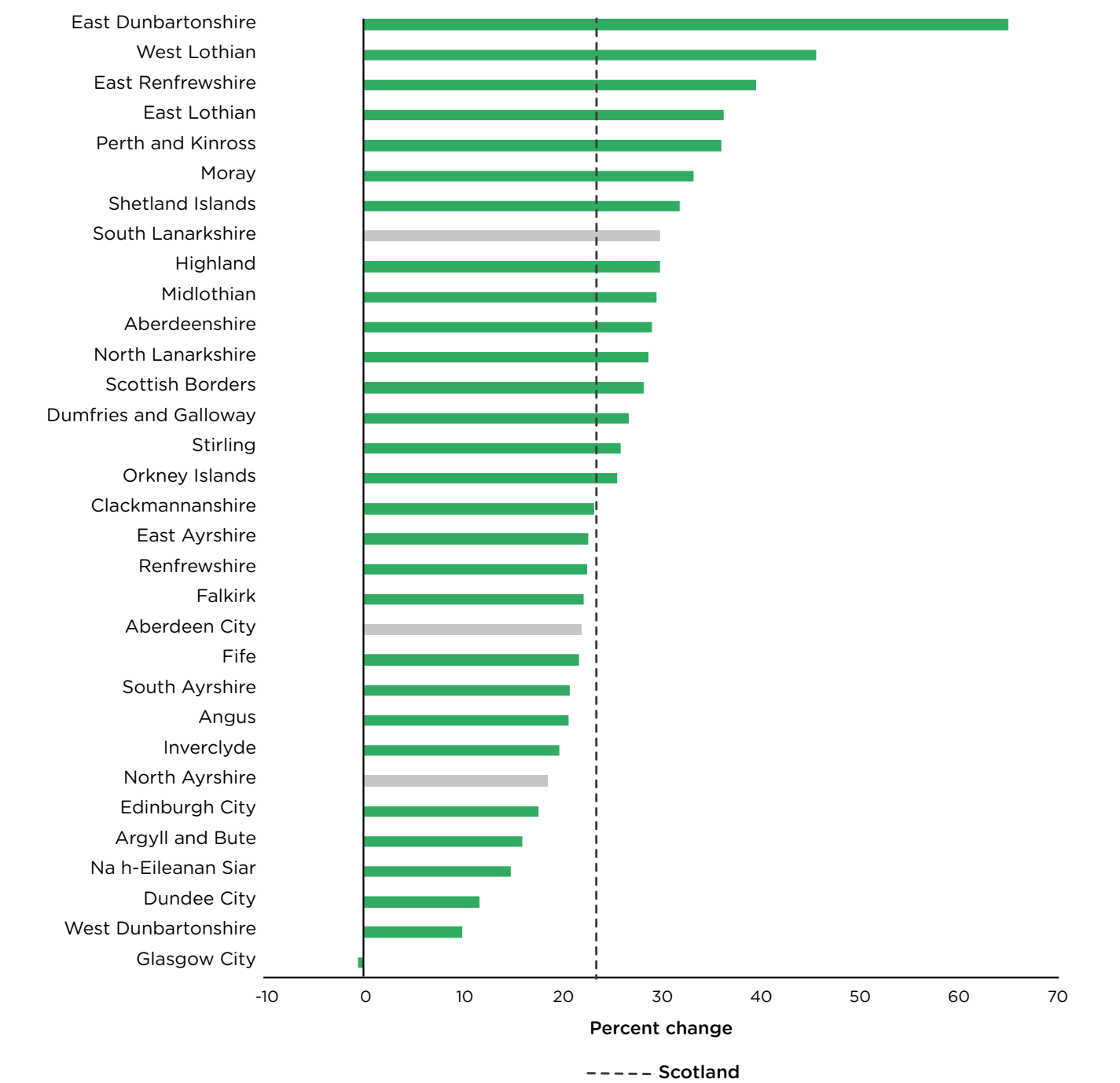


Source: Scotland Censuses (2011 and 2022) [26, 29]

Across Scotland there was an increase of 22 percent between 2011 and 2022 in the proportion of the population aged over 85, with increases in every Council

except for Glasgow City, where life expectancy is lowest and on average below age 85 [26, 29].

Figure 35. Percent change in population 85 years or older, Scottish Council Areas and Scotland, 2011 to 2022

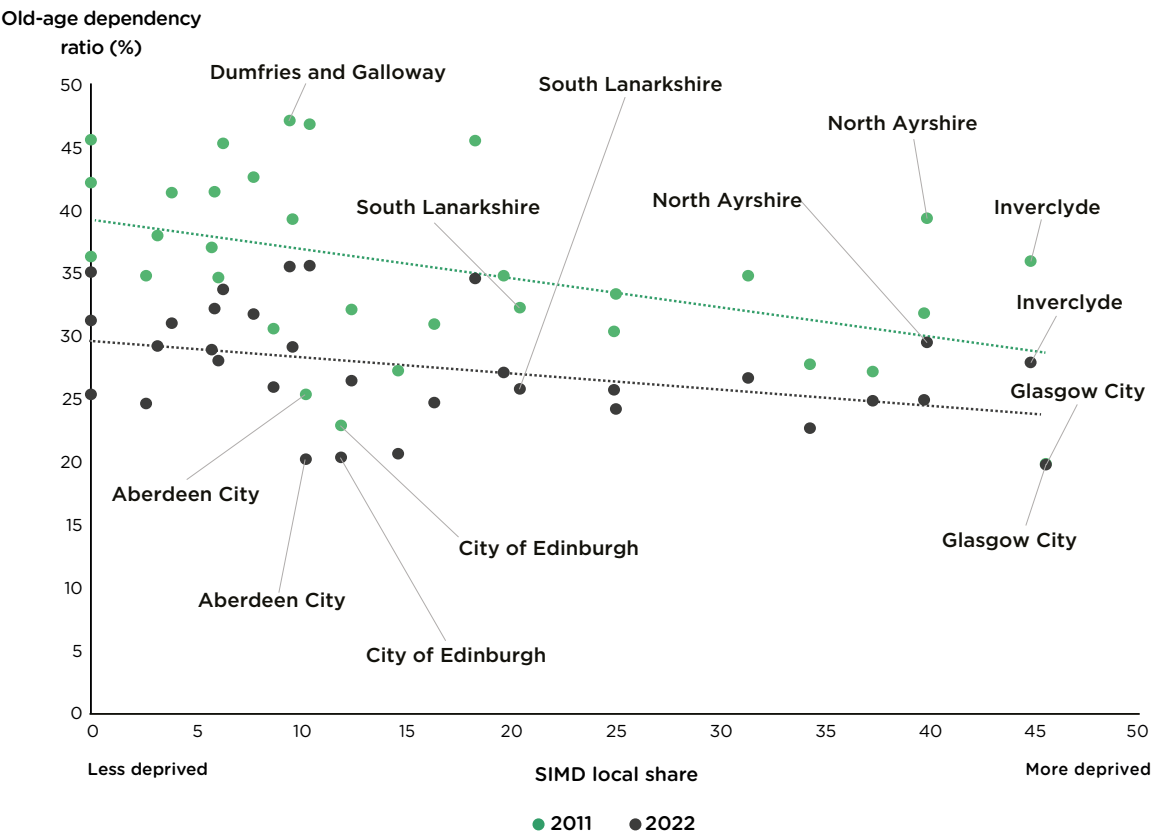


Source: Scotland Censuses (2011 and 2022) [26, 29]

The age dependency ratios show how many people aged 65 and over there are per 100 working age people. The ratio varies from just under 20 people over 65 per 100 working age people compared to just over 47 per 100 in Dumfries and Galloway. Figure 36 shows these dependency ratios by level of deprivation of the

Council in 2011 and 2022, based on Census data. The dependency ratios have increased in every Council with higher dependency ratios in less deprived areas. North Ayrshire is an outlier however, as a relatively deprived Council with high dependency ratios.

Figure 36. Old-age dependency ratio (SIMD Local Share), Scottish Council Areas, 2011 and 2022



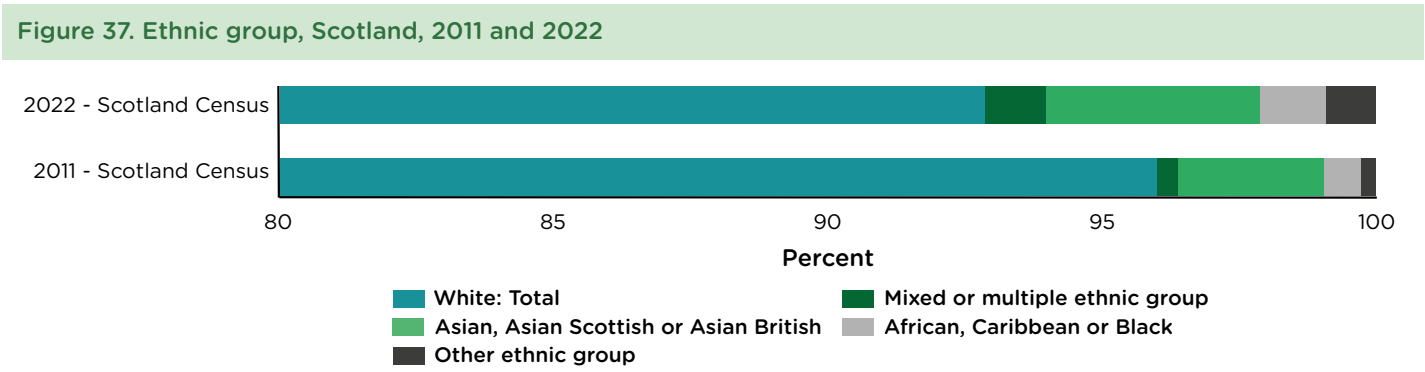
Source: Scotland Censuses (2011 and 2022) [26, 29]



ETHNIC DIVERSITY

The ethnic composition of the Scottish population is changing. As populations diversify, services and support need to respond to meet the needs of different ethnic groups in culturally appropriate ways. Racism and discrimination affect physical and mental health directly and indirectly and contribute to health inequities [70]. While racism and discrimination may be most visible in areas with relatively mixed ethnic populations, there is also discrimination and racism in areas with relatively low rates of ethnic diversity which are often overlooked. In Scotland, as across the UK there are reports of racism in healthcare as well as racism and discrimination in the social determinants of health [71, 72]. The impacts of racism on health in Scotland require further data and consultation to assess the extent of the issues, with stronger accountability for services to deliver culturally appropriate services designed with ethnic minority groups and for organisations generally to strengthen their antiracism approaches.

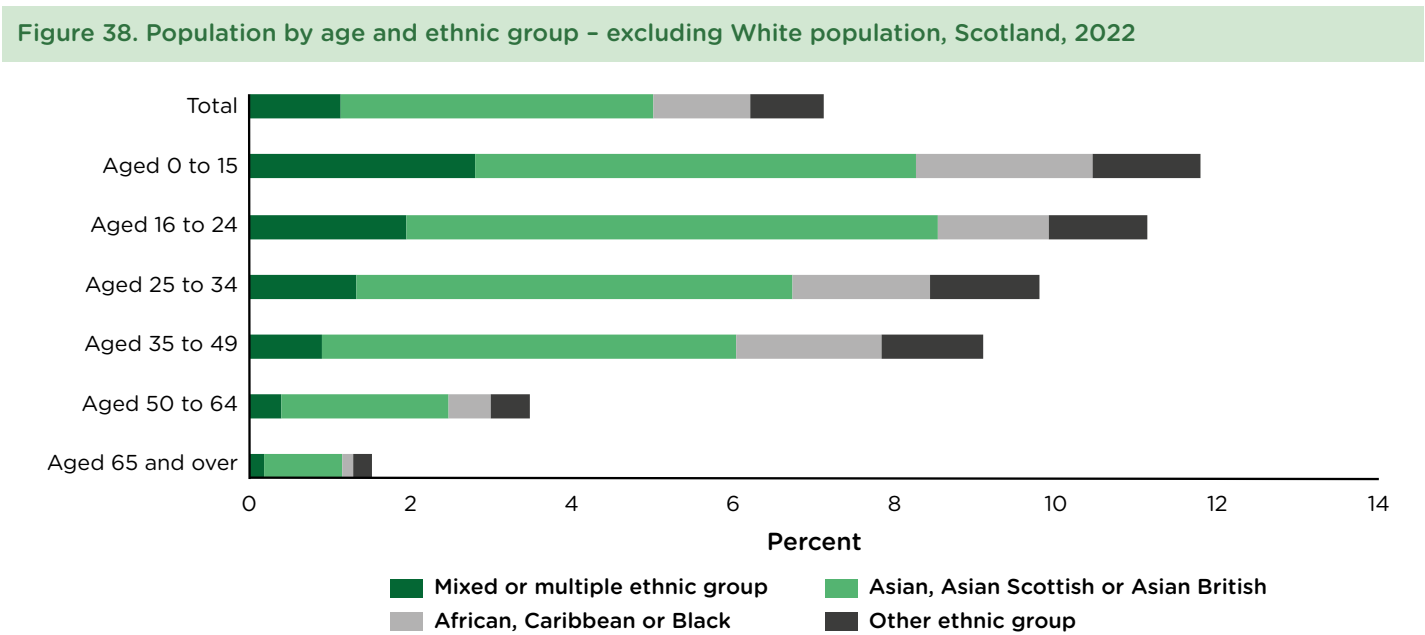
Figure 37 indicates changes in the Scottish population’s ethnic composition between the two last censuses. There have been increases in those identified as ‘Asian, Asian Scottish or Asian British’ from 140,678 (2.6 percent) people to 212,022 (3.9 percent), a 50.7 percent increase. Among those identified as, African Caribbean, or Black’ there were increases from 36,178 (0.7 percent) in 2011 to 65,414 (1.2 percent) in 2022, a 80.8 percent increase. The population described as ‘other ethnic group’, has increased from 14,325 (0.3 percent) to 49,632 (0.9 percent), a 246 percent increase. The mixed or multiple ethnic group category increased 19,815 (0.4 percent) in 2011 to 60,899 (1.1 percent), in 2022, this is a 207 percent increase. These ethnic groups continue to form a smaller proportion of the population of Scotland than that of the UK as a whole. There has been a decrease of 32,534 people in the number of White people between Censuses a 0.64 percent decrease, which is a decrease from 96 percent to 92.3 percent in the proportion of the Scottish population between Censuses.



Source: Scotland Censuses (2011 and 2022) [24, 27]

Figure 38 shows that there is greater ethnic diversity among younger age groups than among older age groups. After the White population, ‘Asian, Scottish

Asian or Asian British’ is the largest ethnic group across all age groups, accounting for 6.6 percent of 16 to 24 year olds in Scotland.

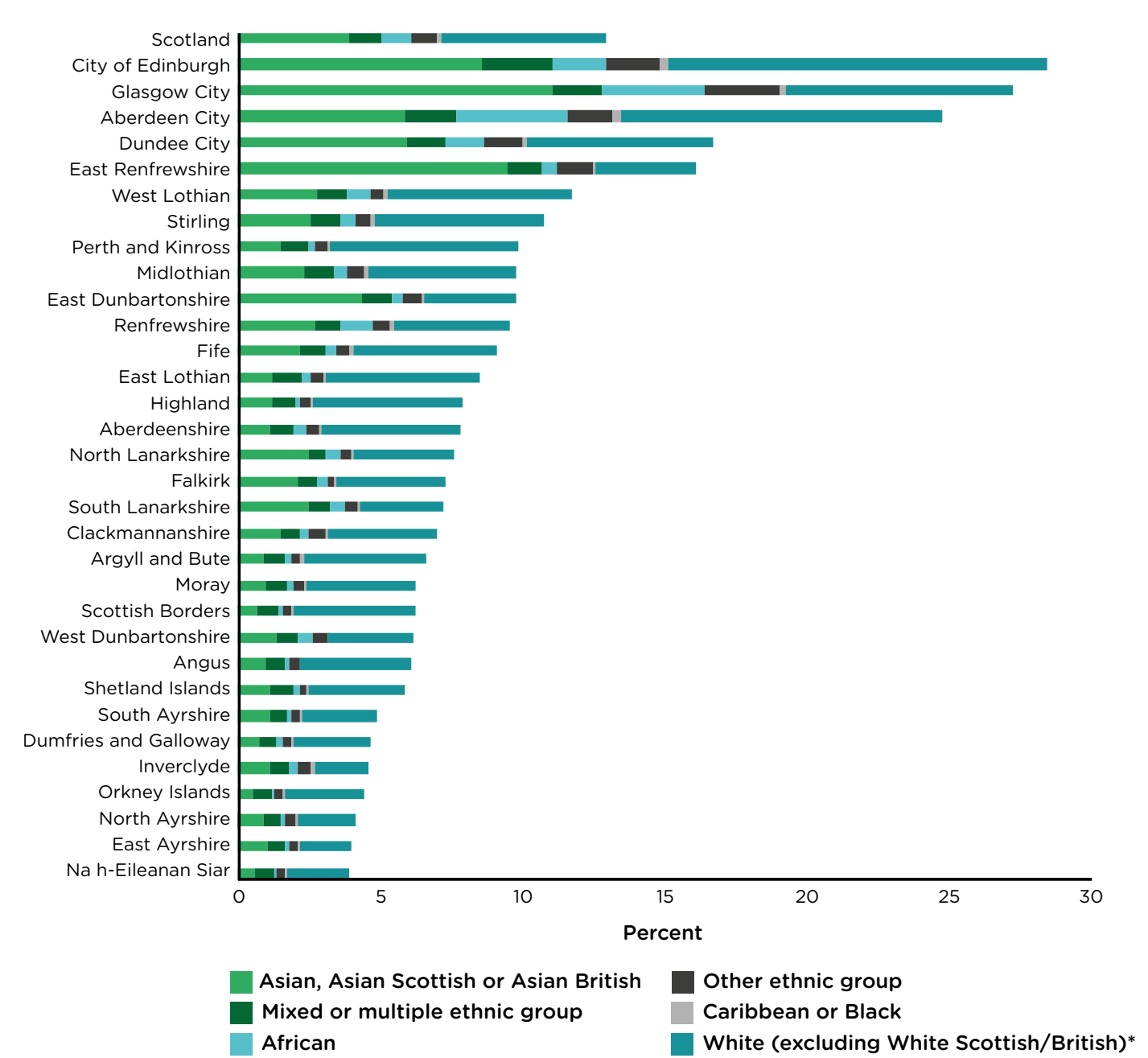


Source: Scotland Census (2022) [24]

There are large differences in the percent of major ethnic groups not including White Scottish/British residents by Council, with much higher proportions in major urban areas, Figure 39. Those areas with lower levels of diversity also need to ensure that the needs of all ethnic groups are being met with culturally

appropriate services and greater accountability for racism. In Chapter 7 we set out the lack of data and evidence to monitor health and other outcomes by ethnicity and to understand the impacts of racism and discrimination, all of which limits accountability and efforts to address racism.

Figure 39. Percent of major ethnic groups excluding White Scottish/British, Scottish Council Areas and Scotland, 2022



Source: Scottish Census (2022) and Institute of Health Equity (2025) [2, 26]

DEEPENING INEQUITIES POST-COVID

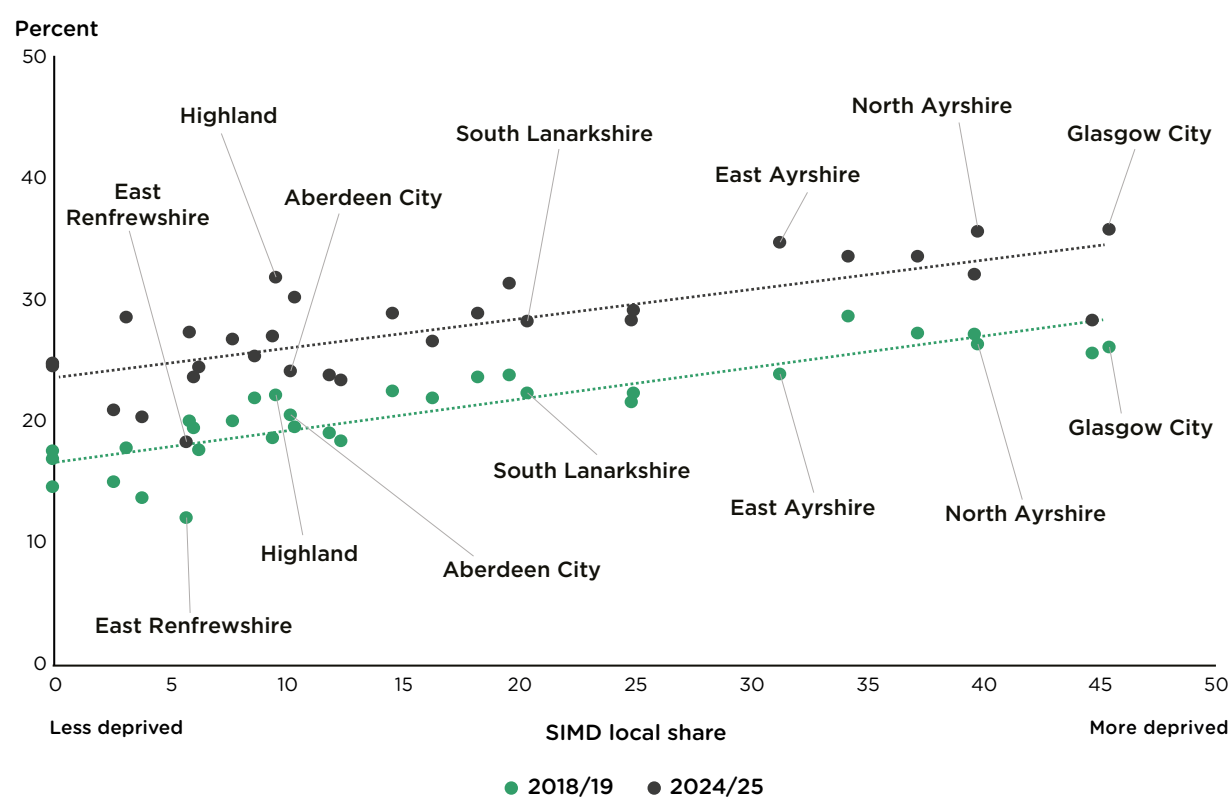
The COVID pandemic reduced life expectancy and healthy life expectancy across Scotland and as noted in Chapter 2, many more deprived areas have not recovered to pre-pandemic levels of health. The pandemic also led to widening inequities in health and in the social determinants of health [73]. While the immediate health impacts of the pandemic were well understood, there has been less focus on how well different areas have been able to recover. Many of the negative and inequitable health and social determinants of health impacts from the pandemic continue to be felt and are even accelerating. In this section we highlight how health and the social determinants of health have deteriorated since the pandemic in more deprived areas, and how widening inequities should inform efforts to address inequities and improve health.

SCHOOL ABSENCE

Since the pandemic there have been large increases in the rates of persistent absence (10 percent or more sessions missed) in schools, with much higher rates among young people who are eligible for free school meals and living in deprived areas. Being absent from school affects levels of educational attainment and employment and income, while also being associated with higher rates of crime; all of which are harmful to health and contribute to health inequities [74]. Figure

40 shows increases in rates of persistent absence from school in every Council following the pandemic. With inequities related to level of Council deprivation persisting, although not widening. In the previous report we highlighted that rates of persistent absence within Councils were much higher, nearly 10 percent difference across Scotland, among pupils eligible for free school meals and those not eligible [3].

Figure 40. Percent of pupils persistently absent* primary, secondary, and special schools (SIMD Local Share), Scottish Council Areas, 2018/19 and 2024/25



Source: Scottish Government (2025) [75]

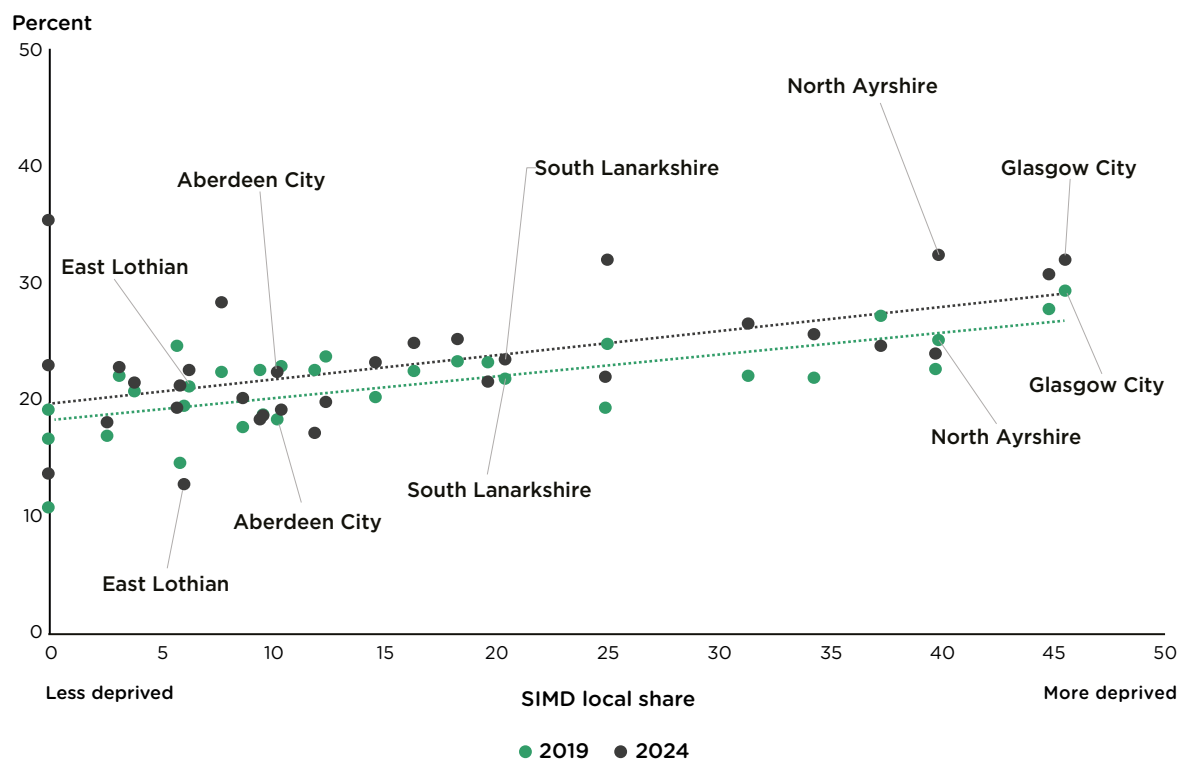
Note: *Persistent absence refers to the proportion of pupils who miss 10 percent or more of the academic year.

ECONOMIC INACTIVITY DUE TO ILL HEALTH

Rates of economic inactivity increased across Scotland between 2019 and 2024, with persisting, although not widening differences in rates of economic inactivity between Councils related to their level of

deprivation within Councils [76]. Among those who are economically inactive there have been large increases in the proportion of people who are economically inactive due to being long-term sick.

Figure 41. Percent of those who are economically inactive who are long-term sick (SIMD Local Share), Scottish Council Areas, 2014 and 2024



Source: NOMIS – APS (2026) [76]

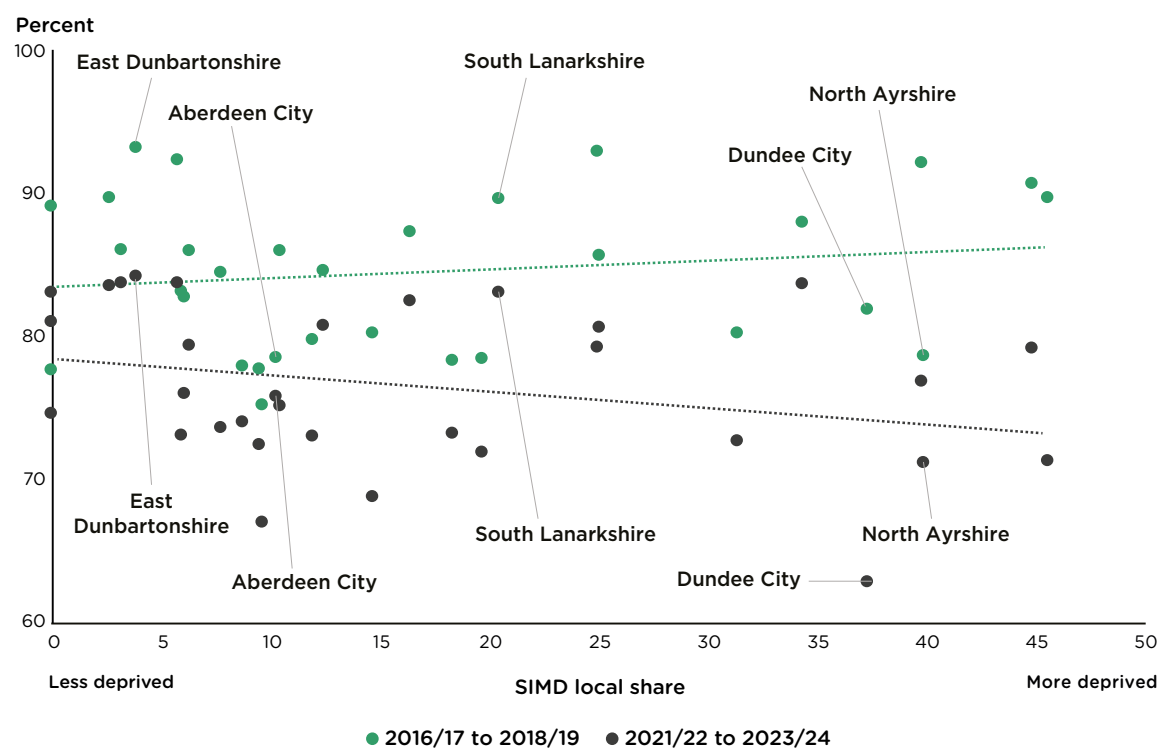


LOSS OF TRUST

One impact of COVID, experienced across the UK, has been declining trust in governments and services, partly attributed to the spread of misinformation via social media, confusing advice during the pandemic and services which did not meet the needs of all communities appropriately [70, 73]. More deprived

communities and some ethnic minority groups were particularly poorly served during the pandemic and trust further eroded. Figure 42 shows large decreases in the uptake of the HPV vaccine after the pandemic, which may relate to declining levels of trust and increasing vaccine hesitancy in Scotland.

Figure 42. Uptake of the HPV Vaccine in S1 girls (SIMD Local Share), Scottish Council Areas, 2016/17 to 2018/19 and 2021/22 to 2023/24



Source: Public Health Scotland (2025)[77]
Note: Missing data for Na h-Eileanan Siar 2016/17 to 2018/19

To provide further insights into continuing inequitable impacts on health and social determinants since the pandemic across Scotland, IHE assessed post-pandemic trajectories in several health and social

determinants of health indicators, comparing outcomes in the eight most deprived Councils in Scotland with the average in Scotland, Box 9.

Box 9. Post-pandemic inequities across Scotland

Comparing changes for a range of social determinants of health in Scotland pre- and post- pandemic, it is clear that compared with Scotland as a whole, more deprived Councils have not recovered as well and that differences between more deprived Councils and the rest of Scotland are increasing. In Table 16 the relative deteriorations among the most deprived third of Councils in Scotland compared with the Scottish average are indicated in red. The indicators show widening inequities in concerns about development among young children, in rates of persistent absence from school, in rates of economic inactivity, employment rates, recorded crimes, HPV vaccine uptake, in secondary school leavers with 1 or more qualification SCQF level 4 and rates of homelessness. These trajectories point to disproportionate and long-term impacts from the pandemic in more deprived areas that require further exploration and additional resources and support to address.

More positively, rates of breastfeeding (also see figures 47 and 48) have improved and drug recorded crimes fallen more in more deprived areas than across Scotland, indicated in green. Prescriptions for mental health conditions have increased less in more deprived Councils than average.

Table 16. Summary of changes in social determinants of health indicators, Scotland average and the eight most deprived Councils

Indicator	Percentage point change in Scotland average	Scotland average values at two time points	Percentage point change in average for eight most deprived councils	Average values for eight most deprived councils at two time points
Breastfeeding Rate (2016/17 to 2018/19 and 2021/22 to 2023/24)	+ 1.5	30.8 to 32.3 percent	+ 2.29	22.7 to 24.99 percent
Developmental Concerns (2016/17 to 2018/19 and 2021/22 to 2023/24)	+ 1.6	15.9 to 17.5 percent	+ 1.98	19.86 to 21.84 percent
Persistent Absence (2018-19 and 2023-24)	+ 6.7	21.8 to 28.5 percent	+ 7.53	26.51 to 34.04 percent
Secondary School Leavers with 1 or more qualifications at SCQF Level 4 (2018-19 and 2023-24)	+ 0.84	10.85 to 11.69 percent	+ 0.79	11.44 to 12.23 percent
Economic Inactivity Aged 16-64 (2019 and 2024)	+ 0.8	22.5 to 23.3 percent	+2.67	26.14 to 28.81 percent
Employment Rate Aged 16-24 (2019 and 2024)	-3	57.9 to 54.9 percent	-7.48	53.48 to 46 percent
Drug-recorded Crime (2018 and 2024)	-19.2*	64.6 per 10,000 to 45.4 per 10,000 rate*	-27.13*	93.58 per 10,000 to 66.45 per 10,000 rate*
Recorded Crimes (2018 and 2024)	-60.2*	916.7 per 10,000 to 856.5 per 10,000 rate*	-47.75*	1,125.56 per 10,000 to 1077.81 per 10,000 rate*
HPV Vaccine Uptake S1 Females (2017 and 2023)	-9.3	84.8 to 75.5 percent	-13.35	87.44 to 74.09 percent
Homelessness Rate (2018/19 and 2023/24)	+ 0.6*	8 per 1,000 to 8.6 per 1,000 rate*	+ 1.42*	9.71 per 1,000 to 11.13 per 1,000 rate*
Prescription for Mental Health Conditions (2018/19 and 2024/25)	+ 1.3	19.5 to 20.8 percent	+ 0.97	21.73 to 22.7 percent

Source: IHE analysis, Various sources available from ScotPHO - Public Health Scotland Data Profiles Tool and other Scottish Government sources.

Notes: 1) Figures show the average change in each indicator between the baseline figures and the end period figure, for the Scotland average and for the average of the eight most deprived Councils.

2) * These are rates and rate differences, not percentages and percentage point differences.

3) Colouring reflects change relative to the Scotland average, not the absolute direction of change. For each indicator, whether an increase or decrease is favourable is determined first (e.g. rising breastfeeding rates are favourable; rising persistent absence is not). Colours then show whether the eight most deprived Councils moved in that favourable direction by more or less than the Scotland average:

- Green: The eight most deprived Councils improved by more than the Scotland average, or deteriorated by less.
- Red: The eight most deprived Councils improved by less than the Scotland average, or deteriorated by more, even if both moved in a favourable direction.

To what extent these widening differences can be attributed to the pandemic is unclear as other economic and social conditions will also have impacted, but reports from service providers and communities also indicate that pandemic impacts are still being felt. Without being able to specify what is directly related to pandemic impacts we recommend that there is additional assessment of inequitable pandemic impacts

and that these are understood through a health equity and social determinants of health lens. Widening inequities and deteriorating outcomes in more deprived Councils in Scotland give greater urgency to the challenge of addressing them, reinforcing the need to take a structural inequality lens and adjust resources and service provision accordingly.

AI AND DIGITALISATION AND HEALTH EQUITY

Social media use, the rapid spread of AI and digitalisation of many services are all having profound impacts on health, although research is still not clear about the extent and inequities in these impacts.

DIGITALISATION OF SERVICES

The digitalisation of services have potential to improve population health by increasing access to services [40]. Digitalisation is included in Scotland's Population Health Framework as a step towards a prevention focussed system [78]. Despite these opportunities there are persistent inequities in peoples ability to access digital services and individual health monitoring tools which must be considered. WHO have set out these challenges globally:

“Digital technologies can expand access to healthcare, financial services and education, reduce social isolation, and enable more responsive public policy through big data and AI. However, these benefits remain unevenly distributed. Around one-third of the global population still lacks digital access, with lower-income communities, rural populations, women, older people, Indigenous Peoples and people with disabilities facing persistent barriers. Without equitable access, digital transformation risks widening existing social and health inequalities.” [40]

Inequities in access to digital services and individual health monitoring are also evident in Scotland. To address these, programmes are in place to ensure services and support are available for those who cannot, or choose not to access services and support via digital routes [79].

SOCIAL MEDIA

Evidence showing the health risks associated with prolonged and harmful use of digital devices, in particular social media is growing, although still emergent. Social media platforms can expose children and young people to harmful content, bullying, misinformation, exploitation and addictive behaviours, while also contributing to poorer mental health, suicidal ideation, loneliness and declining well-being, particularly among adolescents and young women [80]. Prolonged digital use is also associated with physical inactivity [40].

Research from 2022 indicates that excessive screen exposure affects brain development increasing the risk of cognitive, emotional and behavioural disorders in



adolescents and young adults, the authors state that as a result they expect rates of Alzheimer's disease and related dementias to increase significantly from 2060-2100 as today's young people age [81]. Other identified impacts which will affect health in the longer term include reduced cognitive development among babies and children who access and play on digital devices or whose parents are distracted by their own devices [82].

Emerging evidence indicates that the harmful impacts of social media use are not equitably distributed and these inequities are likely to become more pronounced. Recent government advice centres around parents reducing use of digital devices for babies and young children and bans/limits on social media [83]. There are ongoing debates about how effective these will be, but there are also like to be differences in the uptake and implementation of the advice, leading to differences in harm from prolonged use. There are also ongoing debates about the pros and cons of digital access in school including pupils own use and as teaching tools.

ARTIFICIAL INTELLIGENCE

The emergence of Artificial Intelligence (AI), is already rapidly transforming the world economy and how societies function. These transformations are likely to intensify with probable significant impacts on health and health equity. The WHO World Report on the Social Determinants of Health states that “*the introduction of AI may lead to disruption and possible existential risks, which could cause significant harm and widen existing health inequities [40].*” Despite these risks, most assessments of the potential impacts of AI focus on the anticipated economic and

social impacts and through the lens of employment and changes in occupational structure. AI will have major impacts on health and health equity through changes in key social determinants of health, such as income, education and employment as well as directly including impacts on mental health with potential for already excluded and deprived communities to be worse affected. There are likely to also be generational impacts, with children and young people’s education and entry into employment more restricted.



ENVIRONMENTAL AND CLIMATE CRISES AND HEALTH EQUITY

The climate, biodiversity and other environmental crises are intensifying with immediate and long-term impacts on health and health equity. In 2025 the Chief Medical Officer of Scotland emphasised this.

“The triple planetary health crisis – climate change, loss of biodiversity and air pollution – continues to be the greatest global threat to human health. It remains, in my view, a public health emergency.” [84]

The direct physical and mental health impacts of climate breakdown include changing exposure to heat and cold, increased exposure to UV radiation, air pollution, pollen, emerging infections, flooding, and the impacts of extreme weather events such as storms and floods. Indirect impacts include impacts on the livelihoods of individuals as prices for food, water and costs of domestic energy and utilities increase. Supply chains are at risk from extreme weather events, and global security threatened [85]. Such impacts are not equitable and tend to affect people living in more deprived areas. The indirect impacts of climate change on health and wellbeing are felt through deteriorations in key social determinants of health including through transport, housing and green space.

In the UK four key areas of action would bring benefits to public health and reduction of health inequities whilst contributing to the mitigation of, and adaptation to, climate change: transport, buildings, diets, and sustainable economic and employment models. Running through all of these are reduced air pollution, better diets, increased levels of physical activity, improved building standards and better work-life balance [86]. In Scotland there is further focus on the social determinants of health, nature-based solutions and community resilience and a focus on health equity [87-89]. There is a representative from PHS included in the Third 2026 Just Transition Commission in Scotland [90].

Positively, actions to combat climate change and protect biodiversity which have equity considerations at their heart, can improve health and health equity directly and through the social determinants of health. Examples of these ‘win wins’ for climate, biodiversity and health equity include increasing housing insulation, active travel, green space provision and reduced air pollution.

WHO have set out that aligning climate and health objectives has the potential to deliver substantial co-benefits estimating that global action on climate change could save 7.5 million lives, and that the health gains from improved air quality through a rapid global transition to clean energy would repay transition costs twice over [91]. WHO provide examples of policies which have positive impacts on equity in health and the social determinants of health. The Canadian state of British Columbia introduced a carbon tax on consumption, the proceeds of which were used to reduce other taxes or to provide direct cash transfers to low-income consumers, with net progressive impact [40]. In the United Kingdom, research on environmental inequalities informed targeted funding decisions that benefit populations living in deprived areas who are most vulnerable to environmental risks [40].

The IHE collaborated with Friends of the Earth to demonstrate the positive health and equity impacts of housing insulation and other measures to regulate indoor temperatures. The report showed that the cost of retrofitting 9.6 million households at risk of fuel poverty, while expensive, would be outweighed by savings from improved productivity and reduced NHS, social care, and carbon costs [86]. Other assessments of health equity and environmental, co-benefits are available [85, 92-95].

Actions to reduce greenhouse gas emissions (GHG) emissions and protect biodiversity must have health equity as an explicit policy goal with routes to achieve this. This requires careful consideration of who benefits and who pays for different policy measures: the costs should not be unfairly borne by people on low incomes.

The Scottish Government emphasise that a just transition is an outcome and a process - a transition undertaken in partnership with those impacted by the transition [90]. The transition from oil and gas extraction in the North Sea to renewable energy production across Aberdeen City, requires mitigation of any inequitable impacts.

Box 10. Aberdeen City - The 'Just Transition'

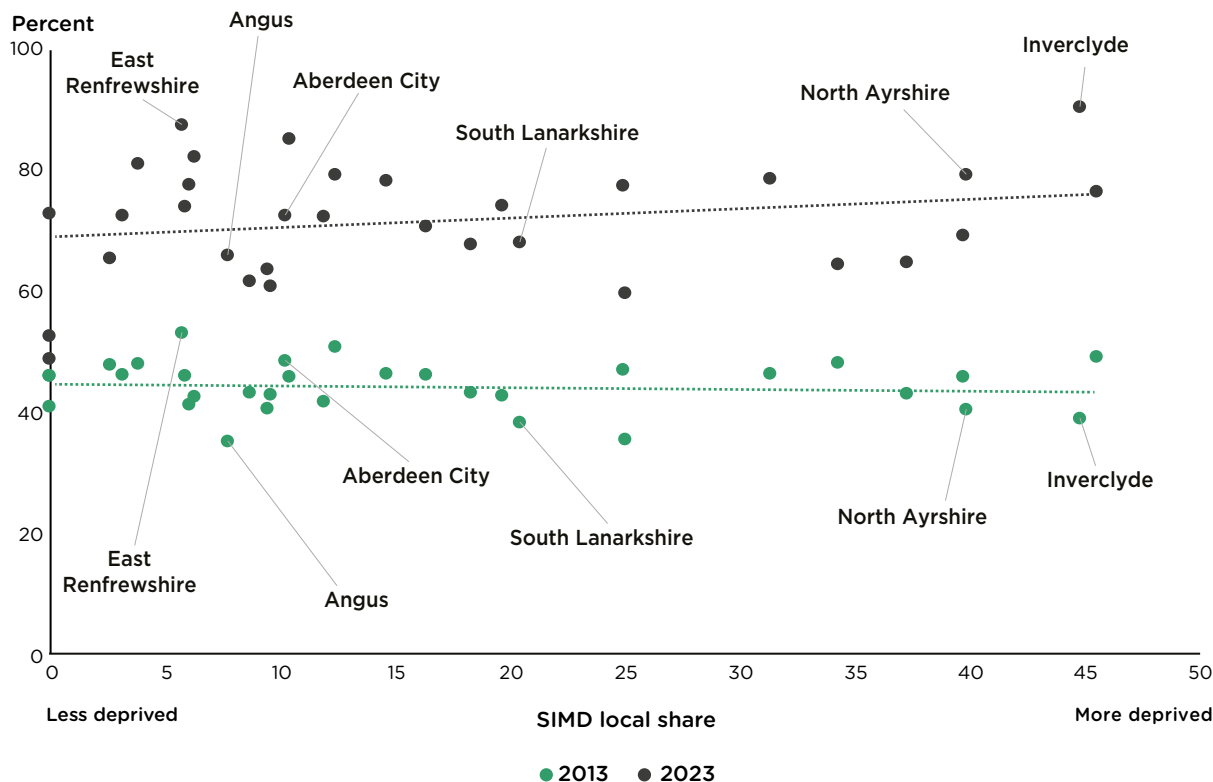
Aberdeen City and the wider region is at the forefront of efforts in Scotland to transition towards a low-carbon economy through investment in renewable energy, green industries and new infrastructure. The transition is intended to be 'just' with positive impacts for those most affected by the transition away from oil and gas, and with equity considerations embedded to mitigate negative impacts for employment, local supply chains and communities.

The report *"A Just Transition for Aberdeen and the North East"* highlights how the costs and risks of change are being experienced unevenly and many workers in oil and gas industries, especially contractors, supply-chain employees, and those in more insecure forms of employment, facing uncertainty about future job opportunities [96]. The report also notes that access to retraining and skills support is not yet comprehensive enough to meet the needs of all affected workers, with gaps in provision and barriers such as time, cost and awareness limiting uptake.

As the impacts of transition are not experienced equitably, there is inevitably opposition from those who are most negatively affected. Widescale opposition to the charges incurred as a result of the Ultra Low Emission Zone in London led to further consideration and additional subsidies being introduced for lower income households. Had the inequitable impacts been compensated for at the start the opposition to the measures would have lessened. Meanwhile deaths and ill health from air pollution which disproportionately affect lower income neighborhoods have been significantly reduced in London. A report published in 2026 estimated the number of premature deaths in London attributable to air quality was between 3,800 and 5,100 in 2024, a significant drop from 2019's estimates of 6,400 to 8,000 [97]. Researchers also found that fine particulate pollution – extremely small particles that can have a serious impact on health – fell by 28 percent between 2019 and 2024.

Between 2013 and 2023 there has been a notable increase in levels of concern about climate change across Scotland, with no significant difference between less deprived and more deprived Council areas, Figure 43.

Figure 43. Adults agreeing that climate change is an immediate and urgent problem (SIMD Local Share), Scottish Council Areas, 2013 and 2023



Source: Scottish Household Survey (2023) [98]

Note: Na h-Eileanan Siar and Shetland Island 2013 values overlap.

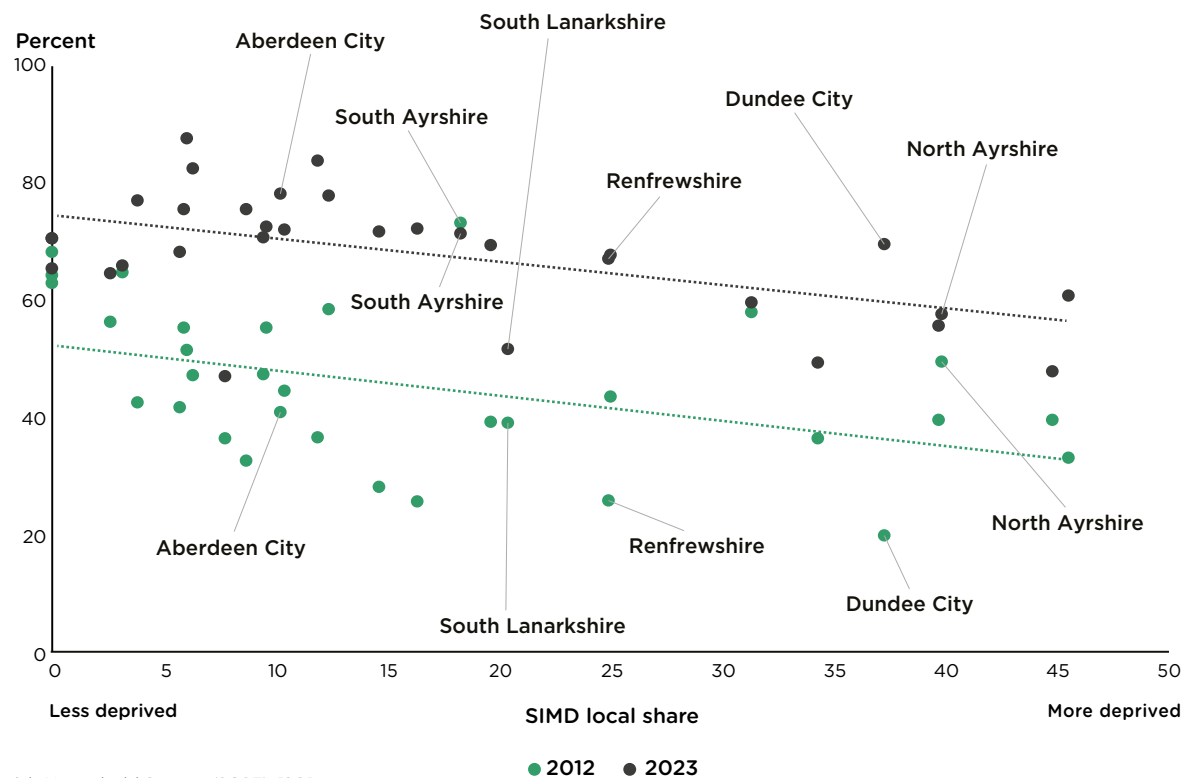
Positively, there have been more visits to outdoor spaces among adults in Scotland between 2012 and 2023.

Visiting the outdoors has positive impacts on physical and mental health [99] and leads to greater interest and

understanding in environmental considerations and nature, leading to support for environmental protection measures [100]. However, there are still substantial differences in the proportion of the population who visit outdoor spaces one or more times a week, by level of deprivation of Councils. In Dundee City, however, there has been a striking improvement. Efforts to

further encourage people to visit outdoor spaces must be directed towards supporting people living in more deprived areas and those facing discrimination. Anticipating discrimination, concerns about safety, access to clean toilet facilities and physical access, affect more deprived communities and ethnic minority groups and those with disabilities.

Figure 44. Adults who visit the outdoors* once a week or more (SIMD Local Share), Scottish Council Areas, 2012 and 2023



Source: Scottish Household Survey (2023) [98]

Note: *The 'outdoors' refers to the outdoors in general, anywhere in Scotland: "open spaces in the countryside as well as in towns and cities, such as woodland, parks, farmland, paths, beaches etc. These leisure trips could either have been taken from home or while you were away from home on holiday, provided the holiday was in Scotland." [98]

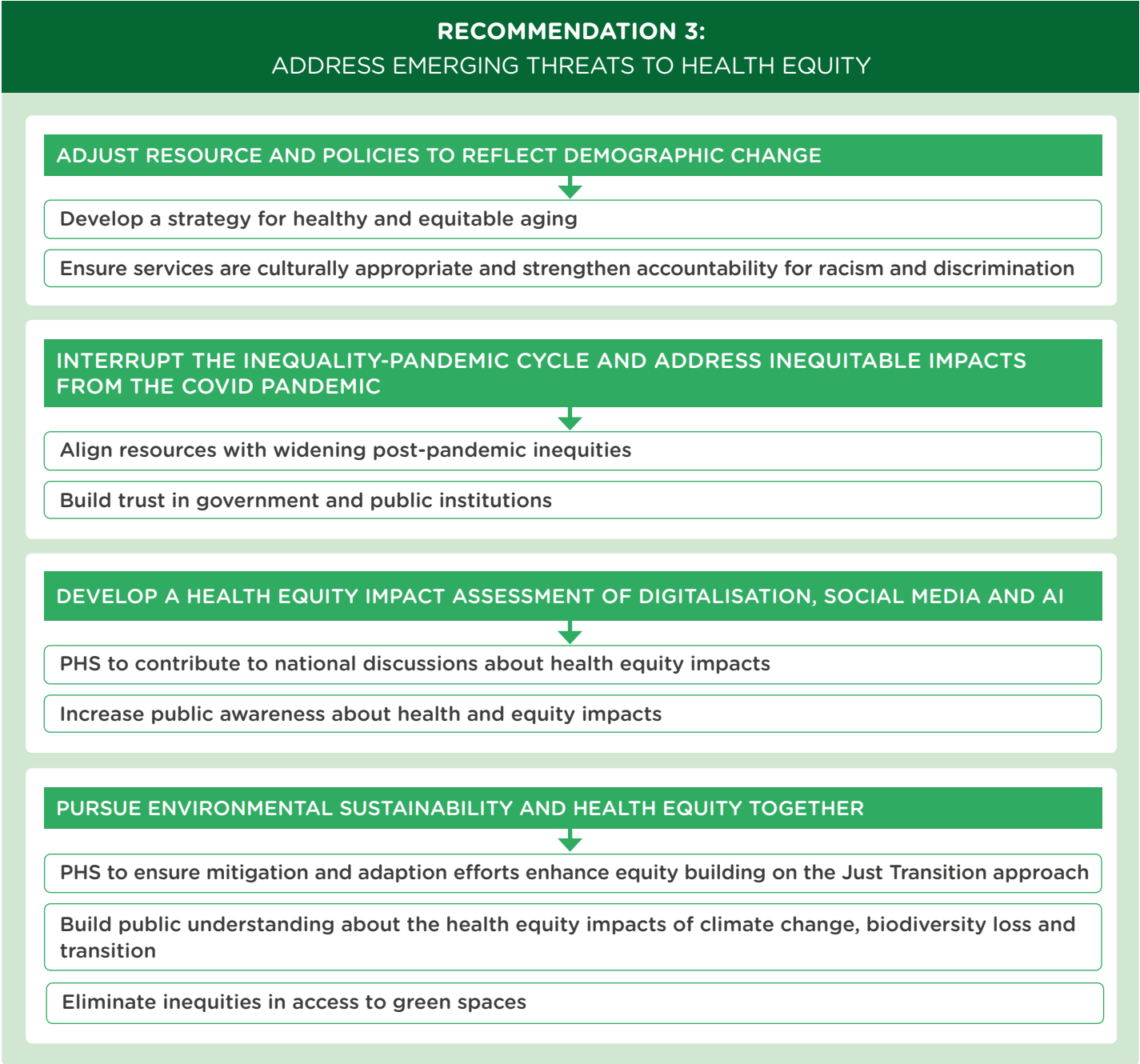
Public support and the increasing evidence about the health equity impacts of the accelerating climate and biodiversity crises must give decision makers in Scotland greater confidence to introduce strong measures to reduce GHG emissions, protect biodiversity and mitigate

ongoing and accelerating impacts. Such measures must involve considerations of equity and health and as such communities and Public Health Scotland continue to be at the forefront of decision making in the required changing policies and approaches.



SUMMARY AND RECOMMENDATIONS

Demographic, economic, cultural and social structures are changing and pose threats to health equity which are not well understood. Among these are ongoing inequitable impacts from the COVID pandemic and the need for future, equity-focussed pandemic preparedness; demographic changes particularly an aging population; the increasing risks to health from social media and AI; and climate and environmental crises. Preparing for these health equity challenges and mitigating risks, must be enhanced with strong public health representation and new research and analysis.



SECTION 2:

DELIVER HEALTH EQUITY

The design and implementation of policies and programmes relate to structural inequities in power, money and resources overviewed in Chapter 3. That is the overarching context which limits or enables effective implementation of programmes for greater health equity. In this section we set out needed changes to the design and delivery of investments and programmes in Scotland, the prioritisation of health equity approaches and the evidence and data which would lead to more equitable impacts. Many of the issues hampering more effective implementation and delivery of policies which have been highlighted through CHES are well established and have been described over many years [2, 4, 64, 101]. An important question is why then, given plentiful evidence about issues with the delivery and implementation landscape in Scotland have these not been addressed? Partly this question can be answered through questioning the political will to address delivery challenges which may involve ‘winners and losers’ and can be opposed. Partly the answer must lie with the complexity of the delivery landscape, and institutional silos which make concerted focus on health and equity more difficult to achieve.

CHAPTER 5

THE DESIGN AND DELIVERY OF PROGRAMMES

In this Chapter we overview and make recommendations to strengthen the design and delivery of programmes and services for health equity including implementation of proportionate universalism, greater strategic coherence, enhanced procurement and commissioning capacity and moving from short to longer term programmes and funding.

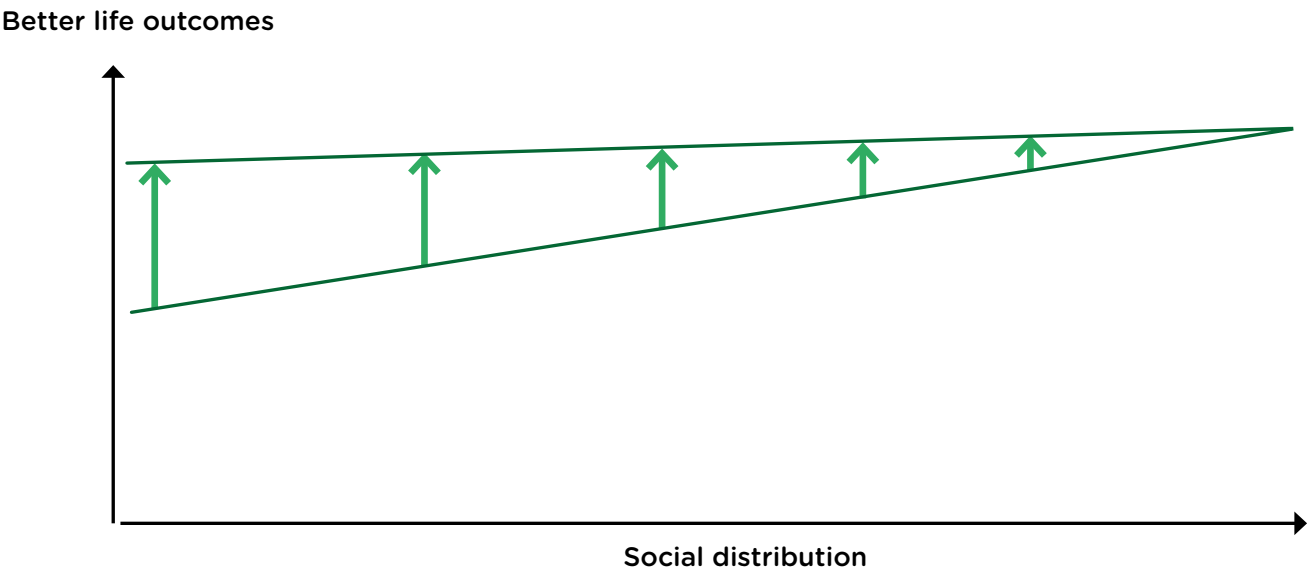
HEALTH EQUITY AND PROPORTIONATE UNIVERSALISM

Scotland has a tradition of designing and investing in universally applicable programmes and services. Universality has the desirable social goal of not treating particular sub-groups as socially excluded. While this ensures that everyone in Scotland benefits from policies and services it does not sufficiently address inequities across the social gradient. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage.

This approach set out in the 2010 Marmot Review for England is known as proportionate universalism [9]. It is entirely possible to have a shallower social gradient in health and wellbeing than is currently the

case in Scotland and certainly the health gradient has steepened in recent years. If it can get steeper, it can get narrower. Change is possible. Indeed, some areas within Scotland have less steep gradients than others.

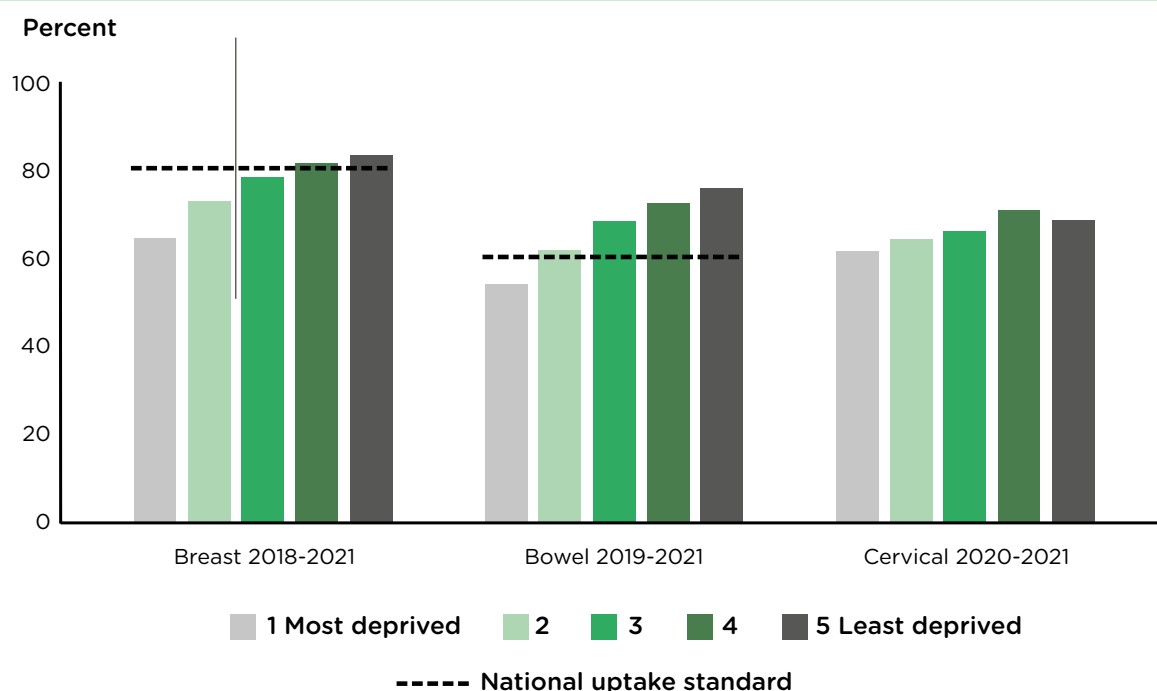
Figure 45. Proportionate Universalism



The gradient in health across Scotland is well recognised and data in Chapter 2 summarises this. Public Health Scotland’s 10 year strategy, Together We Can refers to ‘shifting funding and resources towards those with the greatest needs, that is moving towards proportionate universalism’ [102] [103].

A recent paper sets out the need for greater understanding and implementation of proportionate universalism within healthcare [103]. The paper highlights that universal approaches can inadvertently lead to further inequities, for example in inequalities in access to screening uptake by area deprivation which need to be addressed through a proportionate universal approach, Figure 46.

Figure 46. Screening uptake by deprivation quintile, Scotland, 2018-2021



Source: Public Health Scotland Sources (2023, 2024, and 2025) [103-106]

Notes: 1) The acceptable uptake standard for the Scottish Breast Screening Programme is 70 percent and the achievable standard is 80 percent.

2) There was no national uptake standard for Cervical cancer screening in 2020-2021.

The paper also highlights that targeted approaches, while easier to justify in highly resource constrained environments, do not sufficiently reduce inequities in the social gradient and targeted programmes can be stigmatising, inefficient and vulnerable to cuts as they may not have broad public and political support [103]. IHE have further set out that strict in-out eligibility criteria for services or benefits in social policy, such as free school meal eligibility mean that many people just over the threshold miss out on much needed support and being eligible may lead to stigma and subsequent disengagement from the service provided.

There is still a long way further to go to ensure that proportionate universalism is at the heart of policy and funding arrangements. There is continuing lack of understanding about the gradient in health, what the concept of proportionate universalism means, and how it can be delivered. The CHES programme has sought to create greater awareness among a range of stakeholders and in Aberdeen City to deliver proportionate universal investments.

It is noted that as well as supporting action for greater health equity, proportionate universal approaches would support delivery of existing duties and legislation in Scotland, including the Fairer Scotland Duty (2022), the Human Rights Bill, the Wellbeing and Sustainable Development (Scotland) Bill (2020) [107-109].

Across the UK there have been efforts to embed proportionate universalism in the funding and design of services, but the efforts are still relatively piecemeal,

despite evidence that they can be effective in reducing health inequalities and an efficient way to deliver and resource services. Through the CHES effective proportionate universal approaches have been explored within each place:

- Firstly, by evidencing the health gradient within places and across Scotland there has been acceptance that universal and/or targeted approaches will not sufficiently tackle health inequities. As available resources diminish and need rises allocating funding and services in ways which are proportionate to the scale of need, is the most effective and efficient way to have impact.
- Secondly, summarising evidence of effective proportionate universal approaches from a range of sectors across the UK provided places with ideas for possible ways forward
- Thirdly, by testing out practical routes to embedding proportionate universalism in Aberdeen City it has been shown to be technically possible through commissioning.

Through the CHES Aberdeen City have had a sustained focus on developing proportionate universalism in their strategic plans, and commissioning strategies. The Council have secured the support of political leadership and Council officers and proportionate universalism is embedded in the 2026 LOIP and Locality Plans as a core principle and one of the key measures of success for the plan is the reduction of social gradient [12].



“We are committed to providing strong universal services for everyone in Aberdeen, while ensuring that additional and targeted support is directed to those who need it most. By improving outcomes across the city, while improving them fastest for those experiencing the greatest disadvantage, we aim to reduce inequality and create a fairer Aberdeen where everyone can thrive, regardless of background or circumstance.” [12]

The plan further states that:

“Through the delivery of system change and community action, we aim to reduce inequalities across the social gradient, improve overall outcomes and close the gap between communities, fulfilling our vision of a fairer city in which ‘where everyone can thrive regardless of background or circumstance.’ [12]

Aberdeen City Council is using investment in playparks to explore how services and community assets can be planned in a fairer, more evidence-led way. The purpose is to support fairer decisions by building health equity into everyday planning and investment processes. It responds to a practical challenge: how can decisions about universal services and community assets be influenced so that they actively contribute to reducing health inequities?

The work applies the principle of proportionate universalism in decisions about local investments. By linking the Play Sufficiency Assessment, the emerging Play Strategy, prioritisation criteria, resource allocation proposals and Power BI mapping, Aberdeen City have developed a practical tool to support proportionate universal decision-making. The approach will likely be extended to the other investment decisions to strengthen impact across the gradient.

The analysis is intended to influence live planning and budget decisions by helping the Council move from a general commitment to equity by developing a methodology for identifying priority places, testing investment options and allocating resources in line with assessed need. The approach has led to a clear explanatory framework and visualisation for policy makers and politicians to support the often difficult process of investment decisions in a context of limited resources.

The approach in Aberdeen City is summarised in Box 11, drafted by Aberdeen City Council and PHS for the CHES Learning System, and shows local partners can apply proportionate universalism in practice. It offers learning for other areas seeking to turn health equity commitments into practical action and demonstrates how together local data, national expertise and Council decision-making together support equity aligned action on the social determinants of health and wellbeing.

Box 11. Aberdeen City - Applying proportionate universalism to their play strategy

The approach focuses on playparks because play is important for children's health, wellbeing and development, and as community spaces should be accessible to all children and families. By combining information about playparks, local areas, population health and inequality, Aberdeen City is developing an equity focused approach for deciding future investment in playparks and explaining those decisions transparently to members, communities and partners.

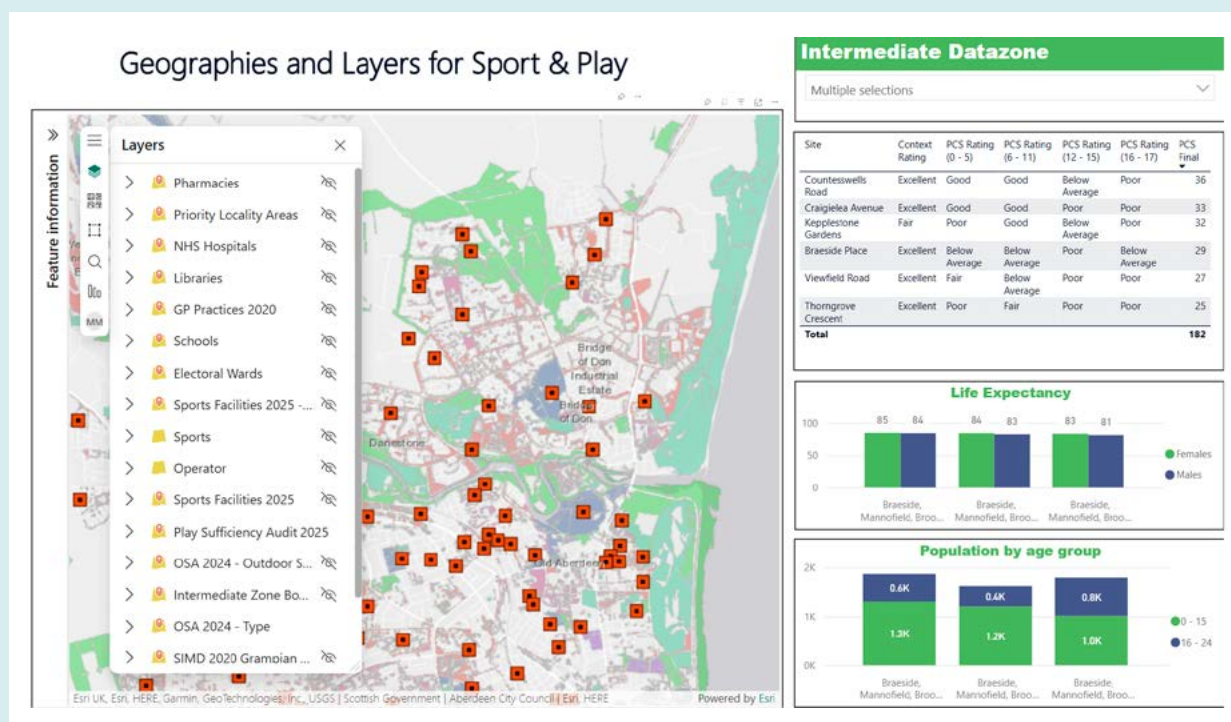
The work involved Aberdeen City Council, the Health Determinants Research Collaborative Aberdeen (HDRCA), the IHE, PHS and the wider CHES programme. Partners contributed expertise in equity needs assessments and data analysis, planning and evidence about the benefits of play. Council planning processes and committee decisions provide an important route for turning evidence into recommendations for future investment. Partners began by considering what proportionate universalism means in practice. To make the concept easier to use, the work focused on decisions which were in train.

Bringing together play and health information

Investments in playparks offered a clear opportunity to test proportionate universalism. Following Aberdeen City Council's first Play Sufficiency Assessment, the Council was asked to refresh a Play Strategy and return with recommendations for future action and investment [110, 111]. The Play Sufficiency Assessment considered the quantity, quality, accessibility and inclusiveness of formal play spaces, alongside the importance of informal spaces such as parks, woodland, beaches and open spaces. It highlighted variation in sufficiency between wards, gaps in quality and accessibility, and the need to understand different play needs by age, ability and community context.

In order to strengthen consideration of potential equity impacts, the team combined information from the Play Sufficiency Assessment with local data including demographic information, levels of area deprivation, rates of child poverty, levels of child health and development, life expectancy and access to open space, schools, libraries and other community assets. Bringing these sources together helped build a more rounded picture of local play environments: not just whether a playpark exists, but who it serves, how accessible it is, what wider assets are nearby, and whether the surrounding community experiences higher levels of need.

Power BI mapping is being used to make this evidence visible and usable. The mapping brings playpark locations together with intermediate zones, data zones, schools, open spaces, community facilities and health equity indicators. This allows officers and partners to view play sufficiency alongside local need, compare places consistently, and identify where small-scale improvements, accessibility upgrades or wider neighbourhood interventions may have the greatest equity and preventative benefits.



Developing a play health equity score

Aberdeen City Council worked with IHE to select measures to include which are important for health and health equity. These measures are being combined for small local areas to create a play health equity score.

The measures cover three broad areas:

- Local social and economic conditions: average SIMD rank; number of children in low-income families.
- Early years and child health: exclusive breastfeeding at 6–8 weeks; healthy weight in Primary 1; developmental concerns at 27–30 months; healthy birth weight.
- Wider health and community indicators: female life expectancy; male life expectancy; youth antisocial behaviour.

The HDRC undertook an evidence review of ‘features of the built and natural environment that influence children’s outdoor free play’ to support the design of interventions. Each measure was scored and combined to give an overall picture for each area. Weightings were added to the measures to reflect their relative impact. The score is intended to support recommendations for playpark investment and help assess whether proposed decisions reflect local need.

The score will sit alongside, rather than replace, professional judgement, community engagement and the findings of the Play Sufficiency Assessment. The scores value is in providing a consistent starting point for prioritisation: identifying areas where poorer play sufficiency overlaps with higher levels of child poverty, poorer health outcomes, and other indicators of disadvantage.

Using prioritisation criteria to inform investment

The approach supports resource allocation decisions. Rather than treating playpark investment as individual asset repairs, the evidence can be used to shape a programme of investment over time that aligns to the Play Strategy and supports greater health equity. This includes identifying priority locations for early visible improvements, testing targeted interventions in high-need areas, aligning capital investment with maintenance requirements, and making the case for revenue capacity where community engagement, co-design, play champions or evaluation activity are required.

Resource allocation proposals can therefore be framed around both fairness and impact: what needs to be maintained for everyone? What needs to be improved first because the evidence shows greater need, and what can be tested through short-term pilots before being scaled across the city? This creates a stronger link between the Play Strategy, the Play Sufficiency Assessment and future budget decisions and the overall strategic priorities for greater health equity and greater equity among children and young people.

Emerging learning

The case study highlights the value of embedding equity considerations and concepts in real decisions. Proportionate universalism became easier to understand and apply when it was connected to practical choices, such as where to improve playparks, how to phase investment, which criteria should guide prioritisation, and how resources should be allocated when demand exceeds available funding.

It also shows how health equity can be built into everyday planning and resource allocation decisions. Local data can make differences between areas and households more visible, while Power BI mapping helps officers and partners see those differences visually and discuss them using a shared evidence base. Council decision-making processes then provide a route for turning that evidence into recommendations about services, assets, maintenance, pilots and investment and into resource allocation decisions.

The approach has potential beyond playparks, with the same principles able to support decisions about other universal services and community assets.

Next steps

The next stage is to refine the play health equity score, testing how sensitive the results are to different assumptions. The score will be used alongside the Play Sufficiency Assessment, Play Strategy priorities, community insight and professional judgement to support recommendations for future playpark investment and to assess whether proposed decisions match local need.

The resource allocation work will then translate the evidence into options for decision-makers. This could include a citywide baseline maintenance approach, a targeted programme for priority neighbourhoods, a small number of test projects in high-need areas, and proposals for revenue support where engagement, co-design, delivery coordination or evaluation are required.

Further work will explore how this health equity approach can support long-term housing planning. This includes considering how investment can be planned over time, alongside annual decisions, within a 30-year plan.

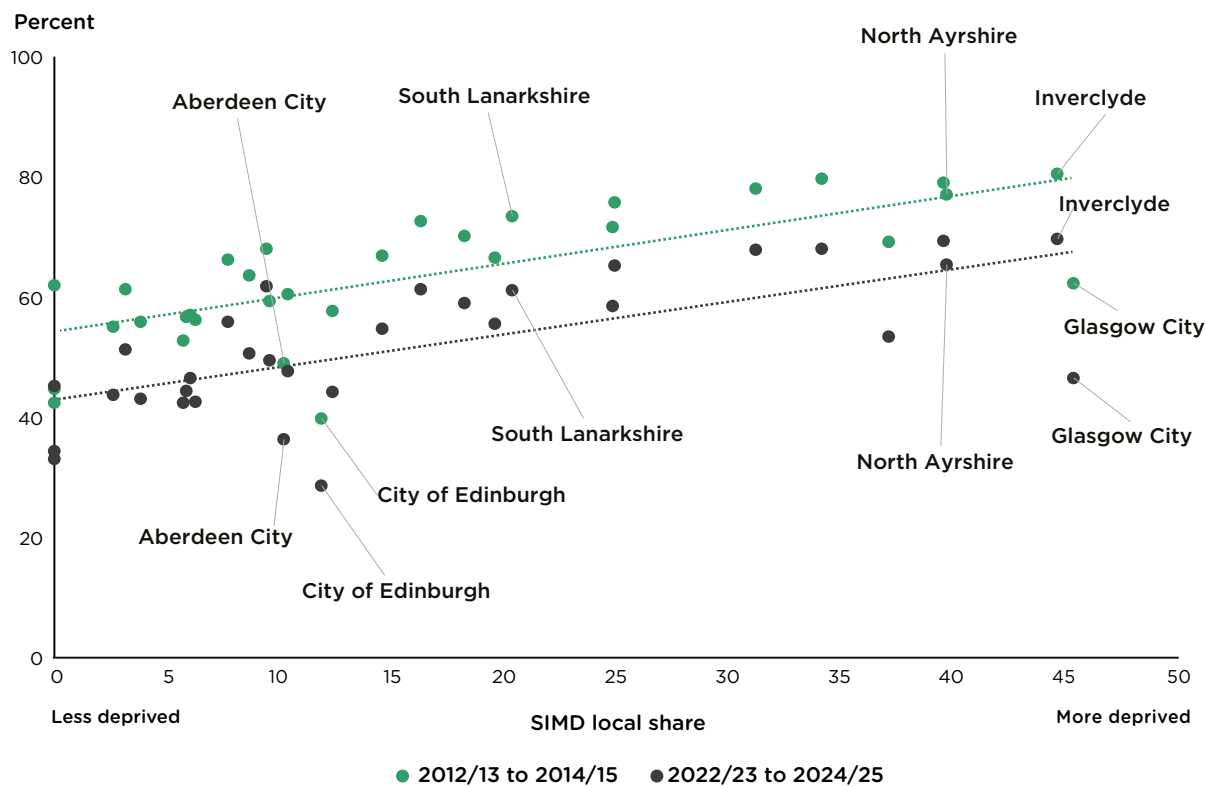
Source: Aberdeen City Council & Public Health Scotland through the CHES Learning System



While not a part of the CHES programme the importance of proportionate universalism as a principle is evident in reductions in inequities in breastfeeding within North Ayrshire and South Lanarkshire. There are a range of positive long-term health and development impacts from breastfeeding and reducing inequities in breastfeeding support efforts to reduce inequities in health and social determinants of health in the longer term.

Figure 47 shows that babies are more likely not to be breastfed at 6-8 weeks in more deprived Councils in Scotland and that there is a gradient in breastfeeding. The graph also shows two comparison time periods, 2012/13 – 2014/15 and 2022/23 – 2024/25. Between the two periods there has been a reduction in the proportion of babies not being breastfed at 6-8 weeks in every Council, although inequities related to the level of deprivation persist.

Figure 47. Babies not being breastfed at 6-8 weeks (SIMD Local Share), Scottish Council Areas, 2012/13 to 2014/15 and 2022/23 to 2024/25

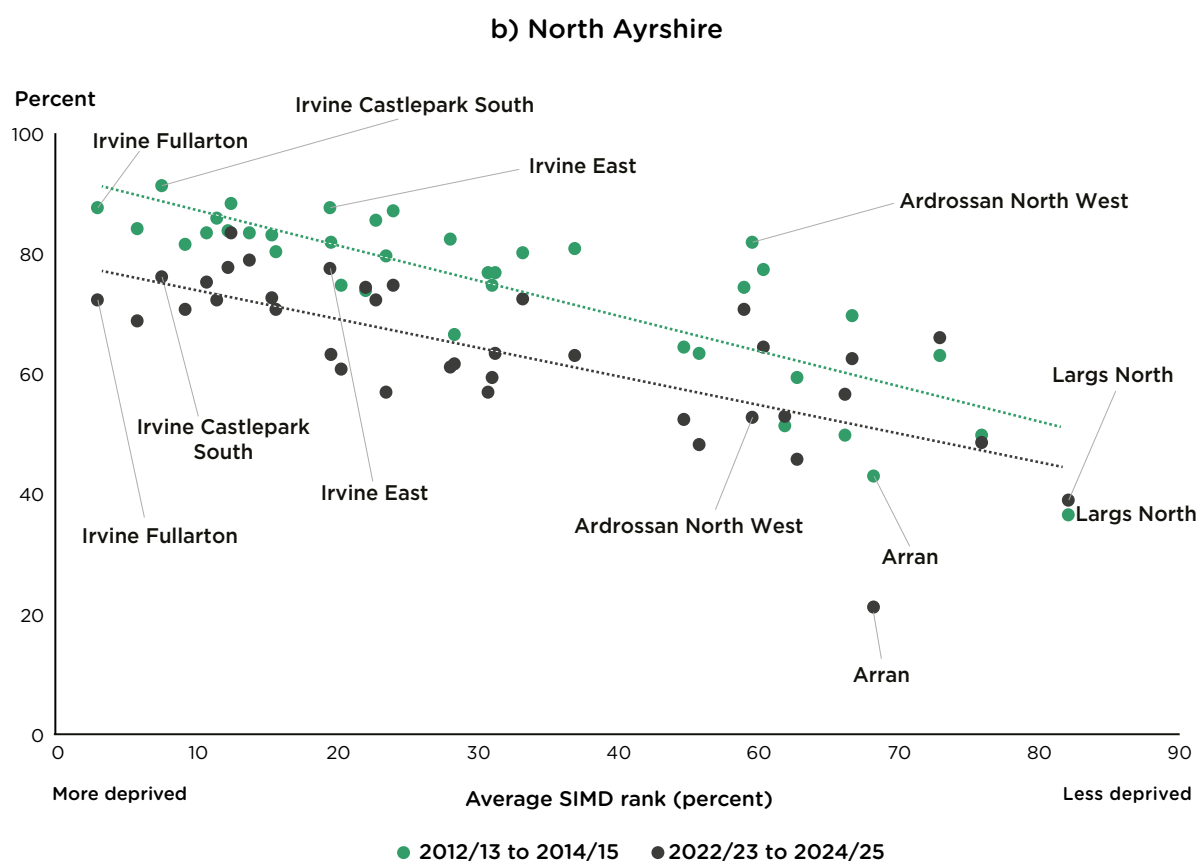
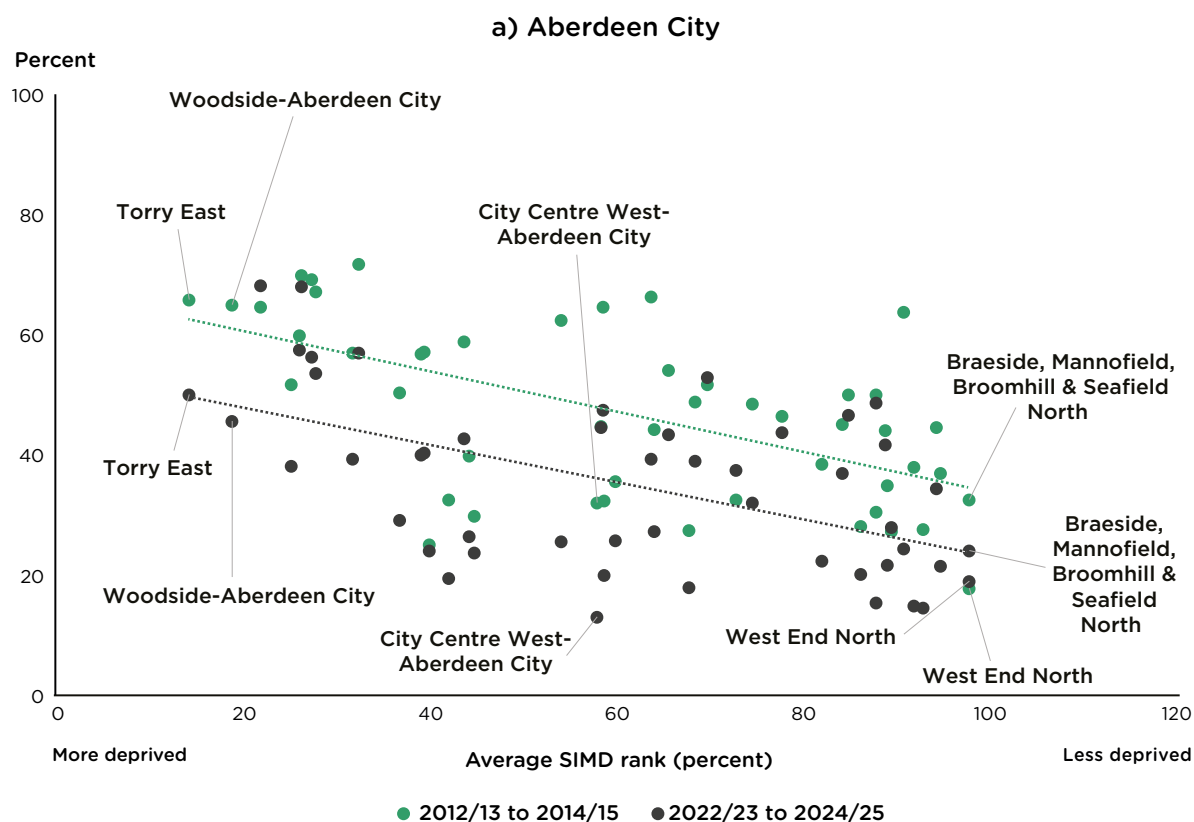


Source: Public Health Scotland (2025) [112]

Data from CHES highlights changes within two of the collaborating places. Within North Ayrshire and South Lanarkshire there have been overall improvements in breastfeeding rates and inequities in rates of breastfeeding have decreased between 2012/13 to 2014/15 and 2022/23 to 2024/25 - the gradient is flattening. This is testament to the work

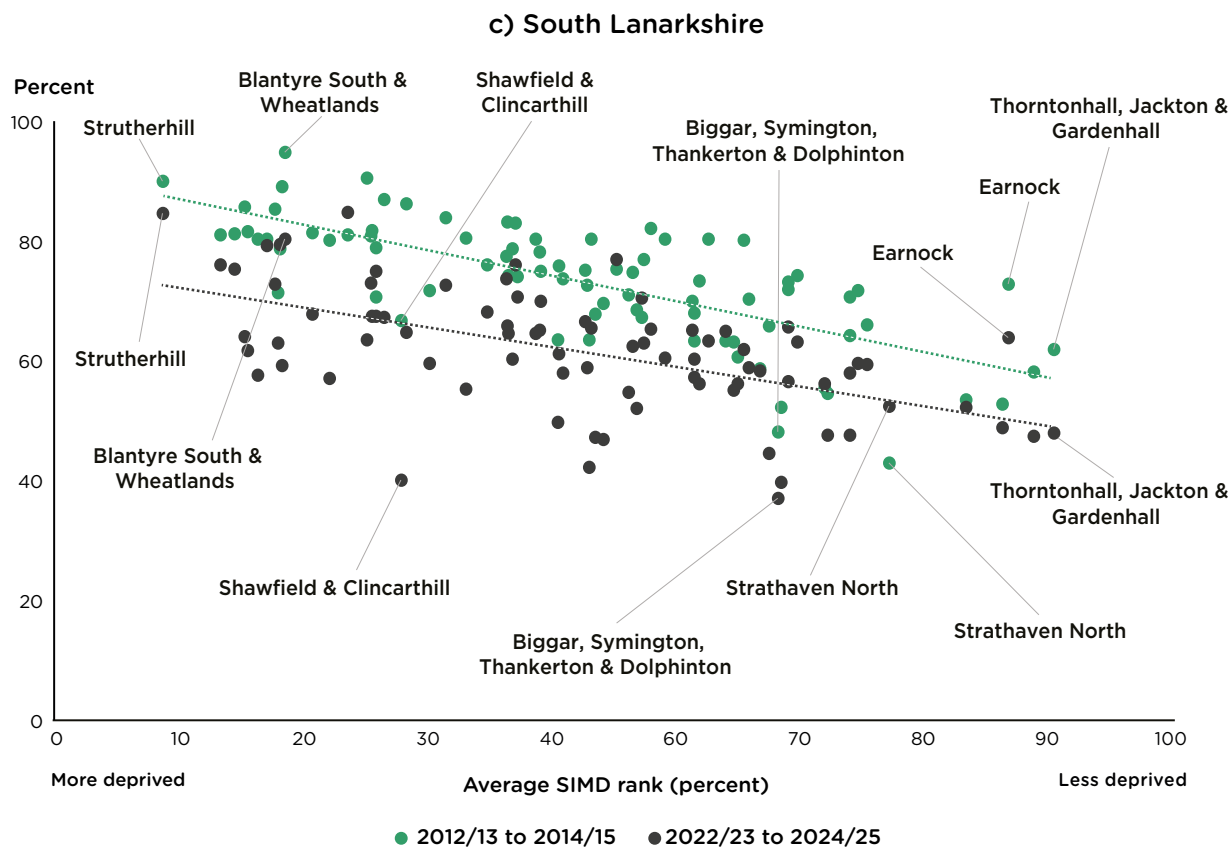
within North Ayrshire and South Lanarkshire to support breastfeeding, with a universal approach but with greater focus on more deprived areas. The patterns of the improvement indicate a proportionate universal approach – universal improvements but greater improvements in more deprived areas.

Figure 48. Babies not being breastfed at 6-8 weeks (Average SIMD rank), Three collaborating places and their Intermediate Zones, 2012/13 to 2014/15 and 2022/23 to 2024/25



Source: Public Health Scotland (2025) [112]

A similar pattern of improved rates of breastfeeding and reductions in inequalities is evident in South Lanarkshire



Source: Public Health Scotland (2025) [112]

The CHES recommend that nationally and locally funding allocations investment decisions and the design and delivery of services and support are designed on the principle of proportionate universalism.



THE FUNDING AND DELIVERY LANDSCAPE

One of the main findings from assessments of the funding and delivery landscape in Scotland is that the complexity is undermining impact and increasing cost [101]. Through the CHES it was also evident from community groups and the three collaborating places that the complex funding and delivery processes are often inefficient, lead to competition within and between sectors, deplete capacity and resources and weaken local areas’ ability to provide services and offer support in ways which local communities have indicated are needed.

NATIONAL AND LOCAL PRIORITIES

Places indicated that programmes which are designed and determined nationally can lead to competing priorities, a lack of community engagement or even an overriding of community priorities as the criteria for eligibility and delivery are set nationally. While none of the places in the CHES were in a financial position to reject any additional investments provided by the UK and Scottish Governments, the funding tended to be provided with conditions about what available resources could be spent on and which geographic areas should be prioritised; these were not always aligned with local priorities which had been developed through the CPP.

In the introduction to this report, we highlighted that the Marmot 8 framework provides a consistent, strategic set of principles for greater health equity which if adopted nationally and locally would provide a coherent route for investments and programme delivery, help identify any gaps and help places prioritise locally with support from national organisations. Across the UK Marmot places identify priorities in the Marmot 8 Principles based on data and community engagements; these shape their approaches to reducing health inequities and align with other local programmes and strategies, ensuring greater strategic and delivery coherence. Scotland has the opportunity to use the Marmot 8 framework through the CPPs and nationally to help reduce the complexity of the strategic and delivery landscape.

TOTAL PLACE APPROACHES

Communities and residents highlight that having many, often short-term programmes running separately but simultaneously in local areas is confusing and can lead to disengagement from services as residents have to navigate and repeat information about their lives. In Scotland the CPP process supports ‘total place approaches’ to some extent, but there are ongoing issues around funding and delivery due to siloed organisational and sectoral delivery, ring fenced programme budgets and funding and contracts for Third Sector organisations

which can drive competition between voluntary sector organisations rather than collaboration. Nonetheless the CPP provides the collaborative governance and decision-making structure and shared outcomes to support total place ambitions.

Total place pilots in England were established in 2009 to test out ways to overcome some of the issues arising from complexity in funding routes, which have also been highlighted through the CHES. The pilots which ran in 13 places in England mapped out funding available via a range of public services in order to identify duplication and inefficiency, Box 12.

Box 12. Total place funding

The Total Place pilots tried to better integrate services so they could work collaboratively and design services around residents expressed preferences about the types of support needed. Total Place pilots ended in England after 2010 following a change of national government. However, the newly established Mayoral Strategic Authorities in England will build on the approach to develop place-based budgets, pooled between several public services. The Institute for Government have made the case for Total Place 2, including provision of some funding to manage the process, reducing the number of small, usually short term and tightly ring-fenced funding pots, by making progress on data sharing across Government to support place based decision making and by supporting regulators to take a more place based and holistic approach to inspections [113].

There are several potential steps to enhancing CPPs total place funding and delivery systems, led by the CPP with support from national governments. North Ayrshire has ambitions to develop a place budget, which would enable them to receive funding and disperse according to local priorities and assessments of inequities, Box 13.

Box 13. North Ayrshire - Place-based budget and decision making

North Ayrshire are championing a move towards total place funding to help them reduce duplication, inefficiency and more effectively prioritise places and communities who are experiencing particular disadvantage and poor health. Through participation in CHES and associated programmes such as Whole Family Support, North Ayrshire are looking to further strengthen their response to challenges such as high levels of deprivation, deepening inequities post-pandemic and low and deteriorating financial resilience among residents. They are deploying creative funding approaches such as their Child Poverty and Early Intervention Fund, which incentivises greater collective leadership across the CPP and stronger partnership delivery, as well as promoting innovation and capacity building. In parallel, initiatives such as a newly-integrated Children and Families Plan also put joined-up and integrated support at the heart of service delivery.



Alongside total place budgets, health equity in all policy approaches can help to sustain focus on health equity. This may be organised through a Health Equity Prevention Fund in each place, that is a multi-year, deprivation-weighted grant to local authorities and CPPs that integrates existing silo funding.

Scotland has a strong commitment to health in all policy approaches to tackle health inequities through action on the social determinants of health and Public Health Scotland has expertise in health impact assessments [114].

Richmond, California, provides an example of how a local government can embed and institutionalise Health in All Policies (HiAP) to tackle health inequities through action on the social determinants of health. For over a decade Richmond has embedded health equity into decision-making across municipal government departments, recognising that planning, housing, transport, parks, economic development and environmental policies all influence population health. The case study highlights the importance of political leadership, cross-sector governance and community accountability in sustaining a long-term approach to reducing health inequities [115, 116].

Richmond demonstrates that reducing health inequities requires more than isolated public health programmes and demonstrates how strong political leadership, formal governance arrangements, sustained cross-sector collaboration and meaningful community accountability can embed Health in All Policies across

local governments. By treating health equity as a responsibility shared by all sectors and focusing on the social determinants of health, Richmond has created a framework for improving population health has been sustained for more than a decade after the HiAP ordinance was first adopted, Box 14.

Box 14. Richmond, California - Health in All Policies approach

Richmond's Health in All Policy Approach (HiAP) developed over time, rather than through one single policy initiative.

Leadership and governance

The process began by integrating health equity into the city's General Plan through the Community Health and Wellness Element in 2005, which established health as a planning objective rather than solely a healthcare responsibility. This was followed by neighbourhood-based initiatives addressing violence prevention, community safety and environmental quality, enabling planners to demonstrate how improving local environments could reduce health inequities.

Three actions before HiAP:

1. Create the Richmond Health Equity Partnership (RHEP) to bring together non-medical agencies and civil society to implement health element. Included the school district, youth advocacy groups, environmental and conservation groups, etc.
2. RHEP led the creation of a 'health equity report card' for Richmond, including outreach to the hospital and care systems for data.
3. Pilot implementation of neighbourhood project in the most vulnerable area called Pogo Park. Revitalised abandoned park and 'rails to trails' greenway, with community-led design and implementation of the new green space.

Building on these early initiatives, city leaders, planners, public health professionals, community organisations and researchers (the RHEP) worked collaboratively to develop a city-wide Health in All Policies Strategy. Their work led to the adoption of Richmond's HiAP Ordinance, creating one of the first municipal legal frameworks in the United States requiring health equity to be considered across all areas of local government [117]. Rather than establishing a standalone public health programme, health equity considerations were embedded into planning, budgeting and decision-making across sectors including housing, transport, economic development, parks and environmental management.

An evaluation found that implementation was sustained through the creation of a dedicated institutional structure within local government responsible for coordinating HiAP, developing partnerships across sectors and supporting departments to integrate health equity into routine practice [115]. This institutionalisation of HiAP enabled the approach to continue beyond individual political or organisational leaders.

Prioritising health equity and the social determinants of health

Richmond's approach was explicitly designed to improve place-based determinants of health by addressing the underlying social, economic and environmental conditions that contribute to health inequities. The strategy recognised that factors such as neighbourhood quality, housing, transport, employment opportunities, access to parks and environmental conditions have a greater influence on health outcomes than healthcare services alone.

Implementation focused on developing policies and programmes that promoted healthier neighbourhoods while reducing structural inequities experienced by Richmond's predominantly Black, Indigenous and People of Colour communities. The HiAP approach therefore shifted attention upstream, encouraging every city department to consider the health and equity implications of its decisions.

Community accountability

Community accountability was central to Richmond's model and distinguished it from more traditional approaches to local planning. Local residents, community organisations, schools, public health agencies and

researchers were involved throughout the development of the HiAP Strategy. Richmond adopted a process of co-production, bringing together community knowledge, scientific evidence and government expertise to jointly define priorities, develop policies and identify measures of success.

Rather than relying solely on routine health statistics, Richmond worked with community stakeholders to identify indicators that reflected local priorities and the lived experience of residents. Locally collected data was used to monitor progress on neighbourhood conditions and other social determinants of health, enabling both government and community organisations to assess whether policies were contributing to greater health equity. This collaborative approach strengthened transparency and ensured that accountability was shared between government and communities.

Impacts

Richmond's HiAP Ordinance utilised five publicly tracked indicators to monitor population and place-based health equity drivers, using data from the Richmond Community Survey. The indicators measured residents' perceptions of overall quality of life, Richmond as a good place to live, neighbourhood quality, government openness to resident involvement in decision-making, and community openness towards people from diverse backgrounds.

All five indicators improved between 2013 and 2019: the proportion rating overall quality of life as "good" or "excellent" increased from 30 percent to 38 percent; Richmond as a place to live from 36 percent to 48 percent; neighbourhood quality from 53 percent to 66 percent; government openness to resident involvement from 31 percent to 47 percent; and community openness and acceptance towards people from diverse backgrounds from 47 percent to 56 percent [115].

The Iron Triangle neighbourhood in Richmond was the unhealthiest in Richmond. Between 2015 and 2019, almost all 12 health-equity related indicators improved among residents. These covered housing, food, recreation, education, environment, racial/ethnic inclusion and participation in decision-making. However, the neighbourhood did not reach the study's target of 75 percent positive responses.

The percent of Iron Triangle residents with high blood pressure, mental illness, diabetes, heart disease and stroke all were trending downwards between 2016 and 2019, although rates of asthma did not decrease [118].

In 2009, Richmond created a gun violence reduction programme within the city called the Office of Neighbourhood Safety (ONS), a 2019 study of the ONS concluded that the programme was responsible for a 55 percent reduction in gun and homicides and assaults [118].

A strategy in Richmond's Climate Action Plan included a programme for low-income households to receive free roof-top solar energy. As of 2019, 1,718 new roof-top photovoltaic solar energy systems had been installed on low-income households at no cost, and a solar array, or farm, was created in Richmond to deliver free energy to 155 low-income renters that were not candidates for roof-top solar [115].

Richmond's Fair Rent and Just Cause for Eviction Law was formulated as a result of HiAP and led to the establishment of a Rent Control Program in 2017. The programme was created to stop displacement of low-income residents and incentivise new affordable rental units. By 2019 there were 19,418 units within the rent control programme [115].

Richmond's adoption of HiAP has led to establishment of new institutional arrangements that support the implementation of Health in All Policies [115, 116]. Key institutional impacts identified include:

- Embedded health equity within the governance structures of local government
- Established long-term collaboration between city departments, public health agencies and community organisations
- Strengthened the role of planning in addressing structural racism and place-based inequities
- Created new mechanisms for incorporating health equity into routine policy and investment decisions
- Developed locally relevant indicators to monitor progress on the social determinants of health
- Built sustained community participation in policy implementation and evaluation

A combination of total place budgeting and health in all policy approaches underpin the recommendation that a health equity ‘total place’ approach is piloted in phase 2 of CHES. This would bring partners, funding and decision-making together around a shared aim of improving health and reducing inequities across a whole place. Rather than relying on multiple short-term and fragmented funding routes, funding, potentially through a Health Equity and Prevention Fund, would be brought together through a single route and allocated through Community Planning Partnerships. Decisions about investment would be based on local need and deprivation and guided by the Marmot 8 Principles, with longer-term funding and programme arrangements. The approach would also help simplify the fragmented strategic and delivery landscape by embedding health equity across local policies, investments and decision making.

SHORT-TERM FUNDING AND PROGRAMME CYCLES

One of the drivers of complexity in the delivery landscape and contributing to the lack of focus on the social determinants of health is short term funding for programmes.

Evidence repeatedly shows that short term programmes undermine impacts and lead to dysfunctions in delivery. Short term funding:

1. Means it is often impossible to demonstrate impact on health and the social determinants of health which take time to show. This undermines both the potential impacts and weakens the case for investment in the social determinants of health. The CHES assessment of potential impacts, Box 8, on health equity from early years interventions, for instance, indicate that these have strong positive impacts for health equity but take a lifetime to demonstrate full returns [13].
2. Leads to rapid turnover of programmes and those which are impactful, appreciated and well-used by communities often end due to short funding cycles. This can exacerbate mistrust in services and the feeling that nothing works to help people.
3. Is difficult for organisations to manage. Third Sector organisations repeatedly state that much of their resource and capacity goes into applying for grants and reporting on impacts and that they are unable to maximise the potential benefits of the support they provide.
4. Is inefficient; much of the funding is allocated to designing and establishing programmes and then winding them down before they have time to be impactful.

The 2025 Public Service Reform Strategy reaffirmed the importance of prevention but acknowledged that systemic barriers, including short-term funding cycles,

siloed budgets, and lack of shared data infrastructure have limited their implementation [119]. As many have before, we recommend funding to be multi-year and without the onerous impact reporting and demands for returns on investment which may take years to show.

To meet these pressures in UK wide Marmot Places, changes are often implemented in a 3 stage but simultaneous process. Firstly, accelerator programmes with immediate impact, often with a relatively narrow reach, medium-term programme and implementation operations and thirdly longer term structural and system shifts which support action on social determinants of health and health equity for the long term.

Four yearly, or shorter, political cycles contribute to frequently shifting priorities, and it is important to recognise and lead the cross-party support which is needed, to move towards longer term investments and programmes for health equity.

COMMISSIONING AND PROCUREMENT FOR HEALTH EQUITY

Commissioning and procurement processes often limit opportunities for effective, long term investments in the social determinants of health. Commissioning cycles are often relatively short term and require demonstration of impact, however, investments in the social determinants of health can take many years to show impact. Multiyear and flexible funding is needed to support investments in prevention and the social determinants of health, supporting organisations to develop programmes with local communities and deliver outcomes over the long term.

More strategic, long-term and collaborative commissioning approaches can improve resource use and deliver greater impact through coordinated planning and there are positive examples of integrated commissioning involving health and social care organisations collaborating towards shared outcomes. In Scotland this is led by the Integration Joint Boards which develop Strategic Commissioning Plans. Beyond Health and Social Care services, CPPs involve strategic planning and delivery involving a range of public sector bodies and Third Sector organisations through Local Outcome Improvement Plans.

Strategic commissioning needs to ensure coherence between organisations and between national and local programmes. While the benefits of collaborative commissioning are well established in Scotland, equity focussed commissioning has been relatively weak. As set out in Box 15, Aberdeen City have developed a tool to strengthen equity focussed commissioning.

There are many places and organisations which have adopted community wealth building approaches in Scotland. The NHS Anchor Institution Programme has

been supporting NHS Boards to embed Community Wealth Building pillars, Box 15. Many Local Authorities have also adopted the approach including North Ayrshire. The Community Wealth Building (Scotland) Act 2026 offers further opportunities for directing investments and spend locally and for reducing deprivation through public procurement and the extension of anchor organisation approaches [120].

Box 15. Community Wealth Building in Scotland

There are five core pillars:

- Public sector procurement to focus on local organisations for supply chains
- Prioritising fair pay
- Managing physical assets to support local environmental, social and economic value, including through community asset transfers
- Inclusive ownership of organisations including employee and community owned organisations
- Building local and regional financial systems to benefit communities

Public Health Scotland have assessed positive potential impacts on health equity stating that:

“The Health Impact Assessment concluded that CWB has significant potential to benefit health, help reduce health inequalities and achieve other positive outcomes. CWB should be recognised as a positive public health intervention as well as an economic approach.” [121]

Procurement and grant giving are frequently onerous and time-consuming processes. Often, Third Sector organisations do not have sufficient capacity to apply or have to devote a significant proportion of their resources to meeting the requirements, rather than provide the support they are set up to deliver. Further, most grant giving and procurement processes lead to competition rather than collaboration between organisations and sectors. Procurement which invites collaboration is beneficial for applicants and for impactful delivery. Procurement and grant giving must be simplified to enable Third Sector organisations to collaboratively deliver support without wasting their resources and capacity.

The North Ayrshire Community Investment Fund offers a route for Third Sector organisations to deliver on the social determinants of health, Box 16.

Box 16. North Ayrshire - Community Investment Fund

The North Ayrshire Council Community Investment Fund (CIF) is a grant scheme designed to help local Locality Partnerships address specific priorities in their areas. The CIF supports community-led regeneration projects that tackle inequalities in North Ayrshire such as financial deprivation, poorer health outcomes, social isolation, reduced employability, limited access to good food, or reduced access to services. CIF grants are tailored to local needs across the six localities: Arran, Garnock Valley, Irvine, Kilwinning, North Coast, and Three Towns. Some examples of local projects the CIF has supported include Millport Town Hall, Irvine Beach Park, and Radiocity’s wind turbine. These regeneration projects were all shaped by local input, while participatory budgeting is used as a tool for community-led decision-making.

SUMMARY AND RECOMMENDATIONS

This report has emphasised that inequities in power, money and resources shape health equity and affect the implementation landscape in Scotland. This means that delivery and implementation of programmes tends to reproduce or, at best, insufficiently dismantle structural inequities. Due to these persisting structural inequities, national and local funding and delivery arrangements do not always support local action for greater equity, despite the widespread acceptance of the need for action. We note that universal, or targeted services, fragmented, siloed funding and short term, crisis-oriented delivery and some commissioning approaches are not set up to deliver effective action to improve health equity and reduce demand on services. They can in fact, actively undermine health equity and weaken the routes to better health and health equity, wasting scarce resources which could be better invested elsewhere and further excluding and reducing trusts with communities who need the support.

Based on the insights from CHES and the work of the three collaborating places, we recommend the development of programmes and funding routes which are based on proportionate universalism. We recommend simplifying the delivery landscape through the adoption of the Marmot 8 Principles as the national and local strategic framework and adopting a health equity 'total place' approach to funding and delivering programmes. Short term funding and programme cycles often mean that support is not given sufficient time to meet potential and constant changeover is challenging for those involved in delivery and for communities who see a rapid turnover of programmes, including of those most valued. Commissioning and grant giving processes need to be simplified to reduce the onerous processes and demand for data and evidence which is often unobtainable in short term programmes and for organisations with limited resources.

RECOMMENDATION 4:

STRENGTHEN THE DESIGN AND DELIVERY OF POLICIES AND PROGRAMMES

ENSURE POLICIES AND RESOURCES ARE UNIVERSAL AND PROPORTIONATE TO LEVEL OF DISADVANTAGE



Assess policies for equity impacts and make the case with the public

Build evidence and technical capacity to implement, commission and deliver proportionate universalism

BUILD STRATEGIC COHERENCE



PHS to assess policy and programme delivery for complexity and simplify accordingly

DEVELOP HEALTH EQUITY 'TOTAL PLACES'



Extend whole system, total place funding through a Health Equity and Prevention Fund

Strengthen health equity in all policy approaches

Embed proportionate universalism

Implement accelerator programmes alongside longer term programmes for structural shifts

MOVE FROM SHORT TO LONG-TERM PROGRAMMES AND FUNDING



Build public and political expectations about long-term progress for health equity

Develop programmes, targets and funding on 10 year cycles

Simplify procurement and grant giving processes

CHAPTER 6

PRIORITISING HEALTH EQUITY

Greater health equity must, as we set out in Chapter 1, be at the heart of UK and Scottish Governments, as it must for Councils and other stakeholders. In order for this to happen, there needs to be stronger organisational and political leadership for action supported by greater accountability and targets for health equity at national and local levels. In Scotland, ambition is strong, articulated in strategies, supported by boards and collaborations which, while important have not always delivered the intended actions.

There must also be greater capacity. The work of CHES continues and practical learning and evidence about strengthening place-based action builds, however, there are capacity and resource constraints. Building capacity and leadership among different sectors and supporting innovative local approaches will enhance action for health equity. It is well recognised that strong partnerships are required to deliver action on the social determinants. Businesses and health care must be centrally involved. They have potential, which is underdeveloped, to contribute more to improvements in the social determinants of health.

GOVERNMENT DUTIES AND ACCOUNTABILITIES FOR HEALTH EQUITY

The Scottish Government has articulated strong commitment to improving health and reducing health inequities and NHS Boards and Councils have general duties to protect and improve health. Health inequality duties in Scotland are legal obligations requiring public bodies, such as the NHS and local Councils, to actively reduce unjust differences in health outcomes. These duties are primarily enforced through the Fairer Scotland Duty and the Public Sector Equality Duty [107, 122]. However, these duties lack legal enforcement mechanisms and measurable targets and are often seen through the lens of equitable access to services, which is important but does not include action on the social determinants of health and, even if effectively applied do not tackle the structural drivers of health inequities.

LEGISLATION AND CROSS-GOVERNMENT ACTION

Building on the CHES and the identified need for stronger accountabilities, we propose strengthening existing legislation, with enhanced scrutiny for health equity and enforceable accountabilities nationally and locally. These to be underpinned by a national health equity strategy, overseen by a cross government cabinet-level committee responsible for the development of recommendations in this report and progress towards targets for health equity set out below.

At Council level the cross-sector collaborations, developed through CPPs facilitate partnership approaches for action on the social determinants but also tend to have relatively weak and diffuse accountability to deliver and there is variation between Councils. The recommendation for a cross-Government, cabinet level group to ensure prioritisation, oversight and whole of government approach to tackling health inequities has also been recommended by other organisations concerned with health equity in Scotland and across the UK [123, 124]. The approach should also apply to Council accountabilities.



ACCOUNTABILITIES FOR HEALTH EQUITY

The Scottish Government and the Convention of Scottish Local Authorities (COSLA) have jointly developed an approach to improving health and reducing health inequities through Scotland's Population Health Framework 2025-2035 [78], which sets out an ambition to address the social determinants of health and embed prevention in public services to support better health. The framework includes a target to reduce health inequalities, which while helpful is not as ambitious as IHE would advocate.

The framework includes a route *'to strengthen collective accountability for population health outcomes and inequalities based on a shared vision and encourages a range of partners and communities to accept joint accountability and commit to delivering together'*. While the ambition is positive the mechanisms for accountability are relatively weak and rest on shared objectives and data which do not necessarily translate into monitoring and accountability for delivery [123]. Without clear accountability action on the social determinants of health equity slips down the long list of priorities.



A NATIONAL TARGET FOR GREATER HEALTH EQUITY

The Population Health Framework sets out a national aim by 2035 to improve Scottish life expectancy whilst reducing the life expectancy gap between the most deprived 20 percent of local areas and the national average [19]. While this ambition is important, the target has several limitations:

- The improvement in life expectancy is not specified and the reductions in the life expectancy gap could be achieved by improving the health of the bottom 20 percent without raising the overall gradient, and in fact could be achieved by reducing average life expectancy
- The bottom 20 percent of areas contribute to the national average and this creates a moving target (the national average) the progress of which depends partly on success in improving life expectancy in the bottom 20 percent. This makes it difficult to set local inequity strategies – the more successful they are, the further away the target moves and they cannot set a fixed goal.
- Health is based on individuals and hence the populations to which they belong, not on numbers of areas. For this reason, the equity target should be reframed in terms of small areas that contain 20 percent of the most deprived populations and not a count of 20 percent of areas. The current ambition encourages 'gaming', by focusing on the 'low hanging fruit', that is areas with smaller numbers of the population who are deprived. The result of this will be to reduce the overall population impact and hence 'hit the target but miss the goal'.

A strengthened, explicit ambition for greater health equity, with challenging but achievable targets to raise and flatten the gradient through reducing inequities in the social determinants of health, based on the principles outlined in this report needs to be developed.

We propose a new target based on reducing the slope index of inequality to tackle the whole population gradient in health and not just the bottom quintile of area. The target reflects ambitions for 80 percent of the population to have improvements in health, with measurable greater improvements for more deprived population deciles. This would underpin the national ambition for equity of health and wellbeing to be at the heart of Government.

LEADERSHIP AND CAPACITY FOR HEALTH EQUITY

Much of the positive impact of the CHES has come through strong leadership at all levels with significant contributions from PHS, Councils, healthcare and the Third Sector.

PHS had an important convening role in the CHES, supported the data work, established the national data group and the CHES learning system to share evidence, progress and key messages with other places and stakeholders. PHS has championed local innovation through the CHES and supported the flow of information between national and local places to begin to address the implementation gap. Nationally, there is broad system support and will for action on health equity through the CHES Strategic Advisory Group, which has representation from PHS leadership, Council chief executives and CHES leads, COSLA, IHE, the Third Sector, academics, Health and Social Care partnerships, the Scottish Government and the Health Foundation. Based on the momentum and expertise in this group it is recommended that the group continues through CHES phase 2 and develops as a national Health Equity Board to support and advise the proposed cross-Government health equity committee.

The three collaborating places all had strong commitment to addressing health inequity prior to the CHES, but this has been further strengthened through it. There has been active senior leadership support and programme leads have a willingness and motivation to learn and try new approaches. This type of leadership needs to be in place in every Council, underpinned by accountability and political priorities.

Through CHES there has been a willingness to change and try out new approaches both nationally and locally and those working at operational levels report that they have opportunity and incentive to test new approaches and ways of working. It is the encouraging results from the three collaborating places that provide clear indications on what needs to happen more broadly across Scotland, Boxes 17-19.

Box 17. Aberdeen City - Advice and input into the Local Outcome Improvement Plan (LOIP), Local Housing Strategy and Population Health 5-year Strategy

Aberdeen City reports that the CHES programme has played an important role in ensuring that health and equity sit at the heart of Aberdeen City's strategic planning processes and population health plans set out by NHS Grampian. By providing direct input into both the Local Outcomes Improvement Plan (LOIP) the Local Housing Strategy and population health plans, CHES has consistently supported focus on health equity across these key plans and strategies. Further contributions include the evidence for social determinants of health based on experiences in other areas. These inputs have helped to ensure that Aberdeen City's LOIP is grounded in evidence. The LOIP has also been influenced by community voices, to ensure greatest difference for local people and communities across the city. The CHES programmes engagement and contribution to the LOIP development process helped inform a significant shift in the strategic direction of Aberdeen's LOIP [12].

The revised LOIP moves away from 97 separate improvement projects and instead focuses on five integrated whole-system changes aimed at addressing persistent inequalities and improving outcomes over the next decade. The five main areas identified for action are:

1. Positive destinations for children and young people
2. Fair work and economic stability
3. Poverty and homelessness
4. Connected, greener and sustainable communities
5. Preventable deaths and improved health

The revised LOIP explicitly references the social gradient in health, recognising that health and wellbeing outcomes are shaped by the social, economic and environmental conditions in which people live. The LOIP also adopts proportionate universalism as a core principle, acknowledging that while action should improve outcomes across the city, improvement should happen fastest for those experiencing the greatest disadvantage.

These approaches have informed the design of five system changes, ensuring that action is universal across the population while providing proportionately greater support where levels of disadvantage are highest. By embedding Marmot Principles within the LOIP, the plan places a stronger emphasis on prevention, early intervention and addressing the underlying causes of inequality.

The CHES programme helped to facilitate discussions that helped shape the new whole-system approach, and supported a greater focus on equity, collaboration and long-term outcomes. The resulting governance arrangements provide clearer accountability and stronger integration across partners and localities, creating the conditions for coordinated action and ongoing assurance that delivery is contributing to improved outcomes and a reduction in inequalities over time.

Box 18. North Ayrshire - CHES programme approach

North Ayrshire established a multi-agency CHES Steering Group bringing together partners from local government, health, communities, the private sector and the Third Sector around a shared ambition to reduce health inequalities. From the outset, the programme adopted guiding principles to be data informed and community engagement driven. These sit alongside the double diamond model, which provides a framework to move from understanding local challenges to identifying practical actions and delivery priorities. The approach has helped renew focus on health inequalities across the Community Planning Partnership and better alignment of existing resources, strategies and investment around a shared agenda.

This approach provided consistency between partners, created a shared approach to decision-making and helped maintain focus on health equity as the programme evolved. This structure has enabled the programme to adapt and respond to emerging opportunities while retaining a clear strategic direction.

Good North Ayrshire workstreams

Using data and local intelligence, North Ayrshire developed three workstreams based on the Marmot principles which were viewed to be highest priority. These were labelled:

- Good Start – with a focus on Fullarton, Castlepark and Bourtreehill (Irvine)
- Good Jobs – with a focus on Stevenston Haycocks, Ardrossan Central and Saltcoats Central (Three Towns)
- Good Health – across the Garnock Valley

Within the Good Start workstream, examples of targeted work include testing a revised health visiting pathway to enhance provision of earlier support for children and families, and also exploring options for a new multi-agency family-support hub. Within the Good Start workstream, North Ayrshire are exploring a Good Jobs Charter to support fair work and inclusive economic growth while also establishing a new Youth Employment Hub to be based within Ayrshire College. The Good Health workstream includes activities to target cardiovascular disease prevention and also expansion of the existing recovery hub model. All three workstreams are demonstrating how local action can be targeted towards improving health outcomes, with a primary focus on early intervention and co-located services.

The collaborative leadership model that has been established in North Ayrshire through the CHES will continue with strong partnership working across sectors, services and communities. An evaluation framework is also in development that will seek to ensure impact across the programme is captured.

A key learning point from North Ayrshire's delivery experience is that systems change takes time and progress has been strongest where there is enthusiasm and strong leadership commitment to delivering improvements. This approach is enabling activity within existing resources, while building momentum for longer-term change. There is a focus on starting small, learning quickly and building on local strengths to help create a platform for sustainable change that influences how the local system works better together on the building blocks of health.

Good Start Workstream (Principle 1)

1. Universal Health Visiting Test of Change

In North Ayrshire, data indicates a higher-than-expected proportion of children presenting with one or more developmental concerns at the 27-30-month review. Uptake of the 4-5-year health visiting review

has been consistently lower than uptake of reviews for younger children. The expansion of Early Learning and Childcare (ELC) provision has increased the emphasis on educational settings at this stage of a child's development, potentially contributing to reduced engagement with the Health Visiting service.

In response, a test of change is being undertaken within the Bourtree Hill Health Visiting Team with two key components. Firstly, an additional contact at 18-20 months has been introduced to reduce the gaps between earlier and later reviews. Secondly, the 4-5-year review has been redesigned as an opt-in assessment for families where no concerns have been identified during previous contacts. The additional 18-20-month contact is intended to facilitate earlier identification of emerging concerns and provide timely opportunities for intervention and support. The revised approach to the 4-5-year review enables Health Visiting resources to be targeted more effectively towards children and families with identified needs. The test of change commenced in August 2026 and will run until the end of the year. Findings and learning from the initiative will inform a wider review of the North Ayrshire Health Visiting Service and contribute to future service planning and development.

2. Family support in pregnancy and early years

Coinciding with the CHES programme, North Ayrshire was selected as one of six Children's Services Strategic Partnerships (CSSPs) across Scotland to participate in a programme of work with Nesta and CELCIS focused on strengthening family support during pregnancy and the early years.

The programme commenced in early 2026 and involved a series of collaborative workshops designed to explore existing strengths, identify challenges, and consider opportunities for improvement within local systems of support. Representatives from NHS Ayrshire and Arran, North Ayrshire Council, the Health and Social Care Partnership, and Third Sector organisations delivering services across the pregnancy and early years sector contributed to these discussions.

Through this work, Nesta developed a series of recommendations at both national and local levels. To support implementation, an early years-focused strategic group is currently being established within North Ayrshire. The group will incorporate the CHES Good Start workstream and provide strategic leadership for the ongoing development of services and supports for babies, infants, and their families. By creating a sustainable structure for collaboration and improvement, the group will help maintain a long-term focus on enhancing outcomes for children in their earliest years and reducing inequalities across North Ayrshire.

Good Jobs Workstream (Principle 3)

1. Virtual Hub to strengthen partnership working

The North Ayrshire Good Jobs workstream focusses activity on the Three Towns, including Stevenston Hayocks, Ardrossan Central and Saltcoats Central, where deprivation, economic inactivity and poor health outcomes are concentrated. A new Virtual Hub and targeted employability interventions will improve routes into good work.

The Virtual Hub has been established to connect employability, health, housing, and Third Sector partners. It complements rather than replaces existing mechanisms and includes key channels to improve outcomes:

- Partner news: current services, eligibility criteria, contacts and referral routes.
- Case-conference support: anonymised enquiries and introductions, with personal information handled only through established secure processes.
- Partnership opportunities: coordinated outreach, events, employer engagement and joint delivery.

The Virtual Hub was launched in June 2026, following community engagement, neighbourhood data profiling and a roundtable discussion with local employers. The hub supports frontline practitioners to build stronger partnerships, access more resources and support for people.

2. GP Health and Employability Pathway

Discussions to establish a pilot initiative in a Three Towns GP Practice are progressing to connect people experiencing ill-health with employability support through a GP-linked pathway with a particular focus on economic inactivity.

3. Public Health Approach to Learning

Working alongside PHS, Education Scotland and Police Scotland as part of an innovative new programme, a series of workshops is being delivered across school communities to help partners consider how education settings and their wider partnerships can improve health outcomes. Youth and partner engagement activity will support the workstream to turn the shortlisted priorities into deliverable actions.

Good Health Workstream (Principle 6)

1. Targeted cardiovascular disease prevention

A community event was delivered at a Primary School. People identified as vulnerable through GP lists were invited to screening and practical sessions covering CPR, mobility, walking aids and other health information. The intention was to improve access for people who may not routinely engage with preventative services.

2. Recovery hub development

The Alcohol and Drug Partnership is working to strengthen the Kilbirnie Recovery Hub model and explore expansion to Dalry. Related work is considering stronger links with housing, including support for people at risk of homelessness or living in temporary accommodation, and more targeted communication for people who may be reluctant to approach statutory services.

3. Food environment and place-based action

Three Place Standard Tool workshops have examined the local food environment, including work with pupils at Garnock Community Campus. The findings are intended to identify practical local actions and inform wider work on the conditions that support or hinder good health.

4. Community capacity for prevention

Partners are progressing Health Issues in the Community training to strengthen the ability of Third Sector and community organisations to offer low-level early-intervention and prevention support.

5. Wider prevention pathways

Further work is progressing on musculoskeletal health, cancer and cardiovascular screening, support for people with learning disabilities, and use of community and leisure assets.

Box 19. South Lanarkshire - Leadership group and local partnerships

South Lanarkshire has made significant progress through the CHES, strengthening and aligning partnership commitment to tackling child poverty and addressing health inequalities, develop enhanced support to 'give every child the best start in life and securing £8 million of funding to develop this ambition.

The programme is now moving through the development and testing phase and is looking towards embedding prevention and reducing inequalities as core priorities across CPP organisations and to take account of the learning that emerges from the ongoing pilots to drive further transformation.

Leadership group and local partnerships

South Lanarkshire's Marmot Place Programme Leadership Group provided a new and safe space to develop whole systems leadership within the Community Planning Partnership. Leaders from the public and third sectors met monthly to understand and adopt a systems perspective, working collaboratively across sectors to interact and agree what might contribute to improving outcomes for individuals, families and communities.

Leadership Group meetings approached the programme in an emergent manner, leaving programme outputs, implementation and management to operational leads. The purpose of the group is a space for leaders to inform and understand the system, consider the emerging evidence, debate prevention approaches, agree ways forward, and develop a framework for others to pilot and embed. This is a deliberately different approach, which prioritised shared understanding, agreement and commitment to

a longer term transformation, rather than treating the involvement in CHES as a short-term programme to manage.

Experience from South Lanarkshire's Marmot Leadership group has highlighted the importance of leaders acting as system thinkers, relationship builders, culture shapers and enablers. Successful whole-systems leadership relies less on formal authority and more on influence, collaboration and a commitment to reducing barriers between organisations, through pooled funding streams and accountability frameworks, and building trust and shared programmes.

The approach is being embedded across mainstream partnerships. Strong leadership commitment, enhanced use of evidence, significant investment in prevention, and a focus on child poverty are creating the foundations for long-term action on health inequalities and improved outcomes for communities.

- The Integrated Children's Services Plan has been refreshed through partnership co-design, incorporating Marmot evidence and inequality data into priority setting.
- Upcoming reviews of the Child Poverty Commitment, Action Plan and governance arrangements will ensure child poverty and health inequalities remain central priorities across partner organisations.
- Development of a CPP Performance Framework is underway to embed Marmot Principles, apply the evidence to core work, ensure ongoing collaborative leadership, strengthen accountability, and support collaboration to continue to tackle the unfair gaps in life expectancy, opportunity and health the work has exposed.
- The Marmot Leadership Group will move to semi-annual development and review meetings as the programme transitions from development to implementation.
- Responsibility for embedding the Marmot learning and approach will now sit within existing CPP governance structures, led operationally through the CPP Outcomes Leads Group, reporting to the CPP Board.
- A communications plan is being developed to support a new South Lanarkshire narrative focused on prevention, reducing inequality, and prevention. Adoption is planned across the CPP, South Lanarkshire Council, NHS Lanarkshire and wider partners.
- NHS Lanarkshire, South Lanarkshire Council and the Integration Joint Board have jointly committed £8 million to child poverty, early years and prevention activity, including £2 million ringfenced for Third Sector and community sector organisations. Outcomes and governance arrangements are currently being developed.

South Lanarkshire Burnbank Early years pilot

This work brings together a range of public, Third Sector and community partners to develop a proportionate, whole system approach to support that offers every child in Burnbank, and other surrounding communities including Whitehill, Hillhouse and Udston, the best start in life, recognising that all children and their families are not starting from the same point. The programme aims to reduce inequalities in development, health and life chances through integrated, place-based early years support that is tailored to the needs of children and families.

Partners are focused on providing support at an early stage, helping families before challenges reach crisis point. The programme seeks to strengthen parental confidence, resilience and wellbeing, while improving outcomes for children through access to enhanced support, learning opportunities, and the development of parenting and life skills. This approach recognises the wide range of social determinants that influence health and wellbeing.

Burnbank and its surrounding communities experience high levels of deprivation and cumulative disadvantage compared with other areas of South Lanarkshire. In response, the programme offers personalised support alongside community-led and peer support opportunities, ensuring that families can access help that is proportionate to their circumstances. Through this work, partners aim to reduce the inequalities experienced by families in Burnbank.

- The Burnbank Early Years Pilot has commenced, with service co-design underway involving local families and community partners.
- Existing early years staff have been retrained and redeployed to support the new service model launching in September.

- A theory of change and outcomes framework are being finalised.
- Partners are starting to work together through a Prevention Spend Working Group to map and tag collective spend and investment in prevention and possibly an outcome within the pilot project.
- A review of Neighbourhood Planning is beginning in Burnbank, in conjunction with the pilot, and will be expanded to other areas over the coming year.

The programme recognises that meaningful and sustainable change can only be achieved by involving parents in the design and development of the support available to them. Partners are therefore working with families to co-design a whole-system approach that meets their needs across services and within their communities. This approach aims to make it easier for families to access the right support at the right time, while strengthening the social and community networks that help parents and children thrive as they grow.

Alongside service improvements, the programme is developing shared systems, processes and governance arrangements to support effective partnership working and continuous improvement. Transformation outcomes include:

- Strengthening joint governance and administration of place-based approaches across partner organisations.
- Developing a shared partnership outcomes and performance framework.
- Reducing duplication in assessments, referrals and support planning.
- Improving coordination between services and key workers.
- Building a shared understanding of preventative investment and place-based activity.
- Embedding learning and continuous improvement across the partnership.

South Lanarkshire has secured funding from a range of sources to support the Burnbank Early Years Programme. This investment is enabling the transition to the new model of support, facilitating service transformation, capturing learning to inform future scale-up, and supporting ongoing evaluation of impact and outcomes

As noted above, the CHES work nationally and locally was not driven by strong accountability mechanisms, but because there was motivation to work for health equity and to be part of CHES, despite no additional funding being available to support the additional capacity needed. This level of commitment and motivation cannot be assumed and should not be taken for granted and the work must be adequately resourced and not rely on good will which overloads the committed workforce.

Locally public health is based in NHS Health Boards and Councils do not directly employ public health consultants, although there is public health expertise in Councils including environmental health officers and health improvement teams. Directors of Public Health who are employed through Health Boards have legal obligations to advise and support Councils on public health and Integration Joint Boards (IJBs) include health improvement teams. Nonetheless through the CHES it was apparent that there is potential to strengthen public health and health improvement capacity and resourcing within Councils and beyond.

Building on the work of the CHES and the key role that the programme leads have had we propose that every Council in Scotland has a senior health equity lead, who has the specific remit to develop and implement programmes for health equity through the social determinants of health approach outlined through CHES and to influence policy and decision-making. The programmes would contribute to objectives set out in the LOIPs with a strengthened focus on health equity and local targets.

TRAINING AND CAPACITY BUILDING

There is a great deal of motivation and ambition among a range of local and national workforce to contribute to greater health equity. However, more up-to-date evidence and knowledge about how to take action which is relevant and practical for specific workforce roles is needed.

IHE have worked with many parts of the health care system, with business, with public health, transport, housing, education and early years sectors, with environmental health and others and supported these sectors to strengthen their health equity work and to operationalise actions for greater health equity. The practical know-how needs to be built through development of relevant evidence and practical tools for action. Training, support and increased capacity and resources must be available all levels of organisations.

The CHES has had important impacts within Councils and CPPs, and this learning and practical application must now be extended across Scotland, with the involvement of other sectors. Public Services Delivery Scotland and Public Health Scotland can strengthen their learning and training roles for health equity among diverse sectors and workforce supported by relevant data and evidence.

POLITICAL LEADERSHIP

Strong political leadership is hugely important to foster action on the social determinants of health equity, but this leadership is variable and at times too weak to lead the needed decision-making and to build public awareness, highlighted in Chapter 3. The CHES has helped places engage with and build political leadership. IHE experience with national and local engagement across the UK shows that politicians from a range of political parties are encouraged to support decisions for greater health equity when presented with the evidence about the extent of health inequities among their constituents and the drivers of those inequities. Nationally, political party leadership and MSPs can be encouraged to take further leadership on action to reduce health inequities. The local CHES programmes can help, but while Council politicians have been engaged there has been less engagement from local MSPs. Making common cause with political agenda and priorities is helpful in securing the requisite buy in and a strong and accessible narrative is needed to strengthen and encourage political leadership.



BUSINESSES FOR HEALTH EQUITY

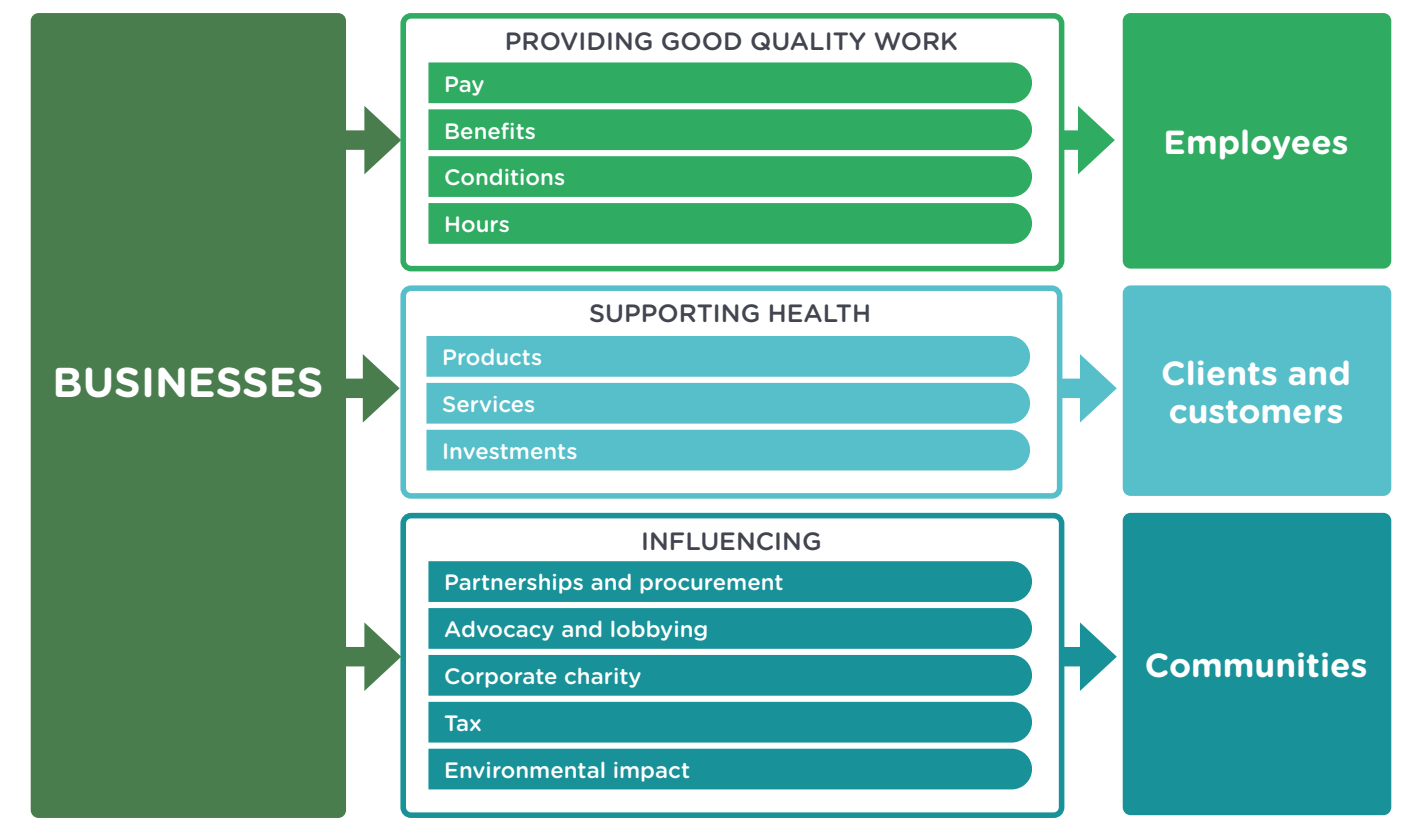
Businesses play an important role in shaping health and must be a partner in creating more equitable health nationally and locally. All too often, however, businesses have not been involved in discussions about supporting better health and contributing to reducing health inequities. Partly this is a result of siloed working and partly stems from the business sector and from public health, not fully recognising the benefits each can bring to the other. There is need for strong protection against unhealthy goods, services, unhealthy working practices and environmental and other harms, overviewed in Chapter 3.

There are important requirements through Fair Work First to ensure that organisations in receipt of public sector grants are paying the real living wage, that there are effective representation mechanisms, for employees and that there is investment in workforce development, no inappropriate zero hours contracts and action to reduce discrimination and reduce the gender pay gap and to offer flexible and family friendly working practices. These are all positive measures for health equity [125].

IHE have previously set out how businesses can positively contribute to health and reducing health inequities, and in work with businesses have demonstrated how this can be achieved. Businesses

affect the health of their employees and suppliers, through the pay and benefits they offer, through hours and job security, and through the conditions of work. Businesses also affect the health of their clients, customers and shareholders through their products and services and their investments. And businesses can affect the health of the communities in which they operate, through their procurement and supply networks, and in the way they use their influence through advocacy and lobbying. The effects on wider society include environmental impacts of business operations, including their carbon footprint and air pollution, as well as the taxes paid by businesses to local and national governments that support policies for health. This is summarised in Figure 49.

Figure 49. How businesses shape health



Source: Institute of Health Equity (2022) [126]



As part of CHES, PHS have engaged with businesses and ran a business roundtable to explore how businesses can contribute to better health and health equity in Scotland. The participants set how they saw their businesses making to health and the social determinants of health, with contributions ranging from local recruitment and beneficial working practices, to significant impacts for local communities. There are important opportunities to strengthen the role of businesses to support the health equity agenda in Scotland.

Next steps include building on the ongoing discussions between Scottish business and PHS to explore levers, including through preferential procurement for

health equity supporting businesses and through the development of further measures to support good work and positive social and health impacts from businesses. The community wealth building approach developed in Scotland is highly relevant to these approaches.

IHE have developed a health equity agenda for the property development industry to embed the conditions for greater health equity in housing developments and through developers' place shaping role [127]. This agenda and its application can be adapted for the property industry in Scotland.

Within the CHES collaborating places engagement with businesses can be strengthened in phase 2.

HEALTHCARE FOR HEALTH EQUITY

Scotland has a long tradition of recognising the importance of action on the social and economic conditions in which people are living which affect their health [84]. The healthcare system of course remains primarily oriented toward treatment of ill health rather than action on the social determinants and there are many programmes underway to reduce inequities in access, experience with and outcomes from services. However, there is more that healthcare organisations and the healthcare workforce can do to improve the social determinants of health. In fact, not doing so jeopardises the primary remit of treating ill health; health deteriorates and health inequity widens and the available resources and workforce are unable to meet the need.

The 2025 population health framework clearly identifies routes towards tackling the social determinants of health.

The NHS in Scotland is about prevention – not just treatment. As an anchor institution it has significant impact on the building blocks of health through employment, commissioning and purchasing, and creative use of its land and assets. It is a population health organisation that works collaboratively with local government to deliver integrated health and social care with an emphasis on anticipatory and preventative care. Community planning with local partners is vital to preventing ill health and inequalities and delivering value-based, sustainable health and care. This includes supporting the health and social care workforce to realise their role in prevention and the delivery of the priorities and actions within the Framework [78].

IHE have outlined several routes through which the healthcare system can support more equitable outcomes in the social determinants of health; as employers, as commissioners and procurers of goods and services, as partners within the national system and local places, as trusted advocates for health nationally and locally and by supporting individuals to secure improvements related to their social determinants of health [128]. These roles are well recognised within Scotland but not always delivered at sufficient scale.



NHS INVESTMENTS IN PREVENTION

Despite ambitions for the healthcare system to focus more on prevention, in 2026 the Scottish Prevention Unit assessed that only 11 percent of NHS Board planned spend was oriented towards prevention activities and of that only 15 percent was directed towards primary prevention [68]. The analysis raises important questions about investments in preventing ill health and supporting action on the social determinants of health through the health care system. None of the activity and spend categories in the NHS which were flagged by the prevention tool constitute social determinants of health activity, although there is some related activity included through family nurse partnerships, health visiting and health improvement activities.

Table 17. Examples of NHS Boards' planned spending within each element of the classification

Classification	Examples
Primary Prevention	• Vaccine programmes • Family Nurse Partnership • Health visiting • Health improvement and promotion
Secondary Prevention	• Screening services (e.g. breast cancer screening, diabetes retinal screening) • Family genetic testing • Pharmaceuticals for addressing early risk factors (e.g. vitamins for deficiencies)
Tertiary Prevention	• Physiotherapy • Assistive technology • Occupational therapy • Pharmaceuticals targeted at stopping disease progression (e.g. heart disease medication, diabetes, anticoagulants, etc)
Enabling	• Lab services • Training for those providing preventative services (e.g. health visitors) • National Services Scotland National Screening oversight function
Acute/responsive/Treatment	• GP responsive activity • Outpatient care • Critical care • Dental treatment • Frontline ambulance services
Other	• Corporate services – finance, HR, marketing, etc

Source: Scottish Prevention Unit [54]

We recommend that prevention investments are increased significantly and the focus of the prevention spend is shifted towards supporting people with the conditions of their daily lives which affect their health.

SOCIAL VALUE PROCUREMENT

Many healthcare organisations and other public sector commissioning organisations are strengthening social value commissioning and procurement as a means to secure social impact locally [129].

To improve health equity Birmingham and Solihull Integrated Care System are using their purchasing power to generate social value and invest in the wider determinants of children and young people's health. The approach demonstrates the potential for procurement to become a strategic lever for addressing health inequities in areas of high deprivation, Box 20.



Box 20. Birmingham and Solihull Integrated Care Board - Strengthening social value through procurement

The ICB made the decision to increase social value weighting in appropriate contracts from 10 percent to 20 percent, with commitments incorporated into contract management. Suppliers are directed to Match My Project [130], a platform connecting businesses with local VCFSE organisations to make their contributions to specific organisations. There is a strong focus on supporting children and young people.

The organisations address the underlying causes of health inequalities. For example, projects focused on financial literacy and helping people avoid high-cost borrowing such as payday loans recognising that financial security is an important determinant of health.

There is an option for organisations to come together and work jointly to support individual projects providing opportunities to pool resources, skills and expertise and strengthen partnerships and collaborations to address health inequities.

Strong leadership has been an important reason for the increased social value contractual weighting and effective brokerage and direct relationships between suppliers and community organisations have been important to progress. While promising, an evaluation of the work, notes that the scale of activity remains relatively small compared with the level of local need, children and young people are not yet consistently involved in shaping projects, and there are challenges in measuring and holding suppliers to account for social value commitments [131].

The Birmingham and Solihull model has attracted national interest, with NHS England adopting the model within its Social Value toolkit.

HEALTHCARE AND ANCHOR ORGANISATIONS AND POPULATION HEALTH APPROACHES

During the CHES, the healthcare system has been a partner in the place-based approaches to addressing inequities by strengthening healthcare approaches to the social determinants of health. Anchor approaches are well established in Scotland and there are further opportunities and ambition to expand their remit and further support action on the social determinants of health. Glasgow City Region Anchor network comprises public private and Third Sector place-based organisations and is oriented towards building community wealth [132].

NHS Boards across Scotland are progressing work to become Population Health Organisations, strengthening

their focus on improving the health of the whole population through prevention, reducing inequalities and collaboration with partners. NHS Grampian is taking this work forward locally, using the national PHO framework and maturity matrix to assess progress and identify priorities for improvement. Recognising that health outcomes are shaped by a wide range of social, economic and environmental factors, the organisation is seeking to move beyond the traditional role of providing healthcare services towards being a strategic leader for population health. This approach aligns with national developments, supports local priorities set out in Aberdeen City's Local Outcome Improvement Plan and is well aligned with the CHES approach.

Box 21. Aberdeen City - NHS Grampian developing as a Population Health Organisation

NHS Grampian presented its proposed strategic priorities for 2026/27 to the Community Planning Aberdeen Board, emphasising the importance of alignment between NHS priorities, the Integration Joint Board and wider community planning partners. During discussions representatives from public health highlighted the need for NHS Grampian to take a stronger leadership role within the Community Planning Partnership, working collaboratively across organisations to improve population health and health equity. The Board was invited to provide feedback on NHS Grampian's self-assessment of its progress towards becoming a Population Health Organisation, recognising that meaningful transformation requires contributions from the whole system rather than the health service alone.

Community Planning partners welcomed the approach and supported the emphasis on strengthening the evidence base to better understand the needs of the local population. The discussion highlighted the value of developing a shared system-wide understanding of population health challenges and using this evidence to inform joint planning, decision-making and resource allocation [133].

There are also opportunities for healthcare organisations to strengthen their approaches on the social determinants of health. The East London Foundation Trust has developed as a Marmot Trust, supporting employees, service users and local communities to improve outcomes in the social determinants of health, Box 22.

Box 22. East London Foundation Trust as the first Marmot Trust

The East London Foundation Trust (ELFT) is working with the IHE as the first Marmot Trust, exploring how an NHS trust can address the social determinants of health, as part of its strategic ambition to improve population health. This involves taking a more upstream approach. As a mental health and community service provider, the ELFT often sees service users whose conditions are caused or made worse by poverty, insecure jobs and living conditions. By taking a more upstream approach, the ELFT seeks to test the boundaries of what an NHS Trust can do to tackle some of the drivers of poor health.

ELFT's initial steps to being a Marmot Trust started with conversations in two specific geographical service areas, Luton and Newham. Working closely with local authorities, the voluntary sector and local businesses, specific areas were identified for shared action. This led to the development of 'Marmot Mountains' working from universal to more targeted population interventions using the Marmot Principles. Commitments made in the early stages of ELFT's Marmot journey are continuing including a focus on poverty reduction and employment support, alongside more recent priorities on homelessness prevention and support and environmental sustainability.

This commitment is reflected in ELFT's Population Health priority areas which include: early years and family support; employment support for service users, carers and local residents; homelessness prevention and support; and promoting the physical health of people with long-term mental health conditions and learning disabilities. A number of programmes have been developed across these priority areas, reflecting several of the Marmot Principles:

Healthier Wealthier families programme aims to improve access to welfare benefits and financial advice by embedding an easy referral pathway in healthcare. Once a person is referred, they receive support from expert advisers including help with benefit entitlements, debt management, and budgeting. This programme has now been rolled out across the Trust with services in Newham, Tower Hamlets and Luton. Evaluation from its pilot year demonstrated the highest risk families gained, on average, £7,933 per year as a result of the service. In Newham alone, around 190 service users have accessed over £1.2 million in benefit entitlements. This programme continues to be rolled out across the Trust.

Apprenticeship levy transfer: In 2025, ELFT worked with local partners to identify GP surgeries requiring additional training support. Through the transfer of unused apprenticeship levy funds, ELFT enabled health and social care staff in primary care settings to access this training, leading to 18 GP surgeries being supported and 21 apprenticeship opportunities created. This strengthened local workforce supply chains and improved employment prospects for local people.

Rough Sleepers Mental Health Project (RAHMP): The RAHMP improves access to mental health support for people experiencing rough sleeping. The team at ELFT works closely with local street outreach teams, and colleagues from the VCSE sector. In 2024, the project established three new mental health clinics at day centres for people sleeping rough, promoting health inclusion and reducing barriers to statutory services.

The ELFT gardening group: The ELFT gardening group promotes access to green space and supports the use of nature in healthcare settings. The initiative enables staff to start projects, seek support, share ideas, and learn from experts. This also encourages the integration of gardening into patient care, supporting both staff and service user wellbeing.

There are many analyses pointing to inequities in access to and from care and that these are related to socioeconomic position and ethnicity. Across the UK maternal mortality differs by maternal ethnicity and the rates of mortality among black women are more than twice that of white women and Asian women are more

than 1.3 times more likely to die [134]. Women from deprived areas have nearly double the risk of dying during pregnancy than those from least deprived areas [134]. Across the UK there is clearly much more to do to improve equity of access to services and equity of outcomes.

While the CHES did not specifically focus on inequities in access to, or experiences of healthcare it is important to note that the social determinants of health also impact access to healthcare and experiences with services [135]. Primary care and neighbourhood health are important routes through which to embed equity and action on the drivers of poor health. Deep End health

care approaches in Scotland (Box 23) were developed to better support the health of deprived communities, by supporting the social determinants of health as well as access to healthcare and supporting the delivery of appropriate services with trained workforce. Since 2019, the approach has been extended to practices serving areas of ‘pocket deprivation’.

Box 23. Deep End, General Practice

General Practitioners at the Deep End work in general practices serving the communities most impacted by poverty and inequality. In addition to focusing on equitable clinical care, the Scottish Deep End project has developed and tested new models of integrated, community-based support. These include the early pilots of Community Link Workers in practices to connect patients with social, financial and wellbeing services, and Welfare Advice and Health Partnerships to provide embedded financial advice within GP practices.

They have also developed initiatives to improve GP recruitment, retention and wider workforce development in communities impacted by poverty and inequalities. Some of these innovations have been adopted by other general practices in Scotland and the rest of the UK.

The Scottish Deep End project demonstrates how strengthening general practice in Scotland’s poorest communities can help to contribute to improved population health and reduced health inequalities. Through its involvement and influence in various pilots and initiatives over the years, the Scottish Deep End project has shown that targeted additional investment in general practices around workforce development, education, advocacy and research can enable general practice to understand and address healthcare inequalities. To have lasting impact and to meet its full potential, this investment needs to move away from short-term funding to sustainable, long-term core funding, allocated according to need.

The Scottish model has since informed similar Deep End initiatives elsewhere in the UK and internationally. [103, 136, 137]



SUMMARY AND RECOMMENDATIONS

This report emphasises the need for health equity to be at the heart of Government. There are national and local accountabilities in places, but these can be strengthened and consolidated, supported by a target to reduce and flatten the gradient in health. Locally, greater prioritisation through leadership and workforce buy-in across many sectors supports health equity and is motivating; the health equity leads in CHES have had important roles in championing and delivering supporting actions and we recommend the role is adopted in every Council.

There is more that businesses can do to support greater health equity across Scotland, and for public sector stakeholders to involve business as a partner in this endeavour. Healthcare, has an important, yet somewhat underdeveloped role in supporting the conditions for better health, as well as continuing to focus on reducing inequities in access and outcomes from services.

RECOMMENDATION 5: PRIORITISE HEALTH EQUITY

STRENGTHEN ACCOUNTABILITY FOR HEALTH EQUITY

- Build health equity provisions into legislation with targets and national and local accountabilities
- Strengthen scrutiny power for health equity
- Establish a cross-government cabinet-level health equity committee
- Develop a new national health equity target with ambition for 80 percent of the population to have improvements in health with greater improvements among more deprived people and places
- Strengthen accountabilities for Community Planning Partnerships with progress reported nationally

ENHANCE LEADERSHIP AND CAPACITY FOR HEALTH EQUITY

- Develop a national health equity board
- Appoint a health equity lead in each Council
- Public services delivery and PHS to develop practical tools to operationalise action

BUILD BUSINESS FOR HEALTH EQUITY

- Engage national and local businesses for health equity
- Reconfigure IHE Business for health equity recommendations for Scotland
- Health equity business criteria to be developed

STRENGTHEN HEALTHCARE FOR HEALTH EQUITY

- Increase investment on the social determinants of health
- Expand social value weighting in NHS procurement to 20 percent
- Expand population health and anchor organisation ambition and remit for health equity and the SDH

CHAPTER 7

EVIDENCE AND DATA FOR HEALTH EQUITY

Through the CHES several gaps in routinely available data, information and evidence have been identified. These are as follows;

1) Mismatch between data on health and many of its social determinants within Council areas

As noted in Chapter 1, much health data are not routinely available below Intermediate Zone level while the index of deprivation, SIMD, is produced at Data Zone (DZ) level. This mismatch does not prevent the relationship between health and social inequalities between Council areas being routinely monitored using each Council areas' share of most deprived DZs, for example. Nor does it necessarily prevent data on health and social conditions being aggregated into deciles or quintiles of deprivation for monitoring purposes within Council areas. However, this broad brush approach can create conceptual issues in making comparisons and practical problems when constructing deciles from multiple sources. By aggregating non-contiguous areas in this way, it also complicates identifying those physical areas that are contributing most to patterns and trends in health inequities and hence in planning and monitoring local area-based interventions.

To better understand how health inequities are distributed at a granular level we constructed a deprivation indicator based on the population weighted average rank of the Data Zones in each Intermediate Zone [20]. This enabled us to use routinely available data to identify which aspects of the Marmot 8 Principles had the strongest relationship with health inequities in the three collaborating areas. It also enabled local areas to undertake their own analyses of locally held data and strengthen their understanding of the local drivers of health inequities, plan interventions or policy changes, as examples below illustrate. It also facilitates rigorous local monitoring of impact in the future

2) Data about alignment of resources with social need

Resources to address the social determinants of health come in many forms – public finance, staffing, voluntary activity, capital goods. Not only are all these interconnected, but their governance is highly segmented both horizontally and vertically. Horizontally, services are delivered by a range of local agencies – health, Council services, police, fire, private and voluntary organisations. Vertically some service are directly funded nationally within Scotland, some initiatives by UK-wide agencies and some from Council or local health sector funds. As a result of this overlapping jigsaw of funding sources and spending, there is no consistent data on available funding which makes it difficult to assess and monitor whether the scale and intensity of resources available in a small areas are sufficient to reduce inequities effectively. It is equally difficult to assess and monitor whether resources are being distributed in a proportionately universal way across Council area, our analysis in Chapter 3 tried to assess these.

3) Data and evidence to support strategic planning

There are several additional types of information identified in CHES which are required to support a strategic approach to reducing inequities in health and its social determinants based on the Marmot 8. Currently this data and other information are not always available to the extent or regularity needed to support this approach.

- Community perspectives and insights are not always readily available nor undertaken in ways which allow for effective representation of the needs of a wide range of communities and households who are experiencing the effects of disadvantage and exclusion. Moreover such qualitative insights are not always accorded parity with data sources in strategic and commissioning decisions.
- Evidence about returns on investment and cost-effectiveness needed to support decisions about future investment and disinvestment.
- Framing of data and evidence to successfully communicate the scale of inequities in health and its social determinants to a range of stakeholders, including the media and general public.
- Information needed to identify the effects of racism (Marmot Principle 7) and climate change and environmental crises (Marmot Principle 8) on health equity and its other social determinants.

In this Chapter, we identify how the CHES has addressed several of the gaps identified above, although there remains work to be done in further developing the progress that has been made and in seeking to fill gaps that have not been adequately addressed.

DATA ABOUT WITHIN AREA INEQUITIES IN HEALTH AND SOCIAL DETERMINANTS OF HEALTH

The data analysis undertaken throughout the CHES has supported the development of national and local strategic approaches and the design and delivery of actions to tackle health inequities and the social determinants of health. The analyses, which shows inequities within places across Scotland, are intended to provide a model for further development of local and national monitoring of inequities in the future.

The data provided through the CHES aligns with other ongoing work across PHS including:

- ScotPHO have developed a Population Health dashboard to support the ambitions of the Population Health Framework and CHES by providing access to the latest data on population health outcomes and inequalities. The indicators are structured around the Marmot 8 Principles.
- ScotPHO plans for a long-term monitoring through a Health Inequalities dashboard and annual report. A sub-national view is part of the expected future scope.
- The National Data Group provided a forum for CHES areas to share their approaches to data analysis and their learning from it and for PHS and IHE to consider the national implications of learnings in the three CHES areas. Examples of outcomes of this are described below.

The analyses undertaken in CHES will assist in future monitoring of health equity and the social determinants of health. PHS will use these insights and those obtained from the evaluation of CHES to look at what already exists and what additional data, analysis or support they should provide, if any.

THE LOCAL DATA

At the start of the CHES, IHE worked with PHS, the Scottish Government and the three collaborating places to develop methods of quantifying and pinpointing sources of health inequities within local areas. This was achieved by relating data on small area health outcomes with the geographic distribution of the determinants of these inequities as discussed above. Charts in this and other reports which show inequities between and within Councils are based on this methodology. The work has led to a more in-depth overview of health inequities across Scotland and within the three collaborating places and the learning shared with all places in Scotland.

The three collaborating places all began by assessing data to develop their CHES approach and within South Lanarkshire and North Ayrshire to prioritise within the Marmot 8 framework. As noted in Chapter 5 through the CHES, Aberdeen City have focussed on developing

a methodology for proportionate universal resource allocations and in their refresh of the LOIP and CPP strategy and already had data available at local area level through their Health Determinants Research Collaboration [12]. The three collaborating places highlighted that the ability to see inequities at local level is an important enabler for action locally and nationally.

Box 24. North Ayrshire - Utilising the guiding principle of being data-informed

North Ayrshire's guiding principle of being data informed led to an early focus on the development of health inequality heat maps combining deprivation, health outcomes and social determinants of health data at locality and intermediate zone. This work identified geographic areas where inequalities were greatest and where action could have the greatest impact. The analysis informed local priorities and directly supported a successful Pride in Places funding bid for the Three Towns locality, helping attract additional investment into communities experiencing challenges related to economic inactivity.

The process highlighted both the value and limitations of available data. While the analysis provided a strong evidence base for action, important gaps were identified around Marmot Principles 7 and 8, as well as gender-related social determinants of health data. A key learning point is that data can be a powerful tool for targeting action but should not be used alone to make decisions due to its limitations and the importance of developing local responses grounded in the experiences of communities.

South Lanarkshire took the methodology and used it to extend their local analysis, building on their Joint Strategic Needs Assessment (JSNA) and the Children's JSNA [138]. Through the CHES, South Lanarkshire developed eight data packs in Marmot Principle areas to complement and enhance the existing data which helped prioritise particular places (Burnbank) and principles (Give Every Child the Best Start in Life) for action and investment. It is the first time South

Lanarkshire has developed this type of deprivation analysis at Intermediate Zone level. Following the analysis, summarised in Box 25, South Lanarkshire are planning more widespread coordinated action among partners, with learning from the work in Burnbank to scale up efforts, proportionately across South Lanarkshire. The analysis provides valuable insight into

how data, local intelligence, and partnership working can be brought together to inform action at a local level. As with many place-based products, the team has also had to consider the political and governance implications of publishing neighbourhood-level rankings, ensuring that the information is used constructively to support improvement rather than stigmatise communities.

Box 25. South Lanarkshire – Marmot Principle data packs

The eight data packs present data at Intermediate Zone levels across South Lanarkshire with a focus on differences by level of socioeconomic deprivation, measured using the SIMD and the IHE's average SIMD rank. The aim is to identify local inequities in outcomes and support decision making, inform targeted interventions and contribute to wider discussions about inequities within South Lanarkshire and within Scotland, through the CHES.

The data packs comprise trends in demographic information and a number of indicators in each of the 8 Principles. The ambition was to provide a simple and consistent approach for organisations within the Community Planning Partnership to:

- Use data and local intelligence to identify priority inequalities
- Understand what is driving these inequalities and differences in and between communities
- Identify practical actions to reduce them
- Move from evidence to action, through combining the data, local lived experience and employee knowledge and
- Support employees to use data and local insight confidently to co-produce and inform service delivery improvements

The data packs highlight important patterns across South Lanarkshire, including:

- Clear inequalities between places
- A strong link between deprivation and poorer outcomes
- Variation across outcomes that is not fully explained by deprivation alone

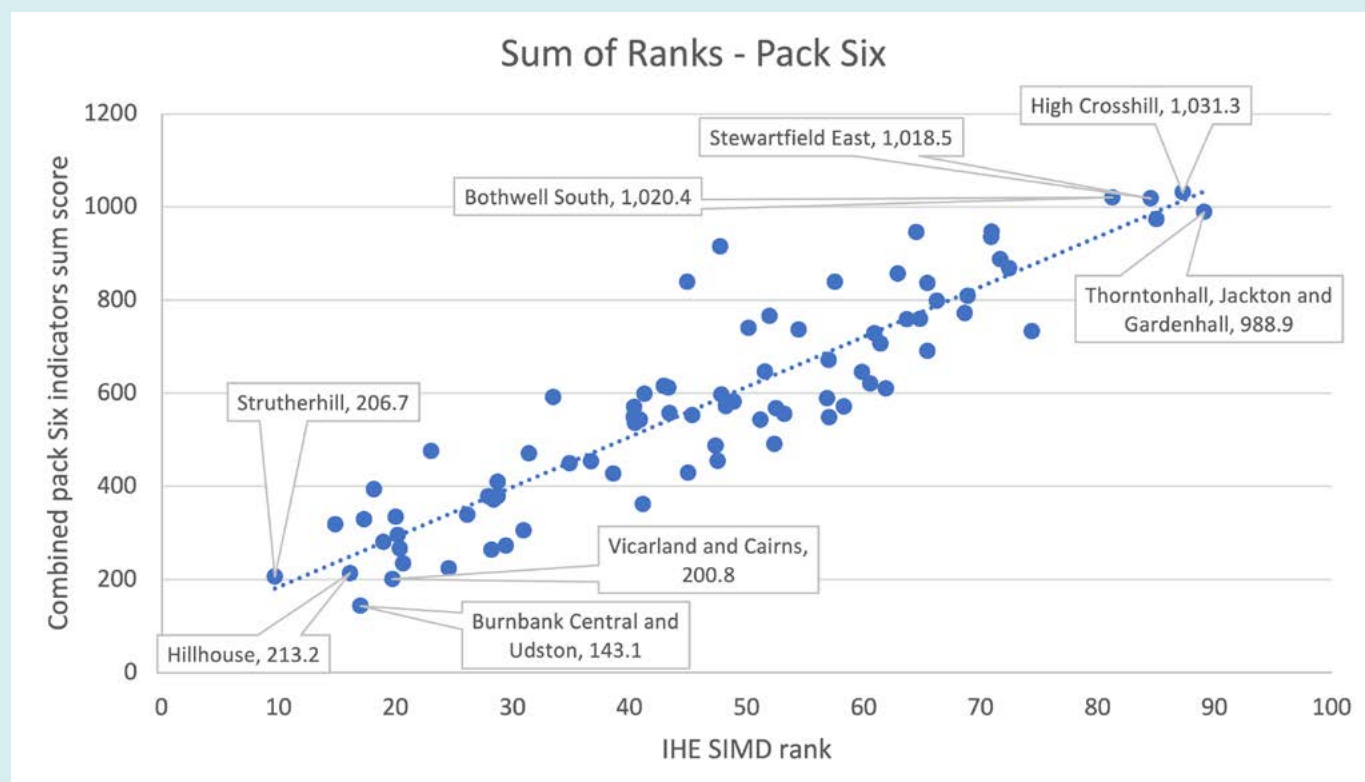
From the data a sum of ranks was created; a composite measure created by ranking Intermediate Zones across the subset indicators in each data pack for all of South Lanarkshire and summing ranks.

For example, a health inequity sum of ranks analysis was provided to indicate overall health inequities within South Lanarkshire related to small area deprivation. The following indicators were included in the composite sum measure.

- Life expectancy, females
- Life expectancy, males
- Deaths, all ages
- Deaths under 75 years
- Deaths aged 15 - 44 years
- Early deaths from cancer
- Early deaths from coronary heart disease
- Coronary heart disease hospital admissions
- Chronic obstructive pulmonary disease hospital admissions
- Asthma hospital admissions
- Emergency hospital admissions
- Multiple emergency hospital admissions in people aged over 65 years
- Alcohol-related admissions
- Bowel screening uptake

The sum of the ranks of these indicators in Figure 50 shows stark health inequities within South Lanarkshire with Burnbank Central and Udston having the lowest rank and the worst health across South Lanarkshire.

Figure 50. Sum of ranks of indicators - III-Health Prevention (Principle 6)



The health gradient in South Lanarkshire is clearly outlined with a close relationship between the health indicators included and levels of deprivation, indicating that deprivation remain a strong influence on outcomes. Efforts to address inequities in health through the social determinants need to be universal, available for everyone in South Lanarkshire but proportionate to the levels of poor health.

Maps have also been produced to show the sum of ranks visually, which has assisted communication and learning about inequities within the area.

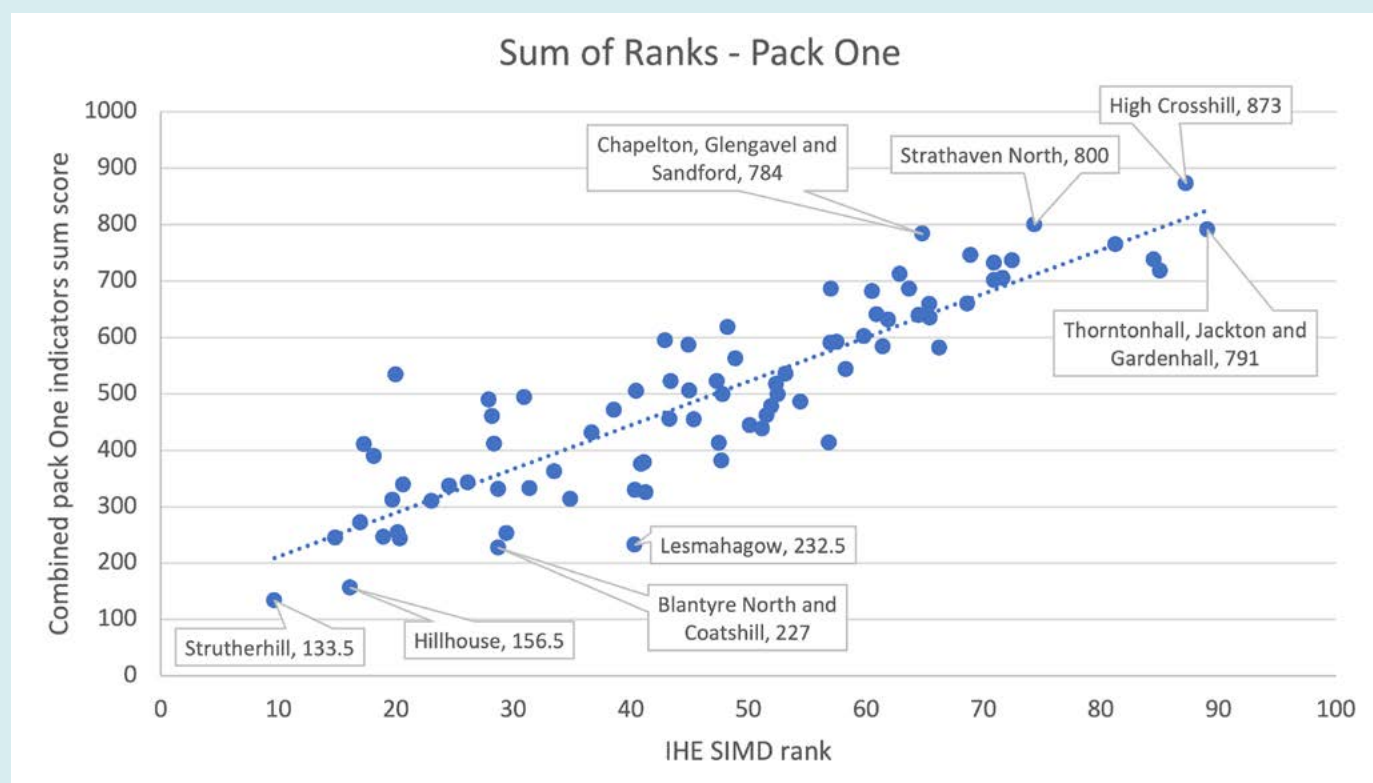
Give Every Child the Best Start in Life in South Lanarkshire became the priority area for the CHES programme. This prioritisation was partly related to the data analysis showing wide inequities within South Lanarkshire.

The overall “sum of ranks” score for available relevant indicators relevant to infant health was created by ranking each Intermediate Zone across the following indicators and summing ranks:

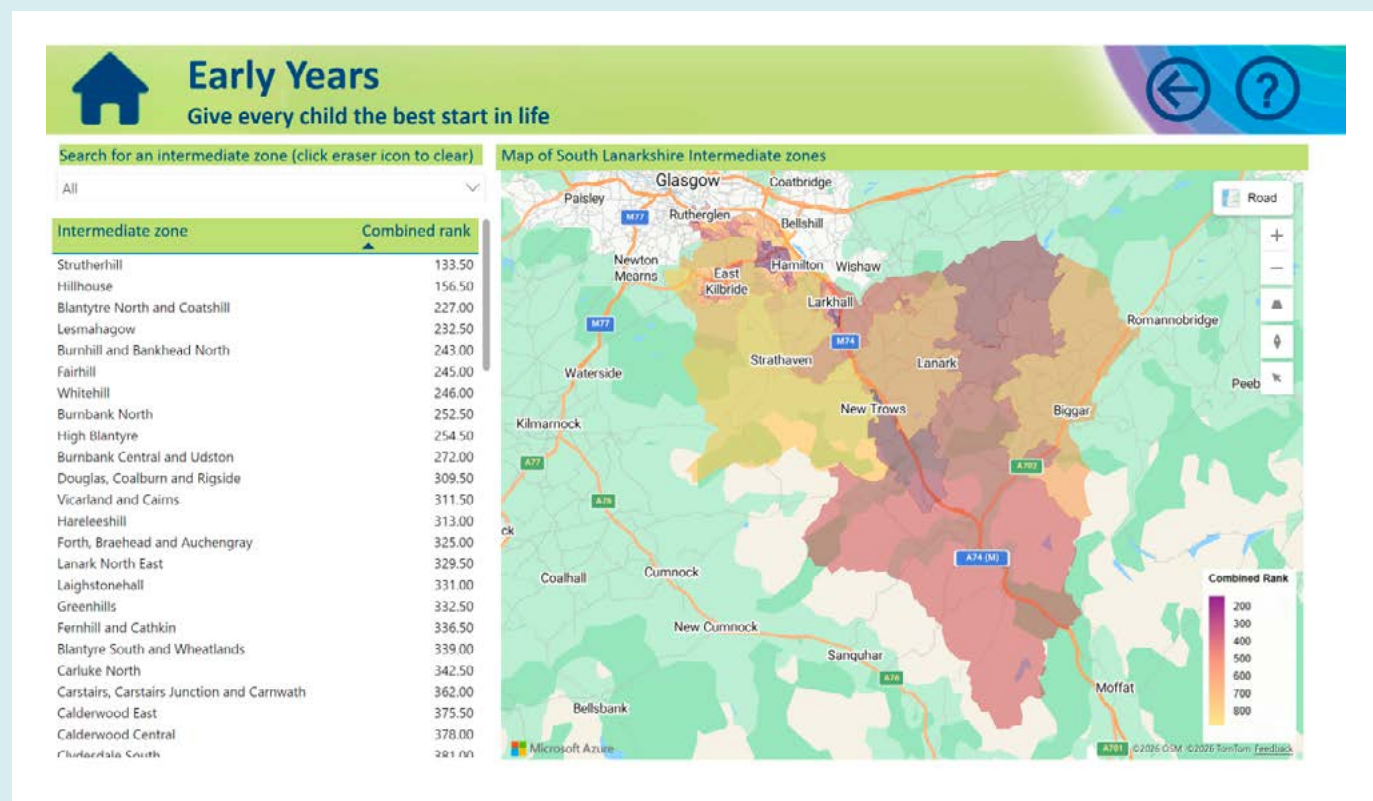
- Women smoking in pregnancy
- Maternal obesity
- Healthy birth weight
- Premature births
- Breastfeeding (overall) at 6-8 weeks
- Developmental concerns at 27-30 months
- Child healthy weight (P1)
- Child dental health (P1 and P7)
- 6-in-1 immunisation at 24 months
- MMR immunisation at 24 months, and child poverty

Figure 51 below shows the sum of ranks by IZ SIMD rank for the indicators above. The figure clearly shows the cumulative inequities experienced by children within South Lanarkshire and the close association with level of deprivation. Children living in Strutherhill, Hillhouse, Lesmahagow, and Blantyre North and Coatshill have the lowest rank scores and experience multiple poor outcomes. The gradient is again clearly evident and efforts to reduce inequities experienced by children in South Lanarkshire must be proportionate to the level of deprivation and associated poor outcomes.

Figure 51. Sum of ranks of indicators - Give Every Child the Best Start in Life (Principle 1)



The sum of ranks map for the early years, shows the sum of rank scores with darker areas representing places with worse outcomes for children.



An overall cumulative rank score analysis and map have been produced bringing together results across the different Marmot Principles. This provides a single summary measure of place-based inequality while retaining the ability to explore the individual themes that contribute to each area's overall position.

Overall, South Lanarkshire have identified that the data packs and maps have helped:

- Identify communities experiencing the greatest disadvantage and the widest inequalities in outcomes.
- Support locality planning, service planning and commissioning.
- Inform discussion with services, partners and communities about where action is most needed.
- Help sense-check local data against operational experience, lived experience and community insight.
- Support proportionate, place-based action to improve outcomes for children and families.
- Monitor patterns over time and support meaningful evaluation of actions and interventions.
- Assess whether the funding in each of the areas is sufficient to the scale of the issues identified in the data analysis

The visual maps have been particularly valuable in helping practitioners identify differences between neighbourhoods that are less apparent in traditional reports and encouraged conversations about where interventions should be targeted and how resources can be directed to areas of greatest need. Although the maps have not yet been widely used as a public communication tool, there are plans to expand their use to support engagement with partners, elected members and communities helping to drive place-based action to reduce inequalities.

In South Lanarkshire there are plans for the CHES Data Group who have led the analysis set out in Box 24 to transition into a Data Implementation Support Group,

providing practical support to partners to support implementation.



ASSESSING WHETHER RESOURCE ALLOCATIONS ARE APPROPRIATE FOR ACTION TO TACKLE INEQUITIES

The CHES has overviewed how well resources are aligned with levels of deprivation with recommendations to reorient these in a way which is more proportionate to the scale of need, but universal in order to raise and flatten gradients in health, Chapter 3.

This analysis is a starting point, but further analysis is needed including how equity aligned resource allocations are within places. In a separate commission IHE are working with North Ayrshire to assess household deprivation, through financial resilience measures, alongside area-based deprivation measures, to inform resource allocations and to assess likely trajectories in inequity and deprivation given low levels of financial resilience and high deprivation.

DATA AND EVIDENCE FOR COMMUNICATION

Data can be complicated to communicate and does not resonate with all stakeholders, including the public and it is important to produce information that relates to day-to-day experiences.

The narrative of health care and individual behaviours dominates in discussions about how to improve health; data which shows associations between health and deprivation and other socioeconomic indicators undermines this narrative and can therefore be rejected or not well understood. Effective communication to politicians and communities and other stakeholders often involves stories, maps and other visual tools.

As part of the South Lanarkshire Marmot Place Programme, the Marmot Data Group worked in partnership with NHS Lanarkshire's Health Improvement Team to develop figurative maps illustrating local health inequalities in familiar locations within South Lanarkshire. The maps focus on the differences in life expectancy for males and females between different intermediate zones, alongside a child poverty map at data zone level. The primary aim was to create a compelling visual resource that would help people understand the relationship between the social determinants of health, health inequalities, and the experiences of communities across South Lanarkshire. The maps support learning and development activities while encouraging conversations about the factors that influence health outcomes, Box 26.

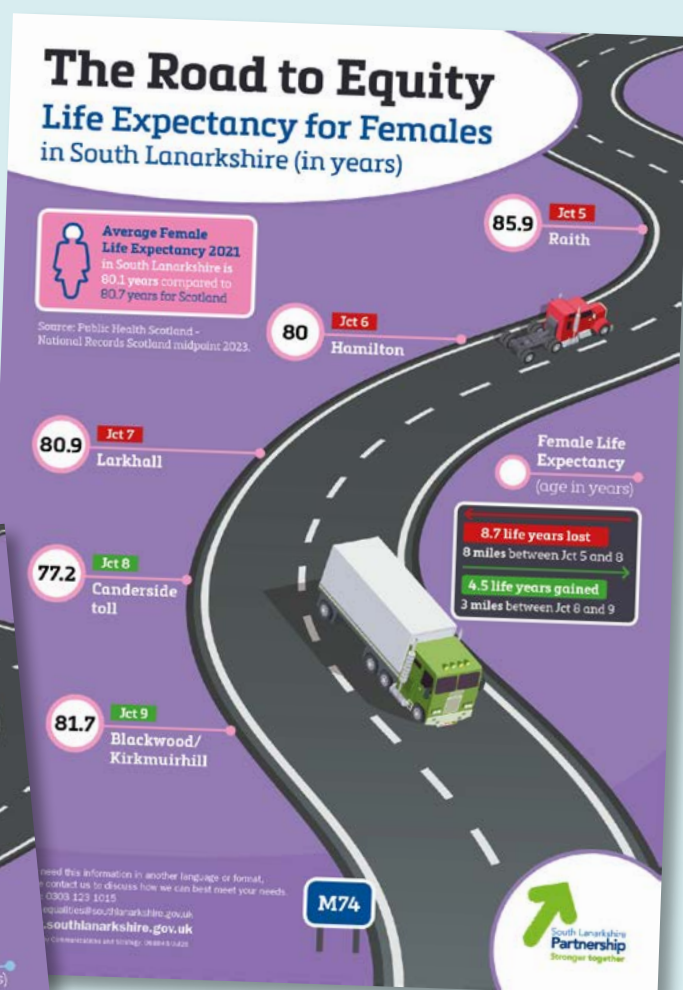
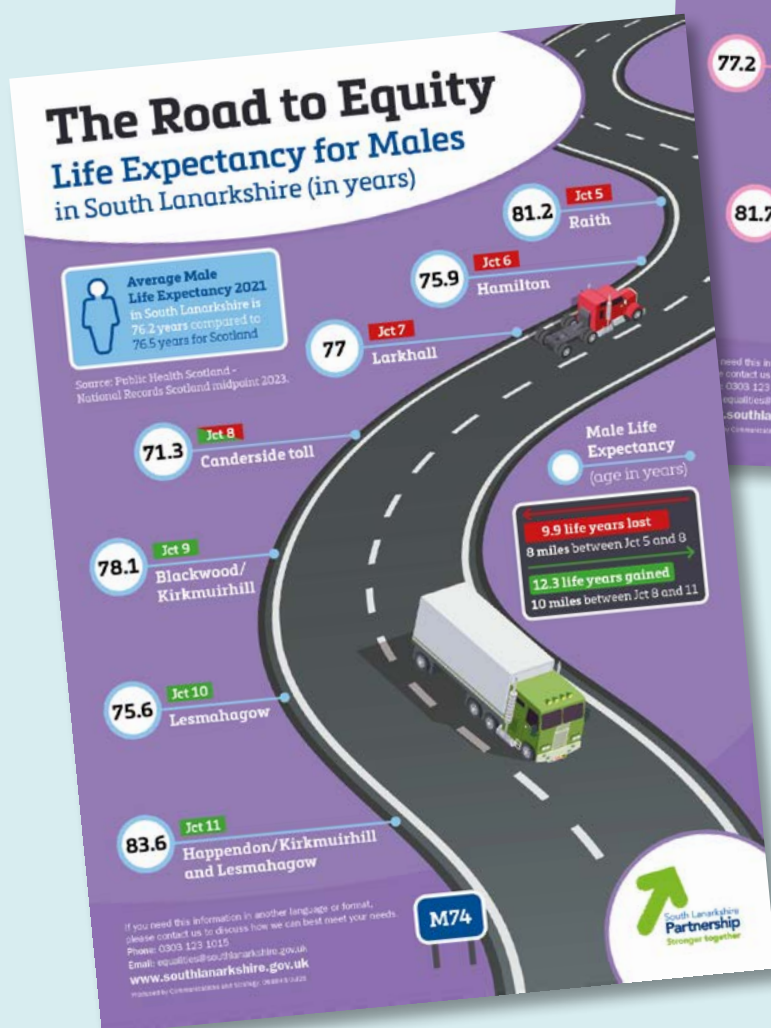
Box 26. South Lanarkshire - Health inequality maps

Following examples used previously in other locations, the main transport route running through South Lanarkshire, the M74, was used as the central visual theme. The maps illustrate how health outcomes vary along the route. This familiar geographical reference point for local people, helps make complex public health data more relatable and easier to interpret.

The maps were co-produced through collaboration between the Marmot Data Group, NHS Lanarkshire, the Institute of Health Equity, South Lanarkshire Council's graphic design team, and a range of Community Planning Partnership partners. Throughout development, the resources were reviewed and refined using feedback from public health partners, elected members, and other stakeholders to ensure they were accurate, engaging, and effective. When national child poverty data was updated during the project, the child poverty map, presented in Chapter 3, was revised to ensure the information remained current and robust.

The completed maps provide a valuable resource that can be used consistently across the partnership. They have been embedded within Health Inequalities Learning and Development sessions to support workforce understanding of local inequalities and the wider social determinants of health. They have also been made available through the Community Planning Partnership's website's Marmot pages and can be used in reports, presentations, and other partnership communications to strengthen the use of evidence in decision-making. By transforming complex datasets into clear, locally relevant visual stories, the project

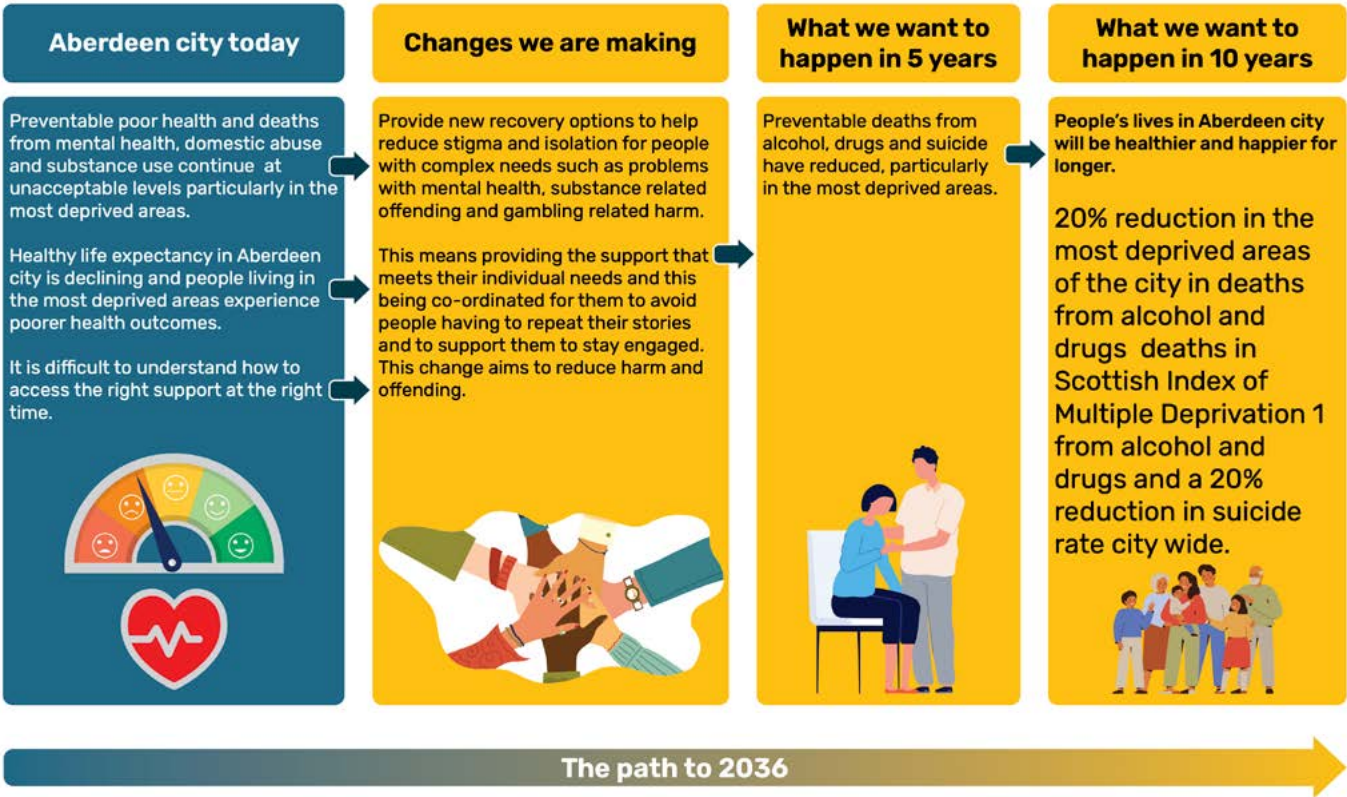
has created a shared resource that supports learning, raises awareness of health inequalities, and reinforces the collective commitment to reducing inequalities across South Lanarkshire.



Aberdeen City included a public version of their Local Outcome Improvement Plan which aims to have a clear and accessible explanation of the issues facing the City and the trajectory to improvements set out in the

LOIP [96]. The figure below is the accessible version for residents relating to the 5th priority in the strategy, preventable deaths and the equity focussed targets.

Figure 52. Preventable deaths graphic, Aberdeen City LOIP



Source: Aberdeen City Local Outcome Improvement Plan [96]

The CHES analytical work has strengthened North Ayrshire’s ability to articulate local challenges and opportunities. The data and evidence developed through the programme helped support a successful Pride in Place funding application for the Three Towns area of Saltcoats, Stevenston, and Ardrossan with analysis clearly articulating the relationship between deprivation, health inequalities and economic inactivity as a compelling case for investment.

Box 27. North Ayrshire - ‘Good North Ayrshire’ narrative change

Feedback from local partners and communities highlighted that North Ayrshire’s language around health inequalities and health equity can feel complex and inaccessible. In response, North Ayrshire developed the ‘Good North Ayrshire’ change narrative, using the Health Foundation’s building blocks of health to communicate ideas in a simpler and more relatable way. Rather than focusing on technical terminology, the narrative helps people understand how housing, employment, education, community connections and local environments influence health and wellbeing.

Initial feedback on use of this alternative language has been positive. Partners who previously viewed health inequalities primarily as the responsibility of health services are increasingly recognising how their own work contributes to improved outcomes. A key learning point from this work is that language matters, with clear and accessible communication acting as a powerful enabler of effective engagement.

CONTINUING DATA NEEDS IDENTIFIED IN CHES

The data analysis and subsequent use have been a central and important feature in CHES and has strengthened understanding and implementation within the places and the national system. Several outstanding data issues have been highlighted, not so far addressed through the CHES:

- **Local collaboration and integration of data.** Data is held separately in different organisations and there are not enough situations where organisations come together for joint purpose and use data for multiple uses. Data governance agreements for sharing suitably pseudonymised data between organisations are urgently needed to support shared understanding and shared outcome frameworks between different sectors and organisations.
- The need to build **local capacity and expertise** in experience of handling and interpreting data.
- While the methodology for understanding small area data has enabled progress in understanding within place inequities, these are not always sensitive or at **a small enough area or household measure to reveal pockets of poverty and rural poverty.**
- The small area data can be **sensitive and difficult to communicate** to the public and with politicians and tools need to be developed to communicate this.



COMMUNITY ENGAGEMENT AND PERSPECTIVES AND INSIGHTS

Scotland has extensive community engagement processes which are at the heart of local strategic development through the CPP and LOIP and in service design. However, there are longstanding issues with how far the engagement is effectively reflected in the design and delivery of approaches, and whether it brings tangible benefits to communities. In Chapter 3 we set out that inequities in power, money and resources, reinforce and exacerbate deprivation, exclusion and ill health among communities. To address health inequities communities need more power and access to resources alongside mitigation of the impacts of structural inequities.

Community empowerment is different from community engagement. Community engagement provides insights about what is driving inequities and possible routes to mitigate it; when engagement is undertaken effectively it can be beneficial to communities participating, when undertaken in a tokenistic way it can be harmful and lead to mistrust and further exclusion. At times community engagement can be extractive and lead to consultation fatigue among communities, particularly when the views which are repeatedly expressed are not then taken up in the design and delivery of programmes.

One of the routes to creating the conditions for communities to have control of their lives, set out in previous Marmot reports, is through equitable, effective and impactful community engagement. And such engagement often reveals issues not represented in the data; IHE have recently focussed for instance on reducing feelings of fear, insecurity, shame and stigma, which were identified by children and young people, and not visible in the data [139]. Programmes were then shaped around trying to reduce such feelings [131]. Information derived through community engagement, surveys and discussions with Third Sector organisations, residents should be considered in conjunction, and on an equal basis, with quantitative information.

There are many assessments of strong routes to coproduction with communities, some set out in the Scottish Government Participation Handbook [140]. Most involve the following key elements:

- Collaboratively designed with a shared purpose with clarity over the reason for collaboration
- Accessibility and inclusion in engagement methods
- Ensuring and demonstrating clear routes to action and benefits to communities
- Building and recognise the value of trust and relationships
- On-going engagement and coproduction
- Flexibility and responsiveness to community views
- Ensuring services and support ‘do with, not to’
- Leading to empowerment and capacity building
- Recognition for participation

The CHES built on existing engagement processes within the three collaborating places in order to understand resident experiences and their views about existing services and support and what changes they identify are needed. The views of communities fed into priorities for the CHES programme and into the design and delivery of appropriate services and also showed the profound and ongoing role of structural inequities.

Alongside data analysis, North Ayrshire recognised the importance of placing communities at the centre of the programme. Rather than creating new engagement processes, the programme built on existing local engagement and combined community insights with data and local intelligence to help shape priorities, workstreams and actions. This helped to ensure that the programme reflected the experiences, priorities and aspirations of local people while supporting collaborative, place-based decision-making, Box 28.

Box 28. North Ayrshire - Utilising the guiding principle of being community engagement driven

At the outset of CHES, North Ayrshire invested heavily in understanding perspectives from communities and partners. This included engagement through Locality Planning Partnerships, locality community “chit chats”, system mapping workshops and ongoing discussion through the multi-agency Steering Group and strategic governance group. These activities helped shape priorities, identify local strengths and create opportunities for a wider range of voices to influence the programme.

This work highlighted varying levels of understanding of health inequalities across the local system. During this engagement most partners could identify a meaningful role for their organisation in contributing to this work. A key learning point is that engagement is not simply about gathering views, it is also an important tool for building awareness, shared ownership and collective action.

South Lanarkshire had a strong focus on quantitative data through the CHES, but they also recognised that engaging with children, parents, and communities can

help validate findings, uncover lived experience not captured in the data, and highlight local assets and barriers that influence outcomes, Box 29.

Box 29. South Lanarkshire - CHES and community engagement

In addition to using the available data, South Lanarkshire highlighted the importance of incorporating other forms of evidence to identify concerns, inequities and routes to action, including:

- Operational data not routinely considered as inequalities data
- Knowledge of how services are accessed and experienced
- Understanding of local context and recent changes
- Lived experience of individuals and families and employee knowledge and experience

South Lanarkshire conducted workshops in several different communities across South Lanarkshire to understand views, insights and experiences on life within communities and where the CHES work can be best placed to have the most impact on improving lives and communities. South Lanarkshire report that involving communities in interpreting this evidence ensures that actions are more relevant, equitable, and rooted in the realities of everyday life. Meaningful public engagement will continue and form a core part of responding to data packs and shaping next steps.

In the development of the Burnbank, Whitehill, Hillhouse and Udston Early Years pilot, local families helped to shape support.

Three listening sessions were held for parents of nursery aged children in June 2026.

The purpose of the sessions were twofold; to enhance understandings of families' experiences of living in the area and engaging with local services and to help inform the design of new ways of delivering family supports in the area that would be most impactful.

Each listening session was hosted in the families' early years or attached primary school setting. Initial contact with the families was made via the Heads of Establishment.

Through this process cross cutting themes were identified:

- Community spirit and a sense of belonging was a significant factor for families. Families are looking for environments that enhanced community connection and communication.
- Consistency of support is important to parents and helps build trust in services.
- Flexibility and accessibility were regarded as being critical to the development of new services, both physically and in terms of delivery method.

The findings are being incorporated into the outcomes and service design of the Burnbank, Whitehill, Hillhouse and Udston Early Years Transformation programme.

Box 30. Aberdeen City - CHES and community engagement

The CHES work is clearly reflected in the Aberdeen City Partnership Strategy and in the Local Outcomes Improvement Plan (LOIP) [12]. The process of developing the LOIP involved a wide range of community organisations and consultations. Over 2087 people participated and the place standard tool was used as a framework for analysis. There were 6 locality events and an outreach programme which went to 98 groups/schools and locations across Aberdeen. Participants were asked to score 14 themes based on their views of how much improvement is needed, what is working well and what needs improvement and to help identify priorities. The input provide an important overview of residents' perspectives and priorities, with responses explored by locality, by area deprivation of participant residence, enabling a comparison of thematic scores by SIMD. Differences by age, gender and ethnicity were also assessed and there was a specific focus on the views of children and young people. Respondents also provided comments on proposals for ways forward and suggested specific actions [141].

EVIDENCE FOR HEALTH EQUITY AND THE SOCIAL DETERMINANTS OF HEALTH

There is a strong and robust evidence base indicating how the social determinants of health impact on health equity based on longitudinal research studies showing close associations between health and socioeconomic position and experiences of adversity, exclusion and discrimination [8-10, 101]. There are also some important long term research evaluations showing the health equity impacts from policies and programmes set up to address social determinants of health, such as the recent Sure Start evaluations [142]. These evaluations provide important learning about how to design programmes to maximise impacts on equity.

There are, however, important evidence gaps which limit action. More evidence is needed indicating where and how local places can best invest their limited resources to reduce inequities in health. This evidence is crucial to inform local decisions about investment and disinvestment. PHS has responded and is developing evidence packages.

Places also requested that IHE provided case study examples of action by other places in several of the Marmot 8 areas, identifying a dearth of this type of information. Increasingly these programmes and actions are not evaluated due to cost and capacity constraints. Some programmes do include impact analyses including for example, the number of people reached, records of their experiences and some, usually short term, outcomes from the intervention. These help suggest programme impacts but rarely track long term outcomes or impacts on health. Places relayed that while they can tell a story about equity impacts

of programmes, they are often unable to measure this or outline how changes have happened and what supported the positive impacts. Theories of change, which adapt as programmes develop and context shifts can be important in achieving both greater impacts and understanding how and why the changes occur. PHS and North Ayrshire are developing theory of change and logic model for the CHES approaches.

The Health Determinants Research Collaborations were established to develop place-based evidence about programme impacts on health equity by building research cultures within local government. There are currently two HDRC programmes in Scotland, HDRC Glasgow and HDRC Aberdeen which was a core partner of the CHES work in Aberdeen City.

In Aberdeen City, the CHES supported the development of a more systematic approach to assessing the potential impact of proposed system changes, with a developing framework for monitoring and evaluation, Box 31.



Box 31. Aberdeen City - Methodology for assessing impact

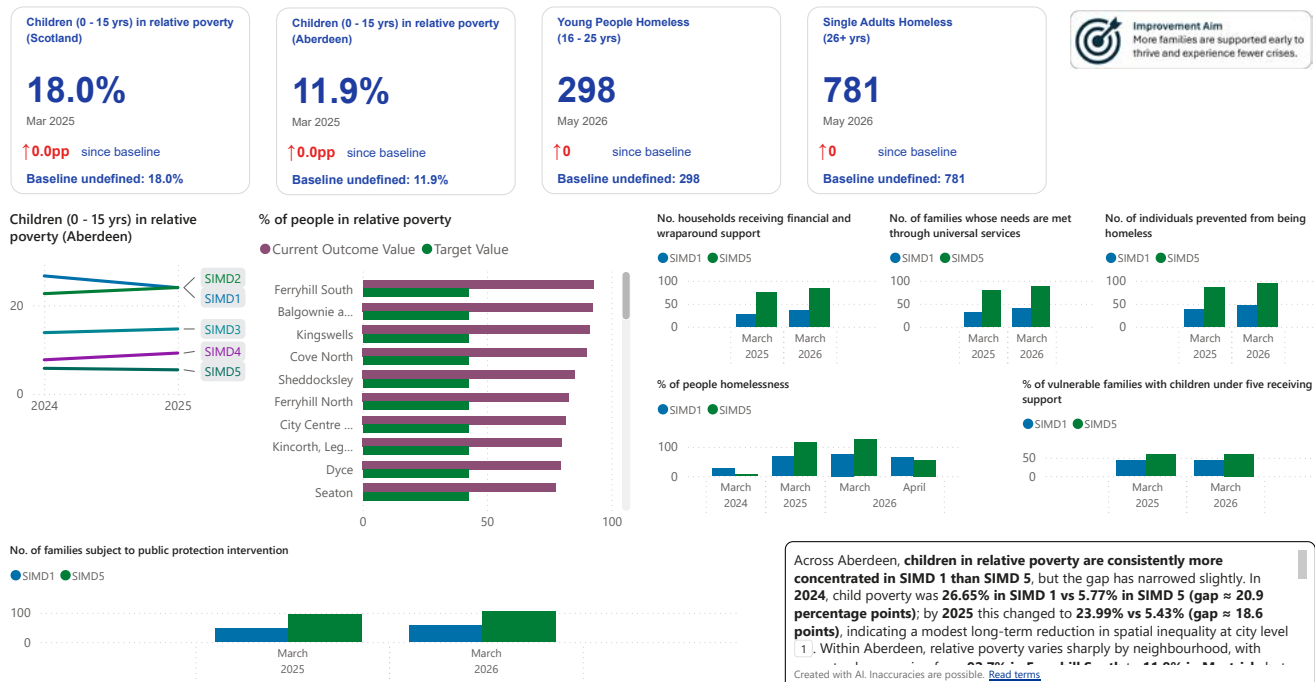
Working with Public Health Scotland and HDRC Aberdeen, Community Planning partners developed a methodology that combines theory of change, health equity considerations, local population data and available evidence to estimate the likely scale of impact of proposed interventions. The approach supports prioritisation and decision-making by helping Outcome Improvement Groups assess whether proposed changes are sufficiently ambitious, understand their likely contribution to improvement aims and identify where additional action may be required. It also provides a framework for monitoring and evaluation as the LOIP is implemented.

System Change	Risk Prevalence	Local Population	Exposed Population	Target Population	Effect Size	Population	Estimated Impact of the System Change
Name of change	Prevalence of the risk factor (indicator measuring improvement aim)	Population for area outcome measured in	Population exposed to risk factor (Risk Prevalence x Local Population)	Population taking part in system change	Relationship between system change and improvement aim from evidence	Target Population x Effect Size	Proportion of exposed population that are no longer exposed Population Impacted ----- x 100 Exposed Population
Community Food	10.2%	227,750 people	10.2% x 227,750 = 23,230 people	5% of exposed population = 5% x 23,230 = 1,161	10-25%	Lower estimate: 1,161 x 10% = 116 people Upper estimate: 1,161 x 25% = 290 people	Lower estimate: $\frac{116}{23,230} \times 100 = 0.5\%$ Upper estimate: $\frac{290}{23,230} \times 100 = 1.2\%$

Importantly, findings from this process have informed the scale of improvement sought within the LOIP. By estimating the potential contribution of individual and combined system changes, partners have been able to develop ambitious but realistic five-year and ten-year improvement targets aligned to the level of change required to improve outcomes and reduce inequalities across the city.

Reducing Poverty & Homelessness in Aberdeen

Progress towards our improvement aim: Reduce the proportion of people in relative poverty and homelessness by 3% by 2031



Children, Families and Lifelong Learning	Economic Stability	Communities and Housing	Neighbourhood and Environment	Health and Social Care
POSITIVE DESTINATIONS 	FAIR WORK 	POVERTY AND HOMELESSNESS 	CONNECTED, GREENER, SUSTAINABLE 	PREVENTABLE DEATHS 
TEN YEAR OUTCOME 1 95% of young people in the Scottish Index of Multiple Deprivation 1 and 2 quintiles groups achieve a positive destination on leaving school by 2036.	TEN YEAR OUTCOME 2 Reduce to 3% the proportion of people aged 16 and above in Scottish Index of Multiple Deprivation 1 that are not in employment and increase by 3% the employment rate of vulnerable groups by 2036.	TEN YEAR OUTCOME 3 Reduce the proportion of people living in relative poverty and homelessness by 6.5% by 2036.	TEN YEAR OUTCOME 4 Increase proportion of people from Scottish Index of Multiple Deprivation (SIMD) 1 who feel they have influence and sense of control by 10% by 2036.	TEN YEAR OUTCOME 5 20% reduction in deaths in Scottish Index of Multiple Deprivation 1 from alcohol and drugs and a 20% reduction in suicide rate city wide.

EVIDENCE TO BUILD THE CASE FOR INVESTMENT IN PREVENTION AND THE SOCIAL DETERMINANTS

Not all prevention investments are effective and certainly not equally effective. While the Scottish Government has clear ambition to strengthen investments in prevention, we noted in Chapters 3 and 6, that the focus remains on relatively downstream prevention, not on action on the social determinants of health. This limited focus is highlighted in an overview of prevention in Scottish public service reform, published in 2026 [69]. Moreover the equity impacts of prevention are not always well understood or developed and prevention can increase, not decrease inequities if equity is not at the heart of prevention investments and programmes.

The CHES collaborating places indicated that they have some understanding about local programme impacts based, mostly on impact analyses, and discussions with practitioners and community groups. However, these were not felt to be sufficient to inform decisions about most effective, and equitable investments in programmes. Places in the CHES requested support to identify the most impactful and cost-effective programmes for health equity, which they were able to deliver. The requests encompassed projected impacts on service demand, on equity and also on what wasn't as effective, but was still being commissioned. Stakeholders noted that funding is rarely available for evaluation or even impact analysis so while programmes were seen to have benefits it is difficult to demonstrate this in order to support longer term and large scale investment.

While the financial case for investments in reducing health inequalities can, and should be made more explicit, the real case for investment in health inequalities is a moral case – health inequities which are the result of inequitable policies and distributions

of power, money and resources are simply unfair and damaging to individuals, families, communities and society as a whole.

In summary and based on the approaches outlined in this report, further evidence is needed to demonstrate:

- **The social, economic and health equity returns on investments** in the social determinants of health compared with crisis services in the short and medium term.
- **Prioritising equity:** How far programmes and services which deliver more equitable outcomes should be prioritised.
- **Prevention Efficacy:** What are the most effective routes and timescales, not all programmes are equally impactful.
- **Evidence on the impacts and costs of scaling up:** Which is often not available.
- **Strategies for “double running”** How to make incremental investments in equitable social determinants of health while maintaining services that are made more expensive by deprivation and are stretched by fiscal constraints.
- **Ascertaining impact:** Stakeholders noted that funding is rarely available for evaluation or even impact analysis so while programmes were seen to have benefits it is difficult to demonstrate this in order to support longer term and large-scale investment.

Alongside evidence about the potential equity impacts and costs of prevention interventions, places highlighted that at programme inception there needs to be greater clarity, based on evidence, about how programmes contribute to shared outcome and performance frameworks. This would also help strengthen accountability.

EVIDENCE GAPS IN MARMOT 8 PRINCIPLES

The evidence base showing how key social determinants affect health is robust, and the Marmot 8 Principles are well evidenced. As noted above there are gaps in the evidence around implementation impacts. There is also only limited evidence in Scotland about the health equity impacts of the emerging threats identified in Chapter 4 and for Principles 7 and 8.

EVIDENCE TO TACKLE RACISM, DISCRIMINATION AND IMPACTS ON HEALTH

It has not been possible to extensively analyse data on health inequities and the social determinants of health by ethnicity in Scotland, due to the limited availability of data and evidence which is disaggregated by ethnicity. Having this data would enable understanding of differences in health and the social determinants of health by ethnicity, and how these differences are related to racism and discrimination and inform actions to address these.

In a report on ethnic minority groups in London, the IHE overviewed the available data by ethnicity, alongside input from community organisations and surveys. The analysis showed wide differences and set out that racism and discrimination were affecting the health and the social determinants of health of ethnic minority groups in London [70]. The report highlighted the lack of data by ethnicity in many policy areas and the insufficient level of disaggregation to allow meaningful

understanding of which ethnic groups experience the greatest differences. There is also a lack of analysis about the interrelationship between ethnicity and other forms of disadvantage and discrimination including socioeconomic position, gender, age and disability within ethnic groups. These gaps are also present in Scotland and need to be strengthened.

Differences in outcomes by ethnicity can signify the existence of systemic inequities and structural racism, however, this cannot be inferred without this type of disaggregated data and supporting qualitative and quantitative evidence. Peoples' experiences of racism and discrimination, including interpersonal racism, experiences with services and systemic and institutional racism must be considered alongside the data. The analyses need to be oriented towards action to address racism.

In 2021 the Wellcome Trust established the research, data and evaluation methods that address structural racism, as part of its wider exercise exploring its approach to antiracism [143]. Principles based on this are set out in Box 32.

Box 32. Wellcome Trust and data on racism

Principle 1: Prioritise antiracism work

It is important for organisations to prioritise antiracism work. In order to do this there must be adequate allocation of resources and time to do the work. Public health organisations must consider this a priority in their work and establish programmes that have dedicated resources and time to design actions, put them in place, and continue monitoring outcomes.

Principle 2: Investigate racial inequity

While many UK organisations collect data that could be used in the investigation of structural racism and health, much of this data is not collected in a way that reflects the complexity of race and ethnicity. The first priority is to ensure that race and ethnicity are routinely recorded during the collection of population level data. This, however, is an endeavour that has the potential to perpetuate structural racism. Without a full understanding of the nature of race – in particular, the fact that race is a sociopolitical construct that does not have any biological underpinnings – public health organisations run the risk of presenting data in a way that unwittingly supports racist narratives [144]. Decisions about the racial divisions used when collecting and publishing data should take into account the historical context behind many racial classifications, and efforts should be made to avoid collectively treating all racially minoritised people as a single group [145].

Principle 3: Meaningfully involve ethnic minority groups in decision making, data collection and data analysis

Any effort to address structural racism through the use of data, research and monitoring requires the organisations who use and collect data to confront any systemic racism that exists internally. In particular, it is important for public health organisations to ensure that racially minoritised people are involved in the analysis and presentation of data surrounding race and ethnicity – not only a research subjects and people

from whom data is collected, but at every part of the research process. This may require a move away from the perceived primacy of quantitative data, and a better understanding of the role of community groups and people with lived experience within the research environment. In particular, many organisations would benefit from the development of training around the importance of race-based data and the way to use and collect it using antiracist approaches.

Principle 4: Take positive action or other targeted approaches to redress racial inequity

It is important for all public health organisations to recognise their key role in creating a more holistic understanding of race, ethnicity and the impact of racism on health. For many organisations, this will go beyond their perceived population health functions – that is, the collection and presentation of data. As previously discussed, decisions surrounding the way that race-based data are presented can have a direct impact on the way that these data are interpreted, and it is therefore the responsibility of public health organisations to advocate for antiracist principles across the research and evaluation landscape [146]. With that in mind, public health organisations who collect and analyse data would benefit from the development of a purpose statement that specifically outlines their approach to race-based data and research to understand and mitigate the impact of structural racism [147].

Principle 5: Use your power to make measurable process towards racial equity

The ultimate goal of research surrounding race, ethnicity and health should be a full understanding of the impact of structural racism on health that allows the systems to address the resultant inequities. Public health and other organisations therefore need to ensure that they are not just collecting and presenting data on ethnic disparities within health outcomes, but that they are playing an active role in the use of research to mitigate the impact of structural racism. Monitoring and evaluation of data collection processes should be embedded into public health organisations, particularly focusing on the completeness of race and ethnicity-based data, the breadth of data collection methods (i.e. utilisation of methods that move beyond the collection of quantitative population-level data), and the discourse and analysis surrounding the data that are collected. In particular, public health organisations would benefit from policies that lay out a pathway for the transformation of data into action, ensuring that the data they collect can be used to promote and facilitate antiracism.

Source: Welcome Trust [143]

Understanding the impacts of racism and discrimination and taking action to address it go well beyond analysis. The evidence must be used to inform action and strengthen antiracism approaches and accountabilities, particularly in a context where reports of racism in the UK are increasing and equality, diversity and inclusion approaches being dismantled. But further analysis and information is needed to understand how racism and discrimination impact on health and the social determinants of health and to strengthen antiracism approaches nationally and locally to tackle these issues. PHS is preparing contributions in this area. In Scotland there are areas with low levels of ethnic diversity, in these areas, racism may be overlooked and ‘go under the radar’ as the issue is not prioritised and capacity to identify and act on racism may be less established.

PURSUE ENVIRONMENTAL SUSTAINABILITY AND HEALTH EQUITY TOGETHER

In Chapter 4, we overviewed the impacts of the climate crisis and environmental threats as health equity impact threats. Despite the growing evidence of inequitable impacts globally and within the UK, the evidence is still quite limited, and much of it based on projections.

As climate crisis impacts accelerate the research and evidence to establish which population group are being most adversely affected and the extent to which existing inequities are being exacerbated. This should be used to develop and implement mitigating actions for health equity as well as reduce overall harm. Furthermore, the equity impacts of these actions need to be included into the development of mitigating and adaptation strategies, set out in Chapter 4 [90].

SUMMARY AND RECOMMENDATIONS

Throughout the CHES there have been important analyses and community engagement which has helped to increase understanding of health inequities and inequities in the social determinants of health and supported prioritisation of issues nationally and locally. Community perspectives have been important and have influenced the prioritisation of particular issues and the design and delivery of approaches.

The CHES has helped address several gaps in routinely available data and information which should help align data on health and the social determinants, support resource alignment with social need and support strategic planning. There remains work to be done in further developing the progress that has been made and in seeking to fill gaps that have yet to be adequately addressed.

RECOMMENDATION 6:
BUILD THE EVIDENCE AND DATA NEEDED TO ADDRESS AND MONITOR HEALTH EQUITY

STRENGTHEN LOCAL AND NATIONAL MONITORING TOOLS BASED ON SMALL AREA DATA (IDZs) and SIMD

ENSURE EFFECTIVE AND IMPACTFUL COMMUNITY ENGAGEMENT

Ensure parity between community views and data

Strengthen Third Sector representation in the CHES

FURTHER DEVELOP HEALTH EQUITY COMMUNICATION TOOLS FOR THE PUBLIC AND POLITICIANS

STRENGTHEN EVIDENCE OF HEALTH EQUITY IMPACTS OF INTERVENTIONS AND FOR INVESTMENT

DEVELOP THE DATA AND EVIDENCE FOR HEALTH EQUITY IMPACTS FROM RACISM, DISCRIMINATION AND ENVIRONMENTAL CRISES (MARMOT PRINCIPLES 7 AND 8)

CONCLUSIONS

Poor health and wide inequities in health persist in Scotland, despite many efforts to address them. The CHES has contributed to national and local understandings about the drivers of health and health inequities and has tested out innovative routes to tackle health inequities. The work with local places has been fruitful and provided innovative routes to tackle health inequities but cannot alone make the needed step change for greater health equity; implementation is constrained by structural inequities and the two challenges must be tackled nationally and locally.

Nationally, health equity must be at the heart of government with significantly strengthened political and systemwide leadership and accountabilities and enhanced support for places to act. The UK and Scottish Governments, hold many of the levers to alter structural inequities and to meet the challenges from emerging threats to health equity. For that to happen equity of health and wellbeing need to be at the heart of government – rediscovering the public good, building public wealth and investing in public assets and in the social determinants of health. Scotland has a strong ambition to improve health equity, reflected in national strategies including eradicating child poverty, achieving inclusive economic growth, delivering a fair transition to net zero and creating sustainable NHS and public services and strengthening prevention, all should have important health equity impacts. However, hitherto the ambitions have not always led to the scale or pace of action required. Action can begin immediately to prioritise and deliver health equity, building political, public and official support and strengthening accountability for health equity and building the needed evidence.

Local approaches can be further developed through establishment of health equity ‘total places’, building on the experiences with three collaborating places during CHES. They include simplifying funding routes and ensuring strategic coherence, with efforts and resources allocated according to equity considerations and ensuring health equity in all policy and actions. Many of the recommendations made in this report can be developed through the continuing work with collaborating places and we see this as an important next stage for CHES.

RECOMMENDATIONS

The recommendations are intended to complement approaches already underway through PHS, the Programme for Government and the Public Health Framework and locally through the work of councils, the NHS and other public services, the Third sector and businesses.

ACT ON THE STRUCTURAL DRIVERS OF HEALTH EQUITY IN SCOTLAND

RECOMMENDATION 1:

PUT EQUITY OF HEALTH AND WELLBEING AT THE HEART OF GOVERNMENT

ENSURE THAT HEALTH EQUITY CONSIDERATIONS ARE AT THE HEART OF SOCIAL AND ECONOMIC POLICIES

RECOMMENDATION 2:

REDUCE INEQUITIES IN POWER, MONEY AND RESOURCES

BUILD POLITICAL LEADERSHIP AND PUBLIC UNDERSTANDING OF HEALTH EQUITY AND ITS DETERMINANTS

FURTHER EMPOWER COMMUNITIES AND THE THIRD SECTOR

INVEST IN HEALTH EQUITY

↓

Adjust resource allocations to align with deprivation and income

Scale up effective approaches

Increase prevention spend

RECOMMENDATION 3: ADDRESS EMERGING THREATS TO HEALTH EQUITY

ADJUST RESOURCE AND POLICIES TO REFLECT DEMOGRAPHIC CHANGE



Develop a strategy for healthy and equitable aging

Ensure services are culturally appropriate and strengthen accountability for racism and discrimination

INTERRUPT THE INEQUALITY-PANDEMIC CYCLE AND ADDRESS INEQUITABLE IMPACTS FROM THE COVID PANDEMIC



Align resources with widening post-pandemic inequities

Build trust in government and public institutions

DEVELOP A HEALTH EQUITY IMPACT ASSESSMENT OF DIGITALISATION, SOCIAL MEDIA AND AI



PHS to contribute to national discussions about health equity impacts

Increase public awareness about health and equity impacts

PURSUE ENVIRONMENTAL SUSTAINABILITY AND HEALTH EQUITY TOGETHER



PHS to ensure mitigation and adaption efforts enhance equity building on the Just Transition approach

Build public understanding about the health equity impacts of climate change, biodiversity loss and transition

Eliminate inequities in access to green spaces

DELIVER FOR HEALTH EQUITY

RECOMMENDATION 4:

STRENGTHEN THE DESIGN AND DELIVERY OF POLICIES AND PROGRAMMES

ENSURE POLICIES AND RESOURCES ARE UNIVERSAL AND PROPORTIONATE TO LEVEL OF DISADVANTAGE



Assess policies for equity impacts and make the case with the public

Build evidence and technical capacity to implement, commission and deliver proportionate universalism

BUILD STRATEGIC COHERENCE



PHS to assess policy and programme delivery for complexity and simplify accordingly

DEVELOP HEALTH EQUITY 'TOTAL PLACES'



Extend whole system, total place funding through a Health Equity and Prevention Fund

Strengthen health equity in all policy approaches

Embed proportionate universalism

Implement accelerator programmes alongside longer term programmes for structural shifts

MOVE FROM SHORT TO LONG-TERM PROGRAMMES AND FUNDING



Build public and political expectations about long-term progress for health equity

Develop programmes, targets and funding on 10 year cycles

Simplify procurement and grant giving processes

RECOMMENDATION 5: PRIORITISE HEALTH EQUITY

STRENGTHEN ACCOUNTABILITY FOR HEALTH EQUITY



Build health equity provisions into legislation with targets and national and local accountabilities

Strengthen scrutiny power for health equity

Establish a cross-government cabinet-level health equity committee

Develop a new national health equity target with ambition for 80 percent of the population to have improvements in health with greater improvements among more deprived people and places

Strengthen accountabilities for Community Planning Partnerships with progress reported nationally

ENHANCE LEADERSHIP AND CAPACITY FOR HEALTH EQUITY



Develop a national health equity board

Appoint a health equity lead in each council

Public services delivery and PHS to develop practical tools to operationalise action

BUILD BUSINESS FOR HEALTH EQUITY



Engage national and local businesses for health equity

Reconfigure IHE Business for health equity recommendations for Scotland

Health equity business criteria to be developed

STRENGTHEN HEALTHCARE FOR HEALTH EQUITY



Increase investment on the social determinants of health

Expand social value weighting in NHS procurement to 20 percent

Expand population health and anchor organisation ambition and remit for health equity and the SDH

RECOMMENDATION 6:

BUILD THE EVIDENCE AND DATA NEEDED TO ADDRESS AND MONITOR HEALTH EQUITY

STRENGTHEN LOCAL AND NATIONAL MONITORING TOOLS BASED ON SMALL AREA DATA (IDZs) AND SIMD

ENSURE EFFECTIVE AND IMPACTFUL COMMUNITY ENGAGEMENT



Ensure parity between community views and data

Strengthen Third Sector representation in the CHES

FURTHER DEVELOP HEALTH EQUITY COMMUNICATION TOOLS FOR THE PUBLIC AND POLITICIANS

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DEVELOP THE DATA AND EVIDENCE FOR HEALTH EQUITY IMPACTS FROM RACISM, DISCRIMINATION AND ENVIRONMENTAL CRISES (MARMOT PRINCIPLES 7 AND 8)

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