



INSTITUTE *of*
HEALTH EQUITY



A FAIRER, HEALTHIER SCOTLAND: THE COLLABORATION FOR HEALTH EQUITY

EXECUTIVE SUMMARY

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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.

INTRODUCTION

Health inequities are the avoidable and systematic differences in health between different groups of people; they are largely the result of structural inequities and the conditions in which people born, grow, live, work and age. These social determinants of health play a larger role in causing health inequities than inequities in access to healthcare, important as they are. There is a **life expectancy difference of 13.6 years for females and 16.3 years for males** between the most and least deprived areas across Scotland.

Avoidable health inequities blight many lives and undermine the wellbeing of individuals, families and communities across Scotland. They also limit possibilities for Scotland’s economic and social progress. Widespread health inequities are not inevitable, they are the result of unfair social, economic and cultural arrangements and are remediable. In Scotland there is much being done to improve health and reduce health inequities despite challenging social, economic and political contexts. But there is an ambition, indeed a need, to do more. The Collaboration for Health Equity in Scotland (CHES) was established in 2024 to analyse barriers to change and develop effective routes to go further to tackle health inequities.

The CHES partnership between Public Health Scotland, the UCL Institute of Health Equity (IHE) and three collaborating places, Aberdeen City, North Ayrshire and South Lanarkshire, has provided important insights and demonstrated practical ways

to tackle health inequities. The first phase (2024-26) has explored why relatively progressive policies in Scotland have not had the desired impacts on health and equity and tested out new approaches in the three collaborating places. The response to this question is that both widening inequities in the structural drivers of health and longstanding implementation challenges are undermining the ambition for better health equity. CHES has provided a bridge between national policy and delivery through Local Government, NHS Boards, Community Planning Partnerships, the Third Sector and communities.

The recommendations set out in the report are based on learning from the CHES combined with existing evidence and analyses. They have been developed by the IHE for consideration. They are intended to complement the shift to greater prevention and the ambitions for health equity in Scotland, including those outlined in the Population Health Framework and Scotland’s Programme for Government.

The recommendations are oriented towards addressing two major challenges through:

- Action on the structural drivers of health inequities
- Delivery for health equity

Under these two main objectives are six principles with more detailed recommendations which are set out in the conclusion.

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

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.

The work with local places has been fruitful but cannot alone make the needed step-change in action for greater health equity; implementation is constrained by structural inequities that require action at a national level across Scotland and the UK. If Scotland is to reduce inequities it must act in tandem, locally and nationally.

Local approaches can be further developed through establishment of **health equity 'total places'**, building on the experiences with the three collaborating places during CHES. This includes simplifying funding routes; better alignment of policies and programmes; efforts and resources allocated according to equity considerations; and putting health equity at the heart of all policies and actions. Many of the recommendations made in this report can be developed through the

continuing work with collaborating places, and spreading the approach to new places, and we see this as an important next stage for CHES.

Meanwhile there needs to be sustained delivery of policy priorities which support health equity by the UK and Scottish Governments which hold many of the levers to alter structural inequities. 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, creating sustainable NHS and public services and strengthening prevention. All should have important health equity impacts. Hitherto, actions in these areas have not been at the scale or pace of action required. Action can begin immediately to prioritise and deliver health equity alongside building public, political and official support and strengthening accountability and building the evidence required.



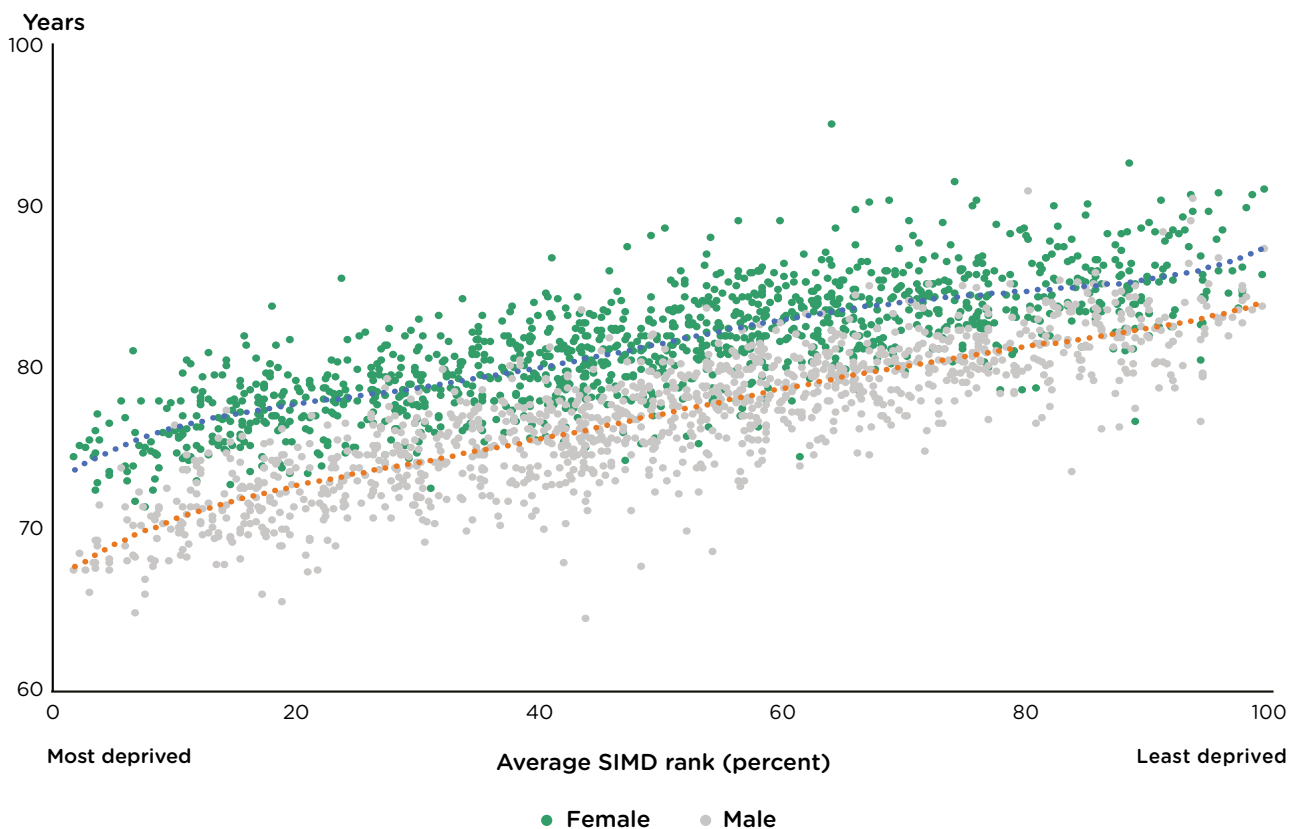
HEALTH INEQUITIES IN SCOTLAND

Figure 1 provides a picture of health inequities within Scotland, each dot representing a small area with a population of between 2,500-6,000 people. **There is a systematic and graded relationship between the level of deprivation of an area and life expectancy**, the greater the average deprivation of an area, the lower the life expectancy of residents. This gradient in health shows that every area, aside from the least deprived areas, are affected by conditions which

worsens the health of their residents and reduces their length of life.

An important implication of this is 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 health equity and for the CHES.

Figure 1. Life expectancy, female and male, by average SIMD rank*, Scottish Intermediate Zones, 2020-24



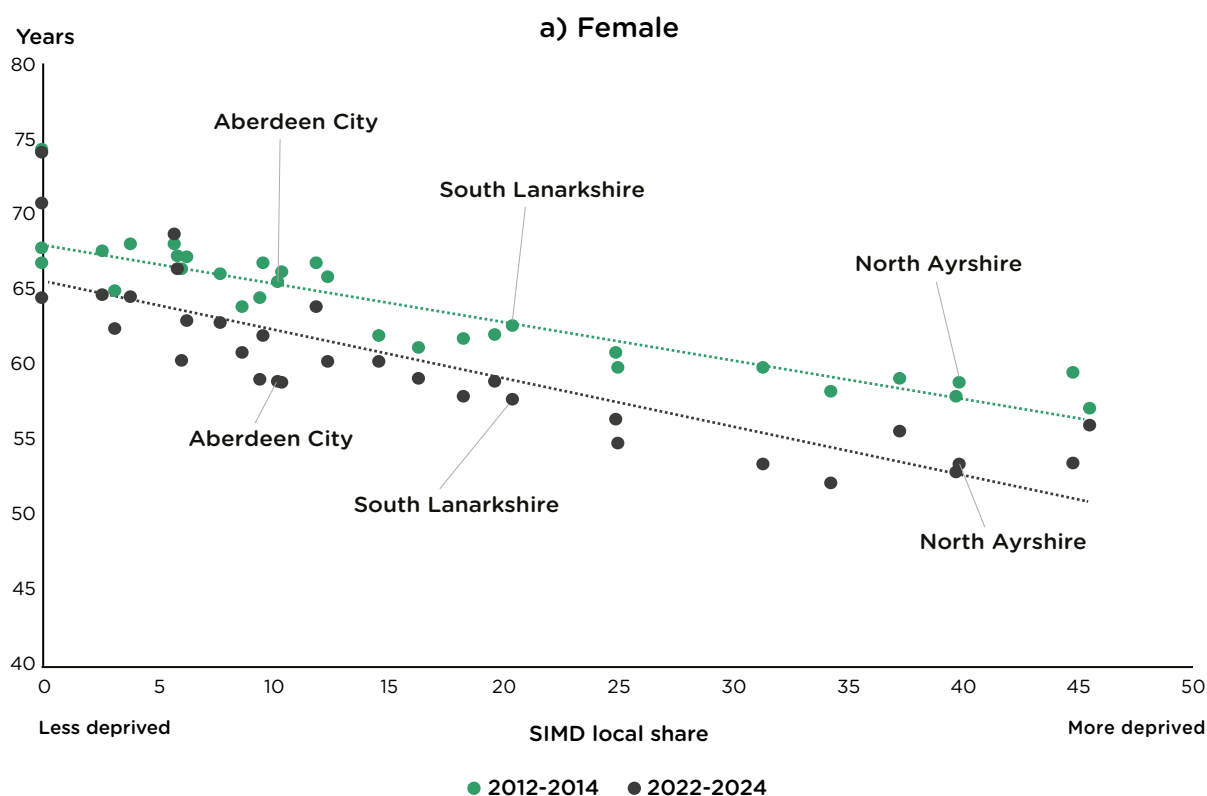
Source: National Records of Scotland (2025) [1]
Note: *SIMD rank refers to Intermediate Zones ordered by the Scottish Index of Multiple Deprivation

Inequities in health are widening

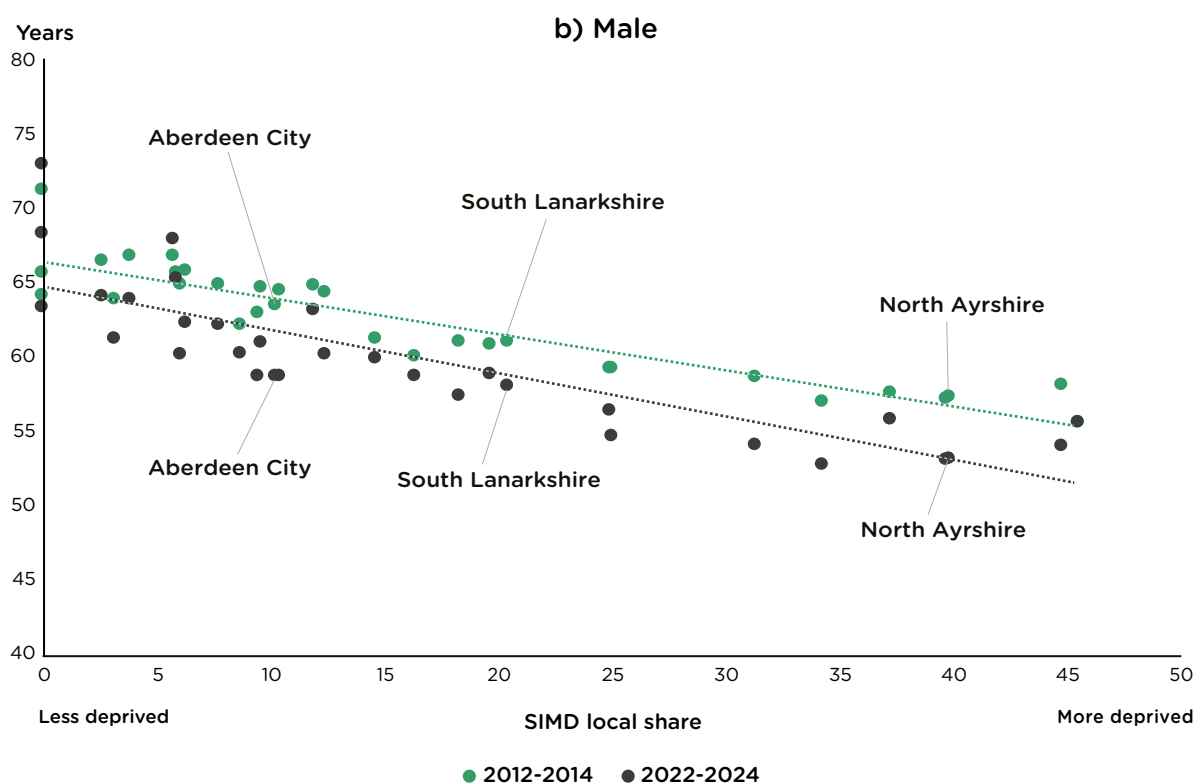
Figure 2 shows that across Scotland healthy life expectancy, that is how long you can expect to live in good health, declined between 2012-2014 and 2022-2024 by 3.6 years among women and 2.8 years among men. The declines have been greater in more deprived

Council areas, leading to widening inequities in health. Among 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 2. Female and male healthy life expectancy (SIMD Local Share), Scottish Council Areas, 2012-2014 and 2022-2024



Source: National Records of Scotland (2026) [2]



Source: National Records of Scotland (2026) [2]

Stark inequities and steep gradients in life expectancy and health are also evident within places, outlined in the main report and summarised in the first report for the CHES [3]. In each of the collaborating places health

is worse the more deprived an area is. Disadvantage continues to structure the opportunities for health of people in Scotland, with inequities visible in quite small areas within every Council.

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. Tackling inequities in health continues to be a priority, evident in national and local policies and strategies across a range of policy areas. Strengthening prevention is an important principle embedded at least since the Christie Commission in 2011. Scotland’s Population Health Framework 2025-2035 provides an agenda to reduce health inequities

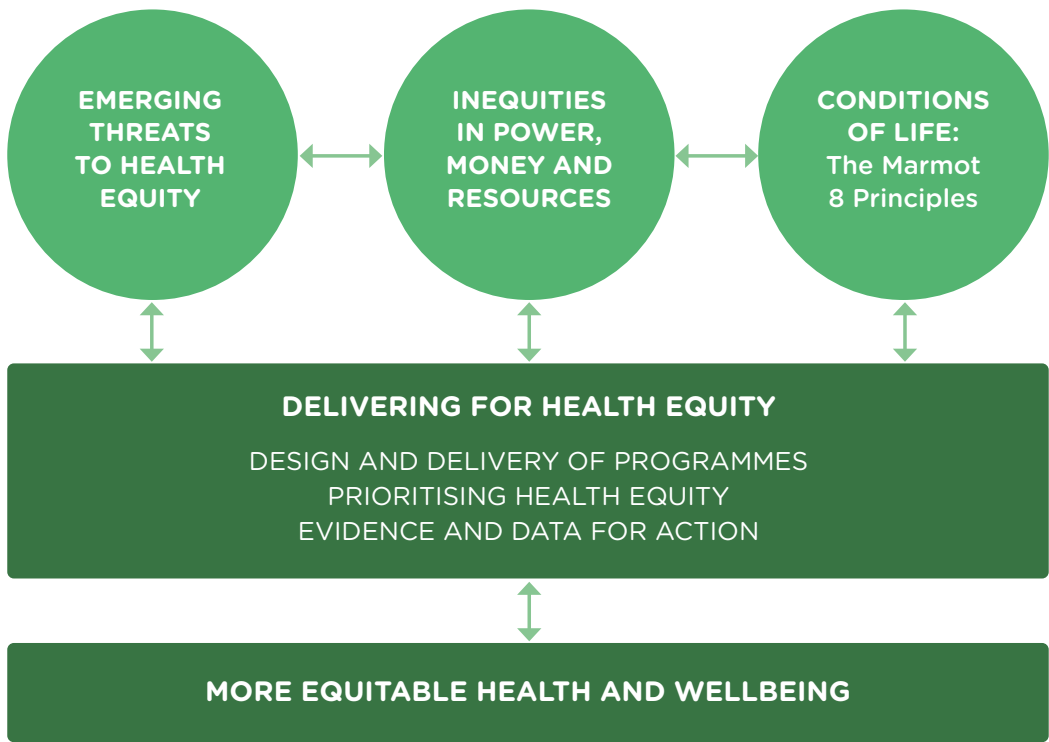
through action on the social determinants of health. This is reinforced by the Programme for Government which is well aligned.

Efforts to reduce poverty and support levels of development among babies and children are showing encouraging impacts. Reductions in child poverty, now the lowest in the UK, should contribute to better health and greater health equity as young people grow and age. There are also some positive indications that harm from alcohol is reducing and there are sustained reductions in smoking and declining rates of suicides.

THE CHES APPROACH

Based on learning from CHES, IHE developed a framework to represent the structural drivers of health inequities and the challenges and opportunities in delivering greater health equity. The recommendations follow the areas of this framework, Figure 3.

Figure 3. The CHES Health Equity Framework



All three CHES collaborating places developed action to reduce health inequities in ways which are related to this framework:

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

ACT ON THE STRUCTURAL DRIVERS OF HEALTH EQUITY IN SCOTLAND

THE CONDITION OF DAILY LIVES

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 inequities. The IHE has developed the Marmot 8 Principles to reduce inequities in daily life [4, 5]. The Principles

provide an important agenda for action and a lens to assess progress. In Scotland, the Marmot 8 were the focus of the second CHES report and have provided the entry points to embed action for health equity within the collaborating places [6, 7].

The Eight Marmot 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 the Marmot 8, conditions of daily life, nor make specific recommendations for actions in these areas, although we do recommend that the **Marmot 8 Principles are at the centre of strategic and delivery approaches to provide coherence and the focus on health equity.**

REDUCE INEQUITIES IN POWER, MONEY AND RESOURCES

At the centre of the framework are inequities in power, money and resources. These have loomed large throughout the work of CHES. They are evident nationally and locally and have profound impact on health throughout people’s lives. They also impact on delivery and implementation; influencing which organisations, sectors, places and communities have greater power and where money and assets are

allocated. Inequities in power, money and resources and their impacts on health equity are widely recognised in Scotland. This recognition must now translate into policy and practice; **health equity must be a central part of the discussions about distributions of wealth, resources and assets.** The continuing unhealthy impacts of some goods and services and corporate practices must be addressed, alongside a recognition that business also has an important, potentially positive role influencing health which can be further amplified.

Build political leadership for action on inequities in power, money and resources

Places and politicians have an important advocacy and leadership role in championing the conditions for better health. In an economic and political context where resources are under huge pressure, politicians

and service providers are often unwilling or unable 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 allocation of resources.

Empower communities and the Third Sector for health equity

Inequities in power frequently manifest in inadequate representation. When local people have less power and influence, their priorities and needs can be overlooked, and the support and investment needed to improve their lives may not follow.

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; partly due to communities facing the consequences of structural inequities.

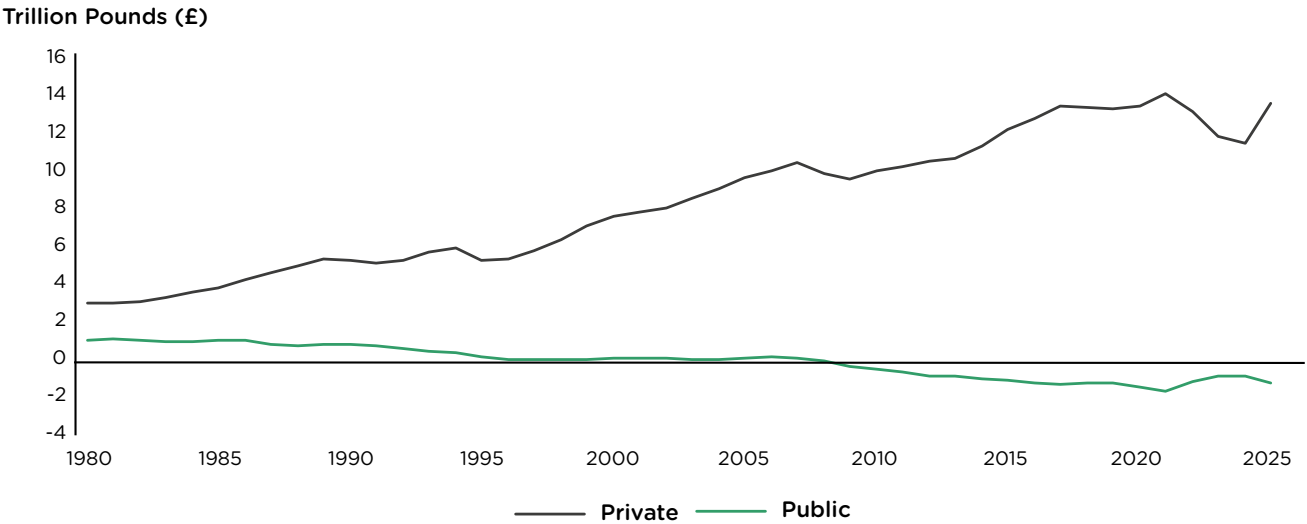
The Third Sector provides essential support in key social determinants of health and in health but continues to be beset by inadequate and fragmented funding, a declining donor base and increasing complexity in people’s needs as crises worsen.

Evidence shows **how transferring power and resources to communities and the Third Sector is possible and impactful**; building local resources and improving the design and delivery of services [8]. Scotland already has the policy architecture to support this shift. Community empowerment legislation, the Place Principle and place-based investment all point towards a model where power, resources and accountability move closer to communities. The opportunity is now to apply this more deliberately to improving health equity, by enabling Community Planning Partnerships, communities and the Third Sector to shape priorities, align funding and act on the conditions that drive unfair differences in health. The three places involved in CHES are developing innovative routes to community engagement.

Invest in health equity

In the UK, as globally, private wealth has increased rapidly since 1980 while net public wealth has decreased markedly, and public debt has grown. As privately held wealth increases, the resources that are available for investments in public goods and assets reduce, undermining opportunities for better health and health equity, Figure 4.

Figure 4. United Kingdom net public and private wealth, 1980 to 2025

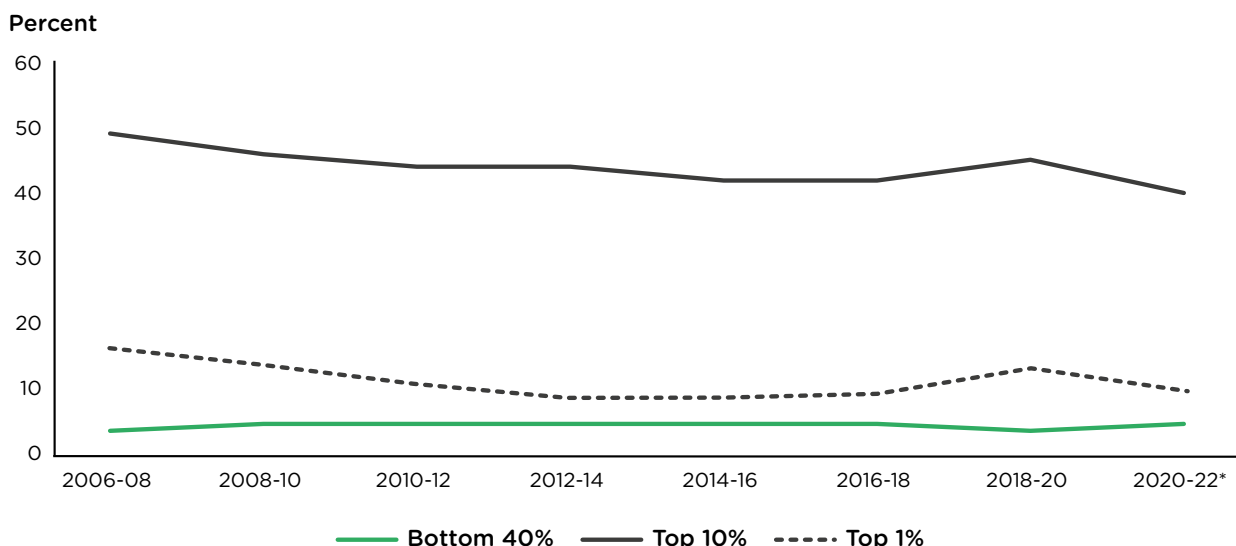


Source: World Inequality Database (2026) [9]

In Scotland inequities in wealth have increased since 2006-08. Figure 5 shows changes in levels of wealth (after inflation) for the wealthiest 1 percent, 10 percent and bottom 40 percent between 2006-08 and 2020-22. While the proportion of wealth held by the top 10 percent has declined over this period from 49 percent

to 40 percent and the top 1 percent from 17 percent to 10 percent, these declines 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 4-5 percent.

Figure 5. Total wealth by wealth distribution, Scotland, 2006-08 to 2020-22



Source: Scottish Government (2025) [10]

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

There are calls for redistributions of wealth, and assets to be transferred to the public realm. Considerations of health equity should be part of these deliberations. **There must be greater recognition in these discussions that distributions of wealth, resources and assets have profound impacts on health equity.**

Even without substantive changes in inequities in wealth and public assets and investments, there is much that can be done to allocate public resources more equitably.

Adjust resource allocations to reflect deprivation

Service allocations are not always sufficiently aligned to levels of deprivation and poverty to reduce inequities. For example, while there have been welcome increases in investments in early learning and childcare in Scotland, these are broadly the same regardless of the proportion of children in poverty in each local authority and average spend per child is similar, Table 1.

Table 1. Average spending on early learning and childcare per child 0-4 years, by quartile of the share of children in relative poverty, in 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) [11]

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

Similarly, healthcare spending for babies and young children is not related to level of poverty for children.

Table 2. 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) [11]

Note: *Based on the share of children in early years in each Council who are in families with low income.

To reduce inequities, we recommend proportionately greater increases in service spending among children living in lower income households and more deprived local authorities.

In an earlier CHES report we highlighted that while the funding formula underpinning the General Revenue Funding Grant allocations from the Scottish Government to local governments reflects deprivation to some extent, the weighting is insufficient to enable Councils to reduce deprivation and disadvantage and therefore poor health. We propose that the criteria and methodology underpinning the General Revenue Funding allocations are assessed and modified to ensure that the funding is sufficient for Councils to tackle and mitigate inequities related to level of deprivation.

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.

Scale up effective approaches for health equity

Reducing poverty, improving housing quality and increasing access to early years support are three important ways 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 [12]. The potential health equity impacts of increasing investments in these three approaches were estimated for Scotland, Box 1, showing significant reductions in deprivation related health inequity are possible, through these large scale, long-term policies and investments.

Box 1. Scotland: Scale of investment and potential change for health equity

Ensuring all residents have the Minimum Income Standard results in a potential **21 percent reduction in inequity in life expectancy among women and 18 percent among men.**

Insulating poor quality housing among low-income households would potentially **reduce inequities in healthy life expectancy by 3.5 percent (female) and 3.7 percent (male)**, the social value of which could reach £26.2 billion.

Extending family support and early childhood interventions could over a lifetime generate a **10-15 percent reduction in inequities in healthy life expectancy.** The social value of the extra healthy life years lived could range from £100 billion to £150 billion every 80 years [13].

Increase prevention spend

CHES is based on evidence that investments and action on the social determinants of health are effective and equitable routes to prevent ill health and lead to greater health equity [14]. However, prevention is often understood as equitable access to services, screening, identifying individual risk factors for disease, and vaccinations. All have an important part to play. But it is also vital to improve the conditions of daily life and thereby prevent poor health and reduce health inequities. Currently investments in prevention are too low, Box 2 [15].

Box 2. Prevention spend

In order to understand levels and proportions of prevention spend, the Scottish Government Prevention Unit assessed the proportion of prevention spend in the Scottish budget and found that only 15 percent of spend was directed towards prevention spending, of which only 18 percent, less than 3 percent of the overall Scottish budget, was tagged as primary, upstream prevention. Vaccinations and immunisations were included in this 3 percent, which while vital are not investments in the social determinants of health [16].

We recommend substantially increasing investment in prevention to improve conditions of daily life and health, supporting the work progressing under Programme for Government to develop a Prevention Investment Framework and prevention target.

ADDRESS EMERGING THREATS TO HEALTH EQUITY

Economic, environmental, cultural and social structures are changing and these 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 equity from 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. 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.**



DELIVER FOR HEALTH EQUITY

Much of CHES has been about exploring more effective and equitable delivery and implementation approaches. Many of the issues hampering this are well established and have been described over many years [3, 14, 17, 18]. An important question is why then, given plentiful evidence about issues with the delivery and implementation landscape in Scotland have these not been addressed?

Our recommendations make the case for needed changes in the design and delivery of programmes and services, increasing the priority given to health equity and ensuring the provision of data and evidence available to inform approaches and decision-making. These cover recommendations to embed proportionate universalism, longer-term funding and a simpler delivery environment. Building on the learning from the three CHES collaborating places we recommend developing health equity ‘total places’ in Councils, which test out these approaches.

STRENGTHEN THE DESIGN AND DELIVERY OF PROGRAMMES AND SERVICES

Universal, and/or targeted services, fragmented, siloed funding and short-term, crisis-related approaches are not designed to reduce the gradient in health. In fact, they can actively undermine health equity, wasting scarce resources and further excluding and reducing trust with communities who need the

support. To strengthen approaches for health equity we recommend approaches which:

Ensure proportionate universalism

Scotland has a tradition of universally applicable programmes and services. While this ensures that everyone in Scotland benefits from policies and services it does not sufficiently address inequities and can be costly. 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, Box 3.

Box 3. Proportionate universalism commissioning, Aberdeen City

Through the CHES Aberdeen City have secured political leadership and support from Council officers to embed proportionate universalism. In the 2026 Local Outcome Improvement Plans and Locality Plans, one of the key measures of success for the plan is the reduction of the social gradient. Proportionate universalism is seen as an important component of commissioning, tested through the Play Strategy. Practical tools have been developed to support decision making for proportionate universalism.



The IHE recommend that **investment decisions and the design and delivery of services and support are designed on the principle of proportionate universalism.**

Simplify the fragmented 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 [17]. 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. This leads to competition within and between sectors, depletes capacity and resources and weakens local areas' ability to provide services and offer support in ways that local communities have indicated are needed.

Develop health equity 'total places'

We recommend testing a health equity 'total place' approach 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. Whole family support is similarly intended to secure this sort of integrated approach. The challenge is to go further and extend the approach to cover the breadth of the 8 Marmot Principles, and to bring in wider funding from partners.

Longer-term funding and programme duration

Evidence repeatedly shows that short-term programmes significantly undermine impacts. As many have before, we also recommend multi-year funding and reporting for programmes, without the demands for evidence of short-term returns on investment, which may take years to emerge.

PRIORITISE HEALTH EQUITY

Strengthen accountabilities for health equity

Positively, there are many duties to protect and improve health and reduce health inequalities in Scotland. However, these often lack legal enforcement mechanisms and measurable targets and are frequently seen through the lens of equitable access to services, which does not

involve action on the social determinants of health. We propose strengthening accountabilities for health equity in the following ways:

Strengthen and enforce existing accountabilities with enhanced health equity scrutiny powers

Build Health Equity provisions into existing legislative requirements with specific sector targets and direct and enforceable accountabilities for reducing health inequities. These to be overseen by a cross-government Cabinet-level committee, responsible for the development of recommendations in this report and progress towards targets for health equity.

A National Target for Greater Health Equity

The Population Health Framework sets out a national aim by 2035 to improve 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 does not relate to the gradient in health. We propose a new target, with 80 percent of the population to have improvements in health, with measurably greater improvements for more deprived population deciles. This proposal means reducing the slope index of inequality to tackle the whole population gradient in health and not just the bottom quintile of areas and 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 leadership at all levels with significant contributions from PHS, Councils, the Third Sector and healthcare. 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 PHS and programme leads have a willingness and motivation to learn and try new approaches. Nonetheless through the CHES it was apparent that there is potential to strengthen public health and health improvement capacity and resourcing within Councils.

Senior health equity lead

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 influencing policy and decision-making.

Strong political leadership

Within CHES local political leadership has been needed. Nationally, political party leadership and MSPs can be encouraged to take further leadership on action

to reduce health inequities. A strong and accessible narrative is required to strengthen and encourage this.

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.

Businesses have potential, which is underdeveloped, to contribute more to improvements in the social determinants of health. The role of business can be strengthened including through the Community Wealth Building Duty, the forthcoming Scottish Governments Health and Work Action Plan and Keep Britain Working plans.

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 that affects their health [20]. The healthcare system of course remains primarily oriented toward treatment of ill health rather than action on the social determinants. There is more that can be done to ensure health care systems can reduce inequities in access and inequities in experiences and outcomes. There are also important opportunities for healthcare organisations and the workforce to improve the social determinants of health at population and individual levels and support action on the structural drivers of health. In fact, not doing so jeopardises the primary remit of treating ill health as population health deteriorates, healthcare resources and workforce experience sustained pressures and services cannot meet the need.

There are many opportunities for healthcare to further support action on health equity through the social determinants of health by strengthening the remit of anchor organisations, building neighbourhood health as an equity focussed partnership, strengthening population health approaches and increasing social value weighting in NHS procurement to 20 percent. Primary care and neighbourhood health are important routes through which to embed equity and action on the drivers of poor health. During the CHES, the healthcare system has been a partner in the place-based approaches drawing on population health approaches, Box 4.

Box 4. Population health care, Grampian

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.

STRENGTHEN EVIDENCE DATA AND INFORMATION FOR HEALTH EQUITY

Through the CHES several gaps in routinely available data, information and evidence were identified which limit understanding about inequities within places and means that the design and delivery of support may not be the most appropriate. These gaps relate to:

1. Mismatch between data on health and many of its social determinants within Council areas.
2. Data on alignment of resources with social need.
3. Data and evidence to support strategic planning.
 - > Community perspectives and insights
 - > Evidence about returns on investment and cost efficacy
 - > Framing data to successfully communicate the scale of inequities in health and the social determinants of health
 - > Information needed to identify the effects of racism and climate change and environmental crises on health equity and the social determinants of health

The CHES supported places to address some of these gaps which led to:

- Deepened understanding of the extent and drivers of health inequities within places
- Identification of priority issues, places and communities
- Communications about the extent of inequalities to build public, political and systemwide leadership understanding and support
- Additional partners and funders being brought in to tackle health inequities.

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.

CONCLUSIONS

Poor health and wide inequities in health persist in Scotland, despite many efforts to address these. The CHES contributes to understandings about the drivers of health and has tested out some innovative routes to tackle them. Through the collaborations there have been a number of positive impacts within the three places, learning for other places and for PHS and other national partners. There is clearly an important local agenda to develop further action for health equity. 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, by simplifying the delivery landscape and aligning resources with levels of deprivation and household poverty.

RECOMMENDATIONS

The recommendations are intended to complement approaches already underway through PHS, the Programme for Government and the Population 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 INEQUITIES

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

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)

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