

Structural inequalities hamper Scotland's efforts to close the health gap

Scotland's efforts to reduce its wide health inequalities are being undermined by an unequal distribution of power, money and resources – the structural drivers of health – and by problems delivering change, including a lack of long-term funding, finds a new UCL Institute of Health Equity report.

A Fairer, Healthier Scotland reinforces health inequalities are largely driven by the conditions of daily life that shape health, including income, housing, work and education (social determinants of health), rather than simply access to healthcare. Access to these conditions is systematically shaped by the structural drivers of health – the systems that decide who gets money, power and resources.

The report highlights that the social determinants of health will only improve if deep-seated inequalities in society are addressed and power and funding is distributed more fairly and devolved to affected communities. To address this the IHE is working in partnership with Public Health Scotland and three collaborating areas – Aberdeen City, North Ayrshire and South Lanarkshire – to test new approaches as part of the Collaboration for Health Equity in Scotland (CHES).

Commenting, Professor Sir Michael Marmot, Director, UCL Institute of Health Equity said: “Scotland has been hit badly by the sluggish recovery from the economic crisis in 2008, which has affected salaries and, in turn, living conditions and health equity. Further, the pandemic, climate change and political instability in the UK government have added to the challenge of addressing health inequalities.”

Health in Scotland is worse than in England, Wales and Northern Ireland

- Men in Scotland's most deprived areas can expect to live 16.3 fewer years than men in the least deprived areas; for women the gap is 13.6 years.
- Healthy life expectancy, meaning how long people live in good health, has fallen by 3.6 years for women and 2.8 years for men in the last decade. The biggest falls have been in the most deprived areas – there is now a gap in healthy life expectancy of more than 22 years for women and 20 years for men between the most affluent and most deprived councils.
- The poorest 40% of people in Scotland hold less than 5% of the country's wealth – this has not changed since 2006–2008.

Sir Michael explained: “The relative stability of government in Scotland, the progressive policies, strong public health sector, collaborative planning and focus on community empowerment are clear positives. Child poverty is lower in Scotland than England and actions, such as minimum unit pricing, have made a difference to Scotland's alcohol-related health problems.”

Why progressive policies haven't closed the gap

The report asks why Scotland's relatively progressive policies and strong ambition for health equity have not delivered better health for all. It finds two reasons:

1. **Unfair systems.** Differences in power, money and resources shape the conditions in which people live such as their income, housing, work and communities. Public wealth has shrunk

markedly while private wealth has increased, leaving less to invest in the things that keep people healthy.

2. **Problems delivering change.** Short-term, fragmented funding and complex delivery arrangements waste resources and make it harder to help the people who need it most. Spending also often fails to reflect need. For example, early years spending per child is about the same whether a council area has high or low child poverty.

What needs to change

The eight Marmot Principles covering conditions in which people are born, grow, live, work and age need to be implemented. To achieve this, the report makes six recommendations:

- **Put health equity at the heart of government**, with a cabinet-level committee to drive progress.
- **Invest where need is greatest**, with funding shared more equitably between councils to reflect deprivation and scaling up action on poverty, housing and early years support – making sure everyone has enough income for a decent standard of living could cut the life expectancy gap by around a fifth.
- **Shift to long-term funding**, with programmes, targets and funding set on ten-year cycles.
- **Create “total health equity places”**, where local funding is simplified into a single pot and allocated proportionate to need.
- **Strengthen accountability**, with enhanced scrutiny for health equity and a new national target for 80% of people to see better health, with the biggest improvements in the most deprived communities.
- **Appoint a senior health equity lead in every council**, and bring businesses and the NHS in as partners, including raising the social value weighting in NHS procurement to 20%.

Investing in health equity: Analysis indicates that poverty, housing quality and early years together could explain up to 70% of the difference in how healthy people say they feel within countries in Europe. As part of CHES, the IHE has explored how large long-term investment in income, housing and the early years could greatly improve health for everyone, with the biggest gains in the poorest communities.

1. **Topping up the 790,000 households who are living below the Minimum Income Standard** would cost around £1.5 billion a year and add about a year to average life expectancy, and around 2.5 years in the most deprived areas. That **would cut the life expectancy gap between areas by about a fifth: 21% for women and 18% for men.**
2. **Insulating poor quality housing for around 500,000 low-income households** would potentially **reduce the healthy life expectancy gap by 3.5% for women and 3.7% for men, with a social value of £26.2 billion.**
3. **Expanding and sustaining childcare, home visits, and health and nutrition checks** for 100,000 under-fives in low-income communities could **reduce the healthy life expectancy gap by 10% - 15%, with a social value of £100 to £150 billion.**

Sir Michael added: “CHES has adopted our eight principles, which cover: a good start in life; education; work and employment; sufficient income for healthy living; environment including housing and transport; social determinants of behaviours; tackling racism and discrimination; pursuing sustainability and health equity together. Action on these areas should accord with the principle of proportionate universalism – universal programmes with effort proportionate to need.

CHES goes further in two ways. It addresses inequities in power, money and resources that give rise to inequities in daily life; and it seeks to understand and overcome blocks in delivery. In addition, the IHE analysis shows that reductions in health inequalities in Scotland are entirely

possible and there is evidence to indicate how and where investments can be made to realise them. There are also important secondary benefits – health improvements and reductions in health inequities will support economic and social development, including, for example, through increased education and employment productivity and tax revenues, as well as reducing the demand for, and costs of, a range of health and social care services.”

Collaboration with three Scottish places, examples of action include:

- **South Lanarkshire:** Working with families in the Burnbank area, Community Planning Partners have secured £8 million to redesign local services to intervene in early childhood before problems reach crisis point. That includes building parents' confidence and wellbeing, offering learning and parenting support, and linking families with community and peer networks. Behind the scenes, partners are joining up how they work: sharing governance and a common set of outcomes, cutting duplicate assessments and referrals, and coordinating better across services.
- **North Ayrshire:** Analysis of local data, combined with extensive engagement with communities and partners, identified three priority places where the themes of Good Start, Good Jobs and Good Health are now being taken forward through targeted action. This approach is helping to align activity around reducing health inequalities while ensuring solutions are shaped by local experience and need. Early progress is already emerging through all workstreams, including exploring a North Ayrshire Good Jobs Charter to promote fair employment practices and support more inclusive access to good quality work.
- **Aberdeen City:** Health equity and support for everyone, scaled up for those with the greatest need (proportionate universalism) are shaping funding decisions across the city, including the development of a fairer, approach to investments in play parks. By combining information from its Play Sufficiency Assessment with local data on deprivation, child poverty, health outcomes and access to community assets, resources are directed to the places and communities that stand to benefit the most. Interactive mapping then brings this to life, allowing officers and partners to see play park locations alongside health and deprivation indicators, compare areas consistently and identify where to target improvements.

Editor's Notes

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About the [Collaboration for Health Equity in Scotland \(CHES\)](#)

The CHES is a partnership between Public Health Scotland (PHS) and the UCL Institute of Health Equity (IHE), led by Professor Sir Michael Marmot. Established in 2024, it aims to strengthen and accelerate action to improve health and reduce health inequalities in Scotland. Nationally, CHES explores why progressive policies have not yet closed the health gap, using Marmot's eight principles for a fairer society. Locally, it works with councils, health boards and partners in Aberdeen City, North Ayrshire and South Lanarkshire to develop and test practical approaches to health equity. The three areas were selected through an open process, with the three areas chosen because they matched the programme criteria most closely. The CHES Learning System shares what is and isn't working across Scotland through webinars, insight reports and a growing community of practice.

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About the [UCL Institute of Health Equity \(UCL IHE\)](#)

The UCL IHE, based at University College London and led by Professor Sir Michael Marmot, was established in 2011 to reduce health inequalities by tackling the social determinants of health: the social, economic, political, physical and cultural conditions that shape people's lives. Its work builds on two landmark reports: the [WHO Commission on Social Determinants of Health](#) (2005–2008) and [Fair Society, Healthy Lives: The Marmot Review](#) (2010). UCL IHE works with national, regional and local governments, global organisations, businesses, the voluntary sector and health services in the UK and internationally. It builds the evidence on what works, helps design and deliver effective action, advocates for change and trains the workforce. In 2013, Coventry became the first Marmot Place. Around [70 places](#) across England, Scotland and Wales have become health equity areas, which includes implementing the eight Marmot Principles framework at the heart of their local strategies.

Marmot Eight Principles for Health Equity

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