Health Inequalities Policy Review

Introduction

While Scotland's health is improving, the gap in health outcomes between the most and least advantaged groups in society is widening. People who are part of a lower occupational class or have a lower level of income, with a lower level of education, have greater health problems, have a poorer quality of life, are sicker for longer and die at a younger age than more advantaged groups. This is what is meant by health inequalities. It is more than just differences in life expectancy across communities, it is the gap between the most advantaged and the most disadvantaged in society and how that impacts on quality of life.

These inequalities are apparent from the earliest stage in life, and their impact can build throughout a person's life. However, the good news is that they are not inevitable; they can be prevented, reduced and reversed.

These inequalities are caused by a complex combination of factors, which cannot be solved by health agencies alone. A number of factors, such as housing, education and employment (commonly referred to as social determinants) all impact on people's life chances and help shape individual opportunities and responses. All agencies across all sectors need to work together to eliminate inequalities.

Voluntary Health Scotland

Voluntary Health Scotland is the national intermediary for a network of voluntary health organisations and workers. Our members range from large national health charities to small, local service providers, and members' interests span service planning and provision, prevention, early intervention, self-management, advocacy, and support for service users and carers. We welcome the opportunity to submit a response to Mr Findlay's Health Inequalities Policy Review.

Throughout 2013 and 2014, Voluntary Health Scotland has worked extensively throughout the third sector to:

- raise awareness of health inequalities and social inequalities
- examine and evidence the third sector contribution to reducing, preventing and reversing the gap between the most advantaged and the most disadvantaged, and
- promote the need for cross-sectoral and cross-issue working, through a range of policy areas and between statutory, voluntary and independent sectors.

The evidence below reflects consultation and discussion with our membership and the wider voluntary health sector across a range of health inequalities themed events. Voluntary Health Scotland is also in the process of conducting research into evidencing the third sector contribution to tackling health inequalities and what support is needed at national and local levels to achieve this. The research will be completed by the end of 2014, with the aim of launching at Scottish Parliament in early 2015.

Review Questions

What is the character of health inequality in Scotland?

We asked representatives from the voluntary, statutory and academic sectors to tell us what health inequalities looked like across Scotland. The majority confirmed that this was related to poverty and people's respective positions in society and the impact of the social determinants of health upon this e.g., housing, transport and education etc. Other identified factors showed unequal levels of health service provision, and their uptake, and social exclusion, isolation and being trapped in situations beyond individual control.

What health inequalities do the people face?

When asked representatives from the voluntary, statutory and academic sectors about the specific inequalities that people face, they listed the following in order of incidence:

- Services – difficulties accessing appropriate services, and distribution of services across Scotland, including different funding and support systems, and the divide between systems of health and social care.
- Poverty – the basic and cyclical effects of poverty on an individual, and the wider impacts of welfare reform and austerity measures.
- Behaviours/conditions – specific health-related conditions such as heart disease, cancer and mental health, and behaviours, such as addictions.
- Loneliness, social isolation, stigma and associated stress – psychological issues, support needs and, personal and community networks.
- Partnership – specifically the lack of joined-up working across health and social care and the third sector.

What role can health and other services play in tackling health inequalities?

NHS Health Scotland, the national agency charged with tackling health inequalities, recognises the complex combination of factors that cause inequalities and acknowledge that this cannot be solved by health agencies alone. Factors such as housing, education and employment impact on people's life chances and help shape individual opportunities and responses. Understanding what works in preventing, reducing and undoing health inequalities is growing as the debate widens, but joined up action has been slow to follow, particularly upstream where the problems develop. All agencies across all sectors need to work together to eliminate social inequalities that are unacceptable in 21st century Scotland. The Scottish Government's 20:20 vision of healthier, longer lives for all needs to apply to everyone.

We fundamentally believe that health inequalities can only be reduced through an integrated strategy and joint action across sectors to reduce inequality and deprivation. As part of this, we need both political and public sector commitment, and cross-sectoral work to address inequalities and ensure the delivery of linked services to support those in greatest need.

The third sector is a major provider of both adult and children's services and works with some of Scotland's most vulnerable people, families and communities. Many voluntary organisations already work with local authorities and, to an increasing extent, health boards,

to jointly identify need, plan and provide services. In doing so, our sector is central to the delivery of services and interventions that prevent and reduce health inequalities. There is a real need to collaborate across cross health and social care, and harness and embed the voluntary sector as an integral partner. Work to tackle health inequalities cannot be done in isolation, but instead requires a whole systems approach with all stakeholders.

What can be done within current devolved arrangements to tackle health inequalities? How could we use further devolved powers to help tackle health inequalities?

There is substantial work that can be undertaken under current devolved arrangements. The first and foremost requirement is for all agencies across all sectors to work together. We need joined-up policies, with reduced silo working, integrated services and connections between them. The Public Bodies (Joint Working) (Scotland) Act is a starting point for the integration of health and social care, but more can be done to ensure that people are at the centre and measures are in place to reduce the inequalities gap. The third sector needs to be respected as an equal partner within this process and engaged in strategic partnerships, joint working and shared agendas when developing and implementing national policies, and sharing information.

Recommendations from the Christie Commission advocate the need for preventive action and this should be a priority. The problems are deep-rooted and structural and require a shift of investment and focus. This agenda, while perhaps not popular with voters, needs far more traction with an accompanying shift in resources. This has to be shared across public, voluntary and private sectors, with communities at its heart. Working hand-in-hand with our local communities needs to continue and be scaled up if it is to make a real difference.

Public Health Minister Michael Matheson's recent Task Force on Health Inequalities also highlighted the need to empower and work with communities to reduce the inequalities gap. The evidence is that some deprived communities are more resilient to health inequalities that others, with a key difference being higher levels of community cohesion, social and voluntary action. Therefore we need to work with communities to build capacity and resilience; a preventative role that the third sector has long advocated and worked to address.

Further devolved powers would increase the ability to tackle social inequalities on a population level, for example in fiscal, economic and monetary policy. This would seek to address the unequal distribution of power, money and resources that are a fundamental cause of social and health inequalities.

What can be done to tackle the Inverse Care Law in health and other public services?

The inverse care law describes the need for health care and its actual utilisation; Those with the greatest need have poorer utilisation and access to services and those with the least need of health care tend to use health services more (and more effectively). This is a large proponent of health inequalities.

Recent work to improve population health has focused on building health literacy of the population and providing universal services for all. An unintended consequence of this has resulted in widening the health inequalities gap between the most advantaged and

disadvantaged groups of society. The most disadvantaged groups suffer; they use poor quality services, to which they have relative difficulty securing access and they suffer multiple external disadvantage.

In order to tackle these inequalities, we will need to target the most disadvantaged groups in new ways – through such means as 'targeted universalism'. This is an approach that supports the needs of particular groups in a proactive way while providing health, and other services, to all. The Marmot Review champions the need for 'proportionate universalism' and reducing health inequalities through universal actions that are proportionate to the level of disadvantage; tackling local inequalities with local action.

Is democratisation of health services important in tackling health inequalities?

The democratisation of health services is an important factor in tackling health inequalities. We, as part of the third sector, strongly advocate the need for co-production and engagement with service users, carers and their representative groups in the voluntary sector. All services should be centred around the person and as highlighted in the Scottish Government's 20:20 vision of healthier, longer lives for all, this needs to include:

- shifting the balance of power to, and builds on the assets of, individuals and communities
- supporting for the self-management of long-term conditions and personal action, and
- supporting partnership working, including the third sector, in Community Planning Partnerships (CPPs) and the new Integrated Health and Social Care Partnerships.

However, for democratisation of services to have an impact on reducing the health inequalities gap, there needs to be a real focus on building capacity within communities to ensure that the most disadvantaged can and are able to engage in this process.

In our submission to the Community Empowerment (Scotland) Bill consultation in January 2014, we noted that there were no provisions for how public bodies should support less empowered Community Bodies to take advantage of new engagement routes. Some constituted Community Bodies are marginalised from mainstream engagement, for example, peer groups, involvement groups or activist groups. These community bodies may not be in a position to mobilise their own participation with public bodies and require further support.

How could community development efforts be better supported to tackle health inequalities?

As previously identified, Public Health Minister Michael Matheson's recent Task Force on Health Inequalities also highlighted the need to empower and work with communities to reduce the inequalities gap. The evidence is that some deprived communities are more resilient to health inequalities that others, with a key difference being higher levels of community cohesion, social and voluntary action. Therefore we need to work with communities to build capacity and resilience; a preventative role that the third sector has long advocated and worked to address. The Glasgow Centre for Population Health and the Community Health Exchange (CHEX) are examples of organisations with rich evidence of the work of community development in tackling health inequalities. Publications of interest include:

Communities at the Centre; Evidencing Community-Led Health

Assets in Action: Illustrating Assets Based Approaches for Health Improvement

This could be further supported by ensuring a shift in focus towards preventative interventions, with an accompanying shift in resources. One of the main pressures on community development work is that of limited funding and short-term funding cycles. Funding mechanisms seem to focus on new, innovative projects, rather than providing a continuity of care, even when faced with compelling evidence of the impact and benefits of community actions.

The statutory sector should be further encouraged to work with the third sector in preventative community work. With the introduction of health and social care partnerships under the Public Bodies Act, this is an ideal time to ensure collaborative work between sectors. However, there needs to be more focus on promoting this much-needed collaboration with statutory sector partners.

How could resource allocation (this could be geographic and in other budget planning terms) to health and public services be re-allocated to tackle health inequalities?

Preventative community based action, as advocated by the Christie Commission, should be a key priority in health and social care integration to prevent, reduce and undo health inequalities. This may mean a shift from acute to community-based interventions.

We appreciate the difficulties associated with this shift, particularly from the media that often calls to maintain the status quo. However, despite the current Government stated commitment to the preventative agenda, the reality is still largely unrealised across Scotland. Effective evidencing of the benefit of preventative community based action is required in a way that convinces public sector partners to invest/shift spending.

Are there any specific policies, initiatives or research evidence from Scotland, UK or internationally that you know of that would help provide ideas in helping tackle health inequalities?

Voluntary Health Scotland is in the process of conducting research into evidencing the third sector contribution to tackling health inequalities and what support is needed at national and local levels to achieve this. The research will be completed by the end of 2014, with the aim of launching at Scottish Parliament in early 2015. Susan Lowes, Policy & Engagement Officer at Voluntary Health Scotland would be happy to discuss interim findings from this research and from our Unequal Lives, Unjust Deaths programme of events to address health inequalities across the life course.

Other relevant evidence from academics signposts to the measures that is likely to be successful in tackling health inequalities:

Clare Beeston, NHS Health Scotland – Health Inequalities: What they are, where they come from and what we can do about them.

Dr Katherine Smith, The University of Edinburgh – What do researchers think needs to happen to reduce health inequalities and what might be the role of third sector organisations?

Contact

If you would like further information on the work of Voluntary Health Scotland to prevent, reduce and undo health inequalities, contact Susan Lowes, Policy and Engagement Officer susan.lowes@vhscotland.org.uk

Voluntary Health Scotland, Mansfield Traquair Centre, 15 Mansfield Place, Edinburgh, EH3 6BB. Tel: 0131 474 6189. www.vhscotland.org.uk mail@vhscotland.org.uk VHS is supported by NHS Health Scotland and the Scottish Government. VHS is a company registered by guarantee. Registered in Scotland No. 267315 Charity No SCO3548