OFFICIAL REPORT
AITHISG OIFIGEIL

# Health, Social Care and Sport Committee

Tuesday 21 June 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

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# Tuesday 21 June 2022

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## HEALTH, SOCIAL CARE AND SPORT COMMITTEE
**23rd Meeting 2022, Session 6**

**CONVENER**

*Gillian Martin (Aberdeenshire East) (SNP)

**DEPUTY CONVENER**

*Paul O’Kane (West Scotland) (Lab)

**COMMITTEE MEMBERS**

*Stephanie Callaghan (Uddingston and Bellshill) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Evelyn Tweed (Stirling) (SNP)
*Tess White (North East Scotland) (Con)

*attended

**THE FOLLOWING ALSO PARTICIPATED:**

Dr Peter Cawston (GPs at the Deep End)
Professor Sir Michael Marmot (University College London)
Dr Shari McDaid (Mental Health Foundation)
Professor Petra Meier (University of Glasgow)

**CLERK TO THE COMMITTEE**

Alex Bruce

**LOCATION**

The Sir Alexander Fleming Room (CR3)

# Scottish Parliament

## Health, Social Care and Sport Committee

*Tuesday 21 June 2022*

*[The Convener opened the meeting at 09:30]*

## Decision on Taking Business in Private

**The Convener (Gillian Martin):** I welcome everyone to the 23rd meeting in 2022 of the Health, Social Care and Sport Committee. I have received apologies from Emma Harper, and two members are joining us online. Everyone else is here.

Agenda item 1 is to decide whether to take items 3 and 4 in private. Do members agree to take those items in private?

**Members** *indicated agreement.*

## Health Inequalities

09:31

**The Convener:** Item 2 is a further evidence session in our inquiry into health inequalities. During today's session, the committee will undertake a round-table discussion with witnesses to explore possible solutions at a policy level that can sustain focus and action on tackling health inequalities across portfolios.

I welcome to the committee Dr Peter Cawston, principal general practitioner, GPs at the Deep End; Professor Sir Michael Marmot, professor of epidemiology, University College London; Dr Shari McDaid, head of evidence and impact, Scotland and Northern Ireland, Mental Health Foundation; and Professor Petra Meier, director, UK Prevention Research Partnership-funded systems science in public health and health economic research consortium.

I believe that all the witnesses have a brief opening statement to make before we start our discussion. I will take them in the order in which I introduced them, so I will go to Dr Cawston first.

**Dr Peter Cawston (GPs at the Deep End):** Good morning, and thank you very much for inviting me to the meeting.

I clarify that I am not the principal GP of GPs at the Deep End; I am a GP principal. I am just one among many GPs in GPs at the Deep End.

I am a GP at Garscadden Burn medical practice in Drumchapel, which is one of the so-called deep-end practices. That term was coined by Professor Graham Watt to describe practices in which the majority of the patients live in postcode areas that are classified as highly deprived by the Scottish index of multiple deprivation. Roughly 100 practices are characterised in that way, and around 50 per cent of postcode areas that are classified as highly deprived are registered with those practices.

I joined my GP practice because I had a deep conviction that general practice and primary care can make a difference to health inequalities. I joined just before my first son was born. He is now 23, so I have worked in Drumchapel for a very long time.

The other witnesses today are much better qualified than I am to speak about how health inequalities are defined. However, I would like to speak briefly to what health inequality means at an emotional level. If nothing else, I have spent 23 years witnessing the impact of health inequality on people's lives, day in, day out. For me, health inequalities mean somewhere between a sense of meaninglessness and a sense of rage. There is a constant labour in not tipping over into hopeless resignation or angry bitterness. I have witnessed that in colleagues in my own life over 23 years and, more than anything else, in the community that I serve.

I will not speak to examples of how health inequalities have impacted on individuals, because I do not want to sensationalise people's experiences. However, one of the most soul-destroying things for me as a health professional has been witnessing on a daily basis how the national health service sometimes unwittingly and sometimes deliberately widens health inequalities and perpetuates divisions in many ways. I hope that we can discuss that today.

I want to briefly mention why I am still idealistic and believe that we can make a difference. I will give three examples of things that have kept me hopeful, if not optimistic, after nearly a quarter of a century of working in my practice.

The first is seeing the difference that good general practice and primary care can make to health inequalities. That can be through a willingness to sit and listen to people and be an ally and an advocate for them, giving them the time to try and understand what is going on in their lives and trying to help them to find a way through; and, if there is no way of finding a way through, to sit with them and listen and not pretend that they do not exist.

On a practical level, that can mean taking the time to explain, allay and understand fears, and to help people to, for example, go for a test that they are afraid of. It can also mean taking the time to support people through bereavement, even when that bereavement is at a tragically early age. Helping someone to die who is younger than yourself is something that we all, working in areas such as Drumchapel, have to do on a regular basis. That is something that we cannot turn away from, but we can make a difference in helping people go through that.

In a very practical nitty-gritty way, through something called safety netting, we make lists of people who we think will not turn up for tests, go for X-rays or go for appointments and then we find out whether they have gone, follow them up and encourage them to go. We also respond to letters to say that people have not attended, not just by filing them away but by phoning up and discussing with them the reasons why they have not attended. All those little actions are like little pebbles thrown into a huge sea of inequality. I believe that those actions help to keep us feeling that we do something meaningful and worth while but, above all, if they were scaled up to a large scale, primary care and general practice could make a difference to health inequalities.

I give a second example. My practice was the lead practice for the community link worker pilot programme a number of years ago. One transformative effect of that for us was to try to become a more community-linked practice. For example, we had a sports day in the practice. We had a treasure hunt around the community where we went to all the places in Drumchapel where people can go for physical activity and learned about how much all those little community centres, gyms, boxing clubs and dancing clubs transform people's lives.

Over the past seven years, we have tried to become a more community-linked practice to understand that, as medical practitioners, we can make the most difference to people's lives if we work alongside the community where we work and help people to access all the resources that are there. Many of those resources are very fragile, and many of them have disappeared, but I believe that strong general practice and primary care that is supported by a community that has a lot of resources for wellbeing can make a huge difference. The community link workers in our practice have helped us to help our patients and individuals find resources and assets in the community.

Finally, I will speak about the third reason why I feel optimistic. Many years ago, one of our practice nurses approached us because she felt frustrated and disillusioned with years of telling people that they needed to make lifestyle changes, while knowing fine well that they did not have the resources or the possibility to make those changes. She asked whether she could start a small group to help people to help one another to make changes. That was five or six years ago, and the group was called Chance 2 Change. Since then, the group has gone on to develop and grow, and it is had a transformative effect on the lives of the people who take part in it. It is no longer run by our practice nurse; it is now run by a peer facilitator, and the group has now joined with the Scottish Government to try and find solutions to the problems that the committee's inquiry is tackling.

Over the past year, I have been a member of the Scottish Government's short-life working group on primary care health inequalities. Chance 2 Change has been an expert reference group for that work. It has had the opportunity both to feed into the recommendations that that work has made and to provide its own report, commenting on the recommendations.

It has been a frightening process for me as a GP, in that most of the members of the group are patients in our practice, and they have not held back in expressing how the past few years have impacted on them, including some pretty sharp criticisms of us. We are not holding ourselves up as any better than or different from the rest of the NHS, but I deeply believe that we can find solutions if we work together in that way.

Finally, I highlight a few things from that process. From the short-life working group, there are five key recommendations. One of those is to have a strong process of national leadership, which I believe this inquiry is helping to provide.

The second is about providing the resources for general practice and primary care teams to do the kinds of actions that I have outlined—and more—in changing how we work and mitigating and changing health inequalities. That includes training people to understand how health inequalities impact on people. However, more than anything, the recommendations look at supporting long-term wellbeing communities in primary care and at addressing the barriers that the NHS, in particular, puts up that widen divisions and perpetuate health inequalities. We need to research and understand what those barriers are and to address the structural discrimination and inequality in the NHS.

Chance 2 Change has brought forward a project on digital inclusion, which involves people helping each other to learn how to use digital technology, so that they can access some of the benefits that that will bring in the years ahead. That has to be an important strategy for helping people. Digital access is now a determinant of health, and there needs to be a strong programme to help people to access digital technology.

However, more than anything, Chance 2 Change has emphasised how relationships are at the heart of health inequalities. In particular, its members have spoken about how they so often feel excluded, disrespected and not listened to. They have strongly spoken to the reality of needing a health service that puts them at the centre.

So often, equity has been talked about as if it is a zero-sum game—as if, to help people who are excluded, we have to disadvantage those who are better off or who already have access to health services. I do not believe that. If we designed a health service around people such as those in Chance 2 Change, so that it is accessible and respectful of them and brings them into the heart of how the health service works, we will have a health service that functions properly and well and makes a difference to health inequalities. I am therefore pleased to be here today, and I hope that our conversation can help us to find practical policies and approaches that will make that a reality. Thanks for inviting me.

**The Convener:** Thank you very much. I come to Professor Marmot.

**Professor Sir Michael Marmot (University College London):** It is a pleasure to be able to talk to you this morning. Let me say first that much of my analysis on health inequalities has been for England. However, all the evidence suggests that what we say about England applies even more to Scotland and to Wales. I have less evidence from Northern Ireland but, as I have said, what I say about England applies to Scotland even more.

I will talk about three phases in thinking about health inequalities. The first is what happened after 2010; the second is the pandemic; and the third is the cost of living crisis.

I will take the first—what happened after 2010. In England, I did the so-called Marmot review, “Fair Society, Healthy Lives”. We had six domains of recommendations for what was needed to address health inequalities: giving every child the best start in life; education and lifelong learning; employment and working conditions; everyone having at least the minimum income necessary for a healthy life; healthy and sustainable places—[*Inaudible*.] Our review of the evidence suggested that, if those six domains of recommendations were followed, health would improve and health inequalities would diminish.

09:45

In February 2020, on the 10-year anniversary of my 2010 review, we published “Health Equity in England: The Marmot Review 10 Years On”, just before the pandemic crashed upon us. What we documented was that life expectancy had more or less stopped improving; on inequalities, the social gradient, which classifies people by where they live and classifies where they live by level of deprivation, had got steeper, which was true in Scotland as well as in England; and life expectancy for the poorest people had gone down—it had got worse—and that was true in Scotland as it was in England.

What the English data dramatically shows—my colleagues in Glasgow assure me that it is the same in Glasgow—is that, looking at the index of multiple deprivation, there is a social gradient and the gradient is steeper in the north of England than it is in London and the south and steeper in Glasgow than it is in the south of England. In other words, a national index of multiple deprivation shows more severe consequences for health in the north of England and in Scotland than it does in London and the south-east. It is more extreme in parts of Scotland.

Then came the pandemic, which exposed and amplified the underlying inequalities in society. What we saw—the Scottish data were identical to the English data—was that the social gradient in mortality from Covid-19 was almost exactly parallel to the social gradient in mortality from all causes. It was slightly steeper in Scotland and in England for Covid-19 than for all causes. What that means is that the causes of inequality in Covid were very similar to the causes of inequalities in health more generally. Yes, we have to control the virus, but we also have to deal with the inequality.

When we compare England, Scotland, Northern Ireland and Wales with other countries, we see that the fall in life expectancy in 2020 and 2021 was steeper than in any other country except the United States. People say that the Prime Minister got the big decisions right. When it comes to Covid, that is not what the evidence shows. Scotland's fall in life expectancy was actually slightly steeper than England's in 2020 and 2021. For England—I think that the data is similar for Scotland—in the triennium 2018 to 2020, compared with the previous triennium, we saw a fall in life expectancy not just in the—[*Inaudible*.] I asked myself why in these islands, in the United Kingdom, we did so poorly in health pre-pandemic and then managed the pandemic so poorly. What is the link? I have suggested that the link could act at four levels: first, poor governance and political culture; secondly, increasing social and economic inequalities; thirdly, disinvestment from public services; and fourthly, the fact that we were not very healthy coming into the pandemic.

Then, we have the cost of living crisis. As I am sure that you know well, inflation of 10 per cent has a much bigger impact on households with low incomes than it does on households with higher incomes, because food and energy make up a higher proportion of the expenditure of low-income households. An overall inflation rate of 10 per cent means something like 8 per cent for households in the top decile of earnings and 14 per cent for households in the bottom decile.

When we look back at why life expectancy failed to improve and health inequality grew in the decade after 2010, we can see that child poverty went up, poverty as a whole went up, inequalities increased and there was disinvestment in public services. Looking at my 2010 recommendations—[*Inaudible*.]—policy went in. I have now added two more recommendations to the six that I laid out. They are to deal with structural racism and discrimination and their consequences, and to pursue the health inequalities agenda and the climate emergency at the same time.

I would say that we know what to do to reduce health inequalities—the evidence is quite strong. We could do it if we had the political will and the organisation to do it. The fact that outcomes have been going in the wrong direction is credible and understandable, because policies have been going in the wrong direction.

**Dr Shari McDaid (Mental Health Foundation):** Thank you for this opportunity to speak to the committee. I will speak about mental health problems on behalf of the Mental Health Foundation, which focuses on prevention of mental health problems. Our work has a strong inequalities lens embedded in it.

We know that mental health problems are not distributed equally across the population, and are not simply a result of genetic or biological factors. The circumstances in which we are born, grow, live and age profoundly affect our risk of developing a mental health problem.

Societal risk factors present barriers to many people's ability to experience good mental health. The fundamental key drivers of mental distress and poor mental health that result in diagnoses of mental health problems include living in lower socioeconomic conditions, facing financial strain or living in poverty, earning below the real living wage and being in precarious employment. That also goes for living in poor-quality housing, living in neighbourhoods that are unsafe due to violence, prejudice and discrimination, and having limited access to clean and safe green space.

Being at risk of prejudice, bullying and discrimination is another key risk factor, and that can arise as a result of a person being identified with a number of social statuses, including being black or a person of colour, being a member of the LGBT+ community, being a refugee or an asylum seeker or being disabled.

Violence against women and girls is another key risk factor for development of mental health problems, as is living with a long-term physical health condition.

We believe that actions to address the risk of people developing mental health conditions and to reduce mental health inequalities need to be taken at three levels: we need to take structural measures, we need to strengthen community assets and we need to increase the resilience of individuals and groups.

Structural measures mean actions to change social and economic influences, and to reduce their impact on mental health problems. Those measures include reduction of income inequality, poverty, unemployment and precarious work, and prevention of domestic violence, discrimination, and homelessness.

Measures to promote community assets—which we heard about from Peter Cawston of GPs at the Deep End—are very important. They include activities to increase social connectedness and to improve community environments, as well as the creation of community spaces and fostering of participation in community decision making.

We also need measures for individuals. Those can include educating people about how to look after their own mental health, creating peer support opportunities and showing people how they can contribute to their own mental health and that of their communities and families.

We need action on all three levels. It is no good putting up a website that tells us to go for a walk to look after our mental health during the pandemic if we live in a neighbourhood where it is not safe to go for a walk, so there is a fundamental interrelationship between the three levels.

We can see that the Scottish Government has taken positive steps towards reducing mental health inequalities. It has doubled the child payment this year, it prioritised reducing child poverty in the recent spending review and there are some new benefits that will support people through the cost of living crisis. However, I noted that the low-income winter heating assistance payment will amount to only £50, which looks a bit thin when compared with what people will need in order to cope with in their heating bills.

The investment in increasing support for women and girls who have experienced violence amounted to £38 million during 2021-22. That is a significant investment to support a rapid response for women who have experienced violence. The Government has also invested in community action to prevent mental health problems, with £21 million last year and £15 million this year being allocated for the communities mental health and wellbeing fund.

We need to build on those steps and to up the effort in order to make a real impact. I will give a handful of recommendations on how that can be done. Our ensuring that there is strong cross-departmental involvement in the new mental health strategy is key. We need concrete commitments from Government directorates beyond the health directorate, because mental health happens outside the health system: it happens in people’s lives—in their communities and environments.

We need to ensure that the newly devolved social security service—which is an important development for Scotland—is non-stigmatising, and that everyone experiences a trauma-informed and respectful service that is sensitive to mental health. We also need to increase benefits to provide an adequate minimum income, and we need those things to happen together. It is not adequate to simply increase the amount of money that people have in their pockets, because there are shame and stigma that come with being on a lower income, so we need to ensure that the experience of obtaining a minimum income is non-stigmatising and respectful.

We need to build community infrastructure for prevention, which means that we need to rebuild and reinvigorate the community spaces where people can gather, learn and support each other. When I think about the cost of living crisis and about what has happened during similar crises in the past, I see that one of the first things to have been cut is library services, but public libraries are important social spaces for supporting people’s wellbeing. We need to ensure that the 1,000 link workers who are being put in place in Scotland—such as those in Drumchapel—prioritise outreach to disadvantaged groups. It is important that they are not stuck in GP services and that they reach out to communities that need them.

10:00

We need to continue increasing investment in community activity for prevention of mental health problems, and we need to sustain some of the good work that has come out of the Covid response programme, such as the mental health, equality and human rights stakeholder forum, and the Scottish Government’s recently established diverse experiences advisory panel, which the Mental Health Foundation is pleased to be hosting.

We know that mental health problems cost the Scottish economy £8.8 billion a year and that many of the mental health problems are preventable. There is a choice for the Government to make now, in the context of recovery from the pandemic and the cost of living crisis. Specific choices can make a difference in terms of preventing mental health problems or allowing the environmental circumstances to run rampant and leave people unprotected.

**The Convener:** The final opening statement is from Professor Meier.

**Professor Petra Meier (University of Glasgow):** How do you follow that? Thank you very much for inviting me.

The committee has now heard from many experts that health inequalities are strongly linked to inequalities in wealth and influence. You have also heard that many of the systems that impact on health inequalities are failing. There are housing systems that do not provide affordable homes, a welfare system that does not prevent poverty, a food system that does not guarantee nutritious food at reasonable prices, an education system that does not provide equal access to high-quality education and, finally, a healthcare system that is—as Peter Cawston rightly pointed out—increasingly less accessible to those with the highest level of need but who do not have the energy to fight for their rights.

That has all been aggravated by the public sector austerity of the past 10 years, as Michael Marmot pointed out. Then came Brexit, Covid, war in Europe and the cost of living crisis. We seem to be in an era of fast-paced change, and we should not anticipate a return to stability. The climate crisis and increased competition for the earth's resources are likely to accelerate our economic and social transformation.

So, how do we deal with that uncertainty and how can we get Scotland into a position of more resilience? I would argue that high levels of inequality, poverty and an unhealthy population make Scotland much less resilient to future challenges. We know that poor health affects all aspects of people's lives, whether it is our ability to enjoy life as a private individual, to be creative or to contribute to society through work, through care giving or through volunteering our time for the common good. It is a tragedy that so many people spend their 50s and 60s in poor health. It is also a big problem for productivity and public sector demand.

To a large degree, our problem is not that we have an ageing society, but premature loss of health. How we deal with the current challenges is therefore critical. Do we play Whac-A-Mole, with bits of support for whatever problem happens to be the most urgent right now—whether it is ambulances, food prices or education gaps due to Covid—or do we attempt to make comprehensive change across a large number of systems at the same time? That would require all Government sectors to agree to work pretty much flat out to take every opportunity to reduce inequalities, including in sectors that might not currently consider inequalities or wellbeing to be within their portfolios.

One way to approach systems change is to think back. What do we wish we had put in place 30 years ago? What would have put us in a much better position now? What would have helped us to develop and not lose an equitable education system and access to affordable homes, good work for all and so on? Importantly, what things are we doing now that we know we will be kicking ourselves for in 30 years' time?

First, we need a frank conversation. If we want to reduce inequalities, we can do it in only two ways. We can redistribute health, wealth and power, or we can try to hold the top constant and bring up the rear—levelling up. Levelling up is politically much more palatable; we would not reduce services in better-off areas or raise taxes so that we could reallocate resources to disadvantaged communities.

However, the money for levelling up needs to come from somewhere. That somewhere is really important: it cannot just come from some minor shuffling around of public sector budgets. If we have growth or opportunities for more big efficiency savings we can use that money strategically, but that is not the situation that we are in.

However we do it, inequality reduction cannot happen without sizeable investment. I will give an example. I am originally from Germany. Since reunification more than 30 years ago, Germany has invested €2 trillion, or €70 billion a year, to bridge east-west inequalities. Much of that has been done through levelling up, but since 1991 it has also included redistribution in the form of a pretty hefty additional income tax of between 5 and 7 per cent—the so-called solidarity tax.

I turn back to Scotland. The unfairness in health inequalities and health outcomes is appalling, because there is nothing more precious than life. We need to have a conversation about how much we really want to reduce health and other inequalities. If we are serious, we need to work out where to redistribute and where to level up. If we want to redistribute, we should look across all the ways in which the Government influences people's lives, and especially the way in which we fund public services. We need to identify inequities in provision, and we need to reprioritise according to the needs of current and future generations. Then, we must consider what can be done with taxes and levies on income, profits, wealth, land, property, luxury goods and—especially—goods that damage our health or the environment.

Where might extra money for levelling up come from? I am a public health expert, not an economist, so others can talk much more knowledgeably about that. However, what is the role of the Scottish National Investment Bank in tackling health inequalities? How can we involve businesses? Importantly, what is the role of public sector investment—not just as regards paying real living wages, but across the board? How can we tweak incentive structures to attract good teachers and doctors, and to provide social housing and jobs for the people who most need them?

We need to ensure that we see public sector investment not as a burden that needs to be minimised, but as an investment that can be optimised to deliver health, wellbeing and sustainability outcomes. Importantly, we need to take the public with us so that they do not buy into a narrative of having lower taxes and a smaller state without realising the impact that that would have on public services.

The Scottish Government has control over many issues, others can be influenced only through lobbying Westminster, or cold be dealt with through independence, and others might be political suicide. However, any conversation needs to start by considering the enormous social, economic and environmental costs of health inequalities and how we can address them.

**The Convener:** Thank you. You have given us lots that we can drill deeper into. That has been a really good start to our discussion.

All committee members have had an interest in health inequalities for some time. While we have been considering the evidence that we have been taking over a number of weeks, it has become clear to us that such issues come up all the time, no matter which inquiry we are working on or which subject we consider on this committee or others. The subject comes up everywhere because of the nature of the causes of such inequalities.

Notwithstanding all that you have said about whole-system and cross-portfolio working, I want to drill into what Dr Cawston said about the structures of the NHS perpetuating inequality and widening divisions. It seems to me that we need to hear more about that. Could I come first to Dr Cawston for more detail on that?

**Dr Cawston:** Yes, certainly. I have found the other contributions fascinating. The causes of health inequality and, to a large extent, the really big solutions lie outside the health service. Nevertheless, modern healthcare has evolved to a stage at which it has a significant impact on whether someone develops premature disability and whether they live out their life in a healthy state, or disabled or unwell.

Access to particularly early intervention in healthcare can have a huge impact on whether a person becomes unwell or disabled or remains well in their 50s and 60s. That is not to diminish the importance of childhood experiences, income and all the rest of it. Nevertheless, health services have a significant impact.

Health services were already struggling before the pandemic, and in my view, the pandemic has highlighted the weaknesses. However, in many ways, the systems that are in place across the board—I include my GP practice in this, I do not set myself apart—tend to take a one-size-fits-all approach, in which a person has to have a degree of ability to advocate for themselves, and must have the competence and ability to navigate through the system in order to access services. There are many moral barriers in place that some people find insurmountable. The health service is a bit like pavements in the 1960s; everyone has equal access as long as they can step up on to the pavement, but those who cannot do so have no means to access them.

An example of that comes from referral to another service of a patient who had mental health problems and did not open letters or read them because they found them threatening. A referral that I made asked if the service could telephone with an appointment time, rather than send a letter. The referral was rejected on the basis that it is not that kind of service: the service sends letters, and that is that.

Another example is of a patient who turned up on the wrong day for an urgent suspected cancer X-ray referral and was turned away because they had missed their appointment even though the request was sitting there and the service operated a walk-in element. However, because they did not follow the referral procedure exactly, they were turned away.

Each individual example can seem to be relatively small, but when those incidents occur literally hundreds—if not thousands—of times a day across the system, the overall effect is that some people who have the most need have the most difficulty accessing the service because of those barriers.

The other part of this is how the health service is resourced and where priorities lie. Our health service is very heavily invested in specialist and hospital-based services, rather than in community-based services, compared with some other countries. That means that we have access to fantastic technology—I am not in any way decrying the importance of specialist services, because we all need them sometimes—but we have the balance wrong in respect of how much we invest in healthcare that is close to people and communities. People are travelling to pain clinics that are three bus journeys away because investment is in a centralised specialised service, which presents a barrier to them.

Community spending reflects demand rather than need, so areas that experience high demand, as reflected in figures, attract weighting for funding. That means that areas that are already demanding of services attract funds and those that do not demand services but have high needs—perhaps through learned hopelessness or resignation—are not captured because of how that funding is weighted. There is a flat level of funding across GP practices regardless of whether a practice is in an area that has high need, low life expectancy and ranks high on the index of deprivation. In other words, deprivation does not attract resource for community-based health funding, but instead, funding tends to be at a flat rate. In other words, deprivation does not attract resource to those areas in terms of community-based health funding; rather, funding tends to be flat across the piece.

Professor Mercer and others have produced research that shows that patients consulting with GPs in areas that are classified as deprived have higher levels of stress and receive less amount of time per problem, because the resources do not follow need.

I could go on and on, but I hope that that has given a few snapshots of what I mean by the institutional way in which the health service widens the health inequalities gap.

10:15

**The Convener:** It is helpful to hear your first-hand experience.

Before I bring in Paul O'Kane, I remind those who are participating remotely that, although we will probably direct our questions to individuals, if anyone wants to add to anything that anyone else has said, they can put an R in the chat box and I will bring them in.

**Paul O'Kane (West Scotland) (Lab):** I thank the witnesses for their insights, which have been helpful.

I want to ask about progress. With regard to Professor Marmot's work and, indeed, a lot of the things that the other witnesses have referred to, it strikes me that a lot of what we have heard is not new—it is not rocket science; it is about looking at what works in communities and investing in it. A lot of that work is done by local authority services or by the third sector. Across the piece, there has been a reduction in funding for those sorts of services. Obviously, we can argue about the politics of the source of that issue, but I simply want to get a sense of whether, despite that backdrop, progress has been made in Scotland in implementing many of these strategies. I will start with Professor Marmot.

**Professor Marmot:** Forgive me, but I will make the same conditional comment that I made at the beginning of the meeting: I have been studying England much more than I have been studying Scotland. However, as I said earlier, I think that we can say that what applies to England applies to Scotland—[*Inaudible*.]

What I described is a really miserable picture at national level, with policies going in an adverse direction from the point of view of health inequalities. The signs of hope come from cities and regions. In 2010, Coventry declared itself a Marmot city and implemented my six domains for action, or recommendations. That was not a randomised controlled trial, so the evidence of effect is, at best, suggestive. However, that said, Coventry saw improvement in early child development; a reduction in the number of young people who were not in education, employment or training; an increase in the number of people earning a real living wage; and a reduction in crime. There were indicators that suggested that things were moving in the right direction.

Since then, Greater Manchester has said, "Well, if Coventry can be a Marmot city, we can be a Marmot city region," and we produced a report called "Build Back Fairer in Greater Manchester". Three weeks ago, working with colleagues in Cheshire and Merseyside, we produced another report, and we are now working in Lancashire and Cumbria. Yesterday, I was in Newcastle upon Tyne—I am getting closer to Scotland—and it looks like we are going to start a programme of work with the north of Tyne region. Gwent wants to be the first Marmot region—[*Inaudible*.]—cities and regions in acting on the evidence.

I agree with what Petra Meier laid out—she and I are on the same page. What she was saying with regard to Scotland is similar to what I have been saying with regard to England and Wales. There is real interest in action at the local level. That does not let national Governments off the hook, as there is much that they could and should be doing, but there is real interest in taking action.

In a way, it is an experiment. If child poverty rates are going up because of decisions that have been made by the Chancellor of the Exchequer, what can cities and regions do to address that problem? As I say, it is an experiment, but there is real interest in pursuing it.

**Professor Meier:** I would like to add a little bit about my fairly recent Scottish experience. I moved up only a year and a half ago, but I think that there are significant and promising differences in the way that the Scottish Government talks about inequalities and makes policy. We hear a lot about wellbeing economy approaches, community wealth building and the thought that is being given to the minimum income guarantee. Although those elements have not yet had the chance to translate into impacts on health inequalities—we have been in an extraordinary situation with the pandemic, so it would have been hard for any policy to push through to a great enough extent—I think that they are the right things to do, because we need to think about what we need to do to increase the wellbeing of the Scottish population and address inequalities.

I can see a lot of movement in the right direction. That is also evident in the way that concerns about climate change and sustainability are increasingly present in conversations about issues such as mental health or inequalities in income. The triangle of health, the economy and sustainability is much better understood in the Scottish Government. One would hope that that will translate into real changes.

At the moment, the focus is perhaps too much on mitigation, rather than on the root causes. For example, although the extra child payment is really important, and it is good that it puts extra money into the pockets of people in poorer households, it does not, per se, do anything to address income inequalities. It will be important to think about what you can do with your money that will have the most long-lasting consequences.

**Dr McDaid:** To get a long-term view, we can look at the Scottish health survey and the information that we have from things such as the Edinburgh mental health wellbeing scores. We can see that there was consistency from 2008 to 2013 and across to 2019—the scores are virtually the same. That tells us that, even before the pandemic, we were not making the progress that we might hope for.

We need to redouble our efforts. The pandemic has worsened mental health inequalities, and it has introduced new categories and groups of individuals—including the health workforce—who are affected by mental health problems but who were not necessarily a focus before. We need to be realistic. A big long-term effort is required. As I mentioned, there are green shoots—that is, there are signs of the kinds of things that will make a difference. However, as others have said, we need to ensure that the magnitude of the effort is equivalent to the disparity that exists.

**Dr Cawston:** In answer to the question, I will mention three signs of progress. One that shows a shift in thinking is that there has been a recognition that the health service and the wider factors affecting health inequalities are not two distinct things—there used to be a divide between those two approaches. Over the past year, the short-life working group on health inequalities in primary care has considered how much the wider community factors that affect health and health services are integrated with one another. The community link worker programme, which has now spread across GP practices throughout Scotland, is a first sign of possible integration between the idea that communities are vital for health and the idea that healthcare services exist to support communities, not to deliver health.

The pandemic has perhaps hastened the spread of the idea that healthcare services can be assets within the community alongside other assets, that we can grow together to improve wellbeing in communities and that such things are not distinct. I emphasise that the way forward needs to be through community wealth building, sustainability and an asset-based and wellbeing community-based approach to health that invests in primary care, general practice, district nursing and mental health services alongside communities as part of the assets in the community. Such things cannot somehow be in distinct boxes.

The second sign of hopefulness for me is that mental health is now central in our thinking. Mental health is critical to addressing health inequalities. The choices that we make in our lives and the way that we respond to our environment and circumstances have a massive impact on our life expectancy and on disability. Helping people to be resilient to the pressures that they are under is critical.

The way that mental health services are organised presents huge barriers to people, particularly people who have addiction problems or people who are engaging in behaviours that were perhaps adaptive to their circumstances but are damaging to their health. A lot of discrimination and barriers are still built into mental health services. The mental health strategy is a sign of progress towards making mental health central to addressing health inequalities.

The inclusion of people in commenting on and helping to develop mental health policy is critical. The involvement of Chance 2 Change in the report of the primary care health inequalities short-life working group is critical in relation to how we understand and plan. For me, that is a big sign of progress.

Those are my thoughts about how we are making progress or, at least, seeing the green shoots of it.

**Professor Marmot:** I remember going to a meeting at Murrayfield—I have no idea what it was about, but the fact that it was at Murrayfield was memorable—and listening to Scottish ministers speak. I said to colleagues that what those ministers were saying was far more likely to address health inequalities than what I heard ministers in London say. I had a similar feeling about Wales. I have had quite a bit to do with the Welsh Government, and I would say that its policies are far more likely to improve health and reduce health inequalities than the policies that are coming out of Westminster. The health inequalities in Scotland and Wales are deeper than they are in England.

That raises a question about what is going on. Are those policies not being put into action? Are they insufficient to address the deep-seated causes of health inequalities? It is—[*Inaudible*.]—try to get an answer to that question, because it relates to what you are going to do next. If you have the right policies, have they just not been applied deeply enough and for long enough, or are there other things that need to be addressed?

**Paul O’Kane:** On that last point, it is correct to say that there are lots of aspirational policies that seek to alleviate such issues. In relation to devolution to local authorities, it seems to me that many of the six priorities that Professor Marmot outlined are what local councils do around, for example, education, employability and building communities. I wonder whether on-going and repeated cuts to local authority budgets have an impact. Professor Marmot, how did Coventry or Manchester deal with what was obviously a reducing picture? Is it your sense that those things will be hard to achieve unless local government is funded appropriately?

10:30

**Professor Marmot:** Very much so. Again, forgive me for talking about England, but with regard to local government funding in the decade after 2010, spending per person went down by 16 per cent in the least deprived 20 per cent of areas, and the greater the deprivation, the greater the reduction. In the most deprived quintile, spending per person went down by 32 per cent. There are 10 local authorities in Greater Manchester, and if you live in one of the more deprived ones—[*Inaudible*.]—funding in excess of 40 per cent. That makes everything much more challenging. Money is not everything, but it is not nothing. Therefore, given the context in which we are operating in those regions, the challenge is what can be done with that reduced level of funding.

It is not that local authorities would not like more money from the centre. As Petra Meier said, although the levelling up budget for 2021 in the north of England was £33 per person, the amount of money that was taken away annually over the decade from 2010 was £413 per person. People have been given £33, but they have had £413 taken away—that is what has been called levelling up. By contrast, as Petra Meier laid out, what happened in Germany was two orders of magnitude greater, so what is being done here is not serious. However, the withdrawal of funding is really serious, so we are operating with severe headwinds at local level.

**Professor Meier:** A lot can be done using the local authority model; a lot of these things are under the control of local authorities. However, the system also introduces a lot of variation and repetition in relation to learning and trying out the same things. Unless there is a really strong evaluation framework and people have the time to do evaluation, a lot of redundancy and extra costs are introduced.

Cities and local areas are the way forward, but we need to work in a more systematic way that involves thinking about what we are trying to achieve and trying out the things that everybody can agree on, rather than letting everybody go their own way.

Local authorities are, of course, funded in very different ways. Some local authorities have five officers working on economic strategy development and so on, and others have just one person working part time on that. New inequalities are introduced when some areas have larger resources to do evaluation, put in funding bids and so on.

In relation to health in place and localism, we need to be careful that we do not make things worse instead of better by having an overarching strategy at the Scottish Government level. I see a lot of really good ideas, with many areas trying out innovative things, but I am a bit worried that that is not well co-ordinated, which can lead to different experiences for people in different areas. We have all heard about the postcode lottery and so on, and we should not let it come to that.

**Stephanie Callaghan (Uddingston and Bellshill) (SNP):** I want to go back to something that Dr Cawston said earlier, which I think goes to the heart of the issues that we are looking at. Dr Cawston, you talked about the fact that those most in need are often the people who are making fewer demands and about learned helplessness. Clearly, we really need to be able to reach into those communities and touch the lives of these people if we want them to be healthy in their 50s and 60s. I am really interested in any comments on that, but, mainly, what key recommendations would you like to see the health committee make in its report to address that?

**Dr Cawston:** Obviously, I echo what has been said about funding, but the comment was made earlier that stigma and the personal impact of health inequalities are critical. There is learned helplessness and resignation among people who are living with health inequalities. There is also learned helplessness among health service providers, which turns into stigmatisation and turning back on individuals—almost blaming people for their problems. That is toxic in health services and it is something that we need to recognise.

With regard to specific recommendations, one of the recommendations that was made by the primary care health inequalities short-life working group was about fellowships for healthcare professionals working in the community around understanding trauma, health inequality and the practical skills that are needed to enable people to access preventative healthcare and interventions that will impact their health. I would like to recommend that as a practical policy suggestion.

Chance 2 Change, the partner group of the short-life working group, has really emphasised how transformative peer support is in communities. In my practice, we have had two peer support groups for people who experience loneliness, marginalisation, disability and addiction. In the community, there are other peer support groups through the addictions network and through a group for men. These groups have a tremendous impact through advocating for people, helping them to develop self-belief, to believe that they themselves matter and that their health matters. Therefore, secondly, I would like to ask the committee to support the development of peer support in communities to allow people to use those assets to improve their sense of agency and their sense that they are entitled to health care and better health.

Part of that has been peer support to become digitally included. We have to recognise that, over the next 10 to 20 years, health services and health itself will be transformed through digital technologies, and digital exclusion will become a massive factor in leaving people behind. I ask the committee to consider peer support for digital inclusion programmes as important in helping people to access healthcare.

**The Convener:** Thank you. I will bring in Dr McDaid, who wants to answer your question, Stephanie.

**Dr McDaid:** I have two things to say about the question why there is lower demand in areas of higher need. First, it makes me think about the perspective of people who are from a black or ethnic minority background. When we talk to representatives of different ethnic minority communities, we hear that, first, they do not necessarily name their experience in the western way, using diagnostic categories such as mental illness, anxiety or depression. They are not necessarily looking for a “mental health service” to help with their situation.

Then, when they seek help, they may be met with a service that is not at all respectful of and sensitive to them, or willing to try to understand how they have experienced their distress, what it means for them and how it fits in with their culture. We have heard that, recently, from engagement with minoritised ethnic communities.

We need mental health services that are not so dependent on a family member identifying that their child or other relative might require mental health care, because that access route might, in itself, be a barrier.

Secondly—I will be honest, this is more from speculation than from evidence—I think that a lot of people who are living with mental distress have a high level of tolerance. They do not necessarily see their situation as something from which they would come forward for help, particularly in the context of the pandemic, a time during which many people experienced that health services were not so available and the health service staff were under huge stress and strain.

I am thinking particularly of carers and people with disabilities, who are resourceful and may not see themselves as deserving of a mental health intervention. However, they are also at a higher risk of isolation, loneliness and mental health difficulties because of those factors.

We need more outreach, messaging and availability of low-level and community-based supports that are easy to access, so that people do not see that as a big hurdle. Even having to go to a GP to seek help, then go from the GP to a specialist service, is quite a high bar for getting low-level support.

**Professor Marmot:** I will respond to the question about learned helplessness. I hear a lot of discussion about poverty of aspiration. My response is that a poverty of aspiration is a legitimate analysis of a poverty of opportunity. We cannot say that the problem is that young people do not have aspirations, if they have no opportunity to do anything with those. Learned helplessness is a reasonable response to growing up in grinding poverty with little prospect for the future. In a way, we cannot deal with learned helplessness without improving legitimate prospects such as education, employment and services.

That links to a second comment: it is incredibly intellectually taxing to be poor. If you are not poor, it is pretty easy to get through the day. If you are hungry, you eat something; if the fridge is empty, you go shopping; and the rent is paid by direct debit. You do not have to think about any of those things. Being poor is really intellectually taxing—you have to think about it all day.

10:45

As one commentator said, if you go shopping with only a small amount of money, it takes a long time because you have to tot up the prices, which could take 45 minutes. If you have £75 to spend, you are in and out in 15 minutes. It is incredibly taxing intellectually to be poor, and blaming people who are in that situation for not thinking in the medium and long terms is a woeful misunderstanding of the intellectual and mental cost of poverty.

**Stephanie Callaghan:** Professor Meier, you spoke about the Scottish experience being significantly different and very encouraging. You also talked about seeing momentum in the right direction, and that there is too much of a focus on mitigation rather than on root causes. In Scotland, what can we do with the limited powers that are available to us to tackle those root causes? At times, it feels as though we are limited to mitigating policy that comes from the UK Government.

**Professor Meier:** I know what you are saying. A lot of powers are not devolved, but there are examples of areas, such as council tax, that could be made much more efficient. At the moment, a higher proportion of poorer household budgets are going on things such as council tax. Therefore, there is a need to look across public sector spending and consider whether there are aspects that you can change. In Scotland, education systems are still very unequal, so are there things that you can proactively recommend be done.

With the green economy, you could think about how to create good jobs with decent pay and conditions, and target them at areas where there is the most need. If you look across all the functions that are available to the Scottish Government, there is a large number of areas, particularly around education and employment, in which it would be helpful for the Government to be mindful of the need to reduce inequalities.

Health inequality is one kind of inequality, and economic and social inequalities are something different, and that is a barrier at the moment. If you look at sustainability, there is not always that consideration of how we multisolve all our different problems and optimise among all the different goals in the national performance framework. I whole-heartedly agree with the framework—it is very strong—but it is about hitting the goals that are maybe not the perfect solution for one issue but that help to address three other goals that we want to achieve at the same time. Therefore, thinking about inequality reduction in all that you do will be incredibly important.

**The Convener:** Dr Cawston, I think that you wanted to come in. I did not spot that before Stephanie asked her second question, so I imagine that you would like to come in on her first question.

**Dr Cawston:** I want to reflect a feeling of discomfort around the term “learned helplessness” that we have been using and echo what Michael Marmot said. It is wrong to somehow suggest that the locus of failure lies in communities and that they need to be rescued from that situation. The most powerful advocates for enablement and helping people to feel that they deserve help come from within communities themselves. In many ways, structures—I speak for the public sector health service specifically—are the barriers to that. I know that, in health service planning, the third sector is very much not an equal partner, and that, in NHS planning, peer groups and patient groups in communities are not equal partners with the health sector.

We need to take away the barriers to people advocating from within communities, rather than saying that, somehow, there is a sense of helplessness that they have taken on themselves. In many ways, we create that through our systems.

**Tess White (North East Scotland) (Con):** I have found this morning’s session really interesting and I have learned a lot, so I thank the panellists for their evidence.

Dr Cawston talked about creating systems—I am summarising—that are a step on to the pavement. A general theme has been the importance of local assets and infrastructure. Dr McDaid mentioned the impact of the loss of local libraries, while Professor Marmot talked about a state of helplessness.

I realise that this is a really complex subject, but in developing resilience and the reasonable prices that Professor Meier talked about, is there a single practical action that would have a dramatic impact? At our previous meeting, we talked about sport, and there was a theme of opening up school estates to communities to improve local health equality. What are the panel members’ thoughts on taking a single action such as opening up school estates to communities so that those assets are available? Can each of you think of something better?

**Dr Cawston:** What has driven me throughout my career has been a belief that wellbeing communities are where health happens. There needs to be a long-term commitment to communities that are wrapped around health services being the places where we make the change in health inequalities, if that is not too broad an answer.

Many community assets have short-term funding and live very precarious lives. If they had the same level of commitment and support as the public sector does, and if they were integrated with health services rather than being seen as a separate thing, they could make a huge difference to health inequalities. All sectors need to be integrated through the community.

**Professor Meier:** I am a systems scientist, so coming up with one particular action will always be difficult for me, because I am trained to think about which systems effects we need to change and what the key levers are. However, it is key that everyone has a fair wage, because in-work poverty is a real problem. Whatever can be done to increase the national minimum wage or to make sure that more people get paid the real living wage will offer a good way out of poverty and all the different things that poverty or being on a low income influences. That would be my one wish-list item.

**Dr McDaid:** I am in the fortunate position of being able to agree with my two colleagues. I absolutely agree with Dr Cawston that it is vital that we build community assets—the spaces where communities can come together and engage with and support one another—and ensure that those spaces are inclusive. School spaces might be attractive for some people, but they might not attract other sections of the community. It is really important that we take a community development approach to how we identify which spaces need to be developed and that we do that in partnership with the diverse communities involved.

I agree with what Professor Meier said about the need for a fair wage, and I am aware that the Scottish Government is exploring a minimum income guarantee .Our own research on the effects of universal basic income shows that reducing the conditionality of social welfare benefits is key to boosting people's mental health. It is not enough to put more money in someone's pocket; that must be done in such a way that they do not have many hoops to jump through to get access to that income. Introducing a minimum income guarantee in the right way, by reducing as much of the conditionality as possible, could be very helpful.

**Professor Marmot:** It is tempting and attractive to ask for one thing. "What is the one thing?" is probably the second most common question in the work I have been doing. Please do not go down that route. If there were only one thing, we would all be doing it. If there were one thing, it would be to put equity in health and wellbeing at the heart of all policy making. Opening up sports facilities is not the one thing. In my own case, we had six domains of recommendation, because we did not think that there was only one thing to do. None of the things that have been suggested are bad; they are all good, but more than one thing has to be done.

**The Convener:** Tess, do you want to follow up on any of that?

**Tess White:** No, that was very thorough. Thank you.

**The Convener:** We will move to questions from Evelyn Tweed.

**Evelyn Tweed (Stirling) (SNP):** My question is for Dr Cawston. Thank you for all the work that you have done in Drumchapel. I worked there many years ago and know the issues that you and your patients have to deal with. I am sure that they very much feel the benefit of your commitment.

I am interested in the internal NHS barriers that you said that patients have to navigate. How can we do better? What would you recommend?

**Dr Cawston:** I spoke earlier about the boundary between hopelessness and rage. Engaging with Chance 2 Change has been a process of people uncovering their rage and then coming back to my own practice with a sense of grievance and hurt at the barriers that we place in front of them—for example, difficulties in accessing appointments or services. I am not speaking to point the finger at other services, but there is a shift in the power dynamic. Allowing chance 2 change involved a process of questioning the service that we offer. At the moment, we are in a position that feels uncomfortable because people are questioning. That says to me that the solution lies in allowing people to question and to hold the barriers that they face up to the light.

There are almost too many barriers to mention, but I have given some examples. The way forward should allow people to question those barriers and to have more say in how services are redesigned. That is a painful and uncomfortable process. I am finding it personally uncomfortable because I want to be defensive and say that I am trying my hardest and that people should see the pressures that we are under. Likewise, questioning how other services operate can elicit the defensive reaction that everyone is trying to do their best. We must learn to set aside that discomfort and have very difficult conversations about how we do things, in order to understand the barriers that people face. That feels to me like a healthier health service.

I am not sure that it is a zero-sum game. I think that all the barriers that we put up make us inefficient. All the things that we do in order to protect our resources actually make us inefficient. I suspect that an operational way that is less defensive of resource, more trusting of people and more willing to bring people in would make for a healthier and more efficient health service.

11:00

The direction of travel has been very much towards fragmentation and making services more and more divided, so that we have more and more types of service. For example, there seem to be dozens of different teams and options for mental health, each of which has its own inclusion and exclusion criteria and its own hurdles to get over.

Redesigning services around people would make us more efficient. It might seem a bit utopian, but, for me, that feels like the way that we need to go as a health service.

The past 10 years have been very focused on living within budgets and defending services and budgets. I suspect that that has made us less efficient, because each little part of the health service is trying to protect its own little part of the budget by defending it against all comers. That is not a healthy way for a health service to be run.

I do not know whether that answers the question. I am certainly not trying to point the finger at other services, because we are all struggling to be inclusive in that way.

Finally, it is also about attitude and culture. Health workers should not be getting ground down and feeling under fire all the time. A lot of those people feel that they are under attack and are just doing their best to get through the day in whatever way is possible. That can be quite discriminatory against the people who feel more challenged or who have more need. It is easier to see easy people and much harder to see hard people. Keeping out the people who have the really complicated, difficult, challenging or unsolvable problems can be a way for health workers to get through the day intact, but that is not the way to go, and it just stores up more problems.

**Sandesh Gulhane (Glasgow) (Con):** Professor Marmot, I remember reading about everything that you were doing when I was at medical school, so it is great to be able to see you and speak to you.

I have a question for Professor Meier. I believe that you founded the Sheffield alcohol research group. Through all the work that you have done and what we have seen, we know that alcohol most impacts people who are more deprived. Two reports have come out on alcohol and minimum unit pricing in Scotland, including one that came out today. Both reports present evidence that minimum unit pricing is not working and that the most vulnerable people, especially those who drink spirits, are cutting back on buying food. What is your response to that? How can we ensure that the impact of alcohol is not felt so greatly in the areas of most deprivation?

**Professor Meier:** I do not quite agree that the policy is not working; it is working, on the whole. There are some very heavy drinkers who might not have had the opportunity to cut down their drinking, so they have substituted alcohol spending for food spending. I do not think that that problem is related to the price of alcohol; it is related to health services not having been available. Addiction services have experienced major cutbacks during Covid. They have been virtually inaccessible unless people have been able to join online groups and make do with things like Alcoholics Anonymous online. The policy has not had many detrimental effects on those very dependent drinkers, but there has been some substitution of food purchases.

I was not involved in the studies that led to those reports, but I have not seen anything that would make me majorly concerned that the policy is not working as intended, because alcohol consumption and alcohol-related mortality and hospital admissions have fallen. It is more about putting protective structures in place, and those have failed during Covid. Again, it is important to think about what you need in the round in order for policies to work for all the people you want them to work for.

I would certainly not advocate going back to cheap alcohol. Minimum unit pricing is one of the stronger policies that the Scottish Government has come up with. Obviously, if you were an independent country, implementing a sensible duty system is something that you would do. However, in the absence of having full tax controls, using minimum unit pricing to raise the bottom-end prices and ensure that shops do not sell pocket-money alcohol is important. The policy affects only high-alcohol-content spirits, which are very damaging to health. I would say that we should put the health structures in place rather than that the policy is not working.

**Sandesh Gulhane:** With respect, alcohol consumption fell among those who were not deprived, but we saw alcohol consumption rise among people who have an alcohol problem and among the most vulnerable people. A report by Public Health Scotland found no clear evidence of a reduction in alcohol consumption among people drinking at harmful levels following the implementation of minimum unit pricing. However, you are absolutely right to say that there has been a collapse of recovery services, which is key. We have also found that those who are drinking have just switched what they drink, as I said in my first question.

The United Kingdom Government has increased tax on the basis of the alcohol level, so tax is increased on spirits and there are lower tax rates for drinks that are weaker in their alcohol content—those that are 3.5 per cent alcohol, for example—and for low and no-alcohol drinks. Should we be promoting low and no-alcohol drinks? Should we introduce a system that looks not just at pricing? In terms of health inequalities, our approach to alcohol is a huge area that does not seem to be quite working.

**Professor Meier:** As I said, the duty reforms are welcome and overdue, but they do not balance out a lot of what has happened in relation to duty over recent years. The duty escalator seemed to be working well but was abandoned. Now, there is a shift in the duty system towards penalising strongly alcoholic drinks, which is welcome.

With regard to what the Scottish Government should do, there is a lot of international evidence on minimum unit pricing working to reduce consumption. It also shows that extremely heavy drinkers reduce their consumption by less, on average, because there is a dependency factor, so I would treat that group separately. There is something to be said for minimum unit pricing being a policy that makes alcohol less accessible to young people and that sends a strong message that cheap alcohol is not a good thing to have in your society.

Taxation on alcohol works across the board, so linking taxation to strength is important. Further, as I said, the policy needs to be implemented as part of a suite of policies that also tackle the reasons for heavy alcohol consumption, which are often linked to mental health issues. It is, therefore, important to have good mental health support and good alcohol support.

The evidence on the link between alcohol pricing, alcohol availability and health outcomes is strong internationally and in Scotland.

**Sandesh Gulhane:** Dr Cawston, you said earlier that there is a standard amount of money going into general practice. Was I mistaken in thinking that, initially, GPs who worked in areas of high deprivation actually got more funding but that, following the introduction of the new GP contract, although there is an element of the funding allocation that concerns deprivation, more money is going to the care of those who are elderly and living with complex needs, which has reduced the money that is going into areas of deprivation?

**Dr Cawston:** I probably need to qualify my reply by saying that I am not a health economist or an academic in this field, so I am having to quote others on the issue. The work of Professor Watt and Professor Mercer before the 2018 change in the GP contract did not find a gradient towards deprived areas. Although there was a deprivation weighting factor in how funding was allocated, as I understand it, the actual end product, in terms of funding going to practices, was flat across practices. My understanding of the research is that there was no weighting, although I might be wrong about that. As I say, I am a front-line GP rather than an academic.

Since the 2018 contract, the way in which funding is weighted has changed. I do not know whether that has made the situation worse, but I understand that Audit Scotland has found that that has not weighted funding towards areas of higher need and that the funding structure is still flat across GP practices.

I am afraid that that is the level of my knowledge on the subject. I have been quoting Professor Watt and Professor Mercer, but I suspect that you would probably need someone who has a better understanding of GP funding at the macro level to drill down into that in greater depth.

**Professor Marmot:** To go back to alcohol, my understanding—Petra Meier can correct me if this is not up to date—is that, if you look globally, you find a clear correlation between mean alcohol consumption and alcohol-associated harm. Also, price relates to consumption. That is all to the good, and it fits with what Petra said.

Within Britain, in general, mean consumption is higher in higher socioeconomic groups, so the gradient goes the other way, but it goes the expected way for alcohol-associated harm in that the more deprivation there is, the greater the frequency of hospital admissions and the greater the mortality related to alcohol. In a way, it is a bit like what I said about Covid in that you need to control the vector—alcohol—and you need to control the virus, but you also need to deal with inequalities, because it is clear that the link between alcohol and alcohol-associated harm is stronger in people of lower socioeconomic position.

**The Convener:** Gillian Mackay joins us online.

**Gillian Mackay (Central Scotland) (Green):** Good morning to the panel. To what extent are health services trauma informed? What improvements need to be made in that area? How do we ensure that all public services take a trauma-informed approach?

**Dr Cawston:** Thank you for that question, which gets to the heart of a lot of what we have been talking about, including the discussion about alcohol. I guess that there is a reason why some people suffer greater harm not only from alcohol consumption but from consumption of all kinds of addictive substances, including nicotine and other drugs. My experience during my time in Drumchapel has been that there is a widespread experience of trauma in communities from adverse childhood experiences and adverse experiences growing up, as well as day-to-day issues of poverty, exclusion, gender-based violence, ethnicity-related discrimination and so on.

11:15

I am not sure that health services are very trauma informed. Many of the behaviours that are adaptive and that people have learned as ways of coping with trauma and dealing with the wider world are experienced as difficult and people are shunned, in a sense, because of their ways of behaving and expressing themselves, rather than services trying to understand what lies behind their behaviour. For example, people who are alcohol dependent might present to health services in ways that are difficult, such as in ambulances on Saturday nights, through attendances at accident and emergency departments or through challenging behaviour at the hospital front desk or the general practitioner.

Part of the stigma that I have been talking about is to do with how people are dealt with and how we understand them. Tackling the stigma involves every person who works in a health and social care setting at community or specialist level having a better understanding of how trauma impacts throughout a person’s life, and how it affects their behaviour. Steps have been taken towards that. There is more availability of trauma-informed training, for example. We have had some of that in our GP practice at some of our protected learning afternoons. However, we still have a very long way to go, not least in understanding the ways in which we retraumatise people.

When people try to access help with their mental health, they face barriers. They have to go through repeated assessments and they are told repeatedly that they do not fit this service and they do not fit that service. That has a way of retraumatising them. As well as being about an individual understanding of trauma, it is about how the system and the barriers that are in place in it reinforce trauma in people.

**Dr McDaid:** Thank you for the question about trauma-informed practice. Our view is that a trauma-informed approach definitely needs to be embedded in health services and extended to other public services such as social security and housing services.

I am certainly aware of the Government's wider trauma-informed workforce programme, but the concern is that, if there is just a one-off training session in the trauma-informed approach, people will be expected to go back to their systems of working and try to remember what they learned during that one-off session or programme. We need some of what Dr Cawston talked about, but we also need to embed reflective practice throughout service provision so that there is on-going reflection and space is provided for public sector professionals and health service staff to be able to reflect on the experiences that they are creating and how they affect those that they come into contact with in their services.

Embedding reflective practice is the next step that needs to accompany the training programmes and education in the trauma-informed approach.

**Gillian Mackay:** We have touched on various factors that might have stigma attached to them. In what ways, if any, do current working practices in health and other public services entrench stigma? Further to what you have said, what work needs to be done to address that at the heart of the services that we are talking about?

**Dr Cawston:** Although, at a superficial level, having trauma-informed practice training is massively important, that also ties into the shift in the power structure and the extent to which the third sector and communities are involved in how services are designed and planned. Having a much greater voice for people who have lived experience of exclusion or trauma, or adverse childhood experiences, is critical in helping us to understand how we should design health services.

I give the example of video consultations, which many hospitals and some GP practices now use. Many people who have had to attend court as witnesses in cases involving adverse childhood experiences, exploitation or abuse have had to do so via videolink. Video interactions can raise issues around such experiences, so they find medical consultations that are conducted in that way quite traumatising. That is something that I learned just recently from talking to individuals.

We need to understand the effects of the ways in which we design practices, and the only way that we can do that is by bringing in people who have lived experience to help us to understand and design services around their needs. We should have trained individuals but, more than anything else, we need to bring communities into the designing of services.

**Professor Meier:** I will talk anecdotally about an experience that I am having. I am currently supporting Ukrainian refugees, and the way in which they have to engage with services, and the sometimes disrespectful way in which services deal with them, is just heartbreaking. Having first-hand experience of something that I have been studying remotely for a while has been powerful.

Someone can be asked to go to a jobcentre, which requires an hour-and-a-half round trip on the bus, only for them to be told that the person they were supposed to see is not there and they will have to come back the next day. When they say that they have a job interview then, they can be told that they will still have to attend the jobcentre at that time. Such experiences take away people's sense of agency—of being able to control their fortunes—in a way that is really demoralising.

The committee will have heard many such examples from people with lived experience, but it is powerful to see that constant onslaught of people not being believed, of their time not being valued and of them being made to jump through various hoops—for example, to register with a dentist or even to find someone who will take them on. As Michael Marmot said, all of that has an effect, and the amounts of time and effort that are involved are a massive resource drain. If someone is already traumatised from fleeing a war, it just makes their life much more difficult.

I am sure that, if people are in a situation where they are otherwise financially vulnerable or have experienced trauma, as so many Scottish residents have, it is very hard for them to navigate a large number of services. There are great help and support programmes, but they are all very bitty and they are not aligned—there is no one-stop shop. People have to be informed and chase every single bit of support, which is really hard work.

**The Convener:** Professor Meier, you have made a point that we have heard a lot. We need services to be aligned so that people do not have to tell their stories many times to multiple people. Do other panellists have reflections on that? The committee has heard some suggested solutions to such issues. It can compound people's trauma if they have to tell the same story over and over again to different people, starting from scratch and not leaving anything out in case it causes difficulty in accessing a service. Dr Cawston, you must hear about such issues a lot.

**Dr Cawston:** Yes. The community peer support group Chance 2 Change has brought them into its commentary on the short-life working group's report. It has developed a model that it would like to be introduced certainly in primary care, but across the health service. It says:

> "See me—I am a person with feelings.
>
> Listen—my opinion matters
>
> Be honest—even if you don't know ...
>
> Help me understand—Please don't tell me what to do ...
>
> Remember I am an expert in your professional hands—50:50 partnership".

It asks that doctors consider peer support as

> "people build confidence ... far more effectively than medication."

It is critical that we go to people and ask them to teach us how to relate in a way that is enabling. I feel very strongly that it is a traumatising experience for people who already face barriers to be told at repeated assessments that they do not fit a service. We have to find a way to get rid of that. It should be the case that, whichever door someone goes through, that is the only door that they will have to use, even if they need another service. The door that they enter through should be the single door that they use. Even if they move on to a more appropriate service, they should not be kicked out of that door and told to find another door. That has to be a thing of the past.

**The Convener:** That will be very helpful as we think about what to recommend in our report.

Evelyn Tweed has a question on intersectionality, which will probably be our final theme. I will look around to see whether any of my colleagues wants to ask a further question, but we have only about five or 10 minutes left.

**Evelyn Tweed:** We have heard from a lot of people who have given evidence that intersectionality is an issue and that they face multiple barriers because of it. What is being done to help in policy and practice terms?

**Dr McDaid:** I am not an academic, so I will not try to define intersectionality. However, one of the activities that the foundation has been engaged in recently is the establishment of a diverse experience advisory panel that will inform the Scottish Government's development of mental health policy. It is the first time that there will be a panel whose focus is on mental health policy but whose members do not necessarily have to have had a diagnosis of a mental health condition or experience of mental health services to be advising on mental health policy. It is quite innovative in that way.

We had strong interest in participating on the panel; there were more than 180 expressions of interest for a maximum of 30 places. We sought people on the basis of whether they have experience of disadvantage or discrimination that might have put them at risk of having a mental health problem, and we found that many people came forward who had experiences that reflected intersectionality. Perhaps they had experienced unemployment, had not had a chance to complete their education or had experience of single motherhood. We have people on the panel who have been victims of violence and have refugee status—they witnessed violence once they had arrived in Scotland.

When we ask people what has put them at risk of having a mental health problem, they point to a number of different circumstances in their lives that they realise have caused them stress and distress and have perhaps put them at risk. Intersectionality is fully alive in individuals' experiences. As Dr Cawston pointed out, however, our systems are not designed for rounded human beings; they are designed for people who fit a single category. That really needs to shift.

That was also found in some research that the Poverty Alliance conducted. We are partners with the Poverty Alliance in a project on poverty and mental health. It has done some research on the experiences of Glasgow-based recipients of universal credit, who said that they need a much more person-centred service than the one that they are receiving.

11:30

**Dr Cawston:** I echo what Professor Marmot said earlier about health inequalities and the climate emergency being the two great emergencies that we will face in the next 10 years. If they were embedded at the heart of every system and sector in the public, private and third sectors, if we understood that tackling those two great emergencies will make the difference between a good future and a catastrophic one, and if there were national leadership on that, we would at least be working towards the same goals. I echo Professor Marmot. The two great emergencies should be embedded in all sectors in order to help us to work across sectors towards the same aims, rather than people pulling in different directions.

**The Convener:** That is helpful.

**Professor Meier:** A lot of intersectionalities come about because things are causally linked and everything is in a system. If someone grows up poor, they are much less likely to have a good education that has an influence on where they live in adulthood, what kind of job they do and, potentially, whether they have help with childcare or end up as a lone carer who struggles for money. Without taking a stigmatising life course perspective whereby everything is predetermined, we can see that a lot of those things are strongly linked. If someone grows up in poverty, their chances of overcoming it and future issues are much lower, and there are health consequences to that.

For me, intersectionality is about a web of causes that stack up against people having healthy outcomes later in life. As Peter Cawston said, thinking in the round about how education, employment, housing and everything else go together to create outcomes will be very important.

**The Convener:** That is all very helpful and it is a good note for us to end on. We very much agree that the roots of health inequalities lie in a lot of different portfolios, which you have all made extremely clear this morning.

We have reached the end of our evidence session. I thank our four witnesses for the time that they have spent with us this morning and for the additional information that they have put in the chat function for perhaps following up on.

At our next meeting, which will be on 28 June, the committee will take evidence from the Minister for Public Health, Women’s Health and Sport in the final evidence session in our inquiry into health inequalities. We will also scrutinise an affirmative Scottish statutory instrument.

That concludes the public part of the meeting.

11:32

*Meeting continued in private until 11:57.*

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