OFFICIAL REPORT
AITHISG OIFIGEIL

COVID-19 Recovery Committee

Thursday 10 November 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 10 November 2022

CONTENTS

COVID-19 RECOVERY COMMITTEE
24th Meeting 2022, Session 6

CONVENER

*Siobhian Brown (Ayr) (SNP)

DEPUTY CONVENER

*Murdo Fraser (Mid Scotland and Fife) (Con)

COMMITTEE MEMBERS

*Jim Fairlie (Perthshire South and Kinross-shire) (SNP)
*John Mason (Glasgow Shettleston) (SNP)
*Alex Rowley (Mid Scotland and Fife) (Lab)
Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Susie Fitton (Inclusion Scotland)
Professor Gerry McCartney (University of Glasgow)
Professor Sir Aziz Sheikh (University of Edinburgh)
Pamela Smith (Public Health Scotland)
Tom Waters (Institute for Fiscal Studies)
Tom Wernham (Institute for Fiscal Studies)
Philip Whyte (IPPR Scotland)

CLERK TO THE COMMITTEE

Sigrid Robinson

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

COVID-19 Recovery Committee

Thursday 10 November 2022

[The Convener opened the meeting at 09:10]

Road to Recovery Inquiry

The Convener (Siobhian Brown): Good morning and welcome to the 24th meeting of the COVID-19 Recovery Committee in 2022. We have received apologies this morning from Brian Whittle.

This morning, we will continue our inquiry into the impact of the pandemic on the Scottish labour market. I would like to welcome to the meeting Susie Fitton, policy manager, Inclusion Scotland, who joins us remotely; Pamela Smith, head of economy and poverty, Public Health Scotland, who joins us in person; Professor Sir Aziz Sheikh, professor of primary care research and development, director of the Usher institute and dean of data, University of Edinburgh, who joins us in person; and Gerry McCartney, professor of wellbeing, University of Glasgow, who joins us remotely.

Thank you all for giving us your time this morning and for your written submissions. We estimate that this session will run up to about 10.20, and each member should have about 15 minutes each to speak to the panel and to ask their questions.

If the witnesses who are attending remotely this morning would like to respond to any issues that are being discussed, they should type R in the chat box and we will try to bring them in. I am keen to ensure that everyone gets an opportunity to speak. I apologise in advance that, if time runs on too much, I may have to interrupt members or witnesses in the interests of brevity.

Could I ask the witnesses to briefly introduce themselves?

Susie Fitton (Inclusion Scotland): I am a policy manager at Inclusion Scotland.

Pamela Smith (Public Health Scotland): Good morning, committee. I am the head of economy, poverty and environment at Public Health Scotland.

Professor Sir Aziz Sheikh (University of Edinburgh): Good morning, committee. I am professor of primary care research and development, director of the Usher institute, and dean of data at the University of Edinburgh.

Professor Gerry McCartney (University of Glasgow): Good morning, committee. I am professor of wellbeing and economy at the University of Glasgow.

The Convener: Thank you very much.

We now turn to questions, and I will begin with Inclusion Scotland. Susie Fitton, thank you for your very detailed written submission. The committee has a keen interest in further investigating long Covid. Your submission says that nearly 4 per cent of people in Scotland are currently living with long Covid, which is around 202,000 people. Of those, 83,000 people have done so for more than 12 months and 44,000 are reporting that it affects their ability to undertake day-to-day activities.

One of the things that I found quite worrying in the submission was the fact that early studies suggest that at least half of those with long Covid meet the diagnostic criteria for ME. We know that ME is a profoundly debilitating neurological disease that can affect multiple systems in the body. I understand that, prior to Covid, there were 21,000 people with ME in Scotland. I note that a substantial proportion of long Covid sufferers are experiencing similar illnesses, which will have a direct impact on their ability to work. I note that you feel that action is urgently needed to address this problem. What would you like to see the Government doing to address that problem?

Susie Fitton: Although some people with long Covid are able to return to work—particularly when their employers make suitable adjustments to support them in the workplace—many people with long Covid have been left in limbo when it comes to getting the right advice, information and support to find out more about the symptoms that they are experiencing. Many disabled people and others have reported to us that they have not been receiving any support or advice and either have not been able to work at all or have been able to work only with reduced hours.

09:15

There is a particular issue for people whose friends and family members are living with long Covid, who have experienced challenges in combining unpaid caring roles with employment. It is particularly acute for parent carers of children and young people with long Covid, especially young people who are not able to attend school as a result of their symptoms.

We would argue that employers need support and advice about how to make reasonable adjustments for someone with long Covid. We ask that employability support be made available to people with long Covid if they are forced to leave work, so that they can re-enter the labour force.

In terms of the things that are affecting people at work, in a recent survey by the Trades Union Congress of more than 3,000 workers with long Covid nine out of 10 respondents experienced fatigue. There are problems with brain fog, shortness of breath, difficulty concentrating and memory problems. Over four in five respondents reported experiencing at least one of a range of pain-related symptoms, with about one third experiencing depression.

We ask that similar measures that have been shown to support people with chronic illness and pain conditions are promoted to employers, such as flexibility in the hours that people are allowed to work. Flexible working in the truest sense has been shown to support people with energy impairments back into work and allowed them to maintain work. We would like to see flexible working. In this rush to get back to normality and renewal and recovery from the pandemic, we are concerned that employers will be less likely to offer real flexibility.

There is some concern that long Covid is not yet necessarily considered to be a disability, because it is not among the conditions that are listed in the Equality Act 2010 as being automatically considered a disability, such as cancer, HIV and multiple sclerosis. The Equality and Human Rights Commission, for example, originally said that it could not say that all cases of long Covid would fall under the definition of disability in the Equality Act 2010. It has since qualified that to say that, if it has a substantial, long-term adverse impact on someone's ability to do normal day-to-day activities, it would count as a disability. However, we need to ensure that employers of workers who are affected by long Covid follow existing guidance when considering reasonable adjustments for disabled people and access to flexible working.

The Convener: Thank you, Susie. That is very helpful.

I will move on to the link between long-term sickness and economic inactivity. Scotland has a higher proportion of 16 to 64-year-olds who are inactive because of long-term sickness when compared with the rest of the United Kingdom; in Scotland, the figure has increased to 7 per cent, compared with 5.4 per cent in the rest of the UK. Why is Scotland relatively worse than the rest of the UK? On an international scale, how do we explain the continued rise in the UK inactivity figures in comparison to other Organisation for Economic Co-operation and Development countries, where the figures are declining?

Pamela Smith: In terms of economic inactivity, the first point that I would like to highlight is that some long-term chronic health conditions are preventable. Many people who are living with chronic conditions are supported to remain in work and remain economically active. When it comes to Covid affecting inactivity, I think that it is still a pretty new condition, so a bit more research is required into the long-term effects.

Also, we cannot look at chronic conditions and long-term sickness in isolation. We know that the intersectionality of disadvantage and inequality manifests itself in poorer health. We know that it is estimated that, for one third of individuals who have long-term chronic health conditions, those conditions could have been prevented through early intervention.

With the lack of good fair work, the lack of access to skills and training for some parts of our community, and the continued impact of people living in poverty, it is difficult to identify one reason because there are so many interdependencies and factors that impact on people's ability to move into sustained employment. Health is one aspect, but there are other reasons for economic inactivity alongside health. It may be to do with the labour market where people live, or it may be to do with other carer responsibilities, so it is quite difficult to isolate health as the only factor. We have to look at the individual and their individual circumstances. Health will be one factor, but it does not follow that by looking at health alone you will reduce the labour market inactivity or increase participation. We need to have a more holistic approach to the disadvantages and inequalities that the individual is experiencing to get them into sustainable labour market participation.

The Convener: I know that Professor McCartney wants to come in, but could I ask a quick question? Do you know why the figures are so much higher in Scotland than the rest of the UK?

Pamela Smith: I do not have any evidence to hand that would indicate why there should be a difference. Again, in a lot of the studies, the cause of economic inactivity is self-reported.

The Convener: Thank you.

Professor McCartney: Your question was about why the trends are so bad and why Scotland is comparably bad. I would like to bring to the committee's attention some of the longer-term history here. Scotland's health in comparison with that of the rest of the UK was improving on average until around 2010 or 2012, albeit that it had always been worse comparatively. There are a number of historical reasons for that, which were summarised in the report by the Glasgow Centre for Population Health in 2016.

Since 2012, we have seen that life expectancy has not improved at all on average. In the poorest areas of Scotland and, indeed, the poorest areas across the UK, life expectancy has gone down. Obviously, mortality and life expectancy are a

pretty blunt measurement to measure health, but we can look at other measures, such as healthy life expectancy, which combines mortality measures with self-reported health. That starts to get into the experience of morbidity and ill health. What we see there is quite a shocking set of figures that predate the pandemic. Between 2011 and 2019, average healthy life expectancy declined by two years. In most deprived 20 per cent of the population, healthy life expectancy declined by three and a half years, and all of that predated Covid.

We are quite clear now that the causes of those stalled mortality trends and healthy life expectancy trends are related to the change in economic policy after the great financial crash in 2008. The change towards austerity policies and the implications that that has had for social security benefits and public service funding and all of that—the austerity package—have had a massive impact. All of that left the population in a very vulnerable state when the pandemic hit. Therefore, in a sense, there is no surprise that, in that context of stalled life expectancy trends and declining healthy life expectancy, a global pandemic impacting on the population would simply exacerbate those trends.

Covid and long Covid have probably made an impact on that, but I would also agree with what Pamela Smith has said. Austerity has also created a context of poor-quality work, precarious work and a whole range of labour market demand factors that mean that economic inactivity has become more common as well. There is a polycrisis of factors driving the trends that we are now seeing.

The Convener: Thank you. That is very helpful.

Murdo Fraser (Mid Scotland and Fife) (Con): Good morning to the panel. I will follow up on some of the questioning from the convener because I think that this is at the heart of what the committee is trying to understand about what has been happening in the labour market. We had some interesting evidence from our panel last week about the reasons for the reduction in economic activity and whether that was directly related to health—for example, whether it was people with long Covid who were struggling to work—or whether it was more about other factors, such as people deciding after two years of home working that they were going to take early retirement because they did not want to go back to an office working environment.

I am interested to get people's perspectives on that. To what extent do you think that this is directly health related? Are there other factors, particularly among the 50 to 60-year-old age group? Professor, maybe you could start. Do you have any thoughts on that?

Professor Sir Aziz Sheikh: I do not have any direct evidence to draw on, so this is mainly anecdotal, but I think that it will probably be a combination of factors.

As has previously been mentioned, there are some very important health drivers that are contributing. Most of those were evident prior to the pandemic. They are largely non-communicable disorders that should be largely preventable through appropriate public health promotion approaches. The fact is that we have not made that transition as a health system—whether in Scotland or across the UK—so it remains largely a curative health system with the vast majority of funding directed at hospitals rather than at public health approaches.

Health is a contributory factor but, clearly, the pandemic has been a massive disruptive catalyst for people thinking about their lives in the wider context. I think that, anecdotally, a lot of people are making choices about having different priorities and trying to live differently. That is also likely to be contributing.

Murdo Fraser: Thank you.

Pamela Smith: From a health perspective, we know that mental health issues, such as anxiety and depression, are the areas of health that are increasing in relation to economic inactivity, particularly among young people, and which are cited more as reasons why people are leaving the labour market. There are issues around mental health and there is a whole cocktail of factors that are impacting on mental health. People are experiencing chronic stress and that is then manifesting itself in other health conditions, such as diabetes, high blood pressure and heart conditions.

It is not all down to the health conditions themselves, because we know that 58,000 people who are inactive due to health conditions want to work. It goes back to the comments that were made earlier about the flexibility of work in the labour market and the ability to access fair and healthy work. A lot of individuals who experience the poorest health have the lowest skills level and they are often in the more precarious sectors of the labour market. They often do not have the luxury of working from home, and the cost of living crisis is likely to exacerbate their mental ill health and anxiety as well.

Therefore, I think that there are issues around the types of jobs, the availability of work and the access to that work, particularly for those with poorer health, and there is a need for mental health support in work to prevent people falling out of work.

Murdo Fraser: Thank you.

Susie Fitton, I noticed in your written submission a reference to the analysis by the Financial Times showing that

"The UK is the only country in the developed world where people have continued dropping out of the workforce in ever greater numbers beyond the acute phase of the pandemic."

There is clearly a specific UK issue here and that will apply equally, or perhaps more so, to Scotland. Do you have any thoughts on what is driving that here as opposed to other countries?

09:30

Pamela Smith: The *Financial Times* analysis last month of OECD figures and the quarterly labour force survey showed that the rate of chronic illness shot up during the pandemic and continued to climb, with millions of working-age people across the UK now experiencing multiple health conditions—co-morbidities. The analysis made clear that the number of working-age people in the UK who are unable to work due to chronic pain had climbed by almost 200,000 in the past two years relative to its former trajectory.

The second biggest contributor to the rise in worklessness has been people dropping out of the workforce due to mental illness. That has already been mentioned by other witnesses, and I am sure that many of us will want to get into more detail on that later in today's evidence sessions.

Inclusion Scotland is obviously focused on what factors have contributed to disabled people and people with long-term conditions in Scotland being economically inactive and what the drivers are behind that. All the figures have shown that, for some time, disabled people in Scotland have been considerably more likely to be economically inactive than those who are not disabled. In 2021, more than 380,000 disabled people aged 16 to 64 were economically inactive. It is important to realise that, although rates of economic inactivity are much higher for disabled people than non-disabled people, that does not reflect less willingness to work. For example, in 2019, around a quarter of inactive disabled people wanted to work; that is a higher proportion than the number of inactive non-disabled people who wanted to work, which was less than one fifth.

I want to make plain that a wide range of factors contribute to disabled people's economic inactivity in Scotland. Those factors were present before the pandemic and during the initial shock, and they are still present in this phase of adjustment to the virus. Factors include poor health outcomes in general for disabled people; a mental health crisis, which we have mentioned; and poorly constructed and, at times, underfunded mental health services. We have also made it clear that poverty and health inequalities are big factors, and that is doubly true for disabled people.

The persistence of the disability employment gap in Scotland and the barriers that disabled people experience in finding and keeping employment, which can lead to them leaving work or not looking for work, are very important in this discussion. Unfair treatment at work during the pandemic has led to some disabled people leaving work and not looking for work. The impact of long Covid, which we have mentioned, and workplace issues experienced by disabled people who are at high risk of the virus is also a factor.

Murdo Fraser: Professor McCartney, what are your thoughts on the question? In particular, is it about ill health or are other factors driving people to leave the workforce?

Professor McCartney: Later on in the evidence session, the committee will hear from Tom Waters and John Burn-Murdoch, both of whom have done relevant work on that. Tom has done some work on understanding society data sets and John Burn-Murdoch's data has already been referred to.

I highlight two things. Even before the pandemic, we had big problems with rising rates of mental health problems being reported across the population, particularly in younger age groups. That will drive a withdrawal from the labour market. We have rising levels of poor self-rated health, which is a contributor to the healthy life expectancy statistics that I was referring to and, again, is a massive driver. There is that context, and, to an extent, Covid is a much more minor impact compared with the decade of problems that we have related to austerity problems.

The pandemic is often seen in terms of the direct impact of Covid—the impact of infectious disease—but there are two other big impacts. We have already discussed some of the social impacts of the changes to employment practices, the changes to people's income, people's social interactions during the pandemic in periods of lockdown and changing working practices. Those all matter for people's health.

We have also seen a big impact on healthcare services. As the national health service and social care had to change models of delivery over the pandemic, we have accumulated a large amount of unmet healthcare need. That is a lot of people waiting for healthcare intervention, so it is no surprise that that group of people is less likely to still be in the labour market as they wait for their operation, joint replacement, mental health intervention or a range of different things. The impact on the health service will also be having an impact.

However, I cannot emphasise enough that Covid has been the cherry on the cake of an awful

decade of health trends that are rooted in the economy. It is the economy that has driven poor health, and we are now reaping the unfortunate rewards of having that much poor health in the economy, in that we have fewer people available and healthy to work in the labour market.

Alex Rowley (Mid Scotland and Fife) (Lab): Good morning. I will start with Pamela Smith. The word "crisis" is being used a lot these days. We seem to have crises everywhere. Mental health is in a crisis. As Professor McCartney said, it was an issue before Covid and, now, mental health is one of the symptoms that has been described in long Covid. Where are we at in Scotland? Is there an understanding of the issues around mental health? Do we know the numbers of people who are suffering mental ill health? As policymakers, what should we be arguing that the Government should be doing?

Pamela Smith: As you know, figures are available in the written submissions around the increase in mental ill health as a chronic and long-term health condition. The issue is that we must tackle mental ill health in a number of interconnected ways. If mental ill health, stress and anxiety have been the reasons for people falling out of the labour market, they remain the reasons why a lot of people do not move back into the labour market. There are a lot of good initiatives out there, such as the Scottish Association for Mental Health's individual placement and support services, in which there is a place and train model that supports individuals, through community mental health services, on their journey into work or towards work.

Such initiatives are very expensive approaches because they cover multiple different needs, the issues are very person centred and needs led and they often happen within a locality and a place where people live and work. Tackling and supporting mental health is not only about health services; it is about all the integrated services that can relieve some of the pressure and stress that exacerbates and contributes to mental ill health and lack of wellbeing.

The mental health strategy in itself will not resolve mental health issues if we do not resolve a lot of the issues that drive poor mental health. Professor McCartney referred to the labour market, the economy and the precarious employment in some sectors that have less access to occupational health services, which does not help any of the mental health support that individuals might be getting from a clinical perspective. Individuals need an integrated action plan, and we must deploy an integrated whole-system approach to tackle mental health, the economy and employment simultaneously.

Alex Rowley: I want to ask Susie Fitton a similar question. On the rising number of cases of mental health, the impact that that is having and the treatment that is either there or not there, what should we, as parliamentarians, be looking at, and what should we be expecting from the Government?

Susie Fitton: Research in lockdown with disabled people across Scotland indicated that disabled people were experiencing a mental health crisis. Obviously, as you have mentioned, the term "crisis" is used too readily, but our survey findings showed that disabled people were being pushed to the brink by the pandemic, and there was an indication that some of those mental health problems would continue even as restrictions were lifted.

We discovered that the social care system during lockdown had basically collapsed. Disabled people had their social care removed or reduced, and they were thrust into caring roles—caring for themselves or relatives—that they had not previously had. Disabled people were worried about food insecurity. They were worried about losing their job, given that the rates of redundancies for disabled people were disproportionately higher, and reduced hours were also an issue.

The indications from lockdown were not good in terms of disabled people's mental health, and disabled people often report poorer health outcomes than non-disabled people anyway.

Other witnesses have mentioned the impact of poverty and wealth inequality on health inequality in Scotland. That is now well understood and largely accepted in the health community. Disabled people are much more likely to live in poverty, which has a significant impact on mental health. Nearly half of all those living in poverty in the UK are disabled people or live in a household containing a disabled person. Disabled people have significantly higher costs that are associated with living with disability. Once those costs are taken into account, half a million Scottish disabled people and their families are living in poverty, which is 48 per cent of all the people in Scotland who live in poverty.

There is growing evidence that the Covid crisis pushed more families into poverty. Disabled people are more likely to say that their finances have been negatively impacted and that they are worried about accumulating more debt. Given that we are now in a cost of living crisis, it is likely that those factors will only intensify. We argue that a whole-system approach that tackles the health inequality and poverty of disabled people is absolutely critical if we are going to start to address mental health issues in Scotland for disabled people. We know that people living in our

most deprived communities are more than twice as likely to experience anxiety and depression and are three times more likely to die by suicide.

Those inequalities have been shown to have been caused in large part by austerity, which has had a drastic impact on the income and health of the poorest and most vulnerable populations in Scotland. Our view is that efforts to tackle poverty inequality are quite key to efforts to improve mental health. We are obviously concerned about the recent announcements of cuts to funding for mental health provision in Scotland, and we are concerned about waiting lists for child and adolescent mental health services, particularly for disabled young children and young people.

These things often get talked about, but we would like to see a whole-system approach to tackling the poverty that is experienced by disabled people as a key element in tackling mental health issues.

Alex Rowley: Professor McCartney, mental ill health is increasing right across the population among both disabled people and able-bodied people. As politicians, parliamentarians and policymakers, what should we be considering? Is the data good enough? What action should we take?

Professor McCartney: I will try to address the question about the scale of the problem.

The best source of data on the number of people who suffer from mental health problems comes from surveys. We have various sources. There is an Understanding Society survey that follows people over time across Great Britain, and there are the Scottish health survey and surveys for other parts of the UK.

09:45

From those we have seen that mental health was either fairly stable or improving for older adults until about 2010. After that, the number of people who reported suffering from mental health problems rose dramatically among people under 65, but the situation continued to improve for those over 65. That lasted until 2019.

Unfortunately, from when the pandemic hit we have poor survey data because response rates went down, which was partly because we could not knock on doors to collect survey data. When you have low response rates or do surveys by telephone, the data becomes so biased that it is difficult to infer much from it. Unfortunately, that is the position that we are in for those survey data sources.

The alternative is service-based data. We can look at the number of people who are in contact with services for mental health problems—for example, the number of people who are admitted or discharged from hospital, or the number of people who are in touch with primary care services. Again, there are problems with that. In terms of secondary care, we have a limited number of beds and the threshold is reached quite quickly. The data does not tell us about variation in need because the services are prioritised for those with the greatest needs and the beds are constantly in use, so we do not get a picture of whether need is rising or falling.

We have had a lot of changes to primary care data sets over the years. The history of variation of general practitioner data collection systems over time has meant that data has never been nationally comparable. There has been a lot of work done by Public Health Scotland and others to create the Scottish primary care information resource system. That would allow for a national comparative data set, which could be really important in terms of people being more able to access primary care than secondary care for mental health issues. That is still in development; we do not yet have good data on trends and mental health contacts from that data system.

That is a very long answer to say that, from 2020 onwards, we do not have great data to allow us to know the scale of the problem. However, I think anecdotally—that is always dangerous—we would expect things to be much worse than they were before the pandemic for all the reasons that you and others have mentioned.

The Convener: Professor Sheikh wants to come in.

Professor Sir Aziz Sheikh: I want to make three points.

The first is that I have just come back from Singapore where I met a team that has been surveying mental health across Singapore, which is a comparably sized country. It has very low prevalence of mental health problems, which has been persistently found to be the case, including over the pandemic. As parliamentarians, you might look internationally. I can certainly make a connection with that team, if that would be helpful. When I asked them why they feel that they have such low prevalence of mental health disorders, they pointed to economic prosperity, relative lack of inequalities and low prevalence of substance disorders—alcohol, drugs and so on. I think that it is important to look internationally.

The second thing to say is that in Scotland we have the best data sources in the world. I think that part of the reason why I have been brought in is that we have created a platform and we have, on virtually everybody, real-time data that links across general practice, hospital and social data. Those data are housed in Public Health Scotland.

Our permissions are only Covid-specific, but if you were to ask us specifically to look into mental health issues and how the pandemic has affected us, we could certainly run that analysis. There are very few places in the world that could do that. It would not take very long, but it would need a specific request and we would have to negotiate permissions.

The third issue that I want to talk about—which I think links to an earlier question—is that in Scotland, at the University of Edinburgh, we have smart data. We have economic data on 1 million people, which includes 140,000 people in Scotland; it is granular data that has been provided by NatWest Group. The data are hosted within the NHS secure data environment. At the moment, I do not think that any country in the world has been able to link economic data and health data; we could be the first place to do that. In Scotland, that would answer a lot of the questions on which we are providing anecdotal evidence or relying on out-of-date survey data. The information could be provided in real time. I understand from speaking with the team yesterday that they feel that other banking groups are willing to provide data; again, that would need specific instruction from parliamentarians.

The Convener: Thank you. Professor Sheikh, I know that you are leading a long-term study on long Covid. Before I move on to Mr Fairlie, what are you hoping to learn from it?

Professor Sir Aziz Sheikh: The work is funded by the chief scientist office of the Scottish Government. We are trying to understand the prevalence of long Covid in Scotland. It is a difficult question because it depends on how you define long Covid. There are symptoms-based approaches such as what has, for example, been undertaken by the Office for National Statistics; I have seen the evidence that is cited in its papers.

Another approach is to ask about the extent of the impact on health systems—encounters in general practice or on-going referrals to the hospital sector. That is something that we are looking at, and we are working on different definitions.

The second thing that we are trying to work out is how to predict who is most at risk of developing long Covid. In preparation for this session, I asked the team to see whether we can look at economic activity. We have data on sick lines that are issued by general practitioners. We have been able to do a very preliminary analysis of that and have been able to identify some risk factors that are associated with increased risk of a person's being signed off with long Covid in Scotland.

That needs more work. There are issues with GPs' reluctance to code for long Covid in records because long Covid is largely a diagnosis of exclusion. Until we have appropriate diagnostic services in play, that will remain a challenge. Nonetheless, we have been able to get some indicators as to which factors are associated with being signed off for long Covid. There is the possibility of doing some in-depth work on that.

The Convener: Thank you. That is interesting.

Jim Fairlie (Perthshire South and Kinross-shire) (SNP): Good morning, and thank you for coming in. I have been sitting here listening last week and this week, and one of my questions is this: are we asking you the right questions for us to get to where we want to go? I think that you started to touch on that. Are we asking the right questions of the witnesses to enable us to get at what we are trying to work out, which is how we can get economically inactive people back into the workplace? Are we doing that?

Professor Sir Aziz Sheikh: The questions are all appropriate. My slight frustration is about the fact that in Scotland we have absolutely phenomenal data sets in the health space: no other country in the world has the data that we have. How do we now deploy the data beyond questions about whether vaccines are working? That would be a relatively straightforward move.

Jim Fairlie: Why is that not happening?

Professor Sir Aziz Sheikh: It is because we do not have permissions, at the moment, and we do not have instruction to do that. We are able to do what we are doing in relation to Covid because the Cabinet Secretary for Health and Sport at the time, Jeane Freeman, asked us to do it and everything fell into place. Therefore, we need high-level instruction that the work is to be done.

There is the wider question whether we can move to whole-system intelligence for NHS Scotland. That will be absolutely crucial if we want to improve services and begin to bend the cost curve. There is also the question about bringing health data—which are so rich—together with economic data, which could be done. Major investments have been made but, again, somebody senior needs to instruct the country to move in that direction.

Pamela Smith: In terms of moving evidence into practice and policy, I think that the committee has spoken previously about the ability to marry up some of the Department for Work and Pensions benefits data. I am probably most interested in how we identify and tackle individuals. We can have data at population level that can tell us certain things, but we know that most economic recovery and social renewal actions have to happen at place level: those places are the neighbourhoods and communities where people live and work.

I am also interested in how the data can marry up with intelligence that is held by local government, which provides support for people through social rented housing, hardship grants, the education system, social work, community trusts and so on. Many people who are economically inactive and who have the inequalities and health issues that we are talking about receive support from a raft of public services.

This comes back to the point that other witnesses have made about whole-system marrying up of data. That is not only about the high level, in terms of the whole population; it is also about being able to drill down in order to know who the individuals are. There have been good examples; for example, through the young person's guarantee, when data that was held on young people from the DWP and data from His Majesty's Revenue and Customs was exported into other data that local partners were able to provide. We could actually get information down to individual level and at partnership level locally, so that we could then look at how services could be needs led, person centred and place based.

We need various levels of data and there are various uses for data in terms of policy and practice. What Professor Sheikh said about marrying up a lot of data that we already have and looking at what that means in practice for policies, programmes and approaches that will start to shift the curve for individuals was very helpful.

Jim Fairlie: You are the head of economy and poverty at Public Health Scotland. Are you talking just about the quality of data that we have in the health system? In my constituency we have 5,155 children living in poverty. That is clearly data at a granular level. Does Public Health Scotland have that level of data, which could be included in a whole-system approach?

Pamela Smith: Public agencies have a lot of different data sets. You will know that work is on-going to marry up that data, and that local government has other data profiles within its systems. Much of the high-level data is fed in by high-level systems so, yes—Public Health Scotland has loads of data.

I have to say that I have been in Public Health Scotland only seven months. I am from a policy and practice background in which we take data, evidence and intelligence and figure out what is best in order to resolve problems and improve outcomes.

Public Health Scotland has a new local working programme in which we are looking to work with all public sector partners locally on economic and health profiles, and on how we can deliver and develop programmes that work. That started with community planning partnerships and local outcome improvement plans, in which we tried to integrate many of the local actions. Within Public Health Scotland, the Improvement Service and other public sector partners there is certainly community profile data that touches on many economic and health issues, as well as on other factors that impact on wellbeing. That takes time and it requires that we are asked to think about how we would profile them together.

Jim Fairlie: I have just an observation that will take two seconds, but Professor Sheikh will speak first then I will come back in.

10:00

Professor Sir Aziz Sheikh: I can answer the specific question. Public Health Scotland has various departments; it is a large organisation. The group that I work with has data on 5.4 million people across Scotland. Those are GP data that are linked with unique identifiers on hospitalisation, mortality and prescribing. In the context of Covid, that includes data on vaccination, testing and so on. We now also have a linkage to census data and a variety of other data sets, so we have very granular data.

The data are updated weekly, on a Tuesday morning, in Public Health Scotland. If there was an instruction, resources and permissions to do so, I could give you weekly data on what mental health looks like in Scotland. The answers could be available, as long as those other things fell into place, within a couple of weeks.

Jim Fairlie: This is just an observation, and you can correct me if I am wrong. We have an extensive range of data. Singapore reports much lower rates of mental ill health and wellbeing and so on. Does that mean that we know about it but Singapore actually just does not?

Professor Sir Aziz Sheikh: No. Singapore runs surveys regularly and response rates are very good, so the data is longitudinal. I was told by that team that even though mental ill health rates are incredibly low, Government officials are not satisfied; they are still concerned.

Jim Fairlie: Thank you. I just wanted to get that clarity on the record. Do I have time for another question?

The Convener: Yes.

Jim Fairlie: I am enjoying this, convener.

Professor McCartney, I would like to come to you. You mentioned that the issue that we are looking at goes back to the austerity policies of 2008. Are there data or studies that would say how far back health inequalities go in Scotland? What I am trying to find out is whether it is only

since the crash in 2008, or does the problem go back further and we are living with a chronic long-term problem.

Professor McCartney: There are various periods to consider. If we look at what is pretty rudimentary data on health inequalities across Great Britain, we find that measures showed that health inequalities declined from the 1920s to the 1970s, then subsequently increased. We have much better data from 1981 onwards on the extent of health inequalities. They increased rapidly from the 1980s onwards until about 1997, 1998 and 1999, when the figures started to stabilise. Inequalities have increased again from 2010 or 2012 onwards and under most measures have been increasing ever since. That is in relation to mortality. When we think about other measures, we see inequalities in almost all measures of health. Whether it is about mental health, mental wellbeing, self-rated health or admissions to hospitals, you see similar trends across all the measures.

On average, life expectancy and mortality figures were improving until around 2012. The figures were flat since then until they declined during Covid. The inequalities have widened, so there is declining life expectancy from 2012 onwards in our poorest 30 per cent or so of areas.

Mental health problems started to worsen for the under-65s from around 2014-15, and prevalence has risen from about 15 per cent to about 20 per cent over that period. As I said, the survey data thereafter are not high quality.

Jim Fairlie: Okay. I think that it was Pamela Smith who said that we have had chronic stress issues from 2008 onwards Where is that coming from? Is it because of economic problems? Is it because of austerity? Is it because of poverty? What is causing chronic stress?

Pamela Smith: I think that Professor McCartney and the Glasgow Centre for Population Health have published information and data on austerity and the links with health from 2008. On the question about the manifestation of mental ill health through austerity, mental ill health is linked to poverty, lower incomes and precarious employment, and it is part of the cycle of inequality. Health inequality is made worse by anxiety and stress, lack of money, lack of healthy food and bad diet, and lack of exercise to improve health. It all comes back to poverty, unemployment and poor work.

We know that most children in poverty have a working adult in the household, so poverty is not only about labour market inactivity and employment; it is about income and income levels. That comes back to the economy and how the labour market operates.

Jim Fairlie: I was going to say that we have large numbers of people in work who are claiming benefits, so it is not about their being labour inactive, but about the quality of the life that they are living.

Pamela Smith: Yes. There are two sides to the matter. Many people with health conditions manage those conditions in work, as well; not everyone who has a chronic health condition becomes inactive. Again, much depends on the nature of the job and what resources, tools and resilience the person has to manage their health conditions.

The Convener: That is great. I am sorry, Jim: we need to move on because of the time.

John Mason (Glasgow Shettleston) (SNP): Building on some of the things that have already been discussed, I believe, Professor Sheikh, that you said that we can compare mental health in Scotland and Singapore. Can we also compare, say, long Covid numbers in Scotland and France, economic inactivity and so on? Are the definitions for all those things the same in different countries?

Professor Sir Aziz Sheikh: With long Covid, we are clearly struggling with definitions internally in Scotland and the UK. That said, it would be possible to do comparative work across countries and jurisdictions, because the teams involved work quite closely together and there is a lot of sharing of information. There is an answerable question around economic activity, but it is not really my area of expertise and I think that others would be better placed to comment.

John Mason: A lot of comparisons and similarities have been drawn between ME and long Covid. To be fair, I think that we have struggled over the years to get a definition of ME, and GPs seem to vary quite a lot in that respect. Is it fair to compare the two?

Pamela Smith: Again, I am not a clinical expert but it appears, from the information that has been made available to me, a lot of the symptoms are the same, but they are self-reported. People report symptoms of fatigue, tiredness and so on, and there are respiratory conditions, too. As we have heard, the definition is not quite clear. A lot of symptoms will manifest themselves in the same ways, but the causes might be different.

John Mason: Do you think that that will become clear over time, or will it be like the situation with ME, which, as some ME people would claim, has still not really been pinned down after 30 or 40 years?

Pamela Smith: Something will always underlie all of those things. Indeed, it is the same with mental health conditions; a lot of that is self-reported by individuals, and some of it gets

questioned as being an excuse to opt out of work. I therefore think that we have to be clear about the definitions as well as about data collection. I know that it involves a lot of self-reporting, but irrespective of how it is defined, it limits and impacts on people's full participation in the labour market.

John Mason: Professor McCartney, did you want to come in on this question?

Professor McCartney: I simply point members towards a rapid evidence review on managing the long-term effects of Covid-19 that was jointly published on 3 November by the London-based National Institute for Health and Care Excellence, the Royal College of General Practitioners and Healthcare Improvement Scotland and which contains a series of sections on identification, assessment and diagnosis, the criteria in that respect, the evidence on treatment and so forth.

What the review shows very clearly is the range of uncertainties at each stage. Different definitions are used, and there is uncertainty in the criteria for pinning it down as well as uncertainty about what works with regard to management, treatment and supportive environments. It lays out a really clear research agenda of answerable questions that need to be looked at, and if resource were to be allocated towards research in this area, it would be a very good starting point. We need to understand how to diagnose, assess and treat long Covid; there will be a range of different options and inferences from other conditions that might or might not work, but it all needs to be tested.

We need an evidence base for this, because at the moment we are under pressure to act in the absence of evidence, and that can do more harm than good. It can, for example, create a lot of iatrogenic harm—that is, harm from healthcare treatments—so we need an evidence base and an experimental context in order to learn more about this.

John Mason: Can I just press you on an issue, Professor McCartney? You have said a few times now that a number of health issues are linked to austerity and economic factors, but is it not the case that certain issues—obesity, say, and perhaps mental health—are also very much seen in better-off parts of the population and, despite that, we have not been able to pin them down and sort them out?

Professor McCartney: Both things are true. Let me very briefly rehearse the evidence on austerity.

We have evidence at three levels about the negative impacts of austerity. First, international comparisons have been made with more or less austere regimes over time, country and place, and that evidence shows that countries that have implemented periods of austerity have had much worse mortality trends.

Secondly, we have evidence at local government level. Councils that have had the biggest cuts to budgets and services, whether they be health or social care, or to aggregate levels, by which I mean benefits, pension credits and the like, have much worse health trends.

Thirdly, there is the individual household level. We have evidence from, for example, the Understanding Society survey, showing that benefit cuts, benefit sanctions or changes to the benefit system that reduce people's eligibility all had massive negative impacts, often on mental health.

We agree that there are issues with obesity and mental health that predate austerity, but the fact is that they have not been helped at all by it. For example, there was a large rise in the prevalence of the population who were obese from 1995, when data first started to be collected, onwards; that plateaued after 2010, but we are seeing the lagged effects now. According to surveys, the level of mental health problems had been fairly flat until around 2015, after which there was a divergence, with a rise in mental health problems in people under 65 and a decline in mental health problems in those over 65.

Finally, we also need to be careful about some of the inequalities data that we routinely use, because they are area-based measures. As we know, the vast majority of people who are deprived in terms of income or employment do not actually live in the 20 per cent most deprived areas. When you look at the statistics for the population, you must remember that it is a very crude categorisation of need. The data is helpful, because it is routinely and quickly available, but, because it is area based, it can mask inequalities that you might measure by social class, educational attainment or income levels, and it can mix up people who are more or less deprived.

John Mason: Thank you for that extremely helpful and really interesting response.

Ms Fitton, the attitude of employers towards both disability and long Covid comes up a few times in your written evidence. In fact, it says at one point:

> "Workers were faced with disbelief and suspicion, with around one-fifth (19 per cent), having their employer question the impact of their symptoms".

Can you say a little bit more about that? What should we be doing to educate employers, help them or whatever?

10:15

Susie Fitton: We have an opportunity to approach participation in the labour market by disabled people and people with long-term illness—including, to our mind, many of those with long Covid—in a different way as part of a post-Covid renewal. It would involve employers switching focus in their approach to inactivity and looking at how we support disabled people and those with long-term illnesses into work. Nearly one in four people in the UK who are inactive because of ill health wants to or is seeking work, but they are unable to start, because of the barriers that they experience to entering or re-entering the workplace.

We think it important not only to switch focus but to ensure that changes that have been made to working patterns as a response to the pandemic—particularly the move to working from home and the large numbers of employees who are doing so—provide an opportunity to look at workplace adjustments and flexibility as a normal part of employment practice. In other words, they should be seen not just as reasonable adjustments for disabled people but as an inherent part of employment and as a means of giving real flexibility.

There is a certain irony in that the changes made to working patterns as a response to the pandemic were adjustments that had been long called for by individual disabled people and those managing long-term health conditions. Disabled people have reported to us that they felt that the response to the pandemic was a response to the majority that disabled people are not part of. For years, people with energy impairments or chronic illnesses have been asking to work from home, and employers have said it was impossible. There is, therefore, an uncomfortable irony in that respect.

John Mason: I think that highlighting that irony is good evidence, but can I press you on that? Is there any sign of employers now thinking differently? We hear that a lot of employers are struggling to get staff, which suggests that they might be more adaptable to taking on people with long-term conditions and disabilities. Do you think that that is happening?

Susie Fitton: We offer as part of our employability work internship opportunities for disabled people, and we have lots of links with employers across Scotland. Many employers are very keen to learn from the pandemic and to think about workplace adjustments as just that, rather than as adjustments for disabled people or people with long-term illness. Employers also have a real opportunity to explore more formal and informal flexible-working options—working not only from home but from other remote accessible locations, offering flexibility in terms of compressed hours and so on—to support disabled people into work. All of these flexible working approaches can support not only disabled people but people who have a long-term illness such as energy impairment, or who have pain or fatigue conditions that might mean that they need to work at different times when they are well.

We also need a switch in focus with regard to employability support. For many years—indeed, decades—efforts to tackle disabled people's economic inactivity and unemployment have been predicated on the idea that what stops disabled people working is a deficit or lack of something to do with the disabled person, and a lot of the emphasis in supporting disabled people to get closer to the labour market has been on a presumed lack of skills or education or a lack of ability to self-manage their health conditions. Our view is that we need to focus on employers and on how inclusive and accessible employment can be. We have ended up having this—

John Mason: I am sorry—we are running out of time. However, I think that you have made your point, which is great.

I want to give the final word to Ms Smith, who has also talked about poor treatment at work. Are the backlogs in the NHS affecting people in getting back to work?

Pamela Smith: In certain sectors of the economy, particularly small and medium-sized enterprises, individuals do not have the same access to occupational health services. Although work is available on that through National Services Scotland, there is still a lot of work to be done with employers and employees on access to in-work support. Previously, a lot of employability services were for people who were unemployed and were therefore about pre-employment support, but we know that a lot more in-work support is required to help people stay in work if they have a health issue; to help them progress in work through, say, upskilling; and to address in-work poverty by ensuring that they can increase their earnings through employment progression. A lot more has to be done on in-work support for employers and employees and on how we implement some of the ambitions in the fair work action plan.

John Mason: We will have to stop now, because I think that we are out of time.

The Convener: Thank you. That concludes evidence taking from our first panel on the impact of the pandemic on the Scottish labour market.

I thank the witnesses for their evidence and their time this morning. If they would like to raise any further evidence with the committee, they can do so in writing; the clerks will be happy to liaise with them on how to do that.

I suspend the meeting briefly to allow a changeover of witnesses.

10:20

Meeting suspended.

10:22

On resuming—

The Convener: We will now continue to take evidence on the inquiry and I am pleased to welcome our second panel to the meeting. We have received apologies this morning from John Burn-Murdoch, the chief data reporter at the *Financial Times*. Joining us remotely are Tom Waters, senior research economist, and Tom Wernham, research economist, from the Institute for Fiscal Studies. Philip Whyte, director of the Institute for Public Policy Research Scotland, joins us in person. Thank you for giving us your time this morning.

We estimate that this session will run until around 11.30 am. Each member should have approximately 15 minutes to speak to the panel and to ask their questions. If those witnesses who are attending remotely this morning would like to respond to an issue that is being discussed, please put R in the chat box and we will try to bring you in. I am keen to ensure that everyone has an opportunity to speak and I apologise in advance, therefore, if time runs on too much and I need to interrupt members or witnesses in the interests of brevity.

I will put the first question to Philip Whyte. What are the main health conditions that account for long-term illness as the reason for economic inactivity in Scotland?

Philip Whyte (IPPR Scotland): They are long standing, which is an issue that will come out through this session. Covid has potentially exacerbated or shone a spotlight on conditions that have existed due to Scotland's relationship with health inequalities, which is long standing—Covid did not create it. For example, I pulled some stats from the Scottish health survey. If you go back to 2008, more than a decade, well before Covid, you see high numbers of people who are not of a healthy weight and significant numbers of people suffering from cardiovascular conditions, long-term limiting illness, respiratory conditions and general mental ill health. Those are all long-standing conditions and it is impossible to separate them from the fact that health inequality has been an issue that has persisted in Scotland for so long. We see it in the continued high numbers of alcohol-related deaths, drug-related deaths and co-morbidities, which have existed for a long time. The pandemic may have exacerbated them in some instances, but it certainly did not create them.

The Convener: I put the same question to Tom Waters. We have two Toms with W names, so I will have to say your full names.

Tom Waters (Institute for Fiscal Studies): Our focus has been on long Covid, so I do not have anything to add to what Philip Whyte said about wider health conditions.

The Convener: I will move on to the next question. What can the statistics tell us about the impact of differing policy approaches in Scotland and the rest of the UK pre-pandemic, during the pandemic and post-pandemic?

Philip Whyte: Do you mean in relation to Covid and the impact on health outcomes?

The Convener: Yes.

Philip Whyte: IFS has done some research at a UK level that might provide some UK context, which I can supplement. Not to put my IFS colleagues on the spot—apologies.

Tom Waters: Can you clarify the question? I am not sure that I quite understood it.

The Convener: What can the statistics tell us about of differing policy approaches in Scotland and the rest of the UK pre-pandemic, during the pandemic and post-pandemic?

Tom Waters: Do you mean with respect to health?

The Convener: Yes.

Tom Waters: When you say policies—?

The Convener: I mean policies regarding the impact of Covid.

Tom Waters: Sorry, I do not have anything to contribute on that. We have focused on the economic policy of the UK Government during Covid and the impact of long Covid subsequently.

The Convener: Okay. Maybe I can ask how we can fully understand the full picture around long Covid when its impact is spread around different statistical sets.

Tom Waters: That is a challenge for a number of reasons. Measuring long Covid and understanding its extent is difficult. Getting the definitions right and even things such as changing question wording can change the number of people who report having long Covid. As is well known, much of the data around long Covid, particularly the data that we have used, is self-reported. It is not confirmed by objective measures.

The approach that we have taken, which I think makes sense, is to look at those people who

report having long Covid—we are subject to any downsides of that self-reporting—and compare their trajectories, pre-pandemic versus post-pandemic, with those of people who before the pandemic looked quite similar to them: people who have similar income levels, jobs and levels of pre-existing health conditions. We looked at what happened to their trajectories and at outcomes such as employment or earnings. That was the approach that we have taken.

10:30

Murdo Fraser: Good morning. One of the issues that the committee is keen to properly understand is the extent to which the decline in the workforce post-Covid is directly down to health issues such as long Covid compared to other factors such as people choosing to take early retirement. I know that IFS has done quite a lot of work on this and I am interested to get your perspectives.

We had hoped to have John Burn-Murdoch from the *Financial Times* along this morning, but unfortunately he is not well. I want to quote a couple of things from the *Financial Times*. In an article he wrote in July, he said that chronic illness was the main driver behind the stalled labour recovery. A more recent article in the *Financial Times*, on 2 November by Delphine Strauss, quotes IFS research and says:

> "The findings challenge the prevailing idea that ill health is the main explanation for the post-pandemic shrinkage in the UK's workforce."

There is quite a contradiction between these two articles. I am interested in getting IFS's perspective on what is going on here.

Tom Wernham (Institute for Fiscal Studies): Part of the reason why a lot of people were suggesting, early on, that ill health might be the main driver of what is going on was that increasing numbers of inactive people were saying that health was the reason for their inactivity. However, our colleagues who have been looking at the data on who is moving in and out of activity have found that most of the people who were saying that they were inactive due to health reasons had already been inactive for a very long time. They are not the people who are moving out of the labour force now. The main reason why people who are moving out of the labour market are doing so now is retirement. It does not look as though health reasons are the main driver of the decline in activity.

Murdo Fraser: You say that people are taking retirement. To what extent do we understand the reasons for that? Did they take early retirement because they were working from home for two years and just decided that they did not want to go back into a workplace environment, or are there other factors behind it? Do we have enough data to explain it?

Tom Wernham: I do not have much specific evidence to talk about that.

Tom Waters: I can speak a bit about that. It is an important question. The cause is not well understood, but we can think of a few possible reasons. One is that people who lost their job in the pandemic or spent a long time on furlough and experienced not working perhaps liked it more than they thought they might and so ended up taking early retirement. That is what you might think of as a preferences explanation. Another explanation is people losing their job during the pandemic, being unable to find a new one and at some point giving up and retiring.

It is fair to say that we do not have definitive answers, but one thing that is important is that most of the newly inactive people—a large proportion of them—say that they do not want a job. They are not looking for one and that is why they are inactive. That perhaps suggests that the explanation is less about being unable to find a job. I am sure that that is going on in some cases, but is perhaps not the primary driver. It is an area where more evidence and more research would be valuable.

Murdo Fraser: I will in bring Philip Whyte in a second, but first I have one follow-up question. We know that there is a cost of living crisis and that household bills for energy and food have gone up substantially over the past few months. Is there any evidence that the people who dropped out of the workforce and perhaps took early retirement thinking that they had enough money to sustain them are now having to rethink that because of cost pressures and inflation?

Tom Waters: We are probably getting to the point where we might be able to see those effects. There is always a bit of a lag in the data that we get, but we might now be able to see those effects coming through.

In broad terms, we have evidence on that from other events that are in some ways similar. We have plenty of good evidence that if someone loses their job, their partner is more likely to go into work to compensate, and you can think of the cost of living crisis making people poorer as being analogous to that.

We should be looking out for the effect in the coming few months or so. We are just about getting to the point where it might be possible to see that in the most recent cuts of data.

Philip Whyte: The IFS has done the most work on this area. To try to get beyond that, you need to

start trying to infer causal links between wider data sets.

I will throw one other thing into the mix. As Tom Waters suggests, if this hypothesis is true, we will maybe start to see it come through in statistics, now that a bit of time has passed, if the hypothesis is true. When the Office for National Statistics undertook a large-scale survey of those aged between, I think, 50 to 64 who left the workforce for whatever reason during the pandemic, it showed that their health was worse than that of others.

The survey also asked for views about leaving the workforce. A large number of people said that they were not confident that their savings and resources would sustain them through their retirement. There is clearly something else driving people's decision to retire if a significant number are not confident that they will be able to financially survive. We may start to see people come back into the workforce if they are not able to sustain retirement through their savings and assets.

Those results might suggest that decisions to leave the workforce were driven by factors other than just a pure desire to retire. However, as both Toms have said, it is impossible to infer causal links from the statistics we have now.

Murdo Fraser: What do we need to do, therefore, to make it more attractive for the of people set whom we have talked about to come back into the workforce? What are the barriers to their working? Do we need more flexible working from employers, for example? Would that help? Are there any other useful interventions?

Philip Whyte: Are you speaking about those who have retired or people generally?

Murdo Fraser: Those who have retired.

Philip Whyte: In Scotland, we are trying to draw inferences from the UK-wide statistics. The IFS work shows that, in particular, those who took retirement were men who were in professional and ultimately better-off occupations. We know that, in Scotland, the public sector makes up a significant proportion of the workforce, so it is possible that those who were in the higher professional classes were overrepresented among the group who retired. Again, it is impossible to disaggregate the data, but if that is true, people's decisions might have been purely a case of saying, "I have done quite well throughout my career, but the pandemic has taken me over the edge and I have decided that that is me done".

Murdo Fraser: In the health service, that might well be the case.

Philip Whyte: That will definitely be the case among those known as the higher managerial class. If that is true, I do not know whether you will ever get those people back. There are those who will come back, however, particularly with the abolition of the retirement age.

The previous panel, including the representative from Inclusion Scotland, talked about disabled people, the social model and whether employers are now fully equipped to support people who do not fit into the usual mould of workers. Can they help them back in and respond to their circumstances? In the UK, the model of work potentially still does not quite work for them, and we may never get those workers back because they have just decided that their circumstances mean that they have no need to come back.

Murdo Fraser: Does the IFS want to comment on this?

Tom Waters: I agree with what Philip Whyte said, but I would add that it is not always the case that we should be targeting 100 per cent employment rates. It is not always the case that it is better for someone to get back into work. What we should be concerned about is people who are able to work and want to work but cannot find a job for whatever reason. The worry is that there might be a lack of skills, financial disincentives—all those sorts of things. My perspective is that if the decision is purely a lifestyle thing, that is somewhat less concerning than if it is about not being able to find a job. That distinction is quite important in thinking about what the policy response should be.

Alex Rowley: IFS research noted that those with underlying health conditions are more likely to suffer from long Covid. Are there any particular underlying conditions that are more prominent among those suffering from long Covid?

Tom Waters: That is a good question. I am looking at Tom Wernham to see whether he knows.

Tom Wernham: It is not something that we have looked at in particular.

Tom Waters: I do not know whether it is something that is known from the previous ONS work on this. I am not sure, I am afraid.

Alex Rowley: If you could find out, that would be great. How can statistical comparisons with other countries better help us to understand the root causes of both long-term sickness and labour market inactivity and link them back to policy and funding?

Tom Waters: Precisely because measuring long Covid is a bit of a challenge anyway, doing comparisons across countries has been a bit more difficult. That said, inactivity in general is pretty well defined across countries; there is a pretty clear definition and lots of countries use the same

measure of inactivity. Our rise in inactivity has been quite a lot larger than that in other countries, as the *Financial Times* article pointed out, but the fact that ours is largely driven by people taking early retirement drives us to think about our pension system perhaps being a relevant factor. It might not be the only factor, but things such as pension freedoms perhaps play some role in the uptick that we have had in retirement-driven inactivity. That is the thing that we should be looking at, but beyond the fact that the UK has seen this faster rise in inactivity I am not sure how much comparison across countries has been done.

Alex Rowley: Philip Whyte, is there any statistical evidence showing any differences in the effects that the different approaches in Scotland and the rest of the UK are having?

Philip Whyte: Do you mean with regard to inactivity in particular, rather than long Covid specifically?

Alex Rowley: Yes.

Philip Whyte: The primary one is employability, which exists in a bit of a complicated and convoluted landscape. The Scotland Act 2016 devolved some elements and that is what led to the creation of fair start Scotland, which services a sizeable chunk of people, but the vast majority who are out of work and are in receipt of benefits will go through the still reserved DWP JobCentre plus system. Scotland has obviously made efforts and there has been a focus on employability over the last few years in particular, not least as part of child poverty ambitions. However, there is a question about whether that has happened at sufficient scale. For example, going by the most recent statistics, fair start Scotland has had more than 67,000 referrals since it was created back in 2018 and, of those, just over 15,000 started a job off the back of being referred to it, so there is a huge disparity. More importantly, of those who started, 50 per cent dropped out before completing the programme. Given that it is a programme that is specifically designed for those who are disabled, have a long-term health condition or are long-term unemployed, that feels like a key driver, but the main issue right now is that it is not being delivered at scale.

Alex Rowley: Is there any impact from the introduction of, for example, universal credit? I think back to before the introduction of working family tax credits, when it was quite common to hear people talk about the poverty trap, which involved people being worse off in a job than they were staying on benefits. Working family tax credits certainly addressed that, but there have been changes since then. Have those changes impacted on people's willingness or ability to get back into the labour market?

10:45

Philip Whyte: I do not know whether they have impacted on that. There are societal issues. Qualitative if not quantitative evidence suggests that even just the aura around universal credit has had an impact. The conditionality and sanctions regime has caused negative reactions for justifiably good reasons for lots of people. There is also a question of whether it proactively and positively enables people to find work. People have 15 minutes with an adviser. Quite often, they do not have time to go through a person's specific circumstances. They are sent on their way, if they have work-related requirements, to do 20 hours or so of work-related activity, which involves them sitting at home, by themselves, using a laptop to look for jobs. What we miss is the person-centred proactive approach.

Yes, there is a question about the impact of universal credit and what it has meant in terms of the amount of money that is available for families, its requirements and negative connotations and the stigma that it creates, but more than anything, it is part and parcel of a system that does not, at times—if ever—genuinely proactively help people into the workplace as opposed to putting in place bureaucratic barriers.

John Mason: I want to follow up on some of those points. Tom Waters, you said that the definition of economic activity is well defined and very much agreed on between countries. My understanding is that, to be economically active, you only have to work one hour a week, which surprised me somewhat because I would have thought that one hour a week and zero hours a week were much the same, whereas 35 hours is quite different. Is that correct?

Tom Waters: To be economically active, you either have to have a job, which could be a one-hour-a-week job, or be looking for work.

John Mason: Surely, as far as the economy is concerned, it is much better having somebody working 35 hours a week than one hour a week.

Tom Waters: Yes, certainly. That is right. It is quite unusual to find people in work and working fewer than 16 hours per week. There are not that many jobs advertised at fewer than 16 hours but, yes, you are right. In raw terms, it is the number of hours worked that matters more than the number of people in work. That is certainly correct: a full-time job is roughly twice as many hours as a part-time job.

John Mason: Fair enough. Another issue that has come up is that we count people as in employment but they might be off sick for quite a long time with, say, long Covid in particular, or something else. Would that create a problem in comparing our data with that of other countries or

do you think that that is fairly accepted internationally?

Tom Waters: That is a good point. Things such as sick-pay regimes differ by country, and that could have an effect. In our work, we found that, when people have long Covid, they remain employed. They are still tied—they have a job that they could go back to—but they are much more likely to work zero hours. They are off work—long-term sick, basically—but they would still show up in the statistics as being employed. I guess that it is possible that another country might have a sick-pay regime that severs the employment link while people are still paid sick pay or something like that, in which case, that person might show up as inactive. I do not know enough about other countries' sick-pay policies, but, certainly in the UK, someone in this situation who is not actually working and is not producing anything in the economy, nonetheless shows up as employed rather than inactive.

John Mason: On the question of early retirement, from the individual's point of view, if they are well off—because they have been a general practitioner or something like that—they can afford it, so, in a sense, we do not need to worry about those individuals, but does the economy as a whole suffer if a lot of 55-year-olds just stop working?

Tom Waters: Yes, it is true that the size of the economy would go down if that happened. The primary worry about that might be the fiscal implication. A highly paid person who stops working at age 55 was paying a lot of tax before they retired and now will not be paying very much, or not as much, tax. That has fiscal implications. That is the main dimension in which that might be concerning from a societal point of view. If someone does not want to work—that is, they do not want to produce whatever it was they were involved with and be paid for it—I would see that primarily as an individual decision, but the tax implications ultimately affect everyone.

John Mason: That is helpful, thank you. Mr Whyte, do you have any thoughts on any of those points?

Philip Whyte: I have similar thoughts. The inactivity point depends on the focus of your policy making. What we view as inactivity counts as those who have fallen out of the labour market. The one-hour-a-week measure is there because it enables those who have fully disengaged and fallen out of the labour market to be measured, which is important because a very specific policy response is needed in relation to that group as opposed to the group of people who are in work or are actively looking for work.

What you do depends on what you are trying to make a policy response to. Are you trying to improve general conditions, which could be primarily for those in employment, or are you trying to genuinely find a way to actively encourage people back into the labour market? As Tom Waters and Tom Wernham have suggested, within the inactive population there is a significant chunk who do not want to work. It is a question of the extent to which you want to expend your resources and energy in trying to get them back in versus a recognition that, for quite often valid personal reasons, some people may never again join the labour market.

Similarly, on the retirement point, as Tom Waters said, it is a loss if those people are no longer contributing to the economy and revenue. However, the important bit is that your economy should be built in such a way that there is a healthy supply of workforce coming through after them in similarly well-paid good jobs. We have not quite addressed those structural issues yet in the UK and Scottish economies to ensure that, once your ageing population disappears from the labour market—I was going to say, once they drop off a cliff, but that it a terrible turn of phrase in this context—your economy is structurally set up to ensure that there is a steady supply of workforce coming behind them. We know that Scotland's economy is particularly at risk in that regard, and maybe that is the bit that we have missed. You want to ensure that people are not disengaging from the workforce for bad reasons, particularly if they want to stay in, but if they are disengaging for good reasons, the vital bit is not trying to get them back in but ensuring that your economy is supporting everyone else coming after them.

John Mason: That is interesting. That recognition that, for some people it is better to be out of work while for some it is better to be in work, is a more nuanced approach than we sometimes get. We were talking about mental health in the previous session. Presumably, for some people, their mental health problem is that they are working too many hours and have a bad work/life balance, and that could improve by them either reducing their hours or leaving the workforce.

On your point about workers coming through, given that our population is forecast to fall, does that have to mean bringing people in from other countries to bolster our workforce or are there other answers to that question?

Philip Whyte: It has been well recognised that migration is crucial to Scotland's economy in a wide variety of sectors. There are concerns that the impact of Brexit might be negative in that area. That, combined with the fact of an ageing population, almost starts to create a perfect storm. If you start to restrict migration while having an

ageing population disengaging entirely from the workforce, what are you left with? You need to ensure that you have a supply of workforce-ready people.

Equally, we know that some sectors have been impacted by the pandemic but again, as witnesses suggested last week, trends in those sectors did not begin with the pandemic; they were already there. In retail, people had already started to shift to shopping online before the pandemic; in hospitality, the drinking culture has started to shift positively, so it is less of a feature; and, in manufacturing, the trend is obvious. There are lots of sectors that were already starting to see a reducing workforce before the pandemic. The pandemic may have accelerated that and have had a particularly pointed effect but it is not clear that those jobs were ever going to come back.

We have also seen that, although sectoral activity has been affected, employment rates have not, so those people are going somewhere and the important bit is ensuring that there is somewhere for them to go, which involves upskilling and reskilling opportunities, lifelong learning opportunities and ensuring that we are investing in new technologies. A huge feature of the Scottish economy is starting to invest in net zero technology. Again, the issue is about scale. I do not think that we are there at scale yet. We are beginning to make the right noises and we certainly have the right approach and outlook about it, but the risk is that we are not scaling up early enough to ensure that those jobs and that skilled workforce are there, and that is where the crunch point of retirement and, potentially, migration and Brexit will start to hit.

The Convener: Murdo Fraser wants to come in on that point, and then I will come back to John Mason.

Murdo Fraser: Following up on the labour market issue, I note that one aspect that nobody has touched on yet is a potential rise in unemployment. The Bank of England has suggested—I think that it was last week—that unemployment is set to double. If that is right, does it not raise a range of other issues? The current tightness in the labour market, which is the real issue, might flip itself over and we might find that we are no longer discussing the difficulty in finding people to do work, but talking about the opposite problem, which is having people who are unemployed and cannot get jobs.

Philip Whyte: I will let Tom Waters and Tom Wernham speak to the UK picture but, in Scotland, that trend has been bucked slightly, albeit that it remains to be seen whether there are economic storms ahead. Employment was broadly protected through the pandemic, although there remains a big question about the extent to which public sector employment has insulated Scotland somewhat, given that it is disproportionately represented in the workforce.

As has been said, among the four home nations, Scottish businesses are currently the least likely to face trouble in recruiting, but the unemployment impact of the pandemic was smaller in Scotland than it was in the rest of the UK. As such, a much smaller cohort of people were trying to find new jobs, including in different sectors. As the scale of the problem starts to grow, that cohort of people starts to grow, and it is not entirely clear whether the economy is structurally set up to be able to support those people into new and different sectors or technologies.

No doubt Tom Waters and Tom Wernham will have something to add from the UK perspective.

Tom Waters: The Bank of England's forecast—it is just a forecast—is for unemployment to grow and to keep growing until the end of 2025, which is three years away. That could mean really quite long periods of unemployment for some people. We tend to worry more about long-term unemployment because that is where people's skills atrophy and they do not build up their human capital while working, which can have longer-term consequences for their labour market prospects. Short periods of unemployment are not great, obviously, but they do not necessarily have such long-term effects. For that reason, the length of a period of elevated unemployment is just as concerning as a rise in unemployment.

The Convener: I will bring in Alex Rowley now and then go back to Tom Wernham.

Alex Rowley: I want to pick up on that last point. We are looking at the labour market inactivity as being linked to Covid, but we might be making a big leap with the assumption that the pandemic has led to it. You have talked about other factors such as skills and training, the welfare system, the lack of support and so on. What impact, if any, did the Covid-19 pandemic have on levels of economic inactivity? Are we barking up the wrong tree here?

11:00

Philip Whyte: I do not think so. It is a tricky one, because everyone in the country—indeed, in the world—was impacted by the pandemic and we absolutely do not want to make light of it or make it seem as if it did not have really severe and significant impacts. There are countless people who lost their jobs, whose health deteriorated or who are now suffering from long Covid. We absolutely need to ensure that that is at the forefront of our minds as we protect and support those people.

However, there has potentially been a tendency for Governments all over to start to view what were long-standing issues through a Covid lens—a tendency to frame waiting lists, unemployment and low economic output as the aftermath as we recover from the pandemic. That is right, but we must not ignore the fact that, in a large number of instances, those were long-standing issues.

We know that there have been severe health inequalities in Scotland, particularly in our most deprived communities, and those inequalities have not gone away. The pandemic may have exacerbated them, but they still exist. We are trying to setting ourselves up for the jobs and industries of the future. Again, Covid impacted on some sectors, but the long-term economic planning for that should have been happening well before the pandemic hit, because it was always clear that certain sectors were going to see a decline and have seen a decline over the past number of years, well before the pandemic.

I do not think you are barking up the wrong tree, but it is vital that, as well as recognising that there are specific impacts as a result of Covid, there were in a large number of instances long-standing trends that need to be addressed no matter what we do in response to Covid.

John Mason: I have a question on that point, which is also tied back to something that you said earlier. One of those long-term trends might be that people are doing less shopping in town and city centres, and maybe less socialising as well. Those things stopped altogether when Covid happened, but there has been a gradual drift back. Where are we in that process? Will the situation that we have now continue—I am thinking especially of city centres—or do we need to wait a bit longer to see whether people will go back to work in offices in the winter when it is cold and so on?

Philip Whyte: I am definitely not a futurologist, but I do not think that anyone wants to be one of those after the past few years. Anyone who is trying to predict the future is probably barking up the wrong tree.

Again, it is difficult to draw any firm conclusions. Businesses have responded differently. I would be surprised if what we see now is not broadly a settled state, but only in the world that we live in. High streets are in decline, but we cannot divorce that from the fact that housing developments have moved out of town because that is where the land for house building is—or, at least, that is where it has been prioritised and invested in. That has had as much of an impact on the decline of high streets, even before the pandemic, as lockdown had.

We recognise that the pandemic has accelerated some trends, but the way that we have structured our economy means that they were always at risk of happening. We cannot have vibrant high streets if we do not have vibrant communities around them.

John Mason: People deliberately went into city centres to shop and to go to cinemas and restaurants.

Philip Whyte: They did, but we know that high streets have been in decline, which has partly been a response to people shifting. If we take cinemas as an example, during lockdown, lots of films started to be aired online before they appeared in cinemas. Will that trend continue? I do not know and I definitely do not want to predict that. However, I know that, although Covid certainly accelerated and impacted on such things, we started to witness those trends well before the pandemic.

John Mason: Tom Waters, I saw you smile a moment ago. Maybe you are a futurologist—I do not know—but do you think that where we are is where we are going to be or do you think that things could change quite a lot, especially in town and city centres?

Tom Waters: I smiled because I liked Philip Whyte's response. I am definitely not a futurologist either.

Casting my mind back a bit, I note that consumer spending plateaued quite early in the pandemic. It fell massively at first and then it rebounded. It then plateaued at below its pre-pandemic level, and it is still there. That gives us some indication that things might not bounce back much further. However, it is very difficult to disentangle that in the current situation, where we have high inflation and a cost of living crisis that are having their own impacts. I would not want to make any firm predictions.

Jim Fairlie: I want to go back to something that you said earlier. I have a feeling that this might be controversial. We have talked about economic inactivity and certain areas of inactivity. Before we started our inquiry, we probably thought that the inactivity existed across all levels, but it now looks as if people are just getting out of the workforce. They are stopping work altogether and retiring. If they are getting out of the workforce, they must be able to afford to not work.

We have heard some suggestions from you and from last week's witnesses that we should not bother to pursue those folk, but do we know that the people who are saying, "I don't want to work" can afford not to work?

Philip Whyte: We need to start to put together data sets on that. As I said earlier, until the data

starts to come through to show the impacts, all that we can do is to infer some causal links. I pointed to the ONS survey, which found that, although people are retiring, they are not actually confident that they have the financial means to be able to sustain that. People may have retired well before the current cost of living and inflation crises hit, and it may be that those things will start to change their minds. People may realise that the small amounts of savings that they have set aside will not see them through. It is really difficult to tell where those people have gone.

We have not covered the fact that there are both primary and secondary reasons. Again, it is impossible to know about this from the data that we have, but about four people in every 10 who become inactive for a reason other than long-term sickness have a long-term condition. There is interdependency. It may well be that someone chooses to retire and become inactive for another reason, but that was the primary driver.

This is all anecdotal because we do not have the evidence, but it may be that someone with a long-term condition was working up to the pandemic and it was the switch that led them to say, "You know, I have been struggling with my long-term condition and the pandemic has made me realise that now is the time to retire". Their primary reason could be retirement, but their long-term condition was still a factor. Given all the variables, we are still unable to really get to the roots of the reasons.

Over and above that, however, I would not take it as a fact that they have gone and they are never coming back so we should give up, because some people will want to come back. We know that how we view age in society is still not great by any means—

Jim Fairlie: I am glad that you mention that, because I am looking at some comments in, I think, Public Health Scotland's submission. It says:

"Early evidence from the Glasgow City Region Intelligence Hub suggests the increase in retirement is due to lifestyle choices, ageist recruitment practices and changes in working practices. Socialising in the workplace"—

I go back to what was said about home working—

"was an element that kept people at work and due to the rise of home working, people have decided to leave the labour market."

Given the need to get away from ageism and the importance of socialising in the workplace, do we need to rethink the ability or the requirement for people to work at home?

Philip Whyte: Again, it is impossible to have a one-size-fits-all model. The social model of disability says that disabled people face barriers not because of their disability but because of the barriers that people put up in response to it. We can spread that out to encompass wider factors including age. Age is not the thing that stops people being really successful in the workforce. What stops that is employers and others continuing to view age as a limiting factor, or at least as an unattractive factor when older people are compared with much younger workers who are going for the same job.

As Tom Waters said, it is not necessarily the case that we give up on them and believe that they have gone forever, but we do not necessarily try to get them back in. We need to fundamentally shift employment practices and our structural or societal view to ensure that those people have the means and the ability to come back in if they want to. Particularly among the inactive population, that is the key thing. We know that many people, once they have disengaged, may never want to come back.

Jim Fairlie: My next question is for Tom Waters—I think that is the name, but I have the wrong glasses on and I cannot see at distance.

One of the statistics in the IFS written submission is that long Covid is increasing the number of people who are in work but on sick leave, which leads to reduced hours. Do we know what the impact will be economically as a result of people who are still regarded as employed but who are not working to the same extent, or at all, because of long Covid?

Tom Waters: I will pass over to the other Tom—Tom Wernham—on the economic impact, as he will have that number to hand.

Tom Wernham: The total impact of lost earnings will be about £1.5 billion per year, or £1,100 per month per worker affected. There will also be a knock-on cost for employers who are having to pay sick pay and a smaller knock-on fiscal impact through lost tax revenues.

The overall magnitude of the total economic impact is not enormous, especially in terms of fiscal revenues and so on. The main concern is the individual impact on those who have to go off sick. It is not a massive chunk of people given the overall context of the size of the workforce although, of course, it still matters. The main concern in many ways is about the individual impact.

Jim Fairlie: We know that the Scottish workforce is ageing more rapidly than the workforce in the rest of the UK, which could be a contributing factor to historically higher levels of inactivity in the Scottish workforce. We are talking about why people are retiring, given that more of them seem to be retiring now. Is there a risk that the pandemic will have a disproportionate effect

on our workforce in Scotland? That is for either of the Toms.

Tom Waters: In thinking about the long-term impacts of the pandemic, we have the issue of retirement and inactivity, which we have talked about, but we also have the impact on long-term productivity. We have had a period of immense disruption, with businesses closing down and so on. Perhaps Philip Whyte will know some of the Scotland-specific numbers, but my sense is that those effects can be at least as big as the impacts on the number of people working. The Office for Budget Responsibility thinks that the UK has become permanently poorer because of Covid. Our long-run gross domestic product is around a couple of per cent lower, and that is because of the effect of the huge amount of disruption and businesses shutting down. That has long-run consequences for productivity and the economy.

My sense would be that the difference in that regard between Scotland and the rest of the UK could be important. I do not know whether Philip Whyte has anything Scotland specific that he could feed in.

Philip Whyte: I make it clear that, until the pandemic, there was a downward trend in Scotland in inactivity as a result of retirement. There was a small uptick during the pandemic, but the most recent stats show that downward trend kicking back in. During the pandemic, we saw retirement as a proportion of inactivity going in the wrong direction again in Scotland, and the main driver was around ill-health.

I do not want to seem to be saying, "Well, they've retired, so we do not need to worry about the older people," because I am absolutely not—I promise. The trend in Scotland has been slightly different to that in the rest of the UK.

11:15

Jim Fairlie: For my last question, I will ask you the same question as I asked the previous panel. Are we asking you the right questions to get to what we are trying to find out in the first place?

Philip Whyte: That is a good question. Goodness, you do not want to get invited to a committee and tell them how to do their job. Convener, cover your ears. [*Laughter*.]

To go back to what I said earlier, the pandemic has had specific impacts. It has exacerbated some conditions and some outcomes for people, but there is a risk of viewing the issues primarily or solely through that prism. Those are long-standing trends. Perhaps what has not come out enough—although I saw that it came out in last week's evidence session—is the relationship between health and prosperity, which are incredibly closely linked. There is absolutely a question about what we do to restructure the economy. We have seen stagnating wage growth and the rise in precarious jobs and jobs with fewer hours and that pay less money. There are structural issues that can cause people to drop out of the economy. We need to address that, and we need to ensure that we have a skilled workforce coming through. We need to address the scale of employability support in Scotland.

On the flipside, obviously, the health system goes hand in hand with that. It is about viewing those two things as more closely related than we perhaps have done. Goodness, it is more than 10 years since the Christie commission, so I dread continuing to talk about prevention, but we are not there yet. We need to see a big shift in relation to prevention and the role that the health service plays in that. We need to start to address the long-term conditions that we know are having an impact on inactivity, and vice versa.

The issue that perhaps needs to be focused on is the role of the health system in shaping economic prosperity and, importantly, vice versa. We know that economic prosperity and health outcomes are very closely related.

Tom Waters: One thing on which you might want an answer would be the issue that Philip Whyte mentioned about the support that is provided at jobcentres for people to get back into work. There have been a couple of Government programmes—the restart and kickstart schemes—to try to improve the situation since Covid. However, we are talking about the increase in inactivity among older workers, and the support that older workers need to get back into work is potentially pretty different from the support that younger workers need. For example, the kickstart scheme is focused on those under the age of 25.

It might be valuable to think about programmes that have worked for older workers in other countries and about running small pilots or experiments in Scotland to help people who want to get into work to do so. That is one thing to think about, going forward.

Tom Wernham: I am not sure whether there is anything else that you should be asking on the cause of inactivity but, in relation to other matters to do with the labour market and the impact of the pandemic, there are questions of whether productivity has been affected, as was mentioned earlier, and whether there is an impact from more people working from home.

You should also have an awareness that many of the impacts of the pandemic—this relates to the earlier point about whether we are barking up the wrong tree—might take much longer to materialise than they have so far. If we are worried about

disruption to education or whether people dropping out of work during the pandemic has damaged their human capital, their productivity in the long term and so on, we might not be able to observe that yet. It will be important to keep an eye on those matters for the much longer term. It may or may not be the case that the pandemic has a bigger effect down the line than it has had now, in terms of the impact on the economy.

Jim Fairlie: Thank you.

Alex Rowley: Philip Whyte mentioned the Christie commission. My view is that progress on Christie has been woeful, but has any research been done on that? We certainly have not got to a position where we are able to shift to prevention, particularly in health, but has research been done on what progress has been made and why it has been so slow?

Philip Whyte: I think that some stuff was done on Christie 10 years on, but I am not sure how in-depth it was. It is difficult because, particularly with a fixed budget, there is a trade-off—if you put more money into prevention, that might mean less money for treatment. However, it is clear that we need to see a shift in that regard.

We recently did a bit of work on that. We know that the incidences of cancer, obesity and cardiovascular disease are all far higher in deprived communities than they are in non-deprived communities. As such, there is preventative stuff that needs to happen, which requires funding and a specific focus on deprivation, but that equally follows through into treatment and things such as early diagnosis and screening.

We have both of those things to an extent. We have action to try to stop smoking and promote healthier lifestyles. As a result of the pandemic, we have started to see more action on early diagnosis, particularly around cancer with the establishment of the early diagnostic centres. However, something is still missing on both of those. This is not a scientific approach but, if you look at various strategies on cancer, obesity and so on and do a "control F" search to look for "deprivation", you might find a sentence that says that people in deprived communities are more at risk of those diseases and illnesses, but you will not find any actions that specifically target such communities, either through prevention or treatment.

That is something that we potentially miss, although we know where the higher incidences and risk factors are. That is often because, if you have a limited pot of money, you try to spread it across prevention and treatment, and you probably want to spread it across everyone. We have done a lot of research on the link between health and prosperity. If you want to start to address regional inequalities, you need to get right to the heart of the issues that deprivation causes. Within health—again, I am not a health expert—that needs to come with a specific focus, in the health system and in funding, on diagnosis, treatment and prevention in those communities, which we have not seen to date.

The Convener: I thank the witnesses for their evidence and for giving us their time. If the witnesses would like to raise any further evidence with the committee, they can do so in writing—the clerks will be happy to liaise on how to do that.

We intend to continue taking evidence in our inquiry in November, before we hear from the Scottish Government at our meeting on 8 December. The committee's next meeting will be on 17 November, when we will continue our inquiry by looking in more detail at early retirement as a driver of economic inactivity.

That concludes the public part of our meeting.

11:23

Meeting continued in private until 11:35.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

The Scottish Parliament
Pàrlamaid na h-Alba