NHS Health Scotland’s Response to:


NHS Health Scotland welcomes the Government’s commitment to reducing poverty and inequality in Scotland. The discussion paper takes a broad view and we appreciate this fresh perspective and the opportunity to take stock of a complex issue.

Tackling health inequalities is at the core of NHS Health Scotland’s task, and because of the relationship between socio-economic and health factors, we see tackling poverty and deprivation as essential to improving Scotland’s health. We are keen to work with the Government towards this goal.

Poverty, Deprivation and Health and Wellbeing

The relationship between economic factors and health and wellbeing is complex. We know that there is a two-way relationship between poor health and wellbeing and poverty and deprivation: ill-health can impair economic productivity and poverty, deprivation and inequality contribute to causing ill-health. Improving Scotland’s economic prospects and health and wellbeing are complementary tasks.

You touch on this two-way relationship in paragraph 20 and in Annex A. However, we feel that a future framework would benefit from an expansion on the links between economics and growth, and health and wellbeing, as well as how you propose to use one to tackle the other. In considering this, you may find the Wales Centre for Health’s report on ‘The Links between Over-Indebtedness and Health in Wales’ and Dame Carol Black’s ‘Review of the Health of the Working Age Population’ helpful.

Other parts of the Scottish Government are undertaking important, related work with which it is crucial that this strategy links up. For example, in developing the framework you should take into account the report from the Ministerial Task Force on Health Inequalities (‘Equally Well’). Connecting with the Early Years strategy currently being developed will also be important to ensure a joined up, comprehensive approach improving the prospects of future generations because, as you state, the impact of poverty, especially on health, is particularly acute in the first years of life.

Definitions of Poverty

We welcome the discussion paper’s view of poverty. Acknowledging that poverty is not just about a lack of money, but also a lack of other services is important to fully understanding the problem and its consequences. The document also uses several different measures of poverty, such as 60% of the median UK income (for the UK child poverty target) and fuel poverty.
Including a fuller explanation of these different measures and their relative merits would improve the document's accessibility.

The Role of Health and Work in Reducing Poverty, Inequality & Deprivation

Employment and the working age population is clearly critical to delivering the ambitions of the Scottish Government:

• The largest number of individuals living in poverty are in this group.

• There is a consequential affect on children.

• People excluded from work due to illness or disabilities consume benefits that could otherwise be redeployed (to low income families and pensioners). If in employment, they could, conversely, make a positive economic contribution.

• An estimate of the total cost of sickness absence and worklessness is estimated to be £100 billion to the UK economy. Pro-rata, this equates to a figure of approximately £10 billion to Scotland, or larger than the NHS budget.

• 'Worklessness is the biggest cause of health inequalities, not disease', (Macdonald 2007).

• Worklessness associated with mental health is a particularly significant issue, with mental health problems estimated to be present in 70% of cases, and as a principal factor in 40%.

Improving Employability

A key lever available to the Government is improving employability (levels of engagement in employment), which must include both helping people to stay in employment, together with assisting those who are excluded and who are able to work, to return to employment.

The Scottish Government is already making significant efforts in relation to the in-work agenda. The Scottish Centre for Healthy Working Lives (SCHWL), as part of NHS Health Scotland, is working to create positive and healthful working environments and improving health and safety. This includes the Dundee Vocational Rehabilitation pilot, which was recently recommended in Dame Carole Black's report as a model which should be extended.

It is crucial to remember that every month, approximately 5,000 people join the ranks of incapacity benefits claimants, and in work activity such as this is crucial in terms of turning off the taps.

In respect of employability, the key government department responsible is the Department of Work and Pensions (DWP), whose powers are presently reserved. It is vital that the relationships between the DWP and Scottish based agencies such as SCHWL and the NHS generally, are strengthened. It
is important that DWP policy and operations in Scotland are aligned as closely as possible with that of the Scottish Government and its delivery arms such as Workforce Plus, local authorities, SCHWL and the NHS generally.

Research into employer engagement in employability has recently been completed by Small Businesses Consortium (SBC) and SCHWL found that employers argued for a more joined-up approach at a local level so that one umbrella agency or partnership body in each area could offer a full range of support options for employers. A common complaint was the confusion caused by competing approaches from agencies. A more coherent approach to the funding and quality assurance of voluntary sector delivery in the employability agenda, would make better sense of the present cluttered environment in which many organisations operate.

Partnership working is still at an early stage and is patchy in terms of its effectiveness in this area. The knock-on affect is felt by employers wanting to engage in this agenda. Whilst progress is being made through the development and delivery of single outcome agreements for each community planning partnership area, funding and budgeting still continues to be a barrier. Pooling resources is a goal that is some distance off. In conjunction with the Scottish Government putting further resources into changing mindset and attitudes to partnership working/delivery/cross referral it could also be linked and enforced through funding. This would go some way to enabling the workforce plus strategy groups to be more coherent in their offerings to employers.

The introduction of the DWP Pathways has contributed in some way to assisting people who are removed from the workplace back to work, and there is good evidence that this is working where services are well joined-up. However, with the sub-contracting of this work it is essential to have monitoring and quality mechanisms in place to ensure that there is equity of delivery of services and value for money for the tax payer. Delivering support for pathways through the NHS would have clear benefits in terms of synergy and value for money.

Whilst Pathways engages with people who are furthest removed from the job market, attention should be given to those who are about to enter the workforce i.e. school-leavers. To prevent a future 'on-flow' to incapacity benefit (IB), vocational training for school pupils and school leavers is essential so that they become familiar with the discipline and advantages of work.

Many people who are attempting to return to work after years of being on incapacity benefit present with a range of problems, the most common being musculo-skeletal disorders and mental health issues which may never be completely resolved, and which will certainly be likely to require ongoing support. The return to the workplace can be challenging and consideration should be given to flexible working hours, allowing these individuals to attend local services or support groups.

By engaging with the Department for Work and Pensions, the Scottish Government could look at the use of some of the benefits formally paid to
individuals to in effect subsidise employment, perhaps for a prolonged period, with guarantees to the employee of a return to their original benefit regime should employment not be sustained. This would remove an important barrier to both employers and potential employees, and there are examples of such approaches being employed in mainland Europe that would be worth looking at in detail. It would be necessary to ensure this arrangement was not exploited by unscrupulous employers.

It is also important to consider infrastructural barriers to employment and employability, much of which does fall into the remit of the Scottish Government, with such barriers including the high cost and availability of child care, transport and the lack of opportunities to work flexible hours to accommodate family commitments.

**Target Groups**

The differentiated approach to tackling poverty and inequality you suggest in paragraphs 54 and 55 is a good idea which we fully support. A ‘one-size-fits-all-approach’ is not suitable and can sometimes exacerbate certain inequalities. However, whilst you acknowledge the consequences of gender, we believe that you should extend a differentiated approach to encompass other groups who struggle to be economically active or are disproportionately likely to live in poverty and therefore suffer ill health.

**Disabled People**

Disabled people, whose economic inactivity rate is four times higher than non-disabled people, are a prime example of a group who would benefit from a differentiated approach. Improving the number of economically active disabled people will contribute to reducing the number of people on incapacity and other benefits and improve the health and wellbeing of this group.

Improving disabled people’s employability will also help reduce poverty as 68% of disabled people have incomes of less than £10,000 per annum and households living with at least one disabled individual are more likely to live on a relatively low income than those with no disabled individuals. You acknowledge the difficulties that many disabled people face in Annex A, but again, we feel that this group would benefit from a differentiated approach to tackling poverty and alleviating its effects. You should also consider the position and needs of carers.

**Black and Minority Ethnic Communities and Religious Communities**

It is difficult to generalise about the economic and social position of Black and Minority Ethnic (BME) groups in Scotland; indeed, it would be quite wrong to approach them as a single, homogenised group. It is clear that the needs of different BME communities vary greatly; for example, whilst 40% of people from Indian backgrounds have university degrees, 43% of people from Pakistani backgrounds have no qualifications at all.

However, the evidence is clear that in general, BME groups are more likely to be economically inactive and deprived. Their economic activity rate is 15%
below that of the rest of the population and after housing costs there are 11% more minority ethnic individuals living in relative low income households than in the white ethnic population. There are very few high level statistics available regarding the health of BME communities, especially as a result of poverty and economic inactivity, partly because of poor monitoring of frontline services. Despite this, given the variety of circumstances of different BME communities, and that overall when compared to the rest of the population they seem to be disadvantaged, we believe that BME groups would benefit from a differentiated approach.

Particular religious communities have very high levels of economic inactivity and it is important to consider this in your strategy. Muslims, for example, have the highest proportion of unemployed people of any religious group as well as the largest proportion of people who have never worked.

Lone Parent Families

When undertaking a gendered approach you should pay particular attention to the needs of lone parents. Twenty two per cent of families with dependent children in Scotland are headed by lone parents, 41% of lone parent households have an income of £10,000 or less, and 90% of lone parents are female. (Scottish Household Survey, 2001/2002)

Children and Young People

Investing in young people’s health is an important public health issue which also has an impact on Scottish economic life. Focusing on the needs of children and young people will both help alleviate the effects of poverty and deprivation may help reduce it in the future. NHS Health Scotland and partners, including the 14 NHS Boards have an important contribution to make to the lives of young people by providing supportive cultures for all young people to become confident and resilient.

To do this, we need to develop multiple points of connections for young people to access information, skills and services that will enhance their life chances.

Work is ongoing to support young people in a range of settings, including schools, colleges, youth work, workplaces and prisons.

All professionals who come into contact with young people have a role to play in securing a healthy future and we recently piloted training with Strathclyde Police on positively engaging young people within their communities on alcohol and related issues. The police are often dealing with the most marginalized young people and we must equip police officers with the skills to support young people into positive lifestyles.

The NHS itself is a key point of contact for young people and the Walk the Talk programme is a national initiative set up to encourage and support youth friendly health services. We still have some way to go in making health services accessible to young people and turn them into places where young people feel safe in seeking advice and support from a range of NHS staff.
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The health outcomes of looked after children and young people are a major cause for concern and NHS Health Scotland will shortly launch a pack for those working with young people who are in care.

**Mental Health & Wellbeing**

As discussed above, mental health can be the cause of long-term worklessness and as such constitutes a major public health concern for Scotland. We see this as a key group to consider targeting in relation to poverty, inequality and deprivation.

Inequality has been shown to be both a cause and consequence of mental health problems. Mental health problems are more common in socially disadvantaged populations, in areas of deprivation, and are associated with unemployment, less education, low income or material standard of living and poor physical health. In addition, the 20%-25% of the population who are obese and continue to smoke are concentrated among the 26% of the population living in poverty; they are also the population with the highest prevalence of anxiety and depression. There is robust evidence that psychological and emotional pathways are an important route through which material deprivation impacts on health, social relationships, and life chances.

NHS Health Scotland has developed a national set of indicators to provide a summary profile in Scotland covering both mental wellbeing and mental health problems. This will provide a way of monitoring the state of mental wellbeing and mental health problems in Scotland, at a national level, and will help inform decision-making about priorities for action and resource allocation. These indicators also cover the contextual constructs related to the causes and consequences of mental wellbeing and mental health problems (e.g. participation, trust, safety, equality, discrimination, financial security and debt, physical environment).

We are also delivering support to develop Black and Minority Ethnic Communities’ Mental Health, rolling out Scotland’s Mental Health First Aid training course, leading the delivery of support for suicide prevention and providing advice and implementation support to the Scottish Government.

We believe that action to improve Scotland’s mental wellbeing and reduce mental health problems will help alleviate the effects of poverty, deprivation and inequality and vice versa.

**Lesbian, Gay, Bisexual and Transgender (LGBT) People**

There is little evidence about the socio-economic circumstances of LGBT people. However, we know that LGBT people sometimes suffer from discrimination at work, exclusion from the family and institutional discrimination through inappropriate service provision. This discrimination can have a detrimental effect on their health and anecdotal evidence indicates that it damages the victim’s earning potential and makes them less likely to be economically active. Therefore, they may benefit from a differentiated approach; but more research in this area is necessary.
Partnership Working

We see the development of a framework which will coordinate action by the local and national tiers of government, agencies and delivery partners including the NHS and third sector as a positive step forward. Explaining how the various policies being pursued across Government come together to contribute to a coherent and unified approach will help provide a clear approach to this complex problem.

One of the principal barriers to effective partnership working, especially in a cross-sectoral situation, is differing targets and goals amongst organisations. Overcoming this in a health improvement context is a key part of our work, which we believe may be complementary to your strategy.

Health Improvement Performance Management (HIPM) Review

The comprehensive approach tackling poverty is similar to the work we have undertaken with the Scottish Government to introduce an outcomes based approach to health improvement and tackling health inequalities. We are seeking to improve coordination across local government, the NHS and community and voluntary sectors by clarifying what the most effective contributions each partner can make to a set of high level national outcomes and indicators set out in the National Performance Framework.

The Health improvement Performance Management Review is developing an outcomes framework for assessing performance at different levels in a delivery context with many different partners in various sectors. Like the poverty framework, the health improvement performance framework not only looks at the high level, long term health outcomes desired, but also makes visible the determinants of health and health inequalities (e.g. social, economic, educational, physical etc.). We have adapted the Scottish Government's delivery triangle to communicate the key outcome categories.
Inequalities in Health Outcomes: All ages

We live longer, healthier lives

We have tackled the significant inequalities in Scottish society

The review proposes that progress in tackling inequalities in health outcomes should be assessed in the medium term using improved differentials in intermediate outcomes which relate to the underlying causes of health inequalities:

- Reduced inequalities in individual health-related behaviours, such as smoking, problem alcohol and drug use, domestic abuse;
- Reduced inequalities in educational outcomes e.g. literacy levels, school leaver destinations;
- Reduced inequalities in economic conditions and work environment e.g. child poverty, low income, financial exclusion, unemployment;
- More equitable access to basic resources and services e.g. adequate and affordable housing, safe community environment e.g. neighbourhood satisfaction, crime rates, opportunities for active travel.

The unique and collaborative contributions of partners across the whole system should combine to cause changes in health inequalities at both high and intermediate levels. Locally, Community Planning Partnerships monitor intermediate outcome measures of whole system progress to help ensure that the actions of a range of partners are together contributing to improvements in the wider determinants of health inequalities. Some of these intermediate outcomes might be priorities for a local authority area and included within a Single Outcome Agreement between the Scottish Government and that local authority (and, in some cases, its local Community Planning partners).

You can therefore use intermediate outcomes as a tool to assist community planning partnerships, and their constituent delivery organisations, to set priorities and plan actions to tackle health inequalities and the socio-economic inequalities that underpin them. They also provide a set of interim outcomes against which to assess the combined success of actions on the ground.
Given the difficulties of working in a similar environment to reduce poverty, inequality and deprivation, a similar approach could be helpful.

Community and Voluntary Sector

We also work with the Community and Voluntary Sectors and are encouraged to see that the importance of improving individual and community wellbeing in tackling poverty and inequality in Scotland as part of the document (paragraph 20). Including community engagement and empowerment to ensure that future policies and practices are informed by the experience of those we are trying to help is also a welcome development. Engaging and empowering has been central to NHS Health Scotland’s work supporting community-led health improvement.

We are now implementing the recommendations of the Community-Led: Supporting and Developing Healthy Communities Task Group (www.healthscotland.com/settings/community-voluntary-publications.aspx) are in partnership with Scottish Government and key national intermediaries (e.g. the Community Health Exchange and Voluntary Health Scotland). The Task Group findings echo much of the content of this discussion paper, particularly the vital role that community-led and voluntary organisations can play in reaching, engaging and supporting vulnerable communities experiencing poverty and helping to prevent the escalation of poverty.

We are leading a programme of activity to help strengthen the impact of community health in Scotland, including helping local organisations and commissioners to measure the economic value and impact of community-led health and a national capacity building support programme for community-led health, which we have commissioned the Scottish Community Development Centre to deliver (Meeting the Shared Challenge: http://www.scdc.org.uk/shared-challenge/?sess_scdc=a56598641881101ff51f3955d676a1b8)

NHS Health Scotland
30 June 2008