

Reducing health inequalities



What NHS
Non-Executive
Directors can
do to make a
difference



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Committed to excellence

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This resource is one strand of a wider induction and development programme led by the NHS Chairs Group and the Public Appointments Office at the Scottish Government.

It was written with, and for, Non-Executive Directors of NHS Boards. However, the document and additional resources referred to within the document may also be of value to Executive Directors of NHS Boards.

NHS Boards should consider how to use this resource in relation to their local Board development. NHS Health Scotland would be pleased to provide support to Boards in this respect.

Ministerial Foreword



When the NHS reached its 65th birthday in 2013, I said it was the ‘embodiment of a just and equitable society’. The Scottish Government is committed to tackling the significant inequalities in Scottish society and NHSScotland’s Healthcare Quality Strategy, the 2020 Vision and the Public Bodies (Joint Working) (Scotland) Bill are all focused on ensuring that the original values of the NHS in Scotland are kept alive and that reducing health inequality is fundamental to improving service quality.

I consider it an injustice that across all social groups in Scotland, where you were born determines how long you are likely to live and for how long you are likely to stay in good health. Health inequalities are largely shaped by the social inequalities and life experiences that disadvantage people and limit their opportunities for good health. For example, the availability of good quality work, education, and housing. However this doesn’t mean that the NHS has no role to play - equity of access to health services and equity in the quality of care that people experience are as important in reducing unequal health outcomes. Providing services in proportion to need is a fundamental element of effective action by the NHS to reduce health inequalities.

I am delighted to welcome a publication that focuses on strengthening the role of Non-Executive Directors of NHS Boards. They have a crucial role in providing the scrutiny and governance necessary to ensure that Boards maintain a commitment to justice and health equity.

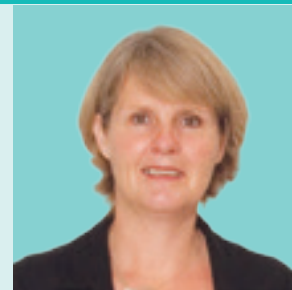
This publication outlines the actions that NHS Boards could and should take to contribute to reducing health inequalities in Scotland. As such, the resource will be of value to executive directors and senior managers as well as to Non-Executive Directors.

I look forward to hearing from Boards about how they have acted on this advice when I meet them for their Annual Reviews.

I commend this resource to all NHS Boards and their Non-Executive Directors.

**Alex Neil
Cabinet Secretary for Health and Wellbeing**

NHS Health Scotland Foreword



This resource has been developed for Non-Executive directors working in national or local NHS Boards within NHSScotland. It focuses on supporting Non-Executive Directors to strengthen their contribution to the role of NHS Boards in reducing health inequalities which will take up an increasing proportion of their attention, and improving the health of the communities they serve.

The resource is clear that there are actions that Boards can and should take to reduce health inequalities. These are actions that lie within the gift of Boards and Non-Executive Directors have a critical role in ensuring Boards take those actions.

We would recommend the resource for use in national and local induction programmes for Non-Executive Directors, and that Executive and Non-Executive Board members see the potential to use this resource for whole-Board development purposes.

On behalf of the NHS Chairs Group and the Non-Executive Director publication working group, we are delighted to recommend this resource to you.

Margaret Burns CBE

NHS Health Scotland Chair with Dr Karen Facey, Non-Executive Director, NHS Health Scotland and Chair of the working group for this publication and Andrew Johnston, Vice-Chair, NHS Dumfries and Galloway

Executive summary

Population health has been steadily improving in Scotland but, at the same time, health inequalities have been growing. Non-Executive Directors can play a pivotal role in ensuring NHS Boards act to reduce health inequalities.

Health inequalities are unfair differences in the health of the population that occur across and between social classes or population groups. They are largely determined by social and economic factors and the way that the resources of income, power and wealth are distributed. In turn, this unfair distribution of resources has an impact on the environments people live and work in: their experience of discrimination and prejudice; the quality of their housing; play and leisure areas; and access to and experience of public services – including health and education services.

Trends and patterns in health inequalities show that they are not inevitable and are closely related to the predominant social and economic climate and public policy, including socio-economic and welfare policies.

Health inequalities are often expressed in terms of the gap between those with the best and worst health outcomes. However, health inequalities exist across the social gradient. This means that the more favourable your social circumstances, such as income and education, the better your chance of enjoying good health and a longer life. In other words, we are all affected to a greater or lesser degree. In addition, there is a complex interaction between social circumstances and personal characteristics, such as age, gender, race and sexual orientation, and health inequalities which is not yet fully understood or addressed.

Although individuals can take action to lead healthier lives and avoid risks to their health, many of the causes of health inequality are beyond the control or the choices of an individual. Government and public services, including the NHS, must take concurrent action. Research over a substantial period of time indicates that these actions must cover the steps that can be taken to undo the fundamental causes of health inequalities, preventing the harm done by the environmental causes **and** mitigating the impact of inequality on individual health outcomes.

A review of policy in Scotland shows that, despite a robust policy landscape:

- public health action on health inequalities currently focuses most on mitigating the effects of inequality and not the fundamental causes
- addressing lifestyle factors through health improvement and health promotion initiatives is not sufficient to reduce health inequalities
- more needs to be done to address the fundamental causes, as well as responding to the effects.

Health and health equity cannot be created or protected by healthcare services on their own – fair and equitable access to resources, such as housing, employment and income are as, if not more, important. Nevertheless, healthcare services have a pivotal role in ensuring that they plan and deliver their services in a way that promotes and protects the right of **everyone** to good health. Health Boards can take action in the following key areas:

- the quality of services the NHS plans and provides
- what the NHS does in partnership, for example, in the development of health and care integration
- the NHS as an employer and procurer
- the advocacy role of the NHS.

Knowing and understanding what to scrutinise in relation to these key areas is a critical element of the role of a NHS Board Non-Executive Director. A set of questions and pointers has been developed in this publication to support the Non-Executive Director in this.

The quality of services the NHS plans and provides

- Is the Board using data and information about inequality to plan its services?
- Is the Board planning for health equity?
- Are Board plans informed by the evidence of what is most and least likely to reduce health inequalities?
- Does the Board look for inequity in patient access and quality of experience?

What the NHS does in partnership

- Do the Board's strategic partnership plans include any intended action to address the fundamental and environmental causes of health inequalities as well as reacting to the effect?
- Is the Board working in partnership with the third and community sector to strengthen community engagement and empowerment?

The Board as an employer and procurer

- Is the impact of inequality being considered in procurement policy and practice?
- Is the Board systematically using equalities data to plan its workforce?
- To what extent are the principles of 'good work' incorporated into the monitoring of the Staff Governance Standard?

The Board as advocate for action

- Are the leaders in the Board actively advocating for action in partnership with local authorities, the third sector and others in their community?
- Does the Board ensure that inequality has a focus within each of its sub-committees?

Introduction

**‘Health inequality is
Scotland’s biggest issue’**

Sir Harry Burns, former Chief
Medical Officer (December 2012)

Average population health has been steadily improving in Scotland whilst, at the same time, health inequalities have been growing. Many people die prematurely or live with preventable illness as a result of inequalities in Scotland. This is a human tragedy, but it also causes a reduction in economic output and increase in social problems. Reducing health inequalities is, therefore, a concern for us all.

NHS Health Scotland is a national Health Board in Scotland, working with the public, private and third sector to reduce health inequalities and improve health.

This resource follows a similar publication developed by NHS Health Scotland for elected members in local councils published in 2012. It has been developed to support Non-Executive Directors working in national or local NHS Boards within NHSScotland. It focuses on supporting Non-Executive Directors to strengthen their contribution to the role of NHS Boards in reducing health inequalities and improving the health of the communities they serve.

NHSScotland’s *Healthcare Quality Strategy* has made a clear commitment to strengthening the contribution of the NHS in reducing health inequalities (see quote on page 9).

This resource provides a high-level overview of what causes health inequalities and what Non-Executive Directors can do to reduce them. It is not intended to provide comprehensive or in-depth information. Signposting to more detailed information is provided throughout the resource. While the role of national NHS Boards differs from that of the local Health Boards, the material in this resource is designed to be of value to Non-Executive Directors in all Boards in considering how inequality is of central relevance to the strategy and governance of their organisation.

Audit Scotland published its national report *Health inequalities in Scotland* in December 2012. A paper accompanying the report set out issues that elected council members and NHS Board Non-Executive Directors may wish to consider in relation to how health inequalities are being addressed within their own council and NHS Board areas. It also

aimed to help elected members and Non-Executive Directors pose questions they may want to ask of Executive Board members, senior professionals and managers in order to seek assurance about local activities and progress. The findings of Audit Scotland's report and the questions posed are used throughout this resource.

This resource is structured as follows:

Section 1: What are health inequalities?

This section provides an overview of the right of everyone to good health and the barriers to that right being realised. It looks at the human right to optimal health and the concepts of health inequality, health equity, equality and human rights. In doing this, the impact that the complex interaction between social circumstances and characteristics, such as age, gender and race has on health outcomes, is outlined.

Section 2: The policy and public sector landscape

This section looks at the policy and public sector landscape within which NHS Boards and Non-Executive Directors are working. It provides an overview of the actions NHS Boards can take and the key governance and scrutiny role Non-Executive Directors can play in relation to ensuring this action is taken.

'NHSScotland is committed to understanding the needs of different communities, eliminating discrimination, reducing inequality, protecting human rights and building good relations by breaking down barriers that may be preventing people from accessing the care and services that they need.'

Healthcare Quality Strategy
(2010)

Section 3: Four ways Boards can act

This section looks at four key areas within which NHS Boards can take action in order to reduce health inequalities. Questions that Non-Executive Directors may want to ask their Executive Director colleagues, or actions they may wish to scrutinise, are provided at the end of each key area.

Section 1: **What are health inequalities?**



Introduction

This first section provides an overview of the right of everyone to optimal health and the barriers that can prevent that right being realised. It looks briefly at the concepts of health inequality, health equity, and equality within the context of NHS services.

In doing this, it describes the potential impact that the complex interaction between social circumstances and protected characteristics, such as age, gender, race and sexual orientation has on health outcomes, or – more specifically – health inequalities. While any number of personal characteristics and circumstances are known to have a potential impact on health (for example, carer status, being a veteran, geographical location), those characteristics, which are protected by law from discrimination or unfair treatment, are referred to as ‘protected characteristics’.

Defining terms

It is important to start with a definition of the terms health, health inequality, health equity, human rights, and equality and what these mean in the context of health and healthcare within Scotland.

Health: the World Health Organization (WHO) created the most widely quoted modern definition of health:

‘Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.’

This definition has not been amended since 1948. However, during the Ottawa Charter for Health Promotion in 1986, the WHO said that health is:

‘a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities.’

This definition clearly illustrates that health cannot be created or protected by healthcare services on their own – personal characteristics and access to resources, such as housing, employment and income are as, if not more, important.

However, this should not be seen as diminishing the pivotal role healthcare services have in ensuring that they plan and deliver their services in a way that does not adversely impact on the right of everyone to good health.

Health inequality: put simply, health inequalities are unfair differences in the health of the population that occur across and between social classes or population groups. Put even more simply, health inequalities means ‘sicker longer, die younger’ (Voluntary Health Scotland Sounding Board event, October 2013).

Health inequalities are often expressed in terms of the gap between those with the best and worst health outcomes. However, health inequalities exist across the social gradient. This means that the more favourable your social circumstances, such as income and education, the better your chance of enjoying good health and a longer life. Put another way, all groups except the best-off experience health inequalities. While there is a significant gap between the wealthy and the poor, the relationship between social circumstances and health is in fact a graded one, as illustrated below:



Source: Scottish Government 2013

Inequalities in mortality are the starkest manifestation of health inequality. However, it is important to remember that inequalities in outcomes can be seen across a range of indicators, including experience of healthcare, and in relation to experience of poorer health within and across groups with shared characteristics.

Health equity: this refers to the differences in the quality of health and health outcomes across different population groups. For example, differences in the presence of disease,

health outcomes or access to healthcare across racial, ethnic, sexual orientation and socio-economic groups.

For NHS Boards, this means recognising that individuals may need to be treated differently according, and in proportion, to their level of need, in order to achieve the same outcome. This is the essence of person-centred care and it should be central to both the allocation of NHS resources and the planning and delivery of services.

Equality: this means ‘ensuring that every individual has an opportunity to make the most of their lives and talents, and believing that no one should have poorer life chances because of where, what or whom they were born, or because of other characteristics’ (EHRC). The Equality Act 2010 includes the General Public Sector Duty. The specific duties indicate how the Scottish Government wants us to implement the UK-wide General Duty. These duties include: mainstreaming equality; setting equality outcomes; impact assessing policies and practices; gathering and using employee information; and focusing on the equal pay and the gender pay-gap.

Equality in the context of healthcare means how understanding individual characteristics and circumstances can help to improve individual care and support at the point of service delivery, as well as avoiding systemic discrimination in the way that services are provided. Recording and utilising information about personal characteristics, and systematically thinking through the impact of service plans or changes on particular groups, will help to plan services that are accessible and beneficial to all. Health inequality impact assessment is an important tool that enables Boards to ensure that they are protecting and promoting equality.

Human rights: these are the basic rights and freedoms to which everyone is entitled. They ensure that people are able to live freely, flourish, reach their potential, participate in society and be treated fairly and with dignity and respect (EHRC). Scotland’s National Action Plan for Human Rights (SNAP) was published in December 2013. It sets out key commitments from government, civil society and the private sector, all aimed at improving human rights protection in Scotland. The Action Plan – a first for the UK – comes after four years of research overseen by the Scottish Human Rights Commission.

Equality is part of the human rights framework, promoting fairness and freedom from discrimination so that everyone can realise their human rights. The International Human Rights Convention includes the right of everyone to reach the highest attainable standard of health.

What determines health?

To take the action necessary to reduce health inequalities, it is first important to understand what determines health and then what causes health inequalities.

The health and wellbeing of individuals and populations across all age groups is influenced by a range of factors both within, and to a larger extent, outside the individual's control.

One model which captures the interrelationships between these factors is the Dahlgren and Whitehead (1991) 'policy rainbow', which describes the layers of influence on an individual's potential for health (see **Figure 1** opposite). They describe these factors as those that are **fixed**, such as an individual's age, sex and genetics, and a set of **modifiable** factors expressed as a series of layers of influence, including: the physical and social environment and wider socio-economic, cultural and environment conditions.

As many of the determinants of health are modifiable, this tells us that health inequalities are not inevitable. It is also important to note from this model that universal healthcare (focused on primary care and free at the point of need) is one of the determinants of health.

What causes health inequality?

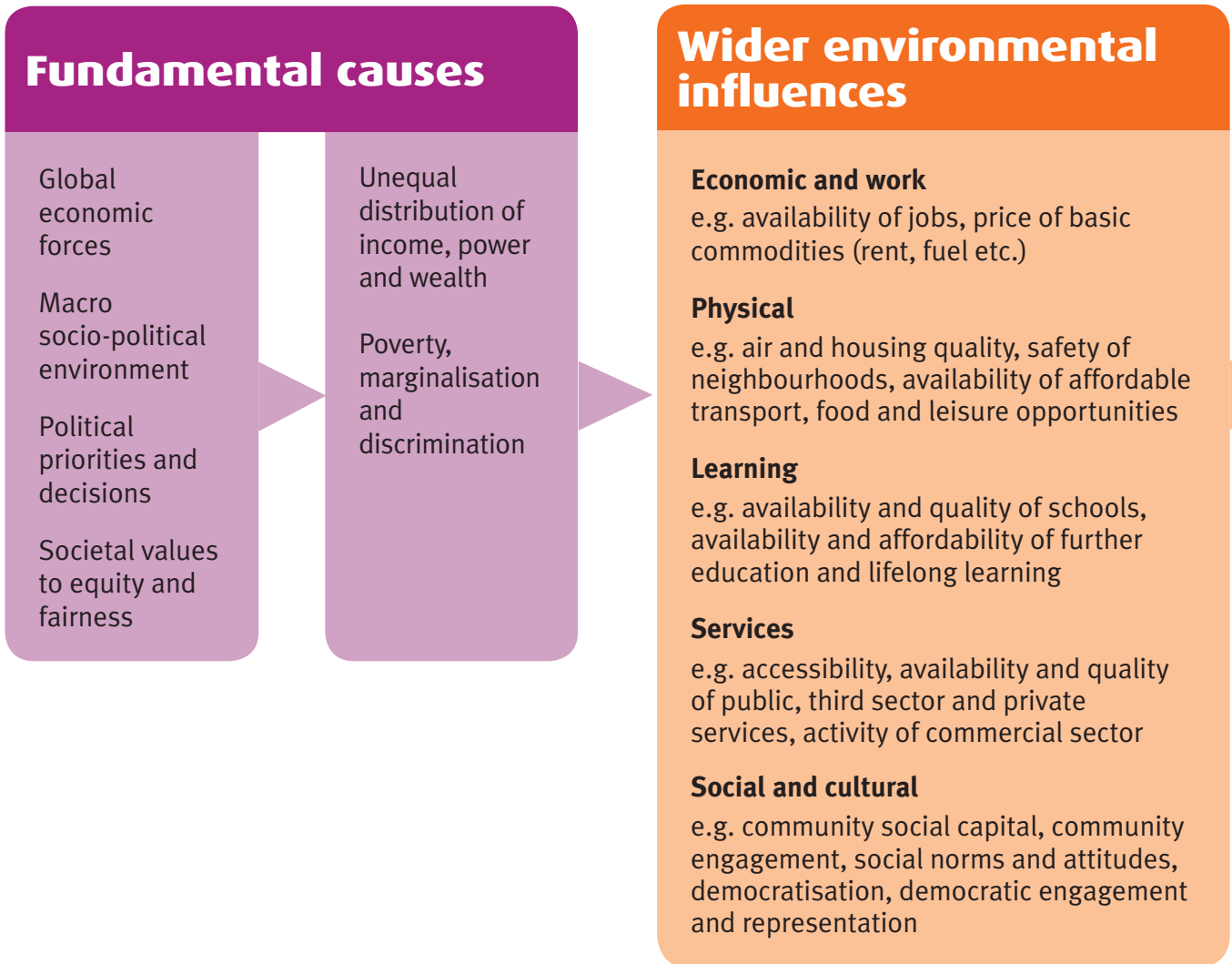
As well as understanding what determines health, we need to understand how these same determinants can cause health inequalities to arise. To do this, NHS Health Scotland has developed a 'Theory of Causation' for health inequalities (see **Figure 2** on pages 16–17).

Figure 1: What determines health?



The Main Determinants of Health (1991) Dahlgren and Whitehead

Figure 2: What causes health inequalities?



Individual experience

Economic and work

e.g. employment status, working conditions, job security and control, family or individual income, wealth, receipt of financial and other benefits

Physical

e.g. neighbourhood conditions, housing tenure and conditions, exposure to pollutants, noise, damp or mould, access to transport, fuel poverty, diet, activity levels, tobacco consumption

Learning

e.g. early cognitive development, readiness for school, literacy and numeracy, qualifications

Services

e.g. quality of service received, ability to access and navigate, affordability

Social and interpersonal

e.g. connectedness, support and community involvement, resilience and coping with mechanisms, exposure to crime and violence

Effects

Inequalities in:

Wellbeing

Healthy life expectancy

Morbidity

Mortality

Health inequalities

Downstream

The starting point for the theory of causation is the left-hand side of the model in Figure 2, and what WHO calls the **‘fundamental causes’**. It is increasingly accepted that health inequalities have their roots in the major socio-political forces that drive decisions and priorities for governments and public bodies. This results in an unfair distribution of power, money and resources. It is this unfair distribution that often leads to discrimination and marginalisation of individuals and groups.

Moving along the model we can see that these fundamental causes in turn influence the distribution of **‘wider environmental influences’**. These are: the availability of jobs; good quality housing; education and learning opportunities; and access to social and cultural opportunities and to services in an area. Because the distribution of these influences is shaped by the same fundamental causes, they tend to be clustered. So some areas and population groups have poorer access to jobs, affordable transport, good quality housing and schools and have low levels of social capital and democratic engagement.

Moving to the next box we can see that the wider environment in which people live and work shapes their **individual experiences** of, for example, discrimination, prejudice, low income, poor housing and access to health services. This results in the **effects** we see in the last box of the model – the unequal and unfair distribution of health, ill health and mortality in the population.

What does this mean for people?

Few people would argue against the principle that everyone (and that includes people who use health services, members of staff and those working in services procured by the NHS) has the right to be treated with dignity and respect and to achieve the highest attainable standard of health.

People are not defined by their characteristics of gender, age, disability etc, nor by their comparative level of power, money and resources. People are complex and come

with unique and variable experiences and circumstances. However we know that some people in Scotland do face discrimination and barriers to access and/or poorer quality of experience when using health services. We also know that all of the factors referred to, including socio-economic inequality and protected characteristics, often interact with each other and lead to inequalities in health outcomes.

However, the systemic nature of the problems and the fact that there is a social gradient in exposure to harm means it is not just ‘the poor’ or ‘the stigmatised’ who are affected – everyone (except those at the very top of the social gradient) is affected.

We know that investment in access to health services which is in proportion to a person’s needs is critical, as is addressing the wide range of barriers to people accessing or getting the best utility from the services they access.

The National Institute for Health and Care Excellence describes access in terms of **physical access** (such as absence of ramps for wheelchair users or poor and/or expensive transport links to hospital services) and **cognitive access**. Cognitive access is described as barriers to understanding complex medical advice or information.

The most common way of describing health inequalities is by area of deprivation because this is where there is the most data on these inequalities exists. However, it is important to remember that area deprivation is only a proxy for need – many of those with the most need do not live in the most deprived areas. For example, it has previously been estimated that only 41% of unemployed people and 34% of low-income households lived in the 20% most deprived areas. Furthermore, health inequalities occur across the social gradient. These barriers therefore exist across the social gradient, not just in the most deprived areas. For example:

- We know that people in the most deprived areas have poorer health and, therefore, require greater access to hospital services – but these people tend to have poorer access and worse outcomes. However, we know that health inequalities occur across the social gradient and so it is likely that access to services will be an issue for many individuals living outside deprived areas, as well as those within them.
- People from deprived areas are more likely to miss hospital appointments due to a range of factors, such as a lack of access to transport. Again we are able to measure

this on an area basis but it is likely that individuals living outside deprived areas may also have problems, particularly if they live in remote areas with poor access to transport and/or have literacy or sensory difficulties (Audit Scotland Report).

- People with protected characteristics often find it difficult to access health services and/or have a poorer experience of their care, often compounding or contributing to poorer health outcomes (Scottish Better Together survey).
- Health literacy is an important barrier to accessing health services and the subsequent relationship between this and poor outcomes for people is becoming increasingly understood. A report produced for the Scottish Government provides background information and recommendations for NHSScotland.

The following excerpt from an NHS Greater Glasgow & Clyde report puts this complex mixture of challenges to access very powerfully:

‘Many of ‘our patients’ face a day-to-day struggle choosing between food or heating and supporting their children when they feel unwell or depressed. For some people communicating with the world is a constant struggle as they do not have fluency in English or they cannot hear or they have not had the opportunity to learn the language of officialdom or medical expertise.

Others may be experiencing abuse because they are perceived as being different and inferior by others because of their ethnicity, their sex, their sexual orientation or their disability. These experiences alone are sufficient to cause health problems, some may make existing health problems more difficult to deal with and some make the experience of seeking care and support, an overwhelming obstacle.’

NHS Greater Glasgow & Clyde (2012)

The story opposite illustrates what this complex interplay of factors can mean at the level of individual experience.

Sandra

Individual experience: Sandra is a lone parent, living 14 floors up in a damp high rise flat with her seven year old son, Sean. She works part time as a school canteen assistant and is on a low wage, topped up by tax credits.

She often goes to her local Housing Office to complain about the damp and the unsafe state of the play area outside, but feels that no one is listening to her. The dampness is affecting her asthma and she has asked her GP, whom she likes, for a letter. She finds it stressful to keep Sean cooped up at home and this also makes her feel isolated. Sandra doesn't read or write very well and worries that she will miss her hospital or housing appointments. She is anxious and stressed most of the time and feels that smoking helps to calm her nerves. Let's look at some of the 'wider influences' and 'fundamental causes' that are linked to Sandra's individual experience.

- **Environmental influences:** Low pay and living in a damp house with unsafe play space is impacting on Sandra's physical and mental health. Smoking is her coping mechanism but is likely to be making her asthma worse. Her poor literacy affects her access to services e.g. reading appointment letters and will have limited her job choices to unskilled, low paid employment. Sandra has a positive relationship with her GP and accesses the service.

Housing policy over a number of years has led to a lack of good quality, affordable housing. Environmental and neighbourhood policies have failed to provide safe play areas for Sean.

- **Fundamental causes:** social forces and political decisions have determined the distribution of power, money and resources that in turn shaped the environment in which Sandra was born, grew up and now lives. Gender-discrimination in pay and expectations of Sandra's role in childcare, together with a lack of accessible childcare, impact on Sandra's income and opportunity to access different work or training opportunities.

Let's look at how things could be different for Sandra:

- **Fundamental causes level:** A progressive economic policy that addresses low pay and assures a living wage and minimum income for healthy living, progressive taxation policy, and equality legislation to close the gender pay gap.
- **Environmental influences level:** Improved housing policy leading to adequate levels of good quality, affordable social housing, with accompanying improvements to the local neighbourhood (lower speed limits, area-wide traffic calming, good quality green space, safe areas for play etc.).
- **Individual experience level:** Public services, which are sensitive and responsive to Sandra's needs, including her housing and literacy needs. Sandra is living in a dry house, so her asthma has improved. There are safe areas to let Sean out to play.

Sandra's GP helped with her asthma and stress as well as helping Sandra to contact a local adult education literacy classes – she also arranged phone reminders for her appointments in the meantime.

After going to the literacy classes and meeting new people, Sandra is now actively involved in local campaigns to improve her community. Improved literacy means she is able to keep hospital appointments and is applying for better-paid work. She is not as stressed or isolated as before and is considering cutting down on smoking.

Key message

Action needs to be taken at all three levels: fundamental, environmental and individual. Action only at the level of the individual is necessary, and will mitigate the fundamental and environmental influences, but it will not be sufficient to reduce health inequalities.

How are we doing in Scotland?

Health inequalities' is used widely in this overview to encompass the concepts of 'equity' and 'equality'. Population health is improving in Scotland for the population as a whole – premature death (deaths of those age below 75) is decreasing and life expectancy is increasing. The Scottish Government monitors long-term trends in health inequality in Scotland. The story for health inequalities is far less positive than that for average population health improvement.

The most common measure of health inequalities is incidence of death at a certain age compared across geographic areas in Scotland using a measure known as the Scottish Index of Multiple Deprivation (SIMD).

We know from these data that there are clear inequalities in health between the most and least deprived in Scotland. In 2009/10, for example, life expectancy at birth for men was 69 years for those living in the most deprived 10% of areas compared to 82 years for those living in the least deprived 10%, a difference of 13 years. The difference in healthy life expectancy (years lived with good health) was even starker, at 47 years for men in the most deprived 10% compared to 70 years for those in the least deprived 10%, a difference of 23 years.

In addition, we know that the manifestation of health inequality (which conditions are causing premature mortality) is changing over time, but that the presence of health inequality itself is not diminishing despite best efforts.

Finally, we know that society and the demographics of Scotland are constantly changing and that there is evidence available, both nationally and locally, on inequalities in patterns of disease and the inter-relationship between illness and, for example, gender, disability, age and ethnicity.

Below are just some examples drawn from the data and evidence available to us:

- People from minority ethnic groups generally have lower mortality than the general population in Scotland. However, there is a higher prevalence of heart disease and diabetes among those in the South Asian population (Gordon et al, 2010).
- People with learning disabilities have been found to have untreated medical conditions that would normally have been identified and resolved for other members of the community. These can be minor conditions but also include serious concerns such as breast lumps or diabetes (Gordon et al, 2010).
- We have a good understanding of how a person's gender is associated with certain health conditions. For example, in terms of mental health and wellbeing, in 2007, 74% of suicide deaths were men, yet women are more likely than men to be admitted to hospital for self-harm and women account for 70% of GP consultations in which a diagnosis of 'anxiety and other related conditions' is recorded (Gordon et al, 2010).
- Studies in Scotland demonstrated that the inverse care law (where resource distribution favours the affluent) was entrenched within general practice and exacerbated by primary care quality measures rather than reversed (Guthrie, 2006). A recent report by the Deep End Practices highlights the need for a more proportionate response to need within Primary Care.
- In 2010, the Scottish Better Together patient survey programme found that patients who were most likely to report poorer experience of Scottish hospitals were those with poorer self-reported health status, a disability, or those requiring translation, interpretation or communication support.

What works to reduce health inequalities?

Much of the research in this field is rich in explanation of the problem of health inequalities and what causes them and the research has also produced clear pointers for policy development to address these causes.

Countries that have lower levels of income inequality also have lower levels of health inequality and crime, with higher levels of social cohesion and generally higher levels of wellbeing (Wilkinson and Pickett, 2011).

There is compelling evidence and growing consensus that the fundamental causes of health inequalities – the unfair distribution of resources such as power, income and wealth – need to be addressed.

Since the 1979 Black Report there has been a steady stream of recommendations to redress the unfair distribution of power, money and resources. However, action has consistently defaulted to addressing the effects rather than the fundamental causes of inequality as they manifest themselves in individual poor health or health-risking behaviour. It is clear that, while addressing effects is important, it is not sufficient and action on the fundamental and environmental causes must be taken at the same time if real improvement is to be achieved.

A review of the evidence of what is most and least likely to reduce health inequalities can be summarised as shown in the table on page 26.

Interventions likely to be effective in addressing health inequalities	Interventions less likely to be effective in addressing health inequalities
<ul style="list-style-type: none"> • Structural changes to the environment, legislation, regulatory policies, fiscal policies. • Income support. • Improving accessibility of public services. • Prioritising disadvantaged population groups, intensive support, and starting young. 	<ul style="list-style-type: none"> • Written materials (pamphlets). • Campaigns reliant on people taking the initiative to opt in. • Campaigns/messages designed for the whole population. • Whole-school health education approaches (e.g. school-based anti-smoking and alcohol programmes). • Approaches that involve significant cost or other barriers (i.e. if it costs the individual significant amount to take part in the intervention).

(adapted from Inequalities in health in Scotland; what are they and what can we do about them?)

The next section looks in more detail at the policy and public sector landscape and the key areas of action for NHS Boards and how the role of Non-Executive Directors in their governance role can be used to best effect.

Section 2:

The policy and public sector landscape



Introduction

The work undertaken by NHS Boards across the country provides the strategic framework to ensure that the management of healthcare is more efficient, more accountable and more effective. Boards bring together key partners who deliver healthcare. One of the main functions of these different bodies is to put government policies into practice in the best way possible.

The role of an NHS Board is to be a Board of governance, which has responsibility for issues such as health improvement, strategic planning and resource allocation. With the other members of the Board, non-executive members will be expected to tackle a wide range of demanding responsibilities, balancing national policies and local needs.

So it is important to consider the policy and public sector landscape that NHS Boards work in through a health inequalities lens. When Non-Executive Directors are making important strategic decisions or prioritising services, they need to consider the impact of their decisions on health inequalities.

Since devolution, a number of policy documents have focused on the issue of health inequalities in Scotland. The influential 1999 White Paper, *Towards a Healthier Scotland*, recognised that health improvement action should encompass the circumstances people live in (the determinants of health) as well as lifestyles and disease. All action was to be underpinned by the need to reduce health inequalities.

In 2007, the Scottish Government set up a Ministerial Task Force on Health Inequalities. The report of the Task Force, *Equally Well*, was published in 2008 and outlined recommendations for tackling the underlying causes of health inequalities under a range of headings including: early years and young people; poverty and employment; physical environments and transport; alcohol, drugs and violence; health and wellbeing. *Equally Well*, along with *Achieving our Potential* and the *Early Years Framework*, were seen as the basis for cross-sector action on reducing inequalities in Scotland. The Equally Well Task Force has been reconvened regularly with their latest report published in January 2014.

Most recently, the NHSScotland *Healthcare Quality Strategy* has put the patient experience and standards of care at the heart of the NHS. This strategy, the 2020 vision for the NHS and Health and Social Care Integration all have improving health and reducing health inequality as fundamental ingredients alongside improving service quality. Key to this is the concept of **person-centred care**, which recognises that healthcare quality is ‘built from the ground up and is dependent on the effects of millions of individual care encounters’.

Care encounters need to be consistently person-centred, clinically effective and safe for every person, every time. However, these encounters cannot be effective without a sound understanding of what determines health and what causes health inequalities.

Despite this robust policy landscape, there is still a gap between the policy aspirations to address the fundamental causes of health inequalities and predominant action. A policy review, carried out by NHS Health Scotland on behalf of the Ministerial Task Force on Inequalities in 2013, identified the key messages shown on page 29.

Key messages from the implementation of policy in Scotland

- Public health action on health inequalities currently focuses on responding to the effects of inequality and not the causes.
- Health improvement and health promotion initiatives to address lifestyle factors are not sufficient to reduce health inequalities.
- More needs to be done to address the fundamental causes, as well as responding to the effects.

Public sector landscape

The context for public sector reform is driven by the recognition that public sector services need to strengthen their ability to both reduce health inequalities and to respond to the demographic challenges Scotland faces: the decreasing numbers of adults of working age and increasing numbers of people in retirement living longer, but not always in better health.

The reduction of health inequalities has been an important component of all public service policy and delivery for over a decade and yet they have continued to increase.

The challenge is clearly outlined in the Scottish Government's response to the Commission on the Future Delivery of Public Services, otherwise known as the 'Christie Report'.

The response outlines key objectives of a reform programme as:

- Public services are built around people and communities, their needs, aspirations, capacities and skills and work to build up their autonomy and resilience.
- Public service organisations work together effectively to achieve outcomes – specifically, by delivering integrated services which help to secure improvements in the quality of life, and the social and economic wellbeing, of the people and communities of Scotland.
- Public service organisations prioritise prevention, reduce inequalities and promote equality.
- All public services constantly seek to improve performance and reduce costs, and are open, transparent and accountable.
- Prevention and preventative spend to be at the heart of public service planning.

The Scottish Government has stated that:

‘Public service organisations should work to extend and deepen a local partnership approach, building on but going well beyond the current community planning partnership model. In particular, there should be a much stronger focus on engaging with people and communities in partnership processes, including the design and development of a pattern of integrated service provision’

Public Bodies (Joint Working) (Scotland) Bill

The Scottish Government has committed to the introduction of an integrated system of health and social care to improve outcomes for people using health and social care services, and to help address funding and demographic challenges over the longer term.

The consultation on proposals for the integration of adult health and social care in Scotland was launched on 8 May 2012 by the Cabinet Secretary for Health, Wellbeing and Cities Strategy and concluded on 11 September 2012. The Public Bodies (Joint Working) (Scotland) Bill was introduced to Parliament on 28 May 2013. The objectives of the intended changes to legislation are that:

- health and social care services are firmly integrated around the needs of individuals, their carers and other family members
- they are characterised by strong and consistent clinical and care professional leadership
- the providers of services are held to account jointly and effectively for improved delivery
- services are underpinned by flexible, sustainable financial mechanisms that give priority to the needs of the people they serve – rather than the organisations through which they are delivered.

Seven outcomes have been identified for the integration of health and social care. The first of these is of particular pertinence to this resource:

Outcome 1 – Healthier living: Individuals and communities are able and motivated to look after and improve their health and wellbeing, resulting in more people living in good health for longer, with reduced health inequalities. Achieving this outcome will require the NHS and its partners to understand the fundamental and environmental causes of health inequality. This understanding will be critical to ensuring that there the right balance is struck between action that needs to be taken by government and public bodies and those by the individual. We have seen that many of the causes of health inequality lie outwith the control of the individual.

The next section gives an overview of four key areas on which NHSScotland can take action to strengthen its contribution to reducing health inequalities.

Section 3:

Four ways Boards can act



Introduction

This section focuses on the four areas within which NHS Boards can strengthen their contribution to reducing health inequalities and the specific role Non-Executive Directors can play to ensure these aspects are addressed.

When considering the complex interplay of individual characteristics, the fundamental and environmental causes of health inequality and the core role of NHS Boards to provide healthcare services, it could be concluded that NHS Boards have little power to reduce health inequalities.

However, whilst it may be true that the NHS cannot solve health inequalities alone, it has a vital contribution to make. This is a contribution that can be substantially strengthened.

What can the NHS do?

The NHS can and should ensure that it does not indirectly harm health through the way it plans and delivers services. It should provide care in proportion to need, free at the point of need. It should also ensure it does not deepen health inequalities through presiding over unequal access and/or discriminatory practice.

Working for Health Equity: The Role of Health Professionals (2013) was published by the Institute of Health Equity. The report highlights that, despite having the most equitable health service in the world, inequalities in social and living conditions are driving inequalities in health across the UK.

The report, which is aimed at those working in the NHS, points out that eight people a second are seen by the NHS, yet not enough attention is given to the social and economic problems (the fundamental and environmental causes) of their poor health.

The following four areas for action have been identified for action in the NHS, based on the above report and the experience of the Scottish Centre for Healthy Working Lives. They are:

- the quality of services the NHS plans and provides
- what the NHS does in partnership
- the NHS as an employer and procurer
- the advocacy role of the NHS.

The quality of services the NHS plans and provides

As stated previously, good quality care cannot be provided consistently if people from disadvantaged groups and/or who have particular characteristics have an unequal experience of healthcare. This needs to be addressed at the level of frontline practice. Equally, it needs to be addressed at the level of how services are planned, resourced and allocated to need. This includes the provision of universal services such as primary care services, including GPs, dentists, pharmacies, practice nurses, health visitors and community nurses. Critical to this provision is the allocation of resources and services proportionate to need. This is a vitally important aspect of the action that NHS Boards can take.

The universal provision of services provides a sense of everyone benefiting, and of society buying into providing for all regardless of means. Allocating these services in proportion to need is necessary if health inequalities are to be reduced. Importantly, universal services delivered in proportion to need means only targeting communities living in particular areas – it means making tough decisions about allocating resources in **all** areas in proportion to need. This is important as we know that there is a social gradient to health inequalities and that not all people with the greatest need live in areas of deprivation.

To allocate universal services in proportion to need, Boards need to know and understand the nature of need within the communities they serve.

What Non-Executive Directors can do in the planning and delivery of services

There are four key areas that Non-Executive Directors should scrutinise when carrying out their role.

1 Information and data

Knowing and understanding the role and statutory responsibilities of the Director of Public Health is important in order to:

Scrutinise to what extent the Board is using evidence of population need, public health profiles and intelligence available from the third sector, elected members, community organisations and others to plan its services.

Determine whether the information the Board is collecting is likely to measure the reduction of health inequality. If not, advocate for the collection of information that will enable the Board to measure its progress in reducing health inequalities.

Scrutinise performance targets – will they have an impact on reducing health inequalities?

2 Planning for health equity

Scrutinise whether strategies, plans and major service change are routinely impact assessed for equality, human rights and health inequality using health inequality impact assessment (HIIA) tools at the earliest possible planning stage. Is the information produced rigorous and is it used to help ensure that fair decisions are made and justifiable?

Scrutinise whether the Board is monitoring the use of hospital services by different groups.

Look for evidence that access to services is planned and delivered in proportion to need and complexity, and that continuity and integration between services is improving.

Enquire as to the extent to which strategies to reduce health inequality and promote health equity are integrated and mainstreamed with the core strategy of the organisation.

Scrutinise whether health inequalities are being considered when financial priorities are set and how (and whether) resources are being allocated in proportion to need.

Scrutinise the allocation of the Change Fund and other funding streams, including their planned or actual outcomes – is the evidence of what is least and most likely to work to reduce health inequalities being used to shape initiatives?

Enquire if the Board, through its contribution to partnership work, is maximising opportunities for collaboration – particularly around the maximisation of joint services and resource to benefit those who are most disadvantaged.

3 Are Board plans informed by the evidence of what is most and least likely to reduce health inequalities? (see table on page 26)

Scrutinise all strategy aimed at improving the health of the population. Is it biased towards individuals opting-in and towards health behaviour change of individuals? Does the Board understand that this bias will not reduce health inequalities?

Enquire as to how the Board mitigates the impact of poor health literacy in all of its services, particularly outpatients and acute-based services.

Is the Board seeking out and learning from initiatives and practices that have been effective in reducing equality gaps elsewhere?

4 Patient and public experience and feedback

Enquire as to whether feedback from patients/service users is collected and analysed to support service improvement.

Scrutinise the methods used to gather feedback (they should be systematic and meet agreed standards) to ensure they are not discriminatory, and review any patterns of feedback that suggest different groups are experiencing services differently.

Determine whether the Board is reviewing patterns of non-attendance for hospital appointments by different groups within the population and whether the Board is using this information to take specific action to help particular groups to access hospital services.

Where applicable, is the Board taking targeted action to improve attendance rates of patients living in deprived areas or amongst those population groups known to be at risk of poor health outcomes?

Scrutinise whether the Board is monitoring the use of primary care, preventative and early detection services by different groups. Is action being taken to improve uptake where appropriate? For example, what is being done to improve access to cancer screening services or free eye examinations?

What the NHS does in partnership

We have seen that health inequalities are caused by factors at a number of levels – many of which are beyond the control of the NHS or other public services – and that single agency effort, such as the NHS acting on its own, will not be sufficient to reduce health inequalities in Scotland.

This means that the added value agencies can bring when they work effectively together must be maximised.

The Scottish Government has clearly described Community Planning Partnerships (CPPs) as the primary mechanism for the delivery of public service reform and improved outcomes for communities. CPPs are the overarching umbrella for all other strategic partnerships including Health and Social Care Partnerships and thematic partnerships such as Alcohol and Drug Partnerships.

Each of the 32 Community Planning Partnerships in Scotland has a key role in reducing inequalities. Advocacy for shared action on the fundamental causes relies on shared values and action at leadership level within NHS Boards and in their role as community planning partners. The strengthened Board responsibilities for single-outcome agreements (SOA) provide an important opportunity for Boards to influence action to prevent and/or mitigate the causes of health inequalities.

‘Reducing health inequalities requires effective partnership working across a range of sectors and organisations but there may be difficulties in getting good engagement between GPs, Community Health Partnerships (CHPs) and councils due to a lack of shared vision and priorities.’

Audit Scotland (2012)

The *Local Delivery Plan 2014/15 Guidance for Boards* highlights the vital contribution Boards need to make in Community Planning processes.

This includes the focus on achieving shared outcomes for communities, particularly in respect of the SOA priorities of: economic recovery and growth; employment; early years and early intervention; safer and stronger communities, and offending; health inequalities and physical activity; and older people. The health inequalities aspect of these key priorities is highlighted in the Health Scotland SOA briefing notes.

To understand this more clearly, a quick overview of the pattern of health inequalities within local authority or CPP partnership areas is presented.

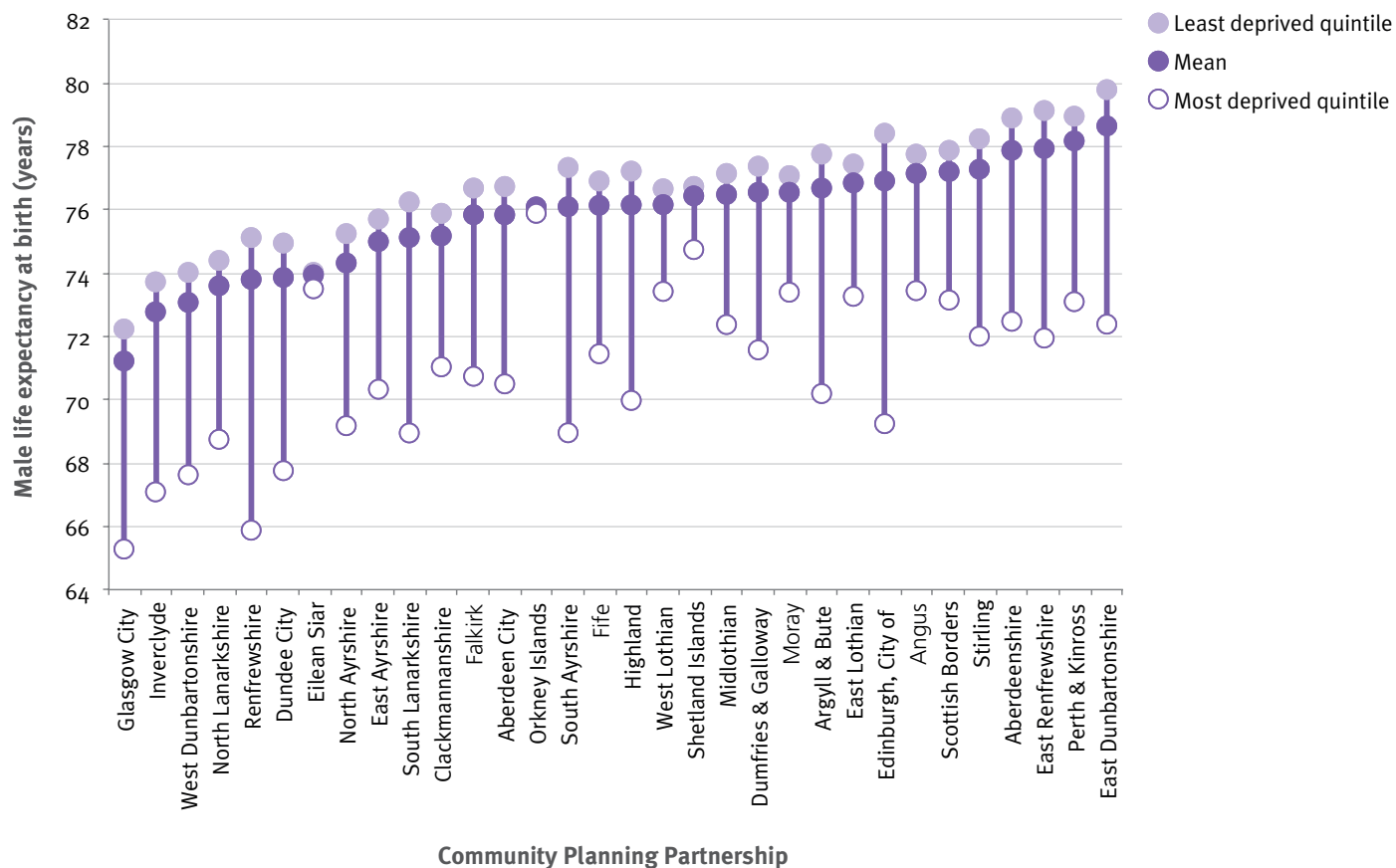
Health inequalities across and within local authority areas

Information about local community health profiles can be sourced from the Scottish Public Health Observatory (ScotPHO). Led by the Information Statistics Division of the Public Health Intelligence Business Unit of National Services Scotland and NHS Health Scotland, ScotPHO brings together information and data on public health from key national organisations. It also has downloadable copies of all ScotPHO publications.

Speak to your Director of Public Health for more information regarding locality profiles and data and how they are used within your Board or in your Community Planning Partnerships.

Figure 3 on page 40 shows male life expectancy at birth in the most and least deprived quintiles within each Scottish local authority area (2006–2010). A similar pattern can be shown for females. This is just one illustration of inequality within and across all local areas.

Figure 3: Male life expectancy at birth in the most and least deprived quintiles within each Scottish local authority area (2006–2010) (Data source: National Records for Scotland)



Working with the public and the third sector to improve quality

The need for public services to work with communities to design services that meet their needs is at the heart of public sector reform agenda in Scotland. The Community Empowerment (Scotland) Bill aims to: make the most of the talents that exist in our communities; deliver high quality and improving public services; and support strong local democracy and local decision-making.

Working with individuals and communities to empower them to take an active part in the planning and design of services (so that services reflect what matters to people and not what matters to services) is crucial to improving the quality of services.

The importance of assets at the level of individuals and communities and the co-production of health is an important driver within public policy in Scotland. The Glasgow Centre for Population Health has produced a very helpful report regarding the use of asset-based approaches.

Working with their local community and voluntary sector groups is essential to achieving this aspiration and can help NHS Boards more effectively involve the public in meaningfully shaping and influencing how services are planned and delivered.

In relation to reducing health inequalities, NHS Boards should ensure that they and their services are reaching out to all the groups and communities that make up the populations they serve. This is particularly necessary for those at most risk from discrimination, prejudice and exclusion, and those who find it most difficult to access and or benefit from the services provided and to make their voices heard.

The third sector includes a wide range of national and local community and voluntary groups who can act as intermediaries or interfaces between the NHS and communities.

The Scottish Government, the NHS and the third sector have worked together to produce a matrix tool; this can be used as both an assessment of the quality of engagement between the NHS and third sector and as a planning tool.

Each NHS Board has a matrix lead and an Executive Director lead for patient and public involvement. They should be able to provide information about what your Board's strategies for community empowerment and public engagement are.

What Non-Executive Directors can do in partnership to reduce health inequalities

Scrutinise how their Board plans, gathers and shares information and intelligence about health needs in communities for integrated partnership planning purposes within CPPs.

Ask how the Director of Public Health is resourced to fulfil WHO essential public health functions 1 and 2.

Scrutinise to what extent strategic partnership plans include any intended action to address the fundamental and environmental causes of health inequalities, as well as reacting to the effects of these.

Scrutinise whether single outcome agreements and other partnership agreements, for example Alcohol and Drug Partnerships, have evidence of clear health inequality outcomes.

Scrutinise the extent to which the Board is working in partnership with the third and community sector to support communities mobilise community assets and the local action that will strengthen local democracy and empowerment.

Ascertain how GPs engage with the Board when developing plans in their locality to reduce health inequalities.

Ensure that HIAs are performed and acted upon when designing new services or redesigning existing services.

The NHS as an employer and procurer

The Healthcare Quality Strategy, the Health Promoting Health Service, the 2020 vision and Staff Governance Standard all highlight the importance of staff health and wellbeing.

There are a wide number of actions the NHS can take under this heading to address inequalities:

- Implementing the Staff Governance Standard and the 2020 Workforce Vision, both of which are aimed at achieving a workforce that is motivated and protected by values of fairness, inclusiveness and good employment practice.
- Supporting the delivery of employment duties, including improving the monitoring of their workforce composition by protected characteristics and having in place equal pay strategies.
- Using the characteristics of ‘good work’ as a baseline against which to measure practice and behaviour relating to employment processes and practice.
- Providing an income that supports healthy living. Although the ‘living wage’ is not always enough to achieve this, it can result in ‘healthy living’ for more people than the minimum wage can achieve.
- Ensuring the workforce across the NHS supply chain procures benefit from the same standard of health, safety and wellbeing at work as Health Board employees.
- In relation to procurement, measuring and scoring in terms of the extent to which these contribute to addressing health inequalities.
- Supporting local small and medium sized businesses to reach a state of readiness to compete successfully in public sector procurement to enhance local economic benefits.

Ensuring equality in access and the quality of the services requires an NHS workforce to know and understand causes health inequalities and to be motivated to see it as part of everyone’s role to address health inequality. This includes not only staff who directly deliver services, but also those who have strategic leadership, planning and governance roles.

What Non-Executive Directors can do to reduce health inequalities as an employer and procurer

- Scrutinise the Board's procurement policies and practice to determine if the impact of inequalities has been considered across the supply chain.
- Use the annual equality report to ensure that the Board is systematically collecting and using equalities data to plan its workforce.
- Scrutinise how health at work policies are implemented and reviewed.
- Ensure the Board undertakes an audit of equal pay and acts upon it to reduce inequalities.
- Enquire to what extent the Board's monitoring of the Staff Governance Standard incorporates 'good work' characteristics.
- Enquire to what extent the Board is confident that they and the wider workforce know and understand the fundamental causes of health inequalities and know what actions lie within their direct gift or within partnership work.
- Scrutinise the extent workforce plans, including senior leadership development plans, ensure that knowledge and understanding of the determinants of health and the fundamental causes of health inequality are integral to these plans.

The advocacy role of the NHS

The *Working for Health Equity* report includes a very clear statement that the NHS, particularly senior leaders, must be prepared to act as advocates to reduce inequality.

NHS Boards have an important role in advocating for action at national and local levels to address the fundamental and environmental causes of health inequality. This means advocating for fairer policy and fairer planning when engaging with policymakers and at community planning levels.

This sort of leadership and momentum is challenging to create and sustain, but it is at the bedrock of the Christie recommendations. The challenge of allocating funding and shared budgets proportionately to need and ensuring action to address the fundamental and environmental causes of health inequalities needs to be met.

'Even among health professionals who have [this] insight, there has been a sense that it is for others to respond; there is not much we can do. But the response we have had from the many organisations and individuals that have helped us with this report, is not only should we be taking action, but there is ample evidence that we can.'

*Working for health equity:
The role of health
professionals (2013)*

What Non-Executive Directors can do as an advocate to reduce health inequalities

- Determine whether the leaders in the Board are advocating for action to redress the unfair distribution of the determinants of people's health – income, power and other resources, such as housing, education and health equity – in partnership with local authorities, the third sector and others in their community.
- Does the Board ensure that inequality has a focus within each of its sub-committees?
- Consider what role you have to champion inequality, equality and human rights within and outside the Board.

And finally an example of advocacy in action...

We have seen that Non-Executive Directors have a key role to play in scrutinising their Boards plans to take action to reduce health inequalities. The following example from the Director of Public Health in NHS Tayside illustrates how this role, together with effective advocacy, can drive the promotion of health equity by NHS Boards.

‘My chairman and our other non-executive colleagues have played an important role individually and collectively in promoting health equity. They did that in the first instance by unanimously approving our Health Equity Strategy – Communities in Control. As you will gather from the title this is a very radical document which has committed NHS Tayside to a very different path from our previous direction of travel locally and from elsewhere in Scotland.

In particular, it has committed us to targeting healthcare and other services towards those most in need – our most deprived communities. This is intended to address head-on the Inverse Care Law which, in Tayside as elsewhere, describes a status quo whereby those most in need are those least likely to benefit from services.

Furthermore, Communities in Control has committed NHS Tayside to targeting co-production and asset-based approaches towards our most deprived populations as it is these communities which are currently least able spontaneously to co-produce solutions to health and wellbeing problems alongside public and third sector agencies.

Following approval of Communities in Control, our chairman and non-executive colleagues have consistently used opportunities in Board meetings, committee meetings of the Board, CHP meetings and Community Planning meetings to question the extent to which papers, policies, discussions, services and approaches are sufficiently focused on the principles outlined in our Strategy.

Through their advocacy they have thus raised the profile in Tayside of health inequalities and the actions needed to tackle them to the extent that there has been a clear organisational culture shift locally towards the pursuit of health equity’.

Dr Drew Walker (December 2013)

In conclusion

We hope you find this publication useful and use it to further develop your understanding of health inequalities and your role in reducing them. We will update this resource on a regular basis – in the meantime please contact us if you would like any further support or information by emailing:

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review](http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review)

Living Wage (Scotland) Bill
[www.scottish.parliament.uk/S4_
MembersBills/Living_Wage_Consultation_
Final.pdf](http://www.scottish.parliament.uk/S4_MembersBills/Living_Wage_Consultation_Final.pdf)

*Working for Health Equity: The role of health
professionals*
[www.instituteofhealthequity.org/projects/
working-for-health-equity-the-role-of-
health-professionals](http://www.instituteofhealthequity.org/projects/working-for-health-equity-the-role-of-health-professionals)

Further reading

Community Benefit Clauses
www.scotland.gov.uk/Topics/Government/Procurement/policy/corporate-responsibility/CSR/SSPAP/ComBen

Reducing health inequalities: What would it take?

www.scotpho.org.uk/downloads/scotphoreports/scotpho131018_whatwouldittake_report.pdf

Targeting deprived areas within small areas in Scotland

www.ncbi.nlm.nih.gov/pmc/articles/PMC37397/

Developing NHS Greater Glasgow & Clyde as an Inequalities Sensitive Health Service: Where is the organisation now after 5 years?

www.equalitiesinhealth.org/public_html/documents/Stocktakewebversion.pdf

Health Inequalities, Deprivation and General Practice in Scotland (RCGP Scotland Health Inequalities Short Life Working Group Report December 2010)

www.rcgp.org.uk/policy/rcgp-policy-areas/~/_media/Files/Policy/A-Z-policy/Time-to-Care-RCGP-Scotland-report-on-Health-Inequalities-2010.ashx

Deprivation and quality of primary care services: evidence for persistence of the inverse care law from the UK Quality and Outcomes Framework

<http://jech.bmj.com/content/60/11/917.short>

Beeston C, McCartney G, Ford J, et al. *Health Inequalities Policy Review for the Scottish Ministerial Task Force on Health Inequalities*. Edinburgh: NHS Health Scotland; 2014 (in press).

