

MRC/CSO Social and Public Health Sciences Unit Response

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| **Title of Inquiry** |
| Inquiry into health inequalities |
| **Name of the consulting body** |
| Health, Social Care and Sport Committee, Scottish Parliament |
| **Link** |
| <https://yourviews.parliament.scot/health/health_inequalities/> |
| **Why did the MRC/CSO Social and Public Health Sciences Unit contribute to this?** |
| At MRC/CSO Social and Public Health Sciences Unit, we conduct high quality research that has a real impact on health and wellbeing, and on reducing health inequalities – both at home and across the globe.  We have a particular focus on developing and using cutting-edge methods to understand how social, behavioural, economic, political and environmental factors influence health. We work with decision makers, practitioners and the public to identify interventions and policies that can have an effective and sustained impact on health and wellbeing, particularly among those most in need. |
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# What progress, if any, has been made towards tackling health inequalities in Scotland since 2015? Where have we been successful and which areas require more focus?

The Long-term Monitoring of Health Inequalities reports go a long way to answering this question (The Scottish Government, 2021a). The most recent report shows that health inequalities have persisted or even widened across several measures since 2015, including in healthy life expectancy, birthweight, and cardiovascular disease. We would emphasise that this was from a starting point of already high inequalities. Inequalities in hospitalisations due to alcohol and drug misuse and inequalities in mental health remain high (The Scottish Government, 2021a). These inequalities are particularly concerning as they lead to large inequalities in suicides and deaths of despair that research in the Unit has a long history of documenting (Allik et al., 2020).

The Long-term Monitoring of Health Inequalities reports focus on a set number of outcomes identified as being important and reliable measures of health which are consistently reported at the national-level and over time. Our work examining inequalities in the early years through combing administrative records to create a cohort of Scottish children and their mothers provides greater information on inequalities at this important point in the life course. Many diseases in later life can be traced back to pregnancy and the early years, so addressing inequalities at this stage has the potential to reduce inequalities across the lifecourse. We have found large inequalities in breastfeeding; parental smoking in pregnancy; maternal mental health; cognitive, social, and physical development; overweight and obesity (Pearce et al, in draft, available upon request) and unintentional injuries (Henery et al., 2021). Our findings show large inequalities in the persistence of health behaviours or poor health throughout earlier childhood, with a dramatic accumulation of risk for those experiencing multiple aspects of social disadvantage. For example, children living in households in the most deprived fifth of neighbourhoods, with a lone parent, who is unemployed are more than 200 times more likely to be exposed to smoke in utero, infancy, and toddlerhood (as opposed to never being exposed to smoke throughout the early years), when compared to children living with married parents, in the least deprived fifth of neighbourhoods, with a mother in a managerial and professional occupation (Pearce et al, in draft, available upon request).

Some critical areas of health, such as multi-morbidity, and aspects of healthy ageing, such as cognitive skills and independence, are also not routinely monitored due to data availability. For similar reasons, there is less evidence about health inequalities according to ethnicity, individual socio-economic circumstances, disability, urban-rural location, and migration status. These are all crucial dimensions and they may intersect to produce worse outcomes (i.e. multiple dimensions of disadvantage can create health effects that are more than the sum of their parts (Poverty and Equality Commission, 2021)). There is also increasing need to monitor how length of life varies between all individuals within Scotland (lifespan variation). Population health is routinely monitored in terms of average mortality levels and health inequalities by the gap in average mortality levels between socioeconomic

groups. Lifespan variation captures variation in age at death within a population as opposed to the inequality in average health that exists between groups. While life expectancy tends to improve when mortality at any ages is reduced, lifespan variation tends to only improve when the greatest decreases in mortality are at premature ages (Seaman et al., 2019) .

We note the recent launch of the Health Foundation independent review of health inequalities in Scotland. We are involved in this work and we seek to address some of these gaps (The Health Foundation, 2022). The report is expected to be published later this year – contact [nadia.kalam@health.org.uk](mailto:nadia.kalam@health.org.uk) for more information or to be kept up to date.

Improved understanding and monitoring of health inequalities will be in vain unless it is accompanied by the incorporation of health inequality impact assessments in the design of all policies, interventions and services and their evaluation. This will provide decision makers with evidence of what actions reduce, and what actions increase, health inequalities, right across the wider system. We revisit this in some of the later questions.

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# What are the most effective approaches to tackling health inequalities and how successful is Scotland in pursuing such approaches?

The importance of the social determinants of health (represented by the Dahlgren- Whitehead ‘rainbow’) are now widely acknowledged (Dahlgren and Whitehead, 2021). To tackle health inequalities, cross-cutting and upstream actions, across these different layers of determinants, are essential. This should include Health in All policies, and Equity in All policies. Without this, key decisions on these important determinants may continue to marginalise health and health inequalities. Specific initiatives will always be homeopathic compared to prioritising the fundamental causes of social inequalities and the upstream determinants of health in mainstream budgets and decision making, including (but not limited to) education, housing, transport, environment, and welfare. We touch on some examples of these below.

The Scottish Government has shown leadership in tackling smoking and excessive alcohol consumption. It has been less obviously successful in addressing the ‘causes of the causes’ of health inequalities. Scotland remains a highly unequal country, with little improvement in income inequality since devolution, and increasing poverty over the ten years prior to the pandemic (The Scottish Government, 2020). The Social Security (Scotland) Act 2018 was intended to create a ’distinctly Scottish system’ of social security ‘founded on dignity, respect and human rights,’ and with the explicit aim of reducing poverty (The Scottish Government, 2021b). 11 social security benefits are now devolved to Scotland, and the Scottish Government has powers to top up reserved benefits, providing it with some levers for directly tackling poverty. The Scottish Government has been willing to use its powers, for example to promote the take-up of benefits and to provide enhanced child payments to low-income families (The Scottish Government, 2021b). However, the Scottish Government is not responsible for Universal Credit, the main benefit for people on low incomes in the UK, limiting its ability to use the social security system to reduce poverty and removing a critically important tool for tackling health inequalities. These limits have been underlined by the measures announced in the UK Government’s Spring Statement. Households receiving Universal Credit will scarcely benefit from the increase in the National Insurance threshold but will lose substantially from the failure to raise the standard allowance to take account of the substantial increase in inflation – leading to a fall in the living standards of the poorest households and a substantial increase in poverty (Hetherington, 2022; Institute for Fiscal Studies, 2022; Resolution Foundation, 2022).

Work on inclusive economy from SIPHER (Systems Science in Public Health and Health Economics Research, 2022), a consortium of researchers across the UK and led from SPHSU, has shown that decent work is crucial for health and health inequality outcomes. This should include job security, sufficient pay, safe working conditions, working hours to suit personal circumstances, opportunities for development/progression and supportive working relationships are currently unequally distributed in society. For those who are not in the workforce due to age or inability to work, income support policies that guarantee a basic

standard of living are important public health policies to help avert the negative health impacts of poverty on both adults and children.

More of our research suggests that policies focusing on the economic determinants of mental health (employment and income) will be helpful in improving population mental health and reducing inequalities, which were already large pre-pandemic and may have widened since. Using UK data, we found that being in paid employment was particularly important for mental health, with job loss leading to a 16% increase in common mental health problems such as anxiety or depression (Kromydas et al., 2021). A systematic review we led found that moving below the poverty line seems to carry a much larger risk for mental health than other types of income changes ((Thomson et al., 2021), full paper available upon request).

This work has identified two important economic policy levers for improving population mental health: the use of active labour market policies to support people into well-paid and supportive employment, alongside a strong welfare safety net that avoids people falling into poverty.

As noted in our national and international reviews (Pearce et al., 2020, 2019) early years are a highly efficient time to intervene in the life course and upstream interventions and policies are the best way to achieve this. Scotland has committed, by law, to ensuring that every child has the best start in life (The Scottish Government, 2018) and progress has been made in areas likely to make a big difference to inequalities reduction (e.g. The Child Poverty Act, the Scottish Child Payment, and the recent extension of free early years learning and education). The Maternal and Child Health Network (MatCHNet, 2022) led from our Unit, is developing a multidisciplinary community of public health researchers, methodologists, policy makers and service providers. This community is prioritising upstream policy interventions that can be evaluated using administrative data and are most likely to support child and maternal health and reduce inequalities. Our policy prioritisation exercise, in conjunction with our stakeholder group, has identified three areas of importance: early years learning and childcare; benefits and grants in pregnancy and the early years; and elements of Universal Credit relevant to families. In the future we seek to evaluate one or more of these policies by making comparisons across the UK countries.

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# What actions would you prioritise to transform the structural inequalities that are the underlying cause of health inequalities?

As noted in section 9, the most impactful ways to support health and reduce inequalities are upstream and require multi-sectoral action at all levels. This must include measures to reduce poverty, by improvements to the social security system. For further details, see answer to section 14. We also make the case for a focus on the early years in sections 8-9.

We would like to draw attention to the issues of the ‘inverse evidence law’ and ‘lifestyle drift’ in the evidence base surrounding health inequalities. The impacts of upstream policies are hard to evaluate as they cannot be tested in trial settings. This can lead to a drift downstream and a focus on health behaviours or other individual level factors which can be easily measured or evaluated. Thus, we are in danger of ending up with the least amount of evidence for the policies most likely to evoke change. Our work in the Unit seeks to address this using agent-based models, micro-simulation studies and quasi-experimental study designs (e.g., natural experiments). We are concerting the efforts of researchers, policymakers, and practitioners through our UK Prevention Research Partnership network (MatCHNet) and consortia (SIPHER). These efforts will enable us to consider whether a policy has or is likely to reduce (or exacerbate) health inequalities. More importantly they allow us to consider which changes to policies (in terms of scale, intensity, and eligibility) can be made to maximise any benefits.

Another key action is to recognise and talk about the importance of places in the reproduction of societal and health inequalities. Our work in the Unit shows that the places people grow up in, and live in, have a *direct* influence on their health and wellbeing (through things like exposure to air pollution, access to good food and green space etc) but they have an arguably more important *indirect* influence too: inequalities in place *create* inequalities in society and economy. Places are like fields which grow lives rather than crops; if we get the social, economic, and physical environment right, it can nurture healthy people, generation after generation. If we get it wrong, the adverse consequences are perpetuated. We continue to have health inequalities because we continue to have social and economic inequalities, and we continue to have those because we continue to have different kinds of place creating them.

We have such low levels of social mobility in Scotland, that most people end up living in the same kinds of place that they grew up in (even if it is geographically somewhere else). They then bring their own children up there and the cycle continues. This is how inequality is perpetuated. If you look at the distribution of poverty within Greater Glasgow for example, the list of less healthy and more disadvantaged places has remained broadly the same for decades and we have found that the correlation between the deprivation levels of postcode sectors is extremely high (Brown et al, 2014). Children growing up in Bearsden are on one trajectory, those growing up in Bridgeton are on another. We need thinking and intervention which recognises the implications of this place-based determinism for population health and inequalities. This geographic lens on societal inequality does NOT mean leaving local

communities sort out their own problems. The geographical location of capital and revenue spending must be monitored, assessed, and controlled. This means adopting an interventionist planning system that is not solely focused on who can build what, where, but also on where educational, retail, leisure, health, transport, and environmental services are sited and, crucially, how they are financially supported and what they spend. Currently, local development plans are very passive when it comes to these things. We need local development plans not simply to be aspirational, but– in partnership with communities - to have *control*.

Young people should be prioritised as key stakeholders in decision-making around addressing the structural inequalities that cause health inequalities. Outputs are expected later this year. Some contributions from the young people who participated are available at the project website <http://creativeinsights.sphsu.gla.ac.uk/> (Creative Insights, 2022).

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# What has been the impact of the pandemic both on health inequalities themselves and on action to address health inequalities in Scotland?

At the MRC/CSO Social and Public Health Sciences Unit, University of Glasgow, we have been carrying out a range of research to understand how the pandemic has influenced health inequalities (MRC/CSO Social and Public Health Sciences Unit, 20212). We also have created an online tool to have discussions with the general public about the potential impacts of the pandemic on health and health inequalities: <https://covid19tool.sphsu.gla.ac.uk/> Here we present some pertinent examples.

The pandemic has been unequal in many ways because people from less advantaged backgrounds have been more likely to contract COVID, more likely to die from COVID, and more likely to experience negative consequences from the disease and resultant social

mitigation measures. It has exacerbated inequalities and the mechanisms that create inequalities that already existed pre-pandemic (Katikireddi et al., 2021). Recovery actions need to be designed to explicitly address the large inequalities that already existed pre- pandemic – we have estimated that over the course of a decade, the deleterious effects of social inequality on healthy life expectancy are equivalent to six unmitigated COVID-19 pandemics (McCartney et al., 2021).

The overall increase in mental health difficulties experienced across the UK during COVID- 19 necessitates action to improve population mental health. A trend towards increasing psychological distress has been occurring since at least 2015 in the UK, which was the backdrop for a jump in distress during the early parts of the COVID-19 pandemic amongst adults. This increase was pronounced in women, adults with more education, and adults from Asian minority ethnic groups ([Niedzwiedz et al 2020](http://eprints.gla.ac.uk/223281/3/223281.pdf)). Worse mental health amongst children in high deprivation areas was found to be maintained during the pandemic. This evidence emphasises the importance of childcare quality, parenting capacity, control in the workplace, and income for supporting children’s mental health and particularly among children who, even before the pandemic, were least likely to experience them (Miall et al, in draft, available on request).

For those with lower wealth resources prior to the pandemic, health is likely to deteriorate even if their income recovers quickly to pre-pandemic levels. We know this from studying the implications of the pandemic for changes in wealth resources and health in the coming decades for the UK (Angelopoulos et al., 2021). We use modelling analysis of household behaviour informed by empirical evidence to predict probable future outcomes. We find that the pandemic amplifies existing inequalities in wealth resources and health and that a deterioration in wealth resources has long lasting effects on health. These changes are accompanied by both a worsening of health for those with already lower wealth resources, and a strengthening of the relationship between wealth and health. Our results are particularly worrying because they suggest that among low wealth resource groups, even those with good health prior to the pandemic, are under increasing pressure to reduce financial outlay to boost wealth resources. This often leads to a reduction in health promoting activities.

Although green space visiting rates have risen during the pandemic inequalities in visiting green spaces have increased. This is because it is more affluent people who have had the greatest access to green spaces and have experienced larger increases in green space visits. Access to private green space at home (i.e. gardens or terraces) has taken on a greater significance. Tenure and housing type inequalities in whether children have spent time outside playing, and in whether older people were able to access nature. This matters because green spaces benefit mental and physical health.

The emerging issue of access to green spaces echoes emerging issues around actions taken to mitigate climate emergency: both issues need to consider their impact on health inequalities from the beginning. Green spaces and climate action interventions need to be designed in ways that lead to reductions in health inequalities. Unless health inequalities are

considered at the initial stages, green space and climate action interventions may be at the expense of those who can least afford it, thereby deepening inequalities. Our work with local and national partners shows that beyond active travel and air quality, there is often little consideration of how intervention options, e.g., for achieving carbon neutrality targets, may impact on health inequalities.

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# Can you tell us about any local, regional or national initiatives throughout the pandemic, or prior to it, that have helped to alleviate health inequalities or address the needs of hard to reach groups? How can we sustain and embed such examples of good practice for the future?

There are three examples given below. Each example is already embedded but sustaining them requires continued endorsement from the Scottish Government and, for Woods In and Around Town and Paths for All, funding over the long term.

1. The John Muir Award is an outdoor education initiative with a record of accomplishment in reaching deprived populations. Evidence suggests a greater positive impact on the children from poorer backgrounds than the more affluent children <https://www.johnmuirtrust.org/john-muir-award>
2. Scottish Forestry’s Woods In and Around Town scheme targets more deprived communities and works with them to transform local woodlands into health promoting community assets. The programme focuses on the location, accessibility, and management of urban woodlands to encourage more use from local people. Trees and woods in towns and cities (the urban forest) provide many benefits, from improving air quality, to wildlife havens. They can also help to economically regenerate degraded urban landscapes. Evidence suggests Woods In and Around Town produces positive behaviour change in local communities. <https://forestry.gov.scot/forests-people/communities/woods-in-and-around-towns-wiat>
3. Paths For All is a third sector organisation with nation-leading expertise in reaching diverse populations with its walking groups. [https://www.pathsforall.org.uk](https://www.pathsforall.org.uk/)

# How can action to tackle health inequalities be prioritised during COVID-19 recovery?

Young people’s perspectives are important to consider in prioritising actions. Young people have been disproportionately impacted by the pandemic, due to widespread educational disruption, increased unemployment and exacerbating the ongoing crisis in youth mental health. Our work exploring young people’s perspectives on addressing health inequalities in the context of the pandemic, will provide insights into the range of policy domains which young people suggest need action to address the social determinants of health and reduce health inequalities (some details of young people's contributions are available: <http://creativeinsights.sphsu.gla.ac.uk/>)

Actions to reduce recurrent COVID-19 outbreaks and preparedness for new outbreaks should be prioritised. This is because disease outbreaks are associated with increasing health inequality. Given the strong link between wealth and health, actions to increase income resilience during COVID-19 outbreaks and other similar events in the future are equally important.

Actions to reduce the financial cost of health promoting activities of those with low wealth resources, for example via targeted subsidies of health promoting expenditure (such as gym membership, access to outdoor spaces, promotion of low-cost health-promoting activities, or healthy eating) to reduce health inequality. This is particularly important following the pandemic because we find that needing to recover wealth resources, post-pandemic, is a strong incentive to reduce health-promoting expenditure.

# What should the Scottish Government and/or other decision-makers be focusing on in terms of tackling health inequalities? What actions should be treated as the most urgent priorities?

Focusing only on specific actions, in isolation, will be a self-defeating approach. There is no ‘silver bullet’ solution here and no one Department or Agency has the remit or powers to make a non-negligible impact on their own. Health inequalities are a systemic problem and prioritising a few parts of the system at the expense of others is unlikely to yield any measurable benefits to population-level health inequalities and may risk increasing inequalities further. To bring about change, all Departments and Agencies need to act, and policies and services designed and implemented, with a clear consideration of their potential impact on health inequalities, and thus each decision made makes a contribution to reducing health inequalities (or at least not make things worse). Collectively, these multiple contributions will potentially be sufficient to bring about significant system change, similar to the accumulation of marginal gains used so effectively by the GB Olympic cycling team.

Wales has led the way on this, with the Healthier Wales Act implementing this ‘Health In All Policies’ approach by requiring Health Impact Assessments (including health inequality impacts) to be conducted for all policies across Government. There needs to be teeth behind the implementation of a Health in all Policies approach, since all too often the decisions

made by Departments, such as Transport or Housing, may consider the health impacts but then prioritise other policy drivers more central to their concerns, such as travel time or housing demand. The problem is that the policies and services that most affect population health are made by decision makers for whom health is not their priority consideration. If this balance does not change, then Health Inequalities will continue to be an unfortunate by- product of decisions across Government. Without recognising health inequalities in all policies, key decisions on key determinants of health inequalities are made by actors whose focus and priorities may not be on reducing health inequalities. Therefore, initiatives to reduce health inequalities should be prioritised in all mainstream budgets and across decision-making domains such as education, housing, transport, environment, and welfare. This includes the commissioning of health and social care services, where inequalities in reach, effectiveness and outcomes need to be considered, as many interventions that improve health for some can still generate health inequalities.

Specific initiatives likely to have a substantial impact on health inequalities include A Minimum Income Guarantee. The Scottish Government is exploring the possibility of implementing a Minimum Income Guarantee (The Scottish Government, 2022). Making linked health and benefit data available for use by Scottish Government analysts and by independent researchers should be prioritised. This would enable a Minimum Income Guarantee scheme to be developed – and scrutinised – against the strongest possible evidence (The Scottish Government, 2021c). At present the Scottish Government’s ability to conduct or commission research of that kind is limited by a lack of access to linked, individual level data on benefit receipt, employment, income and health and other important social and economic outcomes. Such linkages are technically feasible, and the resulting datasets can be made available for research in ways that do not undermine privacy or confidentiality. Attempts by researchers to obtain linked health and benefit datasets have not been successful, despite claims to the contrary by the Department for Work and Pensions (Butler, 2022; House of Commons Work and Pensions Committee, 2019). In our own evaluation of the health impacts of changes to the social security system (Craig, 2021), we rely primarily on survey data, which is extremely valuable but limits the sample sizes available.

The protection and expansion of quality urban green space is another urgent priority. The role of green spaces in reducing or constraining health inequalities is increasingly established by academic research and health benefits may be stronger for more deprived populations (Rigolon et al., 2021). Evidence suggests that both access to, and quality of, urban green spaces matter for their delivery of health benefits (Ward Thompson et al., 2019). Both access and quality of urban green spaces are under threat from fiscal constraint and urban development (Olsen and Mitchell, 2021).

Tackling tobacco retail is another priority. Cigarette smoking remains stubbornly prevalent in more deprived populations and is an increasing driver of health inequalities. Evidence based on monitoring children’s activity spaces (i.e., where children go day to day) suggests a 7-fold socio-economic inequality in exposure to tobacco retail outlets. Tobacco retail is a modifiable

exposure, and the Scottish Government already has a record of accomplishment in the macro-scale intervention required via Minimum Unit Pricing. Simulations of intervention in the retail landscape suggest that policies which optimise both equity and density reduction in tobacco retail are possible (Caryl et al., 2021). This would include restricting tobacco sales to types of outlets (supermarkets for example) or banning sales in areas close to child-related space (such as schools or playparks).

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# What role should the statutory sector, third, independent and private sectors have in tackling health inequalities in the future?

As noted in previous questions, health and inequality impact assessments should be embedded at all levels of decision making. Here we respond to this question using the example of housing associations. The duty to ensure a baseline guaranteed standard of housing lies with the state. Housing associations, and other third sector organisations, do not have the means to solve health inequalities while working in the context of local government austerity. In a more supportive environment, some of these organisations could, in principle, offer a valuable contribution for reducing health inequalities.

Many UK housing associations are offering an increasing number of ‘housing plus’ services, with both direct and indirect impacts on health inequalities (Hjelmskog, 2021). Examples of this work include: supported and sheltered housing; aids and adaptations; extra care schemes and in-house teams of carers; employing clinical staff such as mental health practitioners and occupational therapists; food banks and community pantries; employment and skills training; debt and financial advice and support; accommodating GP surgeries and pharmacies; counselling; food and nutrition; holiday kitchens for children; nurseries; volunteering, training and apprenticeships; running community centres and libraries.

These additional services are inconsistent and fragmented, creating significant variation in the extent and quality of support available to tenants. In the austerity context of local government and public health budget cuts, much of the additional support provided by housing associations represents replacement, rather than additionality, to services that might previously have been universal. Changes to social housing demographics also mean that many people who would benefit from additional social and wellbeing support are now housed in the private rented sector (Bailey, 2020).

The biggest contribution housing associations can make to health inequalities is to continue to provide safe and decent homes. However, they are experiencing tension between their (often conflicting) commercial and social responsibility (Manzi and Morrison, 2018). Housing associations may play a more powerful role in reducing health inequalities if this objective was defined separately and has an independent funded function (i.e., not funded by rental income, and not provided at the expense of their housing obligation).

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| 1. [What progress, if any, has been](#_bookmark0) [made towards tackling health](#_bookmark0) [inequalities in Scotland since](#_bookmark0) [2015? Where have we been](#_bookmark0)  [successful and which areas require](#_bookmark0) [more focus?](#_bookmark0) | Anna Pearce Naomi Miall Rosie Seaman | Anna Pearce Rosie Seaman |
| 2. [What are the most effective](#_bookmark1) [approaches to tackling health](#_bookmark1) [inequalities and how successful is](#_bookmark1)  [Scotland in pursuing such](#_bookmark1) [approaches?](#_bookmark1) | Peter Craig Andy Baxter Rachel Thomson Petra Meier | Anna Pearce Rosie Seaman |
| 3. [What actions would you prioritise](#_bookmark2) [to transform the structural](#_bookmark2) [inequalities that are the underlying](#_bookmark2) [cause of health inequalities?](#_bookmark2) | Peter Craig Andy Baxter Gillian Fergie Anna Pearce | Anna Pearce Rosie Seaman |
| 4. [What has been the impact of the](#_bookmark3) [pandemic both on health](#_bookmark3) [inequalities themselves and on](#_bookmark3)  [action to address health](#_bookmark3) [inequalities in Scotland?](#_bookmark3) | Rebecca Mancy Naomi Miall Anna Pearce | Anna Pearce Rosie Seaman |
| 5. [Can you tell us about any local,](#_bookmark4) [regional or national initiatives](#_bookmark4) [throughout the pandemic, or prior](#_bookmark4) [to it, that have helped to alleviate](#_bookmark4) [health inequalities or address the](#_bookmark4) [needs of hard to reach](#_bookmark4)  [groups? How can we sustain and](#_bookmark4) [embed such examples of good](#_bookmark4)  [practice for the future?](#_bookmark4) | Rich Mitchell | Anna Pearce Rosie Seaman |
| 6. [How can action to tackle health](#_bookmark5)  [inequalities be prioritised during](#_bookmark5) [COVID-19 recovery?](#_bookmark5) | Rebecca Mancy, Gillian Fergie | Anna Pearce and Rosie Seaman |
| 7. [What should the Scottish](#_bookmark6) [Government and/or other decision-](#_bookmark6) [makers be focusing on in terms of](#_bookmark6) [tackling health inequalities? What](#_bookmark6) [actions should be treated as the](#_bookmark6)  [most urgent priorities?](#_bookmark6) | Peter Craig, Andy Baxter, Laurence Moore |  |

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| --- | --- | --- |
| 8. [What role should the statutory](#_bookmark7) [sector, third, independent and](#_bookmark7) [private sectors have in tackling](#_bookmark7)  [health inequalities in the future?](#_bookmark7) | Annika Hjelmskog |  |