Health Inequalities in Scotland: Public Engagement Research

Report by The Diffley Partnership, prepared for The Health Foundation

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Health inequalities in Scotland: An independent review

Diffley Partnership

Contents

Acknowledgements

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There are a range of others whose support we would like to acknowledge, namely:

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- Professor Katherine Smith for her invaluable support with the design and delivery of the deliberative panel sessions, and for sharing her literature review on lay perspectives with us.

Background and Report Structure

This report details the findings of a research programme exploring public perceptions and perspectives of health inequalities in Scotland. The work reflects the public engagement strand of the Health Foundation's independent review of health inequalities in Scotland and was conducted by Diffley Partnership.

Background

The Health Foundation commissioned Diffley Partnership to conduct this piece of research, with a view to better understanding public perspectives on health inequalities, explore how these views changed in response to evidence and deliberation, and understand what interventions the public would support in order to reduce health inequalities.

This strand sits alongside three parallel workstreams focusing on recent trends in health and health inequalities, data trends relating to the social determinants of health, and stakeholder engagement work with relevant groups and practitioners in Scotland.

Approach

The research adopted a deliberative approach, working with a panel of 25 members of the Scottish public over the course of four three-hour sessions to discuss the issue of health inequalities and reflect on evidence presented to them by subject experts. This distinctive approach therefore took participants on a process of learning and deliberation to explore how attitudes and perceptions change, and to explore what interventions participants would support in light of the evidence presented to them. A national survey conducted at the outset of the research served to establish an attitudinal baseline from which to explore changing perceptions.

Presentation and interpretation of findings

This report outlines the key findings of this deliberative piece of research exploring public understandings and perceptions of health inequalities in Scotland. The analysis blends qualitative data from a series of deliberative workshop panel sessions conducted with a broadly representative panel of the Scottish public, with quantitative data from a national survey and the findings of regular polling of panel members.

We explore how members of the public think and talk about health inequalities, how their views change in response to expert evidence and input, and what conclusions they reached over the course of this research.

Our reporting aims to convey the key themes and findings arising from the deliberative panel sessions, and the broad direction of change in panel members' opinions and perceptions. Findings from the national survey are used to capture public attitudes and to establish an initial attitudinal baseline for the wider public. Qualitative insights from panel discussions seek to convey broad themes and tendencies to complement this, and to explore how panel members' perceptions change over the course of the panel.

Deliberative polling – whereby panel members were asked reflective and repeated questions – are used to test and substantiate such changes. The findings from these post-session surveys are communicated in general terms and should not be taken to reflect the beliefs of the wider public. Rather, they are used to show the extent of opinions among the panel members, and/or the extent of change in opinion among panel members over the course of their participation. This is deemed to reflect the broad direction of travel that we might anticipate if this research were replicated with another group.

Report structure

The report begins with an **Executive Summary** of the key findings of this research. This includes the public and the panel's initial impressions and knowledge of health inequalities, the ways the panel's perceptions changed, and the implications this has for reducing such disparities in Scotland. Finally, we outline the panel's conclusions and proposed actions for doing so.

The rest of the report falls into three parts. **Part I** outlines the key themes and findings from prior public research on this topic and the methodological approach taken to this research. **Part II** then summarises the deliberative approach taken, the rationale for applying such methods, and the outcomes and findings from this. This includes reflections on the ways in which panel members' views changed over the course of the panel, their own reflections from this process, and the implications this might have for efforts to reduce health inequalities in Scotland. Finally, **Part III** summarises the discussions, themes and findings of each panel session, sequentially, in greater detail for more specialist audiences who may desire greater detail.

A final section offers **Conclusions** from the research team summarising the findings from the research and offering reflections on what they mean for efforts to reduce health inequalities in Scotland.

Executive Summary

An overview of the key themes, findings and implications of this deliberative research programme.

Executive Summary

This section summarises the key findings of this project, conducted with a broadly representative panel of the Scottish adult population. The purpose of the programme was to explore and understand public perceptions of and attitudes towards health inequalities, how these change in response to evidence and expertise, and to explore and devise potential ways to reduce such inequalities in Scotland.

This deliberative exercise saw a panel of 25 adult members of the Scottish population recruited to attend a series of four three-hour workshops. These sessions explored their initial perceptions and understanding of health inequalities – both as a concept and in Scotland – and subsequently exposed them to evidence through presentations from a series of experts and wider materials. Panel members engaged in facilitated conversations and deliberation with their peers, both in small groups and as a whole, to reflect on what they had heard, and eventually to discuss and devise ways to narrow health inequalities in Scotland.

This deliberative process has shown that the public are able and willing to engage meaningfully, constructively and in an informed and inquisitive manner on issues relating to health inequalities. The panel developed detailed and sophisticated understandings of health inequalities and their determinants, as well as ways to tackle them on the basis of discussion, deliberation and evidence. We can demonstrate that **panel members' views changed markedly over the course of the programme** as this deliberative process continued.

The findings suggest that **there is considerable public concern at the scale of health inequalities in Scotland, a strong sense that these disparities are unfair, and a clear public appetite for greater action to reduce these inequalities, including support for higher taxes and greater redistribution**. The findings also suggest that the public are receptive to high-level 'macro' interventions aimed at the fundamental causes of health inequalities, and challenge certain established assumptions within policymaking circles that the public are more supportive of behavioural approaches.

Public Perceptions of Health Inequalities

- **Panel members and the wider public demonstrated, from the outset, a sincere concern for health inequalities in Scotland, and an appetite for greater action to tackle these**, both of which increased over the course of the programme. Panel members expressed a mix of surprise and dismay at the extent of such inequalities, seeing them as **deeply unfair and unacceptable in an advanced**

country. People were surprised by both the extent of these disparities within Scotland, and at Scotland's poor performance in international perspective.

- Initial perceptions and understandings of health inequalities and health determinants were broadly thoughtful and considered, though **panel members demonstrated an instinctive inclination towards behavioural accounts** that was at odds with the prevailing academic consensus on the causes of health inequalities. **Panel members were also, however, cognisant of the ways in which material and financial circumstances could impact on health outcomes** and inequalities, citing social determinants such as income, employment, housing and neighbourhoods. However, the importance of more political factors and questions (such as power and representation) did not crystallise easily in panel members' minds at first.
- **While panel members demonstrated a reasonable understanding of health inequalities in general, they initially had limited awareness of the nature, causes and extent of these in Scotland**, and of action to date aimed at reducing these disparities. Despite this, they went on to gain considerable expertise and knowledge on the issue.

The Deliberative Process

- **Panel members developed strong and robust understandings of health inequalities and their determinants as the process continued**, demonstrating an active interest in and engagement with the subject matter. Panel members were broadly receptive to evidence and expertise presented to them, and their opinions changed significantly over the course of the panel.
- While a number of **initial impressions were at odds with the prevailing academic consensus on the causes of and solutions to health disparities**, **panel members demonstrated a high degree of receptiveness to new ideas.** They developed a considerable level of knowledge and expertise over the course of their participation and reflected that they had learnt a lot from the process.
- **Early qualitative and quantitative research found significant 'lifestyle drift' among participants – an observed phenomenon whereby members of the public tend to attribute disparities in health outcomes to individual's behavioural choices, rather than socioeconomic factors – though this became less and less evident**. Initial discussions on the determinants of health revolved largely around behavioural accounts and explanations of health outcomes and inequalities, and proposed solutions were primarily educational and behavioural in nature. However, by the final session, lifestyle factors were perceived to have among the smallest impacts on health outcomes.
- We also observed qualitative changes in the ways this factor was discussed, moving from a highly individualised language of 'responsibilities' and 'choices' to a more ecological view of the ways in which wider circumstances could inform or constrain choices. A similar shift saw panel members speak increasingly about empowering individuals through various means, rather than relying more exclusively on educational behavioural campaigns. **For some, however, and especially among older participants and those from more affluent backgrounds, individual responsibility appeared to remain an important point of principle.**

- **Panel members were receptive to, and became much more cognisant of, the fundamental drivers of health inequalities, including inequalities in income, wealth and power**, and the legacies of historical decisions and events. This saw a corresponding increase in support for more redistributive 'macro' policies aimed at these fundamental drivers of health inequalities.
- **Healthcare – in terms of both access and quality – was a key concern and priority for panel members throughout the research**, seen as a key determinant throughout the process and deemed the single most important determinant of health by panel members at the end of the programme. Panel members routinely spoke about inequalities in health *care* rather than health *outcomes* throughout their participation. While much of the academic literature treats healthcare as a distinct consideration – relating to treatment rather than constituting a cause of health inequalities – it is evident that, **from the public's perspectives, the two concepts are inextricably linked**.
- Reflecting on their participation, the vast majority of panel members reported that they had learnt new things as a result of their participation, and all had found the process enjoyable. **All panel members believed that deliberative processes are a good way to inform and devise policy on complex issues** like health inequalities. **A plurality of panel members were hopeful that the research findings would be taken seriously by the Scottish Government, and that they would lead to substantive change**, though some disagreed, and others were unsure.

Reducing Health Inequalities in Scotland

- At the culmination of the research, the panel devised a series of ambitions, priorities and principles for tackling health inequalities in Scotland, **prioritising greater investment in, and more equitable access to, the NHS, and a greater redistribution of wealth and resources through the tax and benefits system**, in addition to action on housing, neighbourhoods, and employment, among others.
- From the perspective of the public, it appears that issues of health inequalities are inseparable from issues of health care. **Many people saw resourcing as a fundamental stumbling block to tackling health inequalities, suggesting that more generous and consistent funding is key to making progress on this**. Many panel members cited issues of resourcing, staffing and retention in the NHS and wanted concerted action to address this.
- **Some panel members expressed disappointment, indignation and/or frustration at what they perceived to be a tokenistic approach to date from Government**, seen to be relying on more affordable but often ineffective behavioural programmes in lieu of more substantial and effective interventions. Many panel members reported disappointment at this approach and wanted greater transparency and dialogue around decision-making from politicians and policymakers.
- Panel members' growing recognition of the high-level drivers of and solutions to health inequalities prompted a mixture of reactions. While approximately two thirds of panel members felt that this made the optimal solutions more evident and, in certain ways, simple, about half also believed that it made progress less likely. There is, according to the national survey findings, no shortage of

public appetite for more action, but rather, according to the panel, a lack of political will to take the necessary steps to reduce disparities.

- **Panel members had very little faith in politicians to make progress on reducing health inequalities in Scotland, on the grounds that they lacked political courage and/or competence.**
- There was some evidence from panel members of growing impatience for action. **Most panel members also believed that Scotland already has the requisite powers to make progress on this issue and would like to see greater action being taken** to reduce inequalities in health outcomes. A small number argued that the economic and fiscal powers and levers necessary to tackle health inequalities decisively should be transferred to the Scottish Government and Parliament.

Reflections & Implications

- **The public is evidently motivated and concerned by health inequalities – widely seen in qualitative discussions as unfair and unacceptable in a wealthy, modern country** – and there is a clear willingness to engage constructively with the issue. When the public is engaged on this theme and evidence is presented to them, our deliberative research would suggest that the issue increases in salience. A clear majority of the panel specifically wanted the Scottish Government to lead and stimulate a national conversation to spur public reflection, understanding and action on the issue.
- **Qualitative discussions suggested that at present, there is limited awareness of the scale and nature of health inequalities in Scotland, and a number of misconceptions around their causes**. However, while members of the public appear predisposed towards behavioural accounts of health inequalities**, there is considerable evidence that they are amenable to more ecological perspectives with relatively little exposure to evidence**.
- **There is low confidence in politicians to make progress on this issue**, with panel members pointing to short-termism and risk-aversion as crucial stumbling blocks. **Panel members outlined a series of principles to guide politicians and policymakers, expressing support for an evidence-based, long-term, cross-party strategy**, bringing together all relevant stakeholders and substantiated with consistent and adequate resourcing. Panel members also expressed support for greater devolution in service design and delivery, and for meaningful community empowerment.
- Prior academic research has suggested that policymakers' decision-making is informed by what they believe the public would support; in the case of health inequalities, this is seen to lead to a preference within policymaking circles for behavioural and educational approaches to tackling disparities in health outcomes, and investment in 'downstream' treatment of health problems in lieu of more preventative 'upstream' approaches. This research programme has demonstrated, however, that **members of the public are receptive and amenable to more ecological accounts of health inequalities, and to upstream 'macro' interventions to reduce them**, including greater redistribution. The panel outlined a series of ambitions that were largely targeted at much more fundamental and/or upstream determinants of health on the basis of the evidence presented to them.

Principles, Ambitions & Priorities

On the basis of panel deliberations, a series of ambitions, priorities and principles by which to tackle health inequalities in Scotland. These were then voted on by panel members, requiring two thirds of panel members' support to be included. The ambitions and principles passing this threshold are outlined below, along with the rationale for their inclusion. These outputs reflect an exercise in deliberation, learning and consensus-building, with an evident potential to appeal to the broader public with the appropriate evidence and case behind them.

Principles

Reflecting on the barriers to progress, the panel, in small groups and supported by the research team, identified and drafted a series of key principles that they believed should guide political efforts to tackle health inequalities in Scotland. These related primarily to procedure and process, while policy prescriptions are addressed elsewhere. Each principle is presented along with the proportion of panel members expressing their support for it, in descending order, and a brief summary of the rationale for its inclusion.

Supported by:

THE SCOTTISH GOVERNMENT SHOULD USE ROBUST EVIDENCE AND EXPERTISE ON THE MOST EFFECTIVE WAYS TO TACKLE HEALTH INEQUALITIES TO DEVELOP IMPACTFUL INTERVENTIONS

Panel members expressed strong support for evidence-based interventions on both principled and pragmatic grounds. The use of robust evidence was associated with improved outcomes and was seen to lend credibility and popular legitimacy to interventions.

Supported by:

THE SCOTTISH GOVERNMENT SHOULD DEVELOP A SUSTAINABLE STRATEGY TO TACKLE HEALTH INEQUALITIES, BACKED UP WITH ADEQUATE, APPROPRIATE AND LONG-TERM FUNDING FOR NATIONAL AND LOCAL SERVICES AND INTERVENTIONS

The panel believed that the complexity and cross-cutting nature of the issue meant that a long-term plan to tackle health inequalities was necessary. The ultimate success of such a strategy was seen, however, to rely upon adequate and consistent resourcing, and suitable mechanisms for implementing this at national and local levels.

Supported by:

THE SCOTTISH GOVERNMENT SHOULD WORK IN COLLABORATION WITH OTHER POLITICAL PARTIES TO DEVELOP A LONG-TERM PLAN FOR TACKLING HEALTH INEQUALITIES IN SCOTLAND IN ORDER TO ENSURE CONSISTENCY AND CONTINUITY, RATHER THAN ADVERSARIAL POLITICS

Adversarial political dynamics were seen as a key barrier to making progress on reducing heath inequalities. This was seen to lead to risk-aversion and paralysis, and panel members suggested that any change of governing parties could see a change in approach that might derail progress. There was a clear appetite for a cross-party plan that could ensure consistency of approach, and that difficult decisions could be taken.

Supported by:

THE SCOTTISH GOVERNMENT SHOULD DEVELOP AN EFFECTIVE AND VIABLE STRATEGY TO TACKLE HEALTH INEQUALITIES IN SCOTLAND THAT BRINGS TOGETHER ALL RELEVANT STAKEHOLDERS, INCLUDING EXPERTS, PRACTITIONERS (FROM HEALTHCARE AND COMMUNITY SERVICES) AND MEMBERS OF THE PUBLIC

It was suggested that at present, the public and relevant stakeholders are largely excluded from and ignored in the policymaking process. There was an evident appetite for greater and more meaningful public engagement, contrasted with what some perceived to be a tokenistic prevailing approach to consultation. There was also a perceived need for greater involvement of practitioners in decision-making and planning to ensure that strategies could be feasibly implemented in practice.

Supported by:

THE SCOTTISH GOVERNMENT SHOULD LEAD AND STIMULATE A NATIONAL CONVERSATION AROUND HEALTH INEQUALITIES ROOTED IN PRINCIPLES OF FAIRNESS, AND WITH TRANSPARENCY AND HONESTY AROUND THEIR DECISION-MAKING

The panel wanted greater action to be on this issue taken by the Scottish Government but were cognisant of the need to bring the public with them on this. The panel suggested the public could be convinced that action on this issue was necessary, but that consent would require a clear explanation of the need for action and the rationale behind any approach taken.

Supported by:

THE SCOTTISH GOVERNMENT SHOULD ACKNOWLEDGE THAT HEALTH POLICIES ALONE WILL BE INSUFFICIENT TO TACKLE HEALTH INEQUALITIES AT SOURCE. INSTEAD, THE SCOTTISH GOVERNMENT SHOULD ESTABLISH A CROSS-POLICY WORKING GROUP (OF CIVIL SERVANTS ACROSS DISTINCT POLICY FIELDS) TO ENSURE JOINED-UP WORKING

Panel members reflected that health inequalities are driven by a range of factors falling across distinct policy fields. While many panel members focused considerably on health policies, there was a broad acknowledgement that this is just one part of the puzzle and an evident appetite for a joined up and holistic approach to tackling health inequalities.

Supported by:

IN LIEU OF 'TOP-DOWN' APPROACHES, THE SCOTTISH GOVERNMENT SHOULD ENSURE RESPONSIVE AND RELEVANT LOCAL SERVICES BY DEVOLVING DECISION-MAKING AND SERVICE-DESIGN DOWNWARDS TO LOCAL AREAS AND COMMUNITIES, ENSURING THE NECESSARY DISCRETION AND FLEXIBILITY FOR SERVICES AND PRACTITIONERS ON THE GROUND

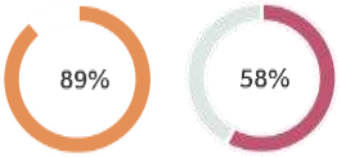
Decision-making in Scotland was seen to be highly centralised and 'top-down', rendering much of it inflexible and unresponsive at a local level. Panel members suggested that local communities are better placed to identify and respond to local needs, and that service-design and delivery should be afforded greater discretionary flexibility to tailor their work to local and/or individual needs and challenges

Ambitions & Priorities

The panel also worked together in small-group discussions to draft a series of statements of ambition relating to action that could be taken to tackle health inequalities in Scotland. Panel members voted on the extent to which they would support each proposal and were invited to choose and prioritise those that they believed would do most to reduce health inequalities in Scotland. Each ambition is presented below in order of prioritisation, with the proportions supporting and prioritising each one detailed alongside, and a brief discussion of the rationale behind each ambition.

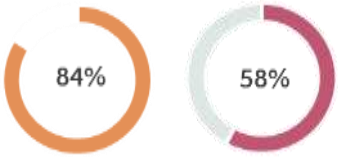
Supported by: Prioritised by:

INCREASE INVESTMENT, SPENDING AND CAPACITY IN THE NHS IN SCOTLAND



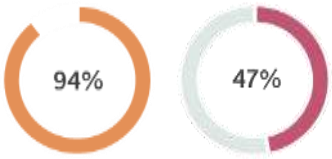
There was widespread concern at the current state of the National Health Service, with many panel members citing resource and staff-shortages. Investment was seen as crucial to tackle existing backlogs and ensure high-quality services into the future. Issues around recruitment and retention were also flagged as long-term priorities.

MAKE THE TAX SYSTEM MORE PROGRESSIVE, SPREADING THE TAX BURDEN MORE EVENLY AND FAIRLY ACROSS WEALTH AND HIGH INCOMES, IN ORDER TO REDUCE INEQUALITY AND FUND HIGH-QUALITY PUBLIC SERVICES



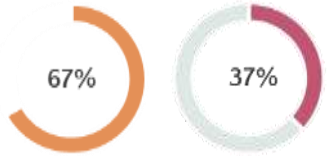
Inequality was seen by the panel to have grown too wide, with an evident appetite for greater redistribution through the tax system, and for greater investment in public services. The current system was seen to be outmoded, unfair and, at times, regressive.

ENSURE A FAIR AND EQUITABLE SPREAD/DISTRIBUTION OF GP PRACTICES AND PRIMARY HEALTH FACILITIES THAT IS REFLECTIVE OF LOCAL NEED AND DEPRIVATION, TO ENSURE RELIABLE AND TIMELY ACCESS FOR ALL



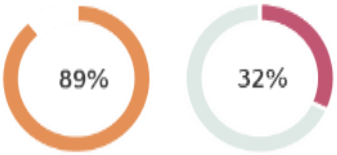
Throughout the life-course of the panel, access to healthcare and local primary care services was a recurring and key concern. This was seen to be inconsistent and often limited, especially in more deprived and rural parts of the country. A preventative approach to health was seen by panel members to require equitable and timely access to primary care services.

USE THE SOCIAL SECURITY SYSTEM TO TACKLE POVERTY AND INSECURITY, AND ENSURE THAT NOBODY FALLS BELOW A REASONABLE MINIMUM STANDARD OF LIVING



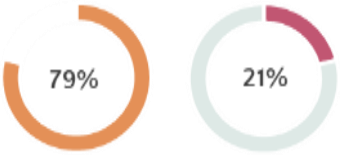
There was a widely held belief and principle that nobody should go without their basic essentials in a wealthy, modern country, and a broad perception that the current social security system is not fit for purpose. It was seen to be stigmatising, insufficient, and unresponsive, failing to provide real security. There was a broad appetite for a fundamental rethink of social security aimed at providing a more empathetic, robust and generous safety net amid growing insecurity.

EMPOWER AND ENCOURAGE ALL INDIVIDUALS TO LEAD A HEALTHY LIFE, BY ENSURING THEY HAVE ACCESS TO ALL THEIR RELEVANT NEEDS, INCLUDING EDUCATION ON HEALTHY LIVING, AFFORDABLE NUTRITIOUS FOOD, GREEN SPACE, AND A DECENT INCOME



Early discussions of health determinants exhibited a high degree of 'lifestyle drift'. As the panel progressed, panel members reflected increasingly on the ways in which wider factors and circumstances could inform and constrain choices, while others evidently considered individual responsibility an important principle. There was broad support for encouraging and instilling healthy lifestyles in people and ensuring access to the requisite resources to do so.

RETROFIT AND INSULATE OLD AND POOR-QUALITY HOUSING TO IMPROVE LIVING STANDARDS AND ENERGY EFFICIENCY

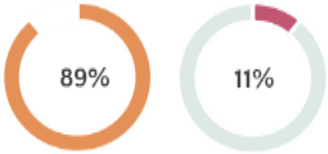


This was seen to reflect an obvious and simple solution to the problems caused by inadequate and unsuitable housing. Panel members suggested that much of Scotland's housing stock is of a poor standard, leading to health issues. Retrofitting was seen as an obvious and efficient way to improve the housing stock without further encroaching on green space.

INVEST IN NEIGHBOURHOOD HEALTH INFRASTRUCTURE (INCLUDING CYCLE PATHS, LOW TRAFFIC ZONES, ETC), AND PROTECT AND EXPAND GREEN SPACE

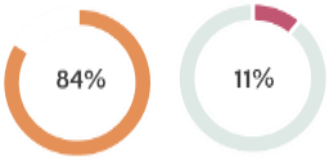
Exercise and healthy living were seen to rely on access to relevant spaces and facilities, though panel members reflected that these are becoming more limited. There were also concerns at the dwindling access to green space, seen to impact negatively not only on physical health, but also mental health.

SUPPORT PEOPLE INTO GOOD-QUALITY EMPLOYMENT THROUGH ACCESSIBLE AND EFFECTIVE TRAINING, AND (DIRECT OR INDIRECT) JOB-CREATION



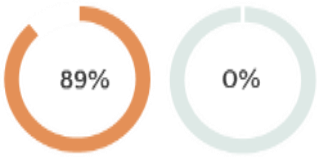
The growth in insecure work and in-work poverty, and their associated impacts on physical and mental health, were seen as a significant challenge. The panel wanted action to improve employment terms, both in terms of pay and conditions, and favoured interventions to support people into good, rewarding and secure jobs.

IMPOSE HIGHER STANDARDS (AND STRENGTHEN ENFORCEMENT) ON HOUSEBUILDERS AND LANDLORDS RELATING TO THE PHYSICAL STANDARDS OF NEW HOMES AND RENTED ACCOMMODATION, TO ENSURE A DECENT STANDARD OF LIVING FOR ALL



Housing was seen to have clear and significant implications for people's health outcomes, with a perception that much of Scotland's housing stock is dated and unsuitable. There was a perception that many housebuilders and landlords do the minimum required of them to comply with current regulation and that this should be strengthened to drive up standards.

INVEST IN AND EXPAND RELIABLE AND AFFORDABLE PUBLIC TRANSPORT TO ENSURE PEOPLE HAVE ACCESS TO THEIR MEDICAL AND NON-MEDICAL NEEDS (E.G. ACCESSING LOCAL HEALTHCARE AND/OR COMMUTING TO GOOD JOBS)



Access to local services was a consistent thread through much of the panel's discussions, and there was concern at people's often limited access to the wider community and labour market. This was seen to be of high importance, especially in worse connected and rural areas, where panel members regularly flagged concerns about access to primary care settings.

Part I:
Introduction, Background & Methodology

An overview of the purpose, design and context of this research programme. We outline the rationale and aims of this body of research, what is already known about public perspectives on health inequalities, and the methodological approaches employed to explore these further.

1.1 Prior Public Research

A body of previous research has explored public lay perspectives on health inequalities from a range of perspectives. This section summarises the existing research as synthesised in a recent literature review conducted for this research programme.[1]

This review of previous research has found that members of the public – and especially those from more deprived backgrounds – have a good understanding of how circumstances shape their health, and lay accounts of health inequalities appear broadly able to grasp the complexity and overlapping nature of social determinants of health. However, this does not always correspond to a clear acknowledgement of health inequalities as a societal phenomenon and/or problem. Previous research has found variation in the extent to which people acknowledge health inequalities, and that such an acknowledgement can prove stigmatising and disempowering.

Interactions with public services are often people's most clear link to the concept of health inequalities and determinants. A perception commonly arises in these discussions that existing services and social safety nets are insufficient in supporting people with experience of disadvantage to achieve positive changes.

Lifestyle factors and behavioural accounts of health outcomes are also afforded significant attention in lay perspectives, with a common focus on alcohol and drug consumption, diet and, to a lesser extent, exercise. (This instinctive tendency among members of the public towards behavioural explanations has been termed 'lifestyle drift' elsewhere in the literature.[2])

Lay perspectives consistently attribute a high degree of significance to the ways in which poverty, unemployment, insecurity, housing and neighbourhoods can shape health outcomes. Psychosocial pathways – including stigma, stress and fear – are often identified as pathways by which material and social circumstances can aggravate health outcomes.

Accounts of lay perspectives also provide evidence of public support for policies aimed at reducing economic, social and political inequalities in Scotland.

There is a perception from people in more disadvantaged communities that recent socioeconomic and political contexts and developments have not been supportive of their health needs. Public perspectives on health inequalities also draw attention to the importance of 'Street Level Bureaucrats'

[1] (Smith & Stewart, Forthcoming)
[2] (e.g. Williams & Fullagar, 2019)

(street-level civil servants and practitioners, such as those delivering public services) and non-state actors (including landlords, unhealthy commodity industries, and criminal gangs) in shaping Scotland's socioeconomic context.

Similarly, lay accounts note the importance of policy implementation (as distinct from policy intentions), with an awareness of how these impact (differently) in practice on people and communities.

Accounts also commonly draw attention to divisions between Scotland's distinct communities and localised behavioural cultures that are damaging to health.

Violence (and criminality) are seen as pervasive in disadvantaged communities and are associated with poor health outcomes.

Much of this previous research has been qualitative in nature, while examples of more deliberative approaches are limited. Most public research on health inequalities has explored public understandings and conceptualisations of such disparities, while very little prior research – notwithstanding a growing body of notable exceptions in recent years – has considered public perspectives relating to potential policy responses and solutions.

1.2 Methodology

This research employed a deliberative approach, working with a panel of 25 members of the Scottish public, in conjunction with expert input and evidence, to discuss and reflect on health inequalities in Scotland and ways to reduce them. This approach differs from more traditional qualitative research methods in its more active inclusion of research participants through a process of learning and deliberation.

This section outlines the approach taken to this research and the methods employed to answer the project's key research questions, namely:

- to explore public attitudes to, and perceptions of, health inequalities in Scotland, and variations within these between population sub-groups;
- to consider the public's understanding of how health is influenced by the wider determinants of health;
- to complement parallel stakeholder engagement work to compare and contrast the understanding and perspectives of the public with those of key actors and experts;
- to explore the perspective of the public on the findings of parallel quantitative work;
- and to provide an exploration of priority areas for action to reduce inequalities.

This section presents an overview of the key stages of the research process, summarised in Figure 1. The following section then provides further detail on deliberative methods, the rationale behind, and design of, the deliberative process, and the specific outcomes and findings relating to this process.

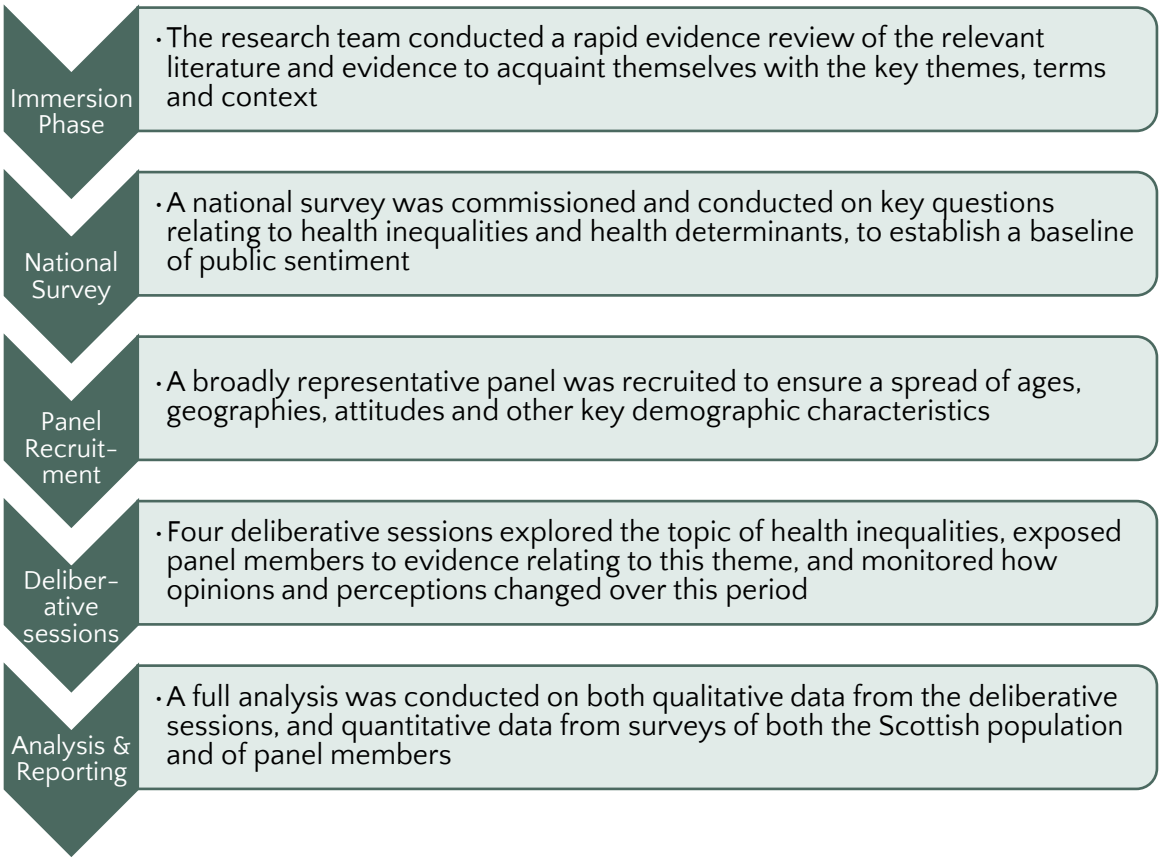
This research employed a mixed-methods approach, albeit principally deliberative qualitative work, but also comprising quantitative data and outputs from both a national survey and regular surveys of panel members between panel sessions.

To begin, a rapid evidence review took in and synthesised the key issues, debates and concepts relating to health inequalities. This short immersion phase was designed to familiarise the research team with the relevant landscape and concepts by which to design a valuable and cohesive deliberative programme.

A national survey was then conducted of the Scottish adult (18+) population on issues relating to health inequalities and health determinants. The survey was issued online using the ScotPulse panel, and received 1,079 responses between the 28th April – 2nd May 2022, weighted by sex and age to 2020 population estimates.

This survey had the dual purpose of establishing a baseline of public opinion on relevant questions and issues, but also served as a recruitment tool for the deliberative component of the research. This gave the research team access, in line with respondents' expressed permission, to their demographic and attitudinal information by which to recruit a diverse panel, as well as contact details by which to invite them to take part in the research project.

Figure 1: Summary of research stages



A panel of 25 members of the public was recruited to broadly reflect the Scottish population using a stratified random sampling approach. This ensured a spread across age brackets and deprivation quintiles (as per the Scottish Index of Multiple Deprivation), with this profile of randomly selected participants then checked to ensure a range of political views and attitudes relating to health inequalities, as well as a geographic spread and a mix of people living in urban and rural areas.

The panel was then convened over Zoom at regular intervals over four sessions (approximately every three weeks) over four calendar months. Each session lasted three hours (including a short break) with a mix of plenary and group discussions, chaired and facilitated by the research team. Each session explored a distinct theme, with external expert guest speakers brought in to share evidence and information with panel members and answer their questions. A further breakdown of the deliberative panel sessions and discussions is outlined below. Sessions were recorded and transcriptions produced, and video recordings allowed for the analysis of visual cues.

Following each session, participants were asked to complete a short survey. This gathered both feedback and suggestions relating to the session itself by which to ensure that participants were finding it interesting and engaging, as well as gathering data on participants' views and reflections relating to the session's substantive themes more specifically.

This generated a wealth of qualitative and quantitative data by which to explore participants' views on health inequalities and related interventions. Qualitative data was discussed among the research team, and data points were coded thematically, allowing for a full thematic analysis using qualitative software QDA Miner. Quantitative data was used to substantiate and contextualise these qualitative findings, capturing the panel's overall views to guard against the possibility of a vocal minority swaying the research team's findings, and to provide more quantifiable and demonstrable changes in opinion.

In the following section we outline the detail of the deliberative process we deployed during this study, before assessing how this process contributes to the strength of the research findings. The deliberative element of this study provides the most powerful insights and conclusions. Sections 3.1 – 3.4 then focus in greater on the deliberative workshops sequentially. (However, Section 3.1 on *'Initial Impressions'* also outlines the key findings from the national survey and the topline results from the survey are provided in an Appendix.

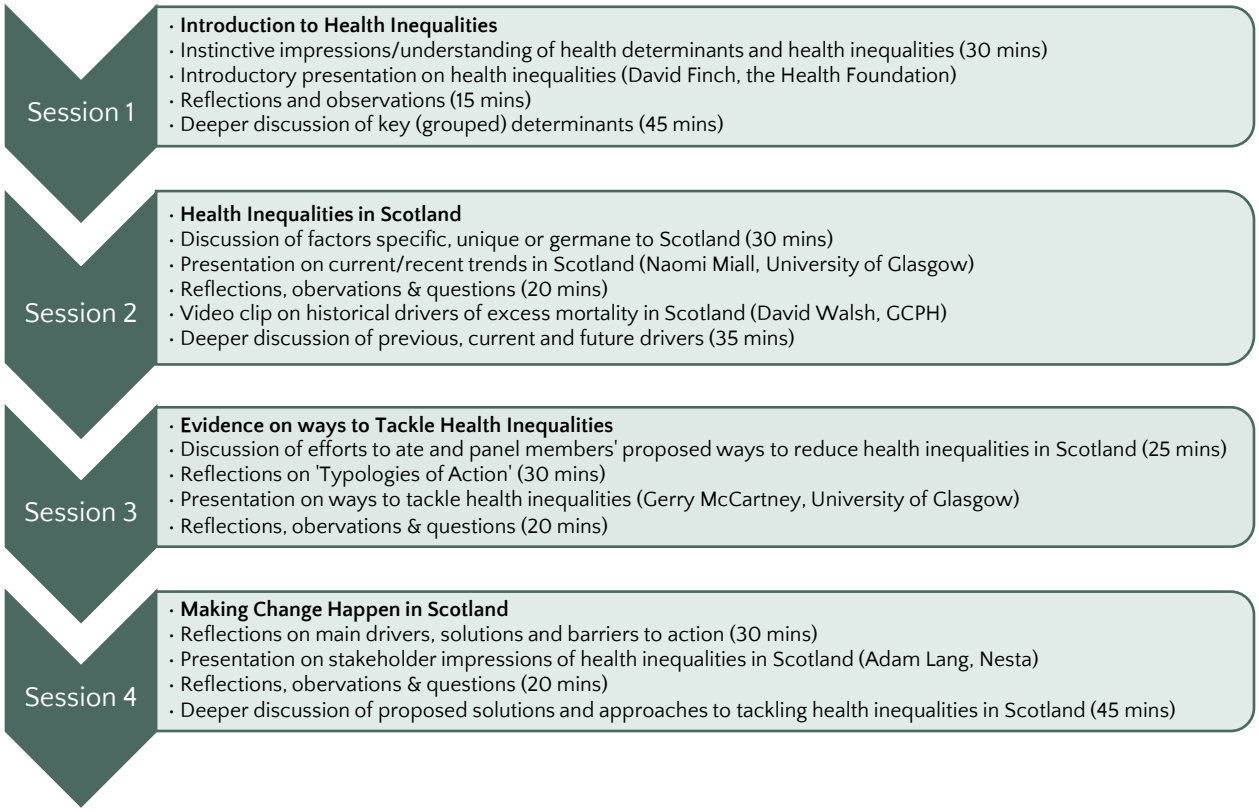
Design and Delivery of Deliberative Sessions

Certain key design principles were applied to the sessions; namely, that the four sessions should cumulatively reflect a cohesive arc and structured process, and that each self-contained session should also function independently and autonomously. This overall arc took panel members from an introduction to heath inequalities in general and, subsequently, in Scotland, through evidence on reducing inequalities, and concluding with a reflection on the current drivers of inequalities, proposed ways to tackle these, and barriers to making progress on this issue.

Each standalone session comprised three key sections, beginning with a discussion of early and instinctive impressions. Typically, this was followed by a presentation, reflection and questions, and

finally a deeper discussion on a relevant (sub-)theme. The flow, themes, content and outputs of each session are summarised below in Figure 2 and Table 3.

Figure 2: Themes, format and in-group activities/discussions of each panel session



Guest speakers were identified and invited on the basis of their specific expertise on the relevant theme and with the support of subject-expert collaborators and agreed with The Health Foundation. They were approached directly by either Diffley Partnership's research team or the Health Foundation and given a short brief on the theme of their presentation. They then exercised a high degree of autonomy over the content and focus of their presentation in light of their relevant expertise. Presentations were followed by opportunities for panel members to reflect on the content in small-group discussions and to ask questions of the presenter in a plenary session. Other materials used included clips and infographics relating to the relevant themes, also selected and agreed with the support of the Health Foundation.

The sessions were convened and run over Zoom, owing to the ongoing Covid-19 pandemic and the ability to bring in geographically diverse individuals without imposing any travel requirements on participants. Owing to the online delivery of the panel's deliberative sessions, certain allowances and

mitigations were made when planning the sessions. It was decided, for instance, on the basis of the research team's experience and wider guidance,[3] to limit sessions to three hours to avoid fatigue and drop-off, running over four Saturday mornings spaced roughly three weeks apart. The sessions were designed, run and facilitated by the research team, comprising a combination of plenary and small-group discussions/activities. Sessions were recorded with the participants' permission, and any notes taken in small-group discussions were saved for later analysis.

Following each session, a survey was administered to panel members. This was designed to gather both feedback on the sessions themselves, and to capture, quantifiably, panel members' opinions (and changes of opinion) relating to health inequalities. This allowed the research team to sense-check emerging themes from panel discussions, and to track changes in opinion by repeating certain key questions at regular intervals. This approach in part mimics 'deliberative polling' which, while usually operating on a larger scale, is seen to reflect how the views of the wider population would change if they were subject to the same deliberative process.[4] These findings, along with the qualitative data from the session, generated a wealth of data on which to base our analysis.

[3] (Willis, Yuille, Bryant, McLaren, & Markusson, 2021; NatCen, 2022)
[4] (Involve, n.d.)

Table 3: Theme, purpose, materials and outputs of each session

Session & Theme	Purpose	Materials & Evidence Used	Outputs
Session 1 – Introduction to Health Inequalities	- To introduce the panel/research programme and its purpose - To introduce the concept of health inequalities and of (social) determinants of health - To capture early, baseline impressions of health inequalities and the main determinants of health, as well as very early indications on proposed solutions	Presentation(s): - David Finch, The Health Foundation, Introduction to health inequalities Frameworks: - The Rainbow Model (Dahlgren & Whitehead, 1991)	- Qualitative data on early impressions / perceptions - Polling on panel members' preferred topic for the subsequent session.
Session 2 – Health Inequalities in Scotland* (*Theme chosen by panel participants)	- To understand panel members' immediate perceptions, knowledge and understanding of health inequalities in Scotland, including factors specific and/or germane to Scotland	Presentation(s): - Naomi Miall, MRC/CSO Social and Public Health Sciences Unit, University of Glasgow, Data and trends (-2010 onwards) on health inequalities in Scotland; - Video clip of a lecture given by David Walsh, Glasgow Centre for Population Health, Historical drivers of excess mortality in the West of Scotland	- Qualitative data on panel discussions - Post-session survey results on the perceived current drivers of health inequalities

Session 3 – Evidence on ways to Tackle Health Inequalities	- To explore panel members' instinctive attitudes towards potential solutions - To test other proposed interventions in light of evidence on their effectiveness	Presentation(s): - Gerry McCartney, University of Glasgow, School of Social and Political Sciences, Evidence on best practice for tackling health inequalities Frameworks: - Typology of interventions to tackle health inequalities (Whitehead, 2007)	- Qualitative data from panel discussions - In-session polls on the perceived effectiveness of typologies - Post-session survey
Session 4 – Making Change Happen in Scotland	- A concluding session, reflecting/drawing on previous sessions, to identify what the panel think are the key drivers, effective solutions, and barriers to action with regards to health inequalities in Scotland - To draft a series of principles and ambitions for tackling health inequalities in Scotland as a final output/conclusion of the programme	Presentation(s): - Adam Lang, Nesta, Stakeholder attitudes with regards to tackling health inequalities in Scotland	- Qualitative data from panel discussions - Panel members' reflections on the deliberative process, gained through a final post-session survey - A series of ambitions, priorities and principles for tackling heath inequalities (voted on by panel members)

Part II:
The Deliberative Process

An overview of the nature, significance, and outcomes of this deliberative research. We outline the characteristics and purpose of deliberative research, and the rationale for applying such techniques here. We then outline and reflect on the key findings and impacts from this deliberative approach – including changes in panel members' perceptions, and the conclusions they reached – and what they mean for efforts to narrow health inequalities in Scotland.

2.1 Deliberative Approach, Impacts & Outcomes

This section outlines the purpose and characteristics of deliberative research and the rationale for applying them to this particular research project. We then discuss how panel members' opinions changed over the course of the programme and what this means for tackling health inequalities in Scotland.

It is the view of the research team that the use of deliberative methods was successful in stimulating an informed and detailed reflection on health inequalities, allowed for the development of constructive and insightful proposals, and supported novel findings with respect to public attitudes towards health inequalities.

Deliberative Approaches

Background

Deliberative, participatory research has a number of distinguishing characteristics that differentiate such approaches from more consultative qualitative engagement (such as that achieved through focus groups or semi-structured interviews).[5] Thus, the "focus is less on personal experience and top-of-mind opinions, and more on designing a method that supports people to consider their views on a social issue".[6] Broadly speaking, deliberative and participatory approaches rely on and offer greater time and space for consideration, reflection and engagement, with a view to "uncover[ing] the public's informed, considered and collective view".[7]

In more practical and procedural terms, this corresponds to three defining characteristics identified within the relevant literature: firstly, such research aims to "reach people's informed and considered judgements in relation to the subject in hand, through a process of public reasoning"; secondly, it involves a process of learning through exposure to evidence and advocacy by subject-experts and/or relevant stakeholders; and finally, "there is an expectation that the beliefs and values of participants may be transformed by involvement in the research".[8] Others have suggested that a further identifying trait is the development of "considered judgements, linked to a goal or purpose, such as formulating recommendations or a statement."[9] As this report outlines, this research project exhibits all of the above-mentioned traits.

[5] (Evans & Kotchetkova, 2009)
[6] (NatCen, 2022)
[7] (Burchardt, 2014)
[8] (Burchardt, 2014, p. 357)
[9] (Willis, Yuille, Bryant, McLaren, & Markusson, 2021, p. 3)

Deliberative approaches can take a number of forms – of varying size, length and levels/modes of interaction – including citizens' assemblies, citizens' juries and deliberative workshops and/or polls. Our longitudinal panel arguably conformed most closely to the citizen's jury model (in terms of size and overall length) though the sessions were more staggered than one may expect from this format, with our panel convening four times over four calendar months.

The panel was also distinctive in its entirely online delivery owing to the ongoing Covid-19 pandemic. An emerging and growing body of literature has defended the application of such methods in an online format, suggesting that recent examples show that with appropriate design and facilitation, online deliberation can stimulate high-quality input, dialogue, and learning.[10]

A number of challenges associated with online delivery have been identified by both the research team and wider literature, including the potential for screen fatigue, lower engagement and lesser interpersonal rapport, as well as technical issues. A number of these challenges were anticipated, and mitigating techniques adopted (such as capping the sessions at three hours and reducing discussion group sizes). A full summary of the design and delivery of each session is outlined below.

Application & Rationale

The research team judged that the technical nature of the subject-matter and the limited body of prior participatory research in this vein made the issue apt for a deliberative piece of work.

The research objectives included developing an "overview of people's experiences and understanding of health inequalities with a focus on wider determinants of health and perspectives on policy interventions." Thus, a deliberative approach was devised to allow for introductory and exploratory sessions around instinctive public attitudes towards and understandings of health inequalities, as well as a more informed discussion of policy solutions. With some notable exceptions, most qualitative research on this subject has followed more traditional methods, and such in-depth deliberative approaches are less evident.[11]

Deliberative engagement methods are deemed apt for complex subjects and consensus-building on social issues and are seen to often lead to attitudinal change among participants.[12] Thus the research team posited that such an approach would be an appropriate vehicle by which to explore initial perceptions of health inequalities and determinants, understand and explore changes in attitudes and

[10] (Willis, Yuille, Bryant, McLaren, & Markusson, 2021)
[11] E.g. (The Health Foundation, 2022)
[12] (NatCen, 2022)

(mis)conceptions, and work towards informed solutions. It was suggested that the longitudinal format and the inclusion of evidence and expertise would allow members to develop nuanced understandings of this complex theme by which to reflect on proposed solutions in light of competing evidence, and to arrive at reasoned conclusions on how to tackle these in a way that could command popular consent and support.

Thus, this deliberative engagement was intended to:

- explore early and instinctive perceptions of health inequalities and health determinants among a representative panel of the Scottish public;
- expose this panel to evidence and expertise relating to health inequalities, and observe how panel members react and respond to said evidence, and understand how their views change in response;
- and reflect on the evidence and identify and agree effective approaches for tackling health inequalities in Scotland.

As this report outlines, the research team considers the application of deliberative methods to have been appropriate and effective. Panel members developed robust and detailed understandings of health inequalities over the course of the programme, and by the start of the final session, their beliefs and observations aligned closely with those of expert stakeholders and practitioners working in relevant fields. Guidance suggests that "deliberation is often thought to lead to opinion change, and this can be seen as evidence that deliberation has been effective";[13] by this metric, this research programme and its use of deliberative methods can be said to be a demonstrable success.

Impacts & Outcomes

The panel developed cogent understandings of health inequalities over the course of the research programme and reported and demonstrated significant changes in their opinions and perceptions. By and large, the panel developed a high degree of expertise in this issue and were able to advance a series of insightful and constructive principles, ambitions and priorities for tackling health inequalities in Scotland that demonstrate a clear understanding of the issue, and an evident potential to engage the public meaningfully in this process. There is a clear appetite for concerted action in Scotland to address disparities in health, and an evident willingness from the public to engage on what they see as an important political, social and ethical issue.

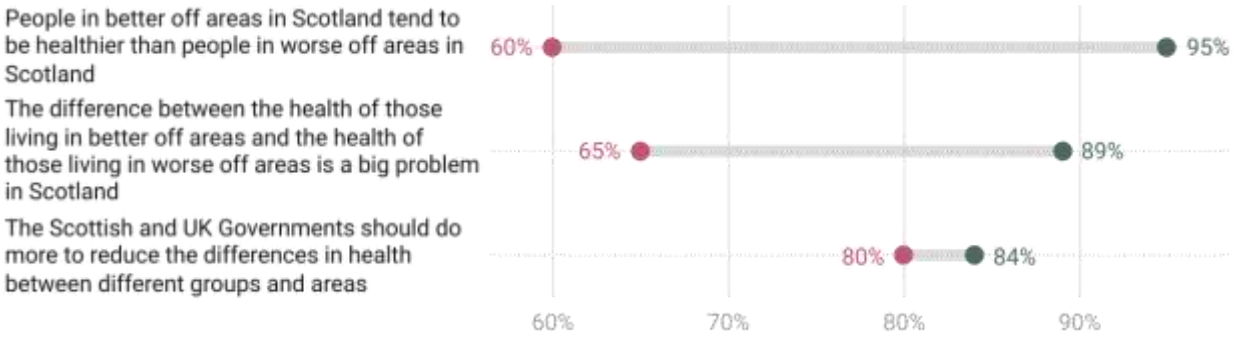
[13] (NatCen, 2022)

Motivation, Interest & Concern

From the beginning of the research, panel members demonstrated interest in and concern for health inequalities, as well as an evident motivation to tackle them. These disparities were seen as unjust in a wealthy, modern country, and many panel members were shocked by the scale of inequalities in health, life expectancy, and healthy life expectancy. It was perceived as deeply unfair that large sections of the population were living not just shorter, but less full lives.

Changes in attitudes towards health inequalities

Proportions of panel members agreeing with each statement prior to the first session (in red) and following the final session (in green)



To what extent would you say you agree or disagree with the following statements? (Showing strongly and somewhat agree only)

This motivation did not wane, but rather, grew over the life-course of the panel, with the proportion of panel members deeming health inequalities both real and a serious issue rising sharply. While the proportions saying that the Scottish and UK Governments should do more to tackle these rose by a smaller margin, the strength of feeling behind this rose sharply.

Awareness & Understanding

While many panel members originally reported a limited knowledge of health inequalities, and there was low initial awareness of the nature, extent and causes of these issues in Scotland, participants engaged constructively, and developed detailed understanding of health inequalities, both in general and more specifically in a Scottish context.

Panel members were broadly receptive to the evidence presented to them, though at times some expressed a scepticism and curiosity that prompted valuable deliberation. On a number of points where awareness was initially low, or where first impressions were at odds with the prevailing expert

consensus,[14] panel members demonstrated a high degree of receptivity to opposing viewpoints and changed opinions to a considerable degree.

By the final session, panellists were able to advance detailed accounts of the current drivers of heath inequalities in Scotland, of the potential solutions by which to reduce such disparities, and of the barriers to making progress on this issue. There was considerable overlap between the perceptions of panel members in these regards and those of expert stakeholders and practitioners engaged by a parallel workstream of the wider *Health Inequalities in Scotland* research programme. This would appear to demonstrate the public's ready receptiveness to evidence and information and ability to engage meaningfully, even with this complex agenda.

Reflecting on their participation in the panel, all members reported that they had enjoyed taking part and hearing other people's perspectives, almost all reported that they had learnt new things, and all participants considered deliberative processes a good way to inform and devise policy on complex issues.

Attitudes & Perceptions

Panel members' views and impressions changed considerably over the course of the programme in response to their discussions and the evidence presented to them.

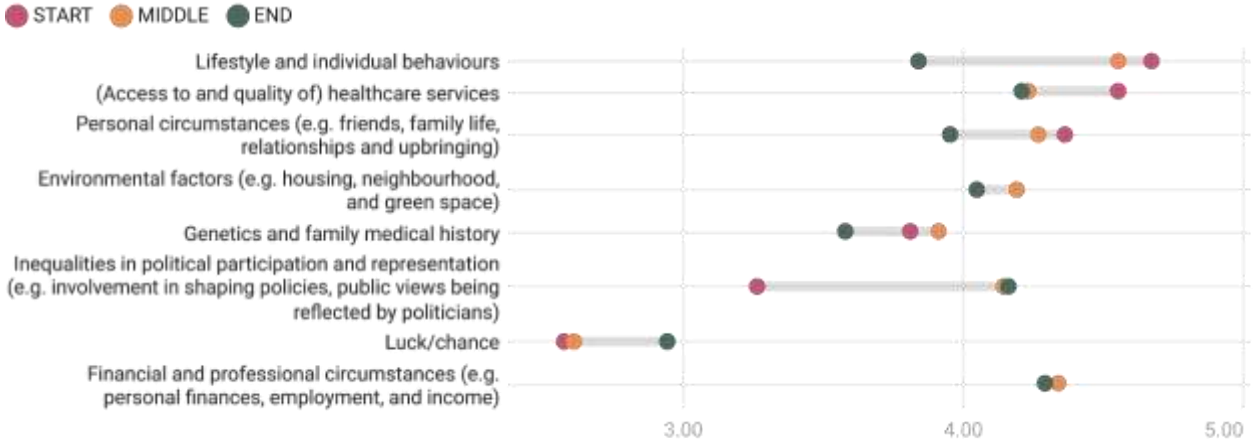
The panel answered a series of repeated questions at regular intervals, providing a quantitative indicator of changing opinions, while qualitative discussions and data added depth to this analysis. In one such question, the panel was asked to estimate the impact/importance of various determinants of health on people's health, and changes in these average figures were tracked over the course of the panel.

The largest changes can be observed for lifestyles and behaviours (falling sharply over the life-course of the programme) and for inequalities in political participation and representation (which rose considerably). A considerable number of panel members reflected in qualitative feedback that the real relative importance of these factors was among the most striking things they had taken from the process. While the perceived importance of healthcare fell slightly over the course of the programme, it retained a leading position, ending up as the greatest perceived determinant of health.

[14] (Smith & Kandlik Eltanani, What kinds of policies to reduce health inequalities in the UK do researchers support?, 2014)

Changes in the perceived importance of various determinants of health

Weighted averages of panel members' estimated impacts of given determinants of health prior to the first panel session, at the mid-point following the second session, and after the final session



Thinking about people's physical and mental health in Scotland, how large an impact would you say the following have on people's health? Please answer on a scale from 1 to 5, where 1 is 'No impact at all' and 5 is 'A very large impact'.

Early discussions of health inequalities and health outcomes ascribed significant predictive/explanatory power to individual behaviours. However, over the course of the process, the importance afforded to this factor fell markedly. It also, however, changed qualitatively, with early discussions largely revolving around questions of 'responsibility' and 'choice' where the onus largely fell on individuals, to a more holistic view of behaviours that took account of the ways in which wider circumstances could inform or constrain lifestyle choices. References to diet and exercise became markedly less common in later sessions, and certain behavioural facets (including drug and alcohol consumption, as well as diet) were increasingly seen as political, rather than individual or moral, failings.

The broad tone of these conversations therefore moved from holding individuals responsible for their actions, and towards empowering people to adopt healthy behaviours and lifestyles not only through educational campaigns, but also by providing the requisite resources to do so. This contrasted sharply with earlier conversations around 'dependency' culture. Similarly, education was increasingly spoken about, not as a way to instil positive behaviours, but to instil a sense of autonomy more broadly in people and to encourage them to take control over their lives.

As the panel moved away from behavioural accounts of health inequalities, the more fundamental determinants of health, such as inequalities in wealth and power, and the political dimension to health inequalities became more apparent to panel members. Panel members began speaking much more regularly, clearly and spontaneously about these factors and related upstream determinants.

Tackling Health Inequalities

The importance of reducing disparities in wealth, income and power became increasingly evident to most panel members, and their proposed solutions came to reflect this increasingly. While initial discussions saw panel members propose educational and behavioural campaigns to tackle health inequalities, later conversations reflected much greater redistributive aspirations and increased concern for financial and material conditions and considerations.

However, panel members also exhibited a degree of disempowerment in response to this realisation. In a post-session survey, approximately two thirds of panel members reflected that the political nature of the key determinants of and solutions to health inequalities made the optimal interventions more obvious, but about half also said this made them less confident that Scotland would make real progress in tackling them.

Many participants lacked faith in politicians to bring about change, and some members began to express frustration at what they perceived to be a tokenistic or performative prevailing approach from government, largely reliant on behavioural and educational campaigns rather than potentially more impactful redistributive efforts. Short-termism and self-interest in politics were seen as crucial stumbling blocks on making such progress.

Panel members were able to identify a series of challenges and barriers – largely political and procedural – that they believed were stymying progress on tackling inequalities, including perceived short-termism in political decision-making, insufficient collaboration in decision-making, and inadequate flexibility to shape planning and services at a local/community level.

On the basis of these barriers and the evidence they had heard over the course of their participation, panel members devised a series of constructive principles, ambitions and priorities for tackling heath inequalities, demonstrating the public's ability to engage meaningfully in this arena.

Reflections & Implications

Even without any intervention or deliberation, there is evident public interest in and concern over health inequalities in Scotland, seen as a fundamental issue of fairness. There is minimal doubt over the veracity or seriousness of such inequalities, though awareness of the scale, nature and causes of these in Scotland is limited.

Similarly, the public – according to both the national survey and early deliberative discussions – appears to hold a number of misconceptions around health inequalities that depart from the prevailing

consensus among academics, experts and practitioners. Initial and instinctive public perspectives appear to attach an outsized importance to behavioural accounts of such inequalities and seem to favour (less effective) behavioural and educational campaigns to reduce these, in lieu of more redistributive and upstream approaches.

Much of the existing literature and research on lay perspectives of health inequalities has found limited and imperfect understanding of these disparities, and significant 'lifestyle drift'. Our research has found, however, that this is not insurmountable. Rather, with some support, the public can develop significant expertise and engage meaningfully with this important topic. With even relatively little exposure to evidence and information, panel members developed significant knowledge and interest in the issue of health inequalities.

At the end of the research, panel members discussed, identified and advanced a series of insightful principles, ambitions and priorities for tackling health inequalities in Scotland. These reflect a valuable exercise in deliberation and consensus-building, coupling evidence with public concerns and principles, that thus have the potential to both reduce disparities in health outcomes and command broader public support.

A body of prior research has suggested that policymakers are guided by what they perceive the public will support; in the case of health inequalities, assumptions of 'lifestyle drift' see policy skewed towards behavioural and educational campaigns.[15] However, the findings from this deliberative research rebuffs this assumption and shows that a case can be easily made for greater intervention, including greater redistribution and upstream 'macro' policies, if the need and rationale for such interventions is explained.

The ambitions advanced by the panel reflect a process of consensus-building and constitute a valuable compromise between the evidence on reducing health inequalities effectively, and members of the public's principles. With the right case behind them, these proposed actions have the apparent potential to form the basis of a popular and publicly supported strategy to reduce health inequalities in Scotland at source, tackling the root causes of inequalities through a package of impactful measures.

[15] E.g. (The Health Foundation, 2022)

Part III:
In-Depth Discussions

Here we provide more detailed accounts of each panel session. We explore the key themes, observations, and findings of each deliberative session in turn.

3.1 Initial Impressions & National Survey: Session 1

This section reflects on the findings of a national survey of the adult Scottish public, and the proceedings of the first panel session to explore initial and early public perceptions of health inequalities. Survey findings are used to reflect the extent of feelings across the wider population, while the deliberative discussions provide qualitative depth and insight beyond this. ('Panel members' and 'participants' refers to those taking part in the deliberative workshop, while references to 'the public' reflects the findings of the wider national survey.)

The first session was aimed at gauging and exploring people's broad understanding and impressions of health, health inequalities and health determinants, as well as how they talk and think about relevant terms and themes.

Key Findings & Reflections

- **In the first panel session, panel members demonstrated broadly robust understandings of health inequalities**, citing disparities between different areas and, to a lesser extent, population groups, though **these were often initially framed in terms of health *care* rather than health *outcomes***.
- **Panel members tended to interpret health inequalities through the lens of their own personal experiences and exposure**, whether this is through their own adverse health experiences or those of family-members, their communities, or what they have seen in their professional lives.
- **Most panel members could provide robust accounts of how determinants impact on health outcomes**. Most noted the nuanced and multi-faceted nature of health outcomes and inequalities, with some observing complex interconnections and interactions between circumstances, characteristics and behaviours that could work jointly against good health.
- However, discussions tended to focus on one determinant at a time (along broadly sectoral lines, such as education). Panel members appeared less inclined to speak in more holistic terms of (intersecting) disadvantage or of 'early years' for instance.
- **Much of the panel's immediate interpretation and discussion of health inequalities related to questions of access to and quality of healthcare services and facilities**, and this emerged from the national survey research as the largest determinant of health in the eyes of the public. Panellists were quick to raise this unprompted, and **factors such as neighbourhood, community and education were largely interpreted through the lens of healthcare, rather than as determinants in their own right**.
- **There was also significant evidence of 'lifestyle drift'** in both the qualitative and quantitative research, **with participants deeming individual choices and behaviours among the top**

determinants of health. However, most were conscious to some degree of the ways in which other factors could constrain individual choices. Probing about differences between *groups* and *communities*, rather than people's health outcomes, encouraged participants to think in more ecological terms.

- **Panel members' proposed solutions are predisposed towards educational and behavioural approaches**, though when offered a wider range to choose from in the survey, they deem educational approaches least effective.
- While panel members are cognisant of the ways in which material circumstances can impact on health outcomes and inequalities, their proposed solutions more readily focus on behaviour change than improving people's and households' material conditions.
- **Health inequalities were perceived as unfair by the public, and their true extent in Scotland was surprising to many panel members**. Differences in life expectancy appeared to resonate clearly with panel members and motivate them to take health inequalities seriously. People were surprised and motivated by the scale of these inequalities, **with many reflecting that they are unjustifiable in a rich, modern country**. The concept of 'healthy life expectancy' also appeared salient, with a perceived injustice that people are living not just shorter but less full lives.

How do the public conceive of and talk about health inequalities?

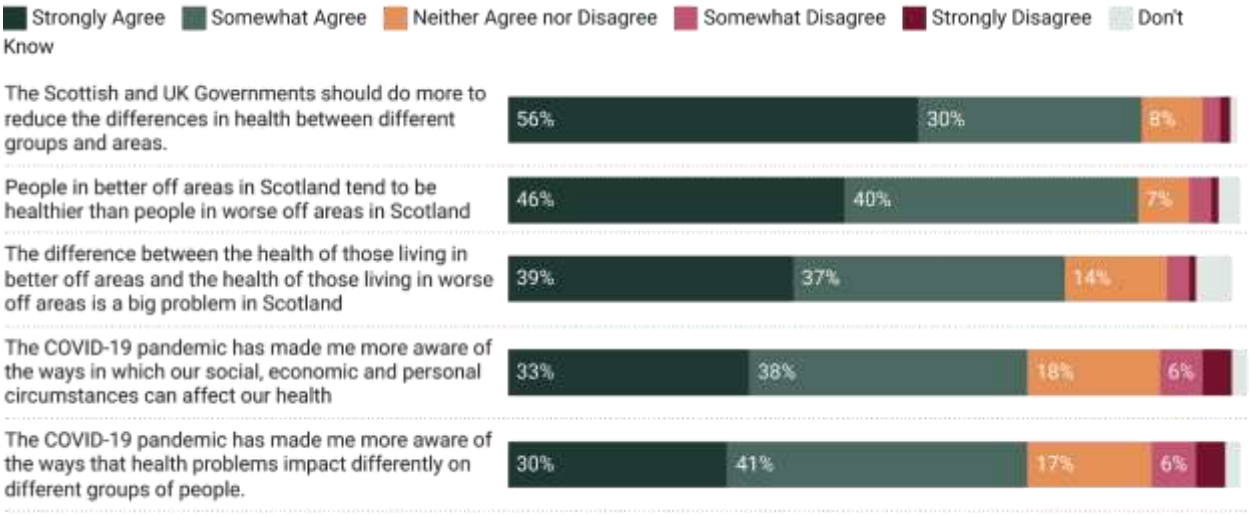
Panel members demonstrated broadly robust, if sometimes imperfect, understandings of health inequalities. Participants identified inequalities between different groups, areas, communities and characteristics – particularly between more or less affluent people and areas – though these were routinely framed in terms of healthcare and facilities. Differences were typically observed on the basis of geography, area, deprivation or income, with less attention paid to communities of interest.

Panel members tended to interpret health inequalities through the lens of their own personal experiences and exposure, whether this is through their own adverse health experiences or those of family-members, their communities, or things they have seen in their professional lives. In many cases, this sees people interpret and discuss health inequalities most immediately in terms of healthcare and access. Panel members spoke of a '*postcode lottery*', but primarily in terms of healthcare access rather than the wider ways in which environment could impact on health, and panel members regularly raised the issue of access to healthcare in rural areas, despite the worse health outcomes in urban areas.

Both our quantitative and qualitative research found concern at the scale and severity of health inequalities in Scotland. The vast majority (86%) of national survey respondents accepted the existence of health inequalities between more and less affluent areas, three quarters (76%) deemed these a big problem in Scotland, and there is an evident appetite for greater action, with 86% saying that more should be done to tackle these (even without any intervention or discussion on the matter).

Public Attitudes to Health Inequalities

Proportions of the public in a national survey agreeing and disagreeing with the following sentiments relating to health inequalities



To what extent do you agree or disagree with the following statements?

Nevertheless, panel members expressed surprise at the scale and extent of health inequalities.

> *"I was surprised at the [differences in life expectancy between different parts of] Glasgow. I didn't realise it was so big: 14 or whatever years [difference]! That is really shocking in this day and age, to still have that big of a gap across what is a relatively small city […] We're meant to be one of the most developed countries in the world and if we've still got such a massive gap, I find that quite shocking, to be fair. I didn't realise it was just so big."*

Disparities in life expectancy and healthy life expectancy appeared to resonate with a lot of panel members, with a very clear sense of injustice that many people were living not just shorter lives, but less full lives.

> *"I thought that [concept of a healthy life] was really useful. If you were offered 65 years of really good health, or 75 but 20 of them were poor, what would you choose? It's just quite remarkable: 72 years of good health in the least derived areas and 47 in the most. You just think good grief! […] I just thought that was quite a remarkable difference."*

Very few panellists expressed scepticism towards the veracity or seriousness of health inequalities. One who did, said:

"I know health and social [factors] run parallel to each other but they are two separate issues. People with health issues and people with social issues, it's two separate topics and I think we're jumping backwards and forwards from one to the other which may be muddying the waters a bit. You can have social issues where you have totally no health problems at all and vice versa where people with health issues have no social issues at all."

Another panel member shared an initial uncertainty at the link between social factors and health outcomes but was able to work through it using the example of his family to deduce a cogent understanding of this.

"I'm not sure I make the connection between health inequalities and maybe I'm struggling a little bit with the difference between health and social [factors]l. I could maybe use my daughter and granddaughter as an example. They used to live right in the centre of the city [...] in a housing association block and they certainly didn't play and socialise there as much as they do now. They've since moved into another rented accommodation in an ex-council estate on the suburbs of the city and every time we talk to them now [...] our granddaughter's at swimming [or] she'll be out with her pals [...] going to the swing park to play and do whatever kids do at that age. That certainly wasn't [happening] when they were in a more city centre, urban area. And probably, talking to our daughter, her health has probably improved."

Understanding & perceptions of health determinants

Panel members demonstrated an awareness and understanding of a wide range of health determinants – both social and non-social – and were largely able to provide relatively sophisticated accounts of how these impact on health.

When panel members were invited to identify and elaborate on factors impacting people's health, common themes that surfaced regularly and consistently across different discussion groups included (in decreasing order of frequency) lifestyles and behaviours, access to and quality of healthcare services, income and (financial) resources at people's disposal, education, and housing, among others.

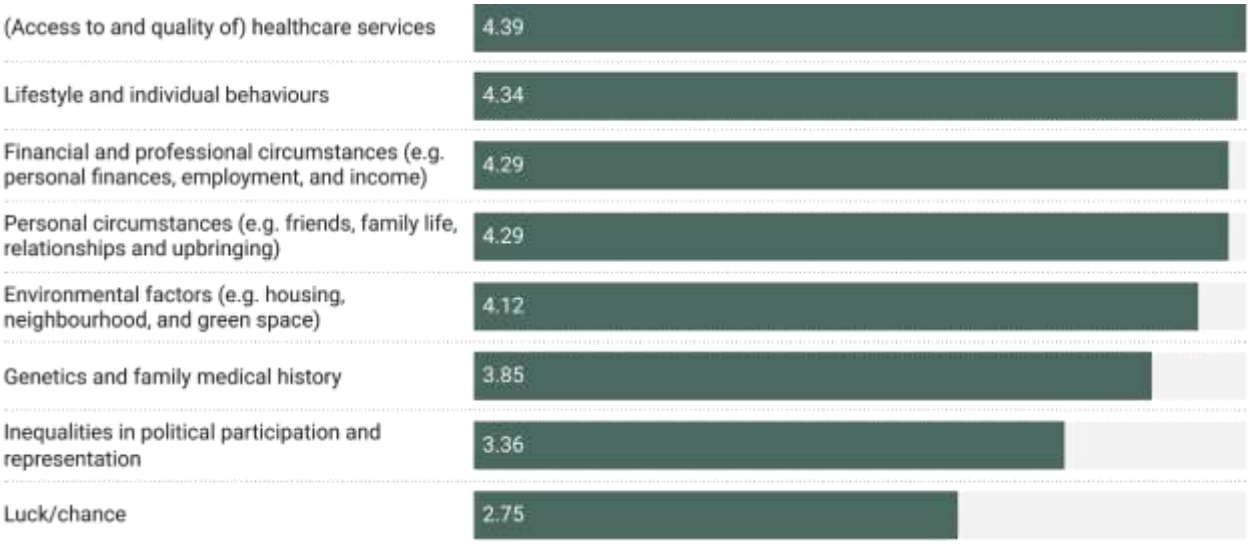
A high degree of 'lifestyle drift' was observed in the first deliberative panel session, whereby inequalities and poor health outcomes were regularly attributed to individual behaviours and choices across groups (rather than social determinants of health). These early discussions inclined, in large part, towards behavioural accounts and downstream factors (especially healthcare access and facilities) in lieu of more social determinants or fundamental high-level drivers.

The national survey findings pointed to a similar ranking of health determinants among the wider population, with healthcare and behavioural factors seen to have the greatest explanatory power for health outcomes, considerably ahead of political inequalities. Similarly, during the first deliberative

session, these more abstract fundamental drivers did not appear to crystallise clearly in panellists' minds.

Perceived Impact of Health Determinants

Weighted average of the perceived impacts of various (social and non-social) determinants of health among the public in a national survey



Thinking about people's physical and mental health in Scotland, how large an impact would you say the following have on people's health? Please answer on a scale from 1 to 5, where 1 is 'No impact at all' and 5 is 'A very large impact'.

According to survey findings, young people afforded greater explanatory significance than their older counterparts to individual behaviours and personal circumstances/relationships, while female respondents considered financial, professional and environmental factors more impactful than males.

Access to healthcare, and its quality, were key considerations for both panel members and survey respondents. As noted above, it was common for panellists to interpret relevant terms and issues in relation to health*care* rather than health *outcomes*. Several panellists, for instance, defined/discussed health inequalities in terms of inequitable access to healthcare, and while several groups mentioned the issue of a 'postcode lottery', this was typically framed in terms of local healthcare services and facilities, rather than wider socioeconomic considerations and determinants.

> *"I suppose a lot of it is to do with postcode, although I hate that saying, 'Postcode Lottery'. You know, where you live, what facilities are available. Say it comes down to cancer treatments [...] I don't know enough about it, but you do hear that if you're in a certain postcode you're more likely to be offered a certain type of service or drug, and that's a massive inequality."*

In most cases these discussions treated such a *'lottery'* as somewhat random, while fewer panellists explicitly related this to local socioeconomic factors or questions of deprivation and affluence.

> *"Postcode lottery is huge. If I call the doctors, generally I can get an appointment that day if I need to. However, within the same authority I know people aren't able to get appointments three or four weeks in advance for what I would say are pretty urgent [issues]. […] And I suspect it's cos [where I live is] quite a green leafy suburb – well to do – whereas maybe other areas are a bit more mixed."*

As noted above, many panel members were instinctively inclined towards **lifestyle and behavioural accounts** of health outcomes, focusing on diet, exercise and habits (such as smoking and/or drinking).

Much of this discussion was characterised by a language of 'responsibility', 'consequences and 'choice'. When panel members were encouraged to think of wider ecological determinants, a few panellists instead sought to reiterate the importance of behavioural accounts, as if this were a point of principle.

> *"I guess all the things we've talked about so far are circumstantial […] but I guess at some point we start to touch on life choices, and good choices and – I hesitate to say 'bad choices' but you get my drift. […] I just didn't want us to [imply] that everything is predetermined."*

However, a number of panel members acknowledged that individual choices might be constrained or determined by other circumstantial and environmental factors, especially financial considerations.

> *"The quality of food you can buy, if you can afford free-range and organic, those things are more expensive. You can afford higher-quality food, fresher food maybe."*

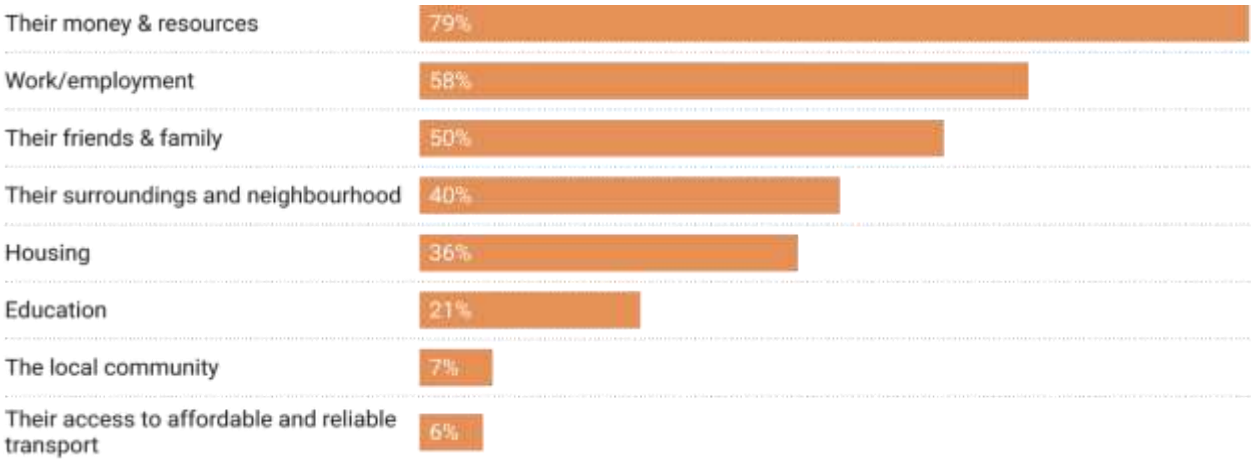
> *"It's all well and good making those decisions [to live and eat healthily], but it actually has to be available to you. The food as well: my husband was ranting about Jamie Oliver the other day cos he's trying to stop you getting deals on food. […] It's still landing that it's gonna be more expensive to buy the healthier stuff you need. So, the good and the bad food is going to be pricey for you!*

While panel members tended to instinctively think that people's health outcomes were determined in large part by individual behaviours, when questions were framed more specifically in terms of different (average) outcomes between *groups* and *communities*, there was some evidence of a greater inclination towards ecological and circumstantial factors.

Of the social determinants of health more specifically, national survey respondents deemed financial and professional factors the most impactful on people's physical and mental health, followed by their friends and family, neighbourhoods, and housing.

Perceived Importance of Social Determinants of Health

Proportions of the public deeming each item a top factor in people's physical and mental health in a national survey



And from the following list, please select the 3 factors that you believe have the biggest impact on people's physical and mental health in Scotland

In the first panel session, members could identify and provide relatively sophisticated lay accounts of various social determinants of health and the mechanisms by which they impacted on health outcomes. Of these, the ways in which income and resources impact on health and interact with other factors were clearest in panellists' minds – consistent with our polling, where income emerged as the most impactful social determinant – though sophisticated accounts were also advanced with regards to housing, neighbourhoods, communities, and employment, among others.

Income and financial resources were seen, in both the qualitative and quantitative early research, as a key determinant of health. This was deemed the most impactful social determinant of health by survey respondents, with 79% of people deeming it a top factor, rising to 86% and 88% in the most deprived quintile and among those reporting poor health, respectively. In deliberative discussions, the connections with health were largely seen as self-evident, with one participant remarking that:

"Naturally, the healthier your income, the healthier you're likely to be."

Panel members were quick to cite the impacts of financial factors unprompted in their discussions, where it was among the most commonly and widely mentioned factor in deliberative discussions. Income was seen to impact both directly and indirectly, mediated via other determinants to bring about adverse health outcomes, and panel members were largely able to advance sophisticated accounts of the mechanisms underpinning this.

Financial circumstances were seen to impact on health outcomes in a number of ways, including by constraining opportunities for healthy living, depriving people of healthy nutritious food, forcing people

into poor-quality and unsuitable housing, constraining access to high-quality and timely healthcare, and by prompting stress, poor mental health and potentially unhealthy behaviours.

> *"You may have financial pressures, that may lead to bad lifestyle choices whether that be drink or drugs. But even outside of those parameters, there's also the [question] of it in that what [can] be afforded within the household. For example, we're all told we should be eating our five fruit and vegetables a day. Now how affordable is some of that, particularly at the moment, where we're seeing maybe 10% inflation in food – how affordable is it going to be for certain households to have those fruit and vegetables?"*

There was broad agreement that finances could negatively impact health when it deprived people of their basic needs, though a few participants suggested that there were diminishing marginal returns from improved personal finances.

> *"But there would come a point where income above a certain level would make not a jot of difference. After – I'll make up a number – 150 grand, would it make that much of a difference?"*

Employment had clear overlap with questions of income, with two key aspects of employment, namely status and conditions, see to impact directly on health, and mental health in particular.

Employment status, unemployment in particular, had clear impacts on health in the eyes of panel members. Unemployment was associated with markedly aggravated mental health, undermining people's sense of worth and purpose. Conversely, a good job was seen to be highly rewarding and stimulating, with positive implications for people's health.

> *"I would say unemployment has a major impact. We're in a one-income household and I'm not working at the minute [because] I've been doing the mother thing. My youngest is now at nursery and in order to find a job that fits in with the school runs, it's difficult and it is starting to affect my mental health. If I'm honest it makes me feel a bit worthless. I'm sure I'm not the only one feeling that way, feeling that I don't have a purpose."*

Having a job was not, however, sufficient in itself to ensure good health. Conditions and terms of employment were widely discussed. The imperative of working to earn a living, in combination with the profusion of low-paid work, saw some panel members report feeling overworked and exhausted. Poor terms, stress and long hours were seen to primarily manifest themselves in adverse mental health, though in certain sectors and professions, a few panellists noted potential risks to physical health as well.

> *"Something I've noticed myself, I study but I also work part-time at the supermarket and finding a balance between working enough to earn enough to live, and focusing on studies can be quite difficult. It's been incredibly stressful. To put it bluntly, I couldn't afford to live if I didn't work so you*

just have to grin and bear it, bluntly. […] The way my timetable fell, I had classes Monday–Thursday and then worked Friday–Sunday so I didn't have a single day off."

Neighbourhoods and communities were seen to have evident impacts on health outcomes and inequalities. Neighbourhoods were typically discussed with reference to the built and physical environment, while communities were seen to relate largely to local facilities, services, supports and peers.

Discussions of neighbourhoods attached a strong significance to local greenspace and environmental factors, with a concern that access to greenspace was dwindling. There was also an evident awareness of and aversion to some of the historical issues around planning and development, including legacies of stigma and ghettoisation, and their ongoing implications for health today.

While community ranked low among social determinants in terms of perceived impact in the survey, it surfaced regularly throughout the deliberative research and across groups. Discussions of community focused on a range of factors, but often revolved around issues of isolation and access services. A number of panel members reported difficulties accessing relevant and necessary services in their community owing to a range of factors including deprivation and rurality.

There was a broad recognition that revitalising and investing in communities could help to improve various aspects of health and wellbeing. A number of participants gave examples of their communities having mobilised and led this process, and participants gave animated and sophisticated accounts of the transformative impact this had had. There was an evident appetite for greater community empowerment.

"I remember when there was a lot of social problems and health problems, like drug abuse, alcohol abuse, and it's interesting that the community themselves basically said 'no, we can't really have this anymore' but over time they've worked hard, and it made a big difference. So again, maybe that links to the idea that they have a sense of 'this is our community'. Before, there wasn't much of a community, it was disintegrated through various issues but it's interesting the way it's changed and there's almost been a breaking point of saying 'no, we can't do this anymore', and a lot of community action groups were started. The place now looks a lot more physically nicer and because of that people are more likely to look after things like stairs. But the biggest difference is seeing bairns out playing, whereas before you would rarely seen them out, now they're out in the grassy bits and all that. So that's quite important, that sense of place and belonging."

Housing was described by some panel members as a fundamental basic necessity, and members were broadly able to see how it could impact on health outcomes. Primarily, this revolved around housing standards. Panellists noted issues of damp, mould and unsuitable accommodation, and the obvious ways in which this could aggravate health issues and inequalities.

"And then of course if you are living in poverty sometimes your living condition aren't very good. Some of the children I teach living in housing that I would say is not suitable for human habitation: dampness and that affects breathing. One child had slugs in their room cos their house was so damp. And cramped conditions because there's not enough housing."

Some panellists noted issues with upkeep and supply of housing, and it was suggested that current ownership and maintenance arrangements are inadequate, with insufficient incentives or obligation to maintain decent standards. Some suggested that more could be done to update the existing housing stock, and that current approaches to this are wanting and under-resourced.

"Very often local councils seem to be fighting to get the funding to do improvements by way of insultation and prevention of dampness, and the trouble is sometimes they do it on a very tight budget and we know what happens when that goes wrong, like in Grenfell Tower."

While **education** was not deemed as influential in the survey as other factors, it surfaced very consistently and organically in the deliberative discussions. Education was seen to occupy a central role in encouraging and enabling positive behaviours such as healthy eating or exercise, but also related to people's understanding of local healthcare services, facilities and access.

"I'm not sure everyone understands the negative effects of [unhealthy] behaviours. So, more education when you are younger on what's going to happen if you continue to follow that path – real clarity on that and detail about the consequences."

"Education is probably an important factor – whether people know that they can access certain help or they don't know."

There was minimal explicit discussion of childhood and adverse experiences. While a number of related issues, such as education and parenting, surfaced to varying degrees in discussions, only a few participants drew a more explicit link between early experiences and long-term health prospects. These individuals typically worked with children or came from more deprived backgrounds.

The 'Building Blocks' of Health

Panel members were relatively quick to note the multifaceted nature of health outcomes, and the composite nature of health determinants. Almost all panel members were able to identify and convey a range of determinants of health outcomes, albeit to varying degrees of detail and clarity. Some were more forthcoming when it came to linking distinct determinants together and expressing a more holistic

view of health determinants. A number explicitly commented on the range and complexity of multiple overlapping determinants:

"For me, a healthy life is about having access to decent food, which a lot of the time comes down to your economic situation. Having decent food, being able to exercise – I don't necessarily mean getting to the gym but being able to get out – and having the mental capacity to participate in things, to have friends, to have a whole, healthy life you would need such a lot of different things. You do need to be able to have access to such things, and a lot of it comes down to the basics.[…] In an ideal world the basis would be having access to these basic things."

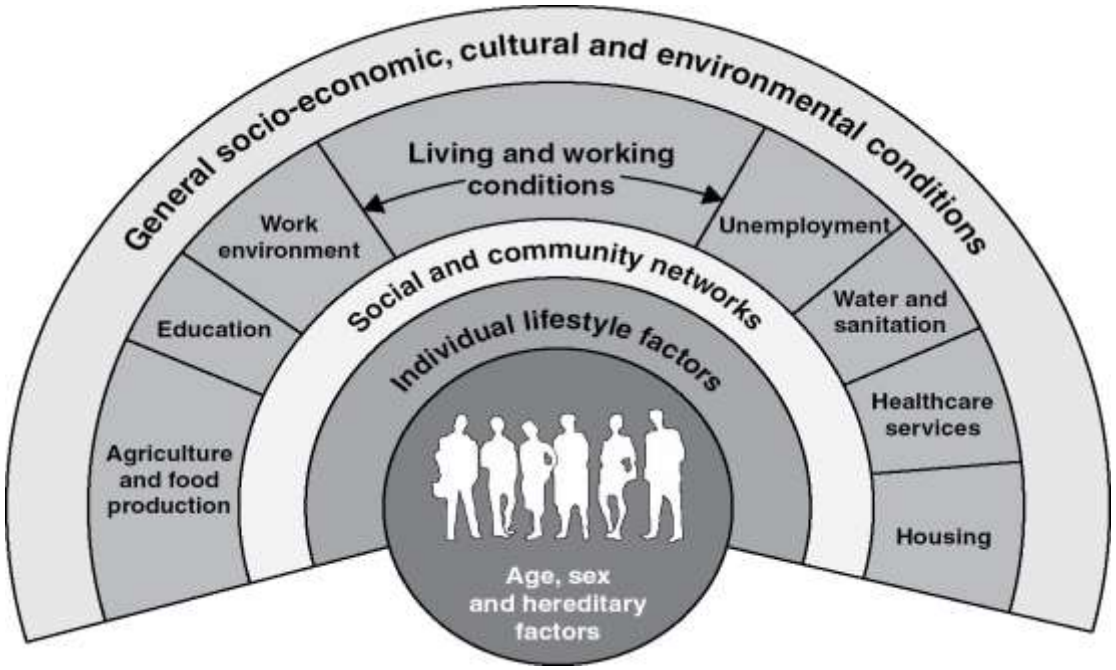
People living in more deprived areas appeared better able to grasp and articulate the range of intersecting socioeconomic factors that could negatively impact on health outcomes beyond behavioural factors. One panel member from a more deprived neighbourhood reflected, for instance, that:

"I think it is hard to think about it individually because everybody doesn't set off on the same level […] There's not the same starting point for everyone. So much of where you live, where you come from, your opportunities come into that. […] For example, where I'm from, if you're living there, you're not in the same state as a child living in Bearsden [where] you've got better facilities, better schools, better opportunities, better housing, all that sort of thing [and] less crime in the area. You are living among less or more money. If you were to compare these two people individually, I don't think that's very fair if one person is living in a high-rise block of flats with dampness, no access to private outdoor space and you are comparing that to someone with a garden."

The '**Rainbow Model**' – a graphical representation of the different levels at which various health determinants operate – was deemed a helpful tool for conceptualising the different types and levels of health determinants. For some, this moderated the importance of individual and lifestyle factors, and called attention to the wider ecological factors at play. A few others interpreted it as reinforcing the centrality of individual choices and behaviours, rather than calling attention to the wider circumstantial factors, though most arrived at a relatively nuanced, balanced settlement on this.

"I think the graphic's a good way of showing it's all pretty interconnected. There is an individual element – at the end of the day you've got your own responsibility to do the best for your own health – [but] there's also a lot of other things [and] sometimes you have limited influence over them […] There's a lot of interaction in factors affecting health."

Figure 5: The Rainbow Model (Dahlgren & Whitehead, 1991)



Solutions & Interventions

A majority of respondents to a national survey judged that all proposed actions to tackle health inequalities would be effective at reducing health inequalities in Scotland. National survey respondents deemed improvements to daily living conditions the most effective method, with nine in ten suggesting these would be effective, followed by investing in communities and improving working conditions.

A smaller proportion (79% of those expressing an opinion) estimated that interventions aimed at more fundamental drivers of inequalities – namely, policies to reduce poverty and inequality – would be effective. However, there was both a greater strength of feeling behind this, with 44% suggesting this would be very effective, and greater opposition, with 21% suggesting this would be ineffective.

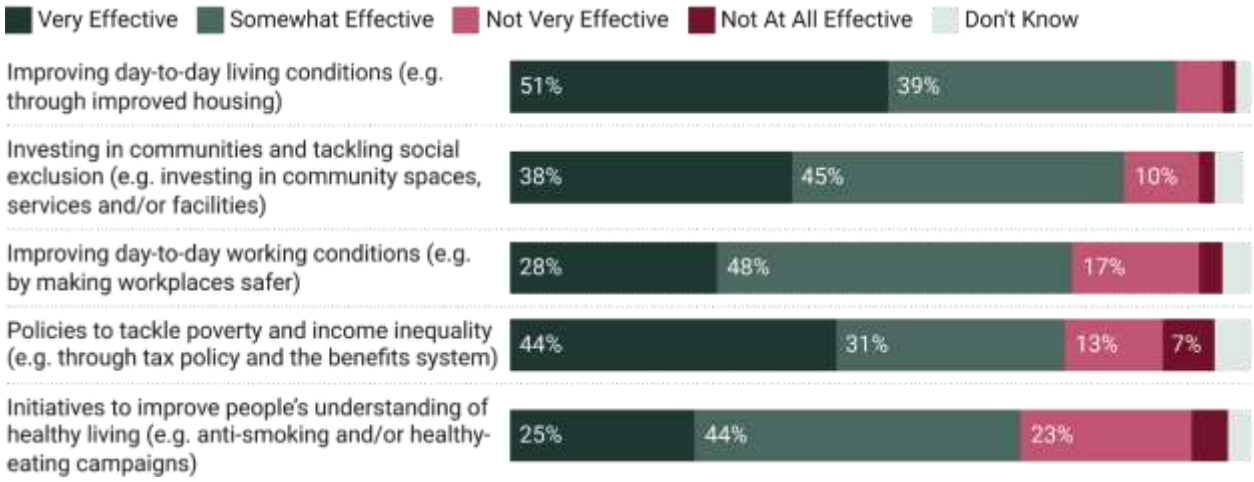
Educational healthy living campaigns were considered the least effective of all proposed approaches, and respondents in more deprived areas were especially likely to deem such approaches ineffective.

The first deliberative session also touched briefly on panel members' proposed solutions. Despite the national survey findings, most of the panel's proposed actions to reduce inequalities were educational and behavioural, including campaigns on healthy eating and living. This would suggest that people

deem other approaches more effective, but that they don't come to mind as easily as behavioural and educational interventions.

Perceived effectiveness of interventions to reduce health inequalities

Proportion of the public deeming each approach in/effective in a national survey



How effective or ineffective do you believe the following would be in reducing health inequalities in Scotland?

Panel members' suggestions included improving understanding and awareness of local services and supports, encouraging healthy eating, exercise and lifestyles, and teaching sound financial management, among others.

However, others challenged the efficacy of educational approaches, either questioning the extent to which awareness campaigns can truly change behaviours, or cautioning that such measures are slow burning. This may explain why survey respondents were more sceptical of educational and awareness-raising campaigns compared to other proposed solutions.

> *"Sometimes the messages are repeated over and over and over again, like covid messages on the radio. It's like' I know, you don't need to keep going on about it.' I know about unhealthy eating and lack of exercise impact on health. It doesn't change things for me. I have rheumatoid arthritis and when I exercise it hurts, why would you do something that hurts?"*

As noted above, there was broad support and appetite for increased community empowerment. There was a broad sense that communities are better placed to identify and respond to local needs and challenges, and many panel members gave first-hand accounts of the positive impacts this had had on their community. There was evident support for greater discretionary decision-making and resource-allocation at a local and service-delivery level.

A few participants also drew attention to 'macro' and financial considerations, with suggestions to increase the minimum wage, establish a more progressive tax system, and a suggestion from multiple participants and discussion groups to introduce a universal basic income scheme to ensure everybody's basic needs are met.

However, some pushed back on these suggestions, citing a perceived culture of damaging 'dependency'. These people were typically older and/or from less deprived areas and appeared to consider individual responsibility an important point of principle. Panel members on both sides of this divide seemed to support principles of individual empowerment, though there was less agreement on how to achieve this.

3.2 Health Inequalities in Scotland: Session 2

Where the first panel session was a primarily conceptual introduction to health inequalities in general, the second was more contextual, exploring the scale and nature of health inequalities within Scotland more specifically. This included a brief exploration of how Scotland fared in international perspective and how health outcomes differed between parts of Scotland.

To this end, participants were divided into four groups. After the initial impressions of each group of the nature, extent and causes of health inequalities in Scotland were gathered, evidence on the historical and current drivers of health inequalities was presented and discussed.

Key Findings & Reflections

- **Panel members initially demonstrated a low level of understanding of the scale and nature of health inequalities in a specific Scottish context**. Participants struggled to accurately compare Scotland to other countries internationally, with mixed accounts of how well or poorly Scotland's health inequalities compare to the rest of Europe and the rest of the UK. More affluent panel members tended to be more optimistic about Scotland's relatively poor position.
- Additionally, **panel members struggled to identify many specific areas or communities that are adversely affected by health inequalities, with many focussing largely on the urban rural divide**. A much smaller number drew attention to low-income groups.
- Following the presentation of evidence on the historic drivers of Scotland's health inequalities participants engaged in discussions on deindustrialisation as a key driver of health inequalities in Scotland, but many maintained a firm belief in the importance of individual choices. This is reflected in the results of a post session survey.
- Discussions of **current (perceived) drivers of health inequalities largely related to funding the challenges faced by the NHS, high and growing levels of poverty and inequality, and behavioural choices in individuals**.
- These findings demonstrate that while initial awareness of Scotland's problems are low, many participants engage eagerly with evidence on Scotland's context and provide innovative suggestions to improve the situation. Equally, **many maintain a principled focus on individual responsibility**.

Initial Impressions of Health Inequalities in Scotland

Prior to the presentation of any evidence, participants were asked about their impressions of the scale, nature, drivers, and adverse effects of health inequalities in Scotland. Impressions of the scale and drivers of health inequalities varied across groups and had mixed levels of alignment with the evidence. On the other hand, diagnoses of the health problems uniquely challenging Scotland and the areas and communities most affected by these were remarkably consistent, and narrow, across groups.

When asked how Scotland's health inequalities compared to other countries internationally and within the UK, participants from more deprived areas were more pessimistic, viewing Scotland as worse than Europe and the rest of Britain – citing poor diets, poor quality of and access to healthcare, lower life expectancy, and women's health as evidence.

"I think we get a really bad reputation for bad diets. In Europe especially I think we are seen as very unhealthy."

"I think we've got a long way to go in terms of catching up with the rest of Britain, or certain parts of Britain. And within areas as well, within Scotland [...] Life expectancy, which I think is worse in Scotland, worse than the rest of Britain."

People from less deprived neighbourhoods had mixed, but overall, slightly more positive views:

"We are probably on an average in Europe. In the UK I would say we are not doing as well."

"We definitely seem to have a better health system than the rest of the UK."

There was a degree of alarm and confusion at the stalling of health improvements in recent years and the widening of certain inequalities, though panel members largely struggled to speculate what may have caused this.

Perceptions of the specific drivers of health inequalities in Scotland were mixed across groups and a number of participants reported limited awareness of this. Participants' discussions covered a wide range of factors, including certain upstream/social determinants – including poverty, housing conditions, and the impacts of deindustrialisation – though the most common points of discussion across groups were the weather, dietary/lifestyle choices, and healthcare quality/access.

Compared to the wide variety of drivers identified above, most participants had a relatively low awareness of the health problems unique or especially germane to Scotland, though a small number of participants pointed to issues including addiction, poor diets and associated problems, and mental

health issues. Similarly, panel members struggled to identify (geographical) areas or (demographic) groups adversely affected by health inequalities in Scotland. The urban-rural divide was a regular focus of group discussions, though much of the panel again framed this discussion in terms of healthcare rather than health outcomes, with many pointing to issues of access in rural areas.

> *"It doesn't matter where you are. Middle of nowhere you can't find a doctor or a counsellor for hundreds of miles around, but if you are in high population areas there will be plenty more resources but there's gonna be so much more demand so it's just as difficult to access."*

This comes despite evidence that urban areas tend to fare worse in term of health outcomes, though only one group suggested that this was the case. Similarly, all groups struggled to identify demographic groups with worse health outcomes, pointing primarily to older people and, in a few cases, to people on lower incomes.

The above demonstrates a general lack of awareness of the extent of health inequalities in Scotland, their causes, and their effects on different groups. Following the presentation on the actual state of health inequalities in Scotland, many participants expressed feelings of surprise and shock at the extent of disparities within Scotland, and how poorly Scotland fares in international/comparative perspective.

In particular, participants expressed surprise and alarm at how unfavourably Scotland's health outcomes and inequalities compared to other European countries, and the extent of disparities in life expectancy and healthy life expectancy, both within Scotland and compared to the rest of the UK.

Historical Drivers

In the second part of the session, participants were shown a portion of a lecture providing historical explanations, based largely on deindustrialisation and slum clearances, for the considerably worse health outcomes in Glasgow and the West of Scotland.

Participants universally found the Glasgow slum clearances and the ensuing new towns' negative impacts on health to be the most shocking part of the presentation, though this manifested differently amongst different groups.

Participants from more deprived areas discussed the lack of transparency involved in these policies, the way mistakes from the past continue to affect people's lives today in a cycle of poverty and stigma, and the lack of agency people have to improve health inequalities in the face of macro level political decisions and economic events such as deindustrialisation.

"It's like the people's fate wasn't in their own hands. It was either local government or central government causing these issues. It had nothing to do with the population themselves, they didn't have much to do with where they were going."

"You just go on with your life and you don't think how much these decisions affect everything around you. I know it seems silly, but that just really hit me"

"Children that I taught who were in deprived situations 15-20 years ago, their children are now coming to us with the same difficulties and issues. There is a script you learn about yourself, to do with your self-esteem: "this is how people like me live." We need to empower people to change as well. I think that's a huge issue. There's the government have written a script way back about taking the cream of the crop and moving them to the nicest areas and that's a script that is held by society. That takes changing."

Some more affluent participants cited their own memories of the conditions in Glasgow in the 1960s to highlight the necessity of these political decisions but lamented the side effects of community breakdown.

"There's nothing intrinsically wrong with living in flats, tenements, or even high rises given it was from slum clearances that had to happen. Conditions were horrendous, they didn't have indoor toilets, in the 70s and 80s people didn't have electric showers or indoor bathrooms [...] We can't have it both ways."

Some participants also pushed back on the political and material focus of other panel members, reasserting the importance of individual choices.

"The video was really interesting, but it didn't discuss any of the topics that we discussed, like alcohol and choices. It was big structural stuff and I get that, I get the importance, but it never mentioned the individual. Never talked about communities. My family left Glasgow in the 70s as it was depopulating and my family made the right choice. We moved to a better quality of life with more green spaces. That's a choice."

"I have found I disagree with a lot of what people say. Too many are blaming the government when a lot of these inequalities are actually people's own doing through their own choice."

Current Drivers

Towards the end of the session, participants were asked again about what they perceived to be the current drivers and solutions to health inequalities. Two main themes were identified in these discussions: issues around government spending and public service resourcing; and individual choices.

Participants engaged in high level discussions of how government spending choices connect with health inequalities. In a post-session survey of panel members, roughly two thirds of participants reflected that the challenges faced by the NHS were a key driver of Scotland's health inequalities and worsening life expectancy, closely followed by rising poverty and inequality. Participants called for greater transparency in how funding decisions are made, suggested various avenues through which funding to the NHS could be improved, and called for a reallocation of political attention and funding away from treatment and towards prevention.

> *"I think when you have a limited amount of money, for me especially, you need to tackle the problem where it is coming from. So, if our society or the areas we live in are having an impact on health issues then that should be addressed first on a priority basis. Because if we start spending money on health then we are only fixing the things after they happen rather than trying to stop them from happening."*

> *"There needs to be more scrutiny and more capability in political decision making that inform the policies at national and local levels."*

Individual choices remained a key talking point across groups but were engaged with more deeply than in initial discussions on diet, exercise and lifestyle. Participants increasingly discussed empowering individuals to make better choices, arming them with sufficient resources to do so, and removing stigma.

> *"There's been a debate across most of the European countries about this guaranteed minimum income [...] I think it was one of the Nordic countries that gave everyone, for arguments sake, £500 on top of what they were earning. I watched a programme with some student. I think it was maybe six months they were doing this trial, and in that six months she used her extra £500 [to] improve her health and what she was eating and that sort of thing."*

3.3 Evidence on reducing health inequalities: Session 3

The purpose of the panel's third session was to explore panel members' instinctive attitudes towards potential solutions and test other proposed interventions in light of evidence on their effectiveness.

Participants were divided into small groups to discuss potential approaches to reducing health inequalities around the following umbrella themes: strengthening individuals, strengthening communities, improving living and working condition, and promoting healthy macro-policies. After initial ideas were gathered, participants were given evidence on the effectiveness on various policies and deliberated the extent to which they could reprioritise in light of this information.

Key Findings & Reflections

- **Panel members' awareness of existing interventions tackling health inequalities in Scotland were low**. The policies mentioned by participants were largely designed to promote healthy behaviours in individuals, such as minimum alcohol pricing and educational/advertising campaigns on healthy living.
- Connected to this, **panel members did not feel that any level of government is taking sufficient action to tackle health inequalities.** There were mixed views on where the blame for inaction lay depending on constitutional preferences.
- Pan**el members' own suggestions for interventions centred largely around similar educational interventions on health lifestyles** and improving/expanding the NHS' capabilities. However, groups that focused on high-level macro policies and improving living and working conditions were able to provide wide ranging suggestions for intervention that went beyond the health service itself.
- Upon the presentation of evidence which highlighted the effectiveness and ineffectiveness of different approaches to reducing health inequalities, a divide similar to that of session 2 emerged amongst participants. **A majority shifted their attention to discussions of healthy 'macro' policies**, but a significant minority remained focused on the role of the individual in determining health outcomes, despite a recognition that policy interventions targeting individual choices are less effective. This is reflected in panel members' answers to survey questions before and after involvement in the first 3 panel sessions.
- Participants identified various challenges to the implementation of policies to reduce health inequalities in Scotland, covering **issues with funding, political will, and lack of public empowerment.**

These findings demonstrate that participants are excited to suggest methods to reduce health inequalities in Scotland in response to a perceived lack of action by governments. The huge shift in panel members' perception of the effectiveness of macro policies in reducing health inequalities demonstrates that respondents do take evidence on board. Equally, as in the second session, a significant minority continued to focus on individual's behaviours despite themselves recognising that policies aiming to change individual behaviours are less effective than they initially thought.

Awareness of Current Action & Preferred Approaches

Participants had, and reported, low levels of awareness of existing actions and interventions to tackle health inequalities in Scotland. By far the most prominent policy in the minds of panel members was minimum alcohol pricing, followed by educational campaigns on healthy living. There were additional, more general, discussions around housing and carbon neutral targets, as well as specific programmes such as 'Healthy Working Wives' and the 'Healthy Start' programme for under-fives.

Participants connected this lack of knowledge on policies targeting health inequalities to insufficient progress being made by all levels of government to tackle health inequalities. These discussions also revealed a degree of confusion over where the power to intervene lies:

> *"NHS is totally devolved, so anything that the NHS in Scotland is not doing right is Holyrood's responsibility. Similarly, there's things like social services which come under a local authority thing, well local authorities are totally devolved so again that's a Holyrood thing if they're not doing enough there, then that's their responsibility. On the other hand, things like Universal Credit, that's determined at a Westminster level at present, therefore anything that hasn't been done there is their responsibility. Obviously, the plan is that that wouldn't always be the case but if I can sum up my own feelings, neither government have done enough on frankly everything really."*

When asked to propose interventions to reduce health inequalities in Scotland, participants acknowledged that actions would need to be targeted and implemented at various different levels, including individual, community and national levels.

The most common proposed interventions to reduce health inequalities focused on educational interventions on healthy lifestyles (at a national and community level), as well as improving access to health and care settings through improvements to public transport, establishing more GP practices, increasing funding to the NHS, allowing people to see the GP more often.

A range of ideas were promoted regarding high-level macro policies, such as getting people into work, reducing shame and stigma in the social security system, using progressive taxation to fund improvements to services and attempting a basic income pilot.

Discussions on community empowerment and improving living/working conditions focused primarily on the need for quality housing and neighbourhoods with green spaces, and sufficient facilities. In order to achieve this, employers, housing associations, developers, and local councils were all expected to play a role.

Evidence on Effective Solutions

Panel members received a presentation on the evidence relating to the effectiveness of interventions aimed at reducing health inequalities. Participants expressed considerable surprise at the limited effectiveness of educational campaigns encouraging healthy lifestyles and behaviours. Some expressed frustration at what they perceived to be a tokenistic approach from government, pursuing educational campaigns with little regard to their limited effectiveness.

The evidence on the significant impact of politics and policy elicited mixed reactions from panel members: most took the information on board and reflected on the perceived need to reduce broader disparities – in wealth, income and power – in Scotland.

> *"It begs the question, given that all of the other initiatives don't seem to do anything, could the government perhaps save money by not involving themselves in them. Or are they wanting to do it to that cosmetically they're trying to do something, even though statistically it appears they're doing nothing. I'm very hesitant to say 'let's stop running education campaigns, let's stop advertising the benefits of this, that and the other', but given the presentation it seems as if that's just throwing money down the drain and we'd be better off feeding it straight into the NHS."*

> *"I think comparing it to Scandinavia is actually quite a good way of looking at it, cos they still have rich people there, but they've managed to reduce the gap in inequalities by a progressive tax system, as well as people changing their attitudes and taking personal responsibility. And again, look at Sweden and Finland: it didn't happen overnight, it took time to change. The solutions sound great on paper but how can we actually get to the point where we can put it into action. How do we get power back and empower communities when all of the decision makers are powerful people who kind of benefit from that system."*

A minority, however, were more insistent, in spite of the evidence presented to them, that changing individual choices was the most effective route to tackling health inequalities.

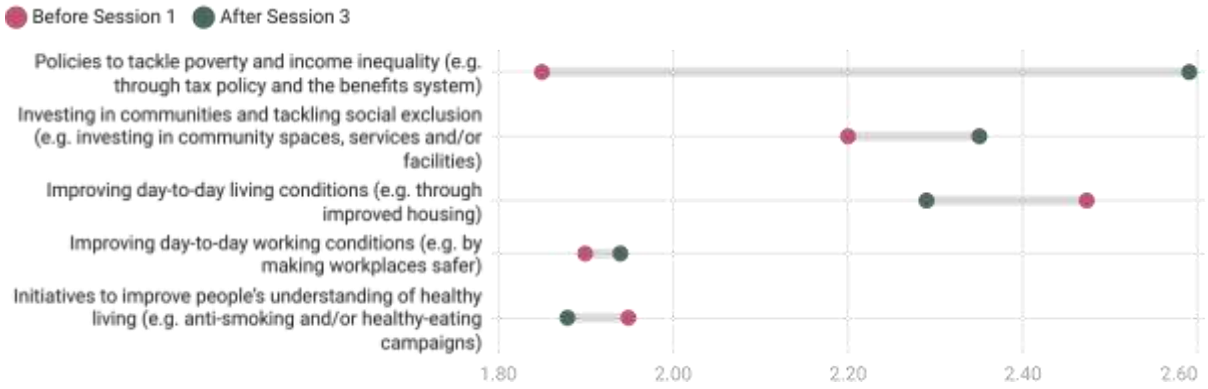
> *"He might have been trying to make the point that you need bigger actions, but I think some of the adverts do work."*

The above qualitative results were reflected in and substantiated by the findings of a follow-up survey with panel participants following the session.

Panel members were asked, both before the first session and following the third session, to estimate the effectiveness of a series of approaches to reducing health inequalities. Interventions aimed at reducing poverty and inequality had been considered the least effective approach, on average, prior to the sessions, but rose to first place following deliberation. Conversely, following exposure to evidence, educational campaigns were deemed the least effective approach. However, despite the evidence presented to them, a quarter of the panel still deemed these approaches 'very effective', pointing to a principled insistence on this.

Changes in the perceived effectiveness of different approaches

Change in the average perceived effectiveness of each intervention, pegged to a numerical scale from 0 ('Not at all effective') to 3 ('Very effective')



How effective or ineffective do you believe the following would be in reducing health inequalities in Scotland? (Average figures calculated for panel members only)

While panel members were largely receptive to this information and evidence, it elicited mixed responses. Approximately two thirds of panel members believed that it made the solutions more evident and obvious, but half said that it made them less confident that Scotland would make progress on this issue.

Perceived impediments to progress were largely political, with many expressing very limited faith in politicians to take meaningful action. The reasons behind this were both political – including short-termism and risk-aversion in politics – and practical – including fiscal constraints and aversion to raising taxes.

"Politics is plagued by short-termism in that it's very unpopular to say we're going to raise taxes to such an extent that they probably need to be raised to have a significant impact. No political party is going to grasp that nettle now."

"The history of taxation that's come from Thatcher is that people are used to a lower level of taxation. To some extent it's been happening worldwide, you've got all the arguments that if you tax the rich more and tax businesses more, they'll all move off to somewhere else, and perhaps they will."

Others, as noted above, credited practical issues around devolution with slowing progress, while others reported or demonstrated uncertainty around where powers are held. An unclear division of powers and the passing of blame between different parts and levels of government were seen to stymy progress.

Finally, the media and a lack of public engagement and empowerment were highlighted by some participants as barriers to implementation. Participants suggested that the media tend to be resistant to reform and can easily derail efforts to change. Additionally, disengagement amongst the public and low voter turn-out were connected with low levels of political will and courage to bring about meaningful change.

"[The] media doesn't help […] It just goes back to the issue of how do we change it, how do we empower people or at least get people to sense that they can change it? Cos if you're told constantly 'This is the only system we can use,' eventually a lot of people will either believe it or just give up."

3.4 Making Change Happen in Scotland: Session 4

The fourth and final panel session reflected on what the panel members had heard and discussed in the preceding sessions. It also saw participants consider the current drivers of health inequalities in Scotland, their preferred and most effective ways to tackle these, and the barriers to making progress on this. Finally, panel members drafted, with the support of the research team, a series of ambitions, priorities and principles for tackling health inequalities in Scotland.

Key Findings & Reflections

- **Compared to the first panel session, the drivers of health inequalities identified by the panel reflected high-level factors (including fundamental and social drivers) to a much greater extent, while behavioural accounts were afforded a much smaller role**. Issues of inequality, poverty and growing insecurity were much more forthcoming in these later discussions, and especially among people from more deprived areas.
- **Discussions of behavioural factors were less common and qualitatively different**, with **a greater focus on empowering individuals to live healthy lives, rather than holding individuals responsible for their health outcomes.** Individual responsibility remained an important point of principle for some however, particularly older participants and those from more affluent areas.
- **There is little faith in politicians to make sustained progress** on this issue, owing to a perceived short-termism and self-interest in politics.
- Panel members expressed **a desire for a long-term, cross-party strategy for tackling health inequalities in Scotland,** as well as increased and consistent resourcing behind this.
- Panel members also outlined a series of **policy ambitions, prioritising investment in, and improving equitable access to, healthcare, and greater redistributive efforts** through the tax and benefits system.
- There is thus an **evident appetite for greater action to reduce health inequalities**, including through upstream interventions.

Drivers of Health Inequalities in Scotland

Panel members were asked to identify what they thought were the main drivers of health inequalities in Scotland at present. The discussions contrasted starkly with those of the first session when a similar question was raised. Where early discussions had revolved very strongly around behavioural accounts, this saw a much greater focus on high-level factors and social determinants.

As in the first session, much of the panel's discussions revolved around challenges with regards to healthcare, especially issues of resourcing within the NHS. This was seen to impact negatively on access to, and the quality of, healthcare services, especially primary care which was considered important prerequisite of a preventative approach.

In terms of the frequency with which other factors were mentioned, financial and economic circumstances – including high and rising levels of poverty and insecurity – followed this. Some cited long-term trends within the economy and labour market such as rising in-work poverty and precarity, while others voiced concern at the more immediate cost of living crisis and the impacts this may have for people's health and wellbeing.

Political decisions and priorities were cited regularly, particularly among participants from more deprived neighbourhoods. This included factors such as austerity, which were seen to have impacted negatively and inequitably on certain groups' health outcomes, while others pointed to more generalised failings at various levels of government, such as implementing ineffective policies/decisions or lacking the conviction to make decisive changes.

Behavioural accounts also surfaced across groups, though these were framed in large part around political and social challenges such as drug deaths and alcoholism, in stark contrast with earlier discussions which centred on more individualised aspects like diet and exercise. This theme surfaced more regularly and readily among more affluent respondents.

Certain other factors were mentioned more exclusively by panel members from less deprived areas, including concerns around greenspace, and education.

Barriers to action

There was a perception from much of the panel that many of the barriers to progress on tackling health inequalities revolved around established procedures and processes at a political/policymaking level. These perceived bottlenecks included short-termism in political decision-making, insufficient collaboration in decision-making, and inadequate flexibility to shape planning and services at a local/community level.

By and large the panel took a dim view of politician's ability and willingness to take, or make the case for, action to tackle what were widely perceived as unfair inequalities in heath. There was a broad perception from many panel members that there is a lack of political will in Scotland to make sustained progress on this issue. Panel members also expressed disappointment and frustration that politicians

did not adequately listen to voters or to stakeholders and practitioners, and/or that they were overly focused on short-term interests.

There was also evidence of growing impatience, with many wanting faster and more decisive action. A number of panel members wanted more to show for two decades of devolution, and others pointed to various previous consultations or bodies of research that had not been actioned.

> *"There's so many possibly good ideas come up but then they can sit on a shelf and nobody does anything about it. It's like 'We've done it' but no you haven't, you haven't actually actioned it."*

Reflecting on these barriers to progress, the panel, in small groups and supported by the research team, identified and drafted a series of key principles that they believed should guide political efforts to tackle health inequalities in Scotland. These related primarily to procedure and process, while policy prescriptions are addressed elsewhere. Each principle is presented along with the proportion of panel members expressing their support for it, in descending order, and a brief summary of the rationale for its inclusion.

Reducing Health Inequalities in Scotland: Principles

On the basis of these barriers, panel members, supported by the research team, drafted a series of principles to guide efforts to tackle health inequalities in Scotland. The panel later voted on these principles, and those which received over two thirds of panel members' support are outlined below, with a brief discussion of the rationale behind them. The high level of support achieved for each one attests to this being a positive exercise in deliberation and consensus-building.

Supported by:

THE SCOTTISH GOVERNMENT SHOULD USE ROBUST EVIDENCE AND EXPERTISE ON THE MOST EFFECTIVE WAYS TO TACKLE HEALTH INEQUALITIES TO DEVELOP IMPACTFUL INTERVENTIONS

Panel members also were conscious of the need to build public support for interventions. There was a sense from some that evidenced effectiveness would lend programmes much needed legitimacy, especially if they were more expensive commitments.

Some panel members demonstrated frustration at what they perceived to be a tokenistic or performative approach from government, seen to be adopting affordable but ultimately ineffective approaches, while others criticised 'ideological' approaches that were not seen to be based in evidence, or that cherrypicked evidence to pursue a predetermined course of action.

"That does sometimes make you worry: is the information being used to try and provide genuine information for making decisions or have people already made up their minds and they're trying to make the data fit their opinions. That's the concern. Stakeholders have their own vested interests."

There was also, however, an appetite for greater flexibility to experiment and trial new approaches if they were also evaluated and could contribute to the evidence on best practice.

Supported by:

THE SCOTTISH GOVERNMENT SHOULD DEVELOP A SUSTAINABLE STRATEGY TO TACKLE HEALTH INEQUALITIES, BACKED UP WITH ADEQUATE, APPROPRIATE AND LONG-TERM FUNDING FOR NATIONAL AND LOCAL SERVICES AND INTERVENTIONS

It was broadly felt that a specific and concerted strategy was needed for tackling health inequalities, given the complexity of the issue, its straddling of diverse policy fields, and the long-term planning it necessitates.

Some suggested that politicians have not advanced a detailed programme to tackle health inequalities – or at least that they have not communicated this adequately to the public – and there was an evident appetite from panel members for a more detail, commitment and clarity. Some pointed to previous inquiries, consultations and commissions that had not materialised into concrete actions, with an evident desire for more meaningful planning.

"They all come out with the buzzwords and it's either incredibly vague or general – like during an election they'll be like 'We want everything to be wonderful' and it's like well of course you do. But again, the question is how do we change that?"

Funding and resourcing were seen to underpin any effective action and strategy, though the longevity of certain funding decisions and streams was called into question. Panel members were in agreement that continuity and adequacy of funding were prerequisites of a practicable strategy to make real and sustainable progress on tackling health inequalities in Scotland.

"Unfortunately, it all comes down to money at the end of the day."

Supported by:

THE SCOTTISH GOVERNMENT SHOULD WORK IN COLLABORATION WITH OTHER POLITICAL PARTIES TO DEVELOP A LONG-TERM PLAN FOR TACKLING HEALTH INEQUALITIES IN SCOTLAND IN ORDER TO ENSURE CONSISTENCY AND CONTINUITY, RATHER THAN ADVERSARIAL POLITICS

Adversarial political dynamics were seen as a key barrier to making progress on reducing heath inequalities.

There was a broad acknowledgment that this field may require some difficult decisions to be taken, but that competitive electoral dynamics may discourage governing parties from taking such action even if it would help to tackle health inequalities. This was seen to lead to paralysis and leave political parties in a risk-averse position, unwilling or unable to take necessary action.

> *"It's that short-term approach of the government and lack of willingness to be unpopular. You sometimes have to take unpopular decisions in the short-term to have long-term gains and nobody wants to make unpopular decisions."*

There was therefore an evident appetite for more collaborative cross-party working, to build consensus and allow for concerted and long-term action on this issue.

> *"I think there needs to be more of an agreement across all parties. Even if your party doesn't come up with the idea or doesn't agree with the other parties, if it's in the best interests of the general public, stop opposing it and causing a fuss for no reason."*

Furthermore, there was an impression that with a change of government, funding streams and policies are often revised considerably, undermining progress on long-term progress on tackling issues like health inequalities. An agreed plan with cross-party support was seen to insure against this.

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THE SCOTTISH GOVERNMENT SHOULD DEVELOP AN EFFECTIVE AND VIABLE STRATEGY TO TACKLE HEALTH INEQUALITIES IN SCOTLAND THAT BRINGS TOGETHER ALL RELEVANT STAKEHOLDERS, INCLUDING EXPERTS, PRACTITIONERS (FROM HEALTHCARE AND COMMUNITY SERVICES) AND MEMBERS OF THE PUBLIC

It was suggested that at present, people and relevant stakeholders are largely excluded from and ignored in the policymaking process.

> *"The [barrier] that springs to my mind straight away is that the decision makers that design the policies don't listen to the people who voted them in, at any level of government."*

There was an evident appetite for greater and more meaningful public engagement, contrasted with what some perceived to be a tokenistic prevailing approach to consultation.

"I was wondering if it was just a box ticking exercise where they said, 'we consulted the public' but [they've] already made up [their] mind."

A number of panel members reflected that their participation in the panel had been a valuable and informative experience that had changed their views, and that a similar inclusive approach could and should be pursued at a national level, bringing the broader public into a discussion of health inequalities, as well as why and how these should be tackled.

"I suppose it's [about] public knowledge and public education as well. These sessions have been really good, and it'd be good if that was made more public via the media so that people understood. That might help change things quite a lot, cos there is still quite a bit of ignorance on how everything works. And it would give them a sense of 'Oh, we can change things' and you're not as powerless as you think you are."

There was especial support for greater inclusion of stakeholders and practitioners in the decision-making and planning process, to ensure that any strategy and/or plan can feasibly be implemented on the ground. It was, however, accepted that this would not be easy, and that the multiplicity if groups and stakeholders active in this field made both consensus-building and task-allocation difficult.

"[There are] problems of getting the government and other groups to all go in the same direction because of people's desire to cling on to their own little power base. So, the government says one thing and the council says something different and the local NHS trust have got all their little power bases, and it's how you align all of these without either having a group at the bottom that does it all or a group at the top that dictates it."

Supported by:

THE SCOTTISH GOVERNMENT SHOULD LEAD AND STIMULATE A NATIONAL CONVERSATION AROUND HEALTH INEQUALITIES ROOTED IN PRINCIPLES OF FAIRNESS, AND WITH TRANSPARENCY AND HONESTY AROUND THEIR DECISION-MAKING

The panel wanted greater action to be on this issue taken by the Scottish Government but were cognisant of the need to bring the public with them on this.

Therefore, they suggested that politicians needed to explain why they were taking action on health inequalities, how this would improve people's lives, what they were going to do to reduce these inequalities, and why they were pursuing this particular course of action. Popular consent and legitimacy were seen as important both as principles and as pragmatic considerations for building and maintaining popular consent.

"If [for example,] taxes are going up a little or be redistributed a little, then someone is going to end up paying more and I think that communication [of why that's happening] needs to be clear. Because there's a clear endgame that at the end of the day health inequality is going to reduce, but that's a huge communication and marketing exercise so that it retains its positivity and doesn't get negative."

There was a broad desire for greater transparency and clarity from decision-makers on their motivations and rationale as part of a more honest discussion around the inevitable difficult decisions to be made., with some suggesting that politicians are not always good at doing this.

"Politicians could do a better job of explaining 'Look, I'm very sorry, we're going to do this. I realise that's not exactly a vote winner but you will thank me in five years' time where hopefully I will get re-elected for doing something'. Politicians sometimes aren't good at explaining."

It was also suggested that a national conversation around health inequalities could help build public support for action to tackle this, especially in the face of groups that might be resistant to such change.

"You generally find that [the media is] usually inevitably hostile towards anything that might go wrong – that doesn't help because it makes policymakers more risk adverse, so we won't be radical or different. So does that mean we need braver politicians and policy makers who will say 'Look, we need to do this'."

Supported by:

THE SCOTTISH GOVERNMENT SHOULD ACKNOWLEDGE THAT HEALTH POLICIES ALONE WILL BE INSUFFICIENT TO TACKLE HEALTH INEQUALITIES AT SOURCE. INSTEAD, THE SCOTTISH GOVERNMENT SHOULD ESTABLISH A CROSS-POLICY WORKING GROUP (OF CIVIL SERVANTS ACROSS DISTINCT POLICY FIELDS) TO ENSURE JOINED-UP WORKING

Panel members reflected that health inequalities are driven by a range of factors falling across distinct policy fields. While many panel members focused considerably on health policies, there was a broad acknowledgement that this is just one part of the puzzle.

"I'm thinking that they need to establish working parties to tackle each bit. So, there's several causes of health inequalities, could they have a working party for each of the causes."

However, established working practices were seen to be siloed, with insufficient holistic, joined-up thinking on these issues.

Diffley Partnership

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IN LIEU OF 'TOP-DOWN' APPROACHES, THE SCOTTISH GOVERNMENT SHOULD ENSURE RESPONSIVE AND RELEVANT LOCAL SERVICES BY DEVOLVING DECISION-MAKING AND SERVICE-DESIGN DOWNWARDS TO LOCAL AREAS AND COMMUNITIES, ENSURING THE NECESSARY DISCRETION AND FLEXIBILITY FOR SERVICES AND PRACTITIONERS ON THE GROUND

Decision-making in Scotland was seen to be highly centralised and 'top-down', rendering much of it inflexible and unresponsive at a local level.

Community empowerment and local devolution recurred across many of the panel's conversations and it was suggested that local communities often know their specific needs and how to address these better than central government. However, a number of panel members noted that it may not be in the immediate interests of those who hold power to cede it.

> *"We do have an awful lot of centralisation. Not many politicians give away power […] Centralisation has to stop but it's not going to stop overnight. Central government needs to at least try to trust local government and fund it at the same time."*

> *"I certainly don't agree the amount of central control that there is in Scotland because we are a very different country in the sense that if you look at the difference between the Central Belt and the Highlands and Islands, they could be different countries. So, the needs of these remote areas are totally different to if you're living in Edinburgh or Glasgow, for example, so it is appropriate for these local authorities and these health boards to look at their particular problems."*

Similar challenges were observed at a service-delivery level as well, with inflexible design and delivery of local services seen to hinder truly effective, tailored and responsive local services. Panel members therefore expressed support for greater discretionary flexibility for local services, and those delivering them, to tailor their work to suit local and/or individual needs and challenges.

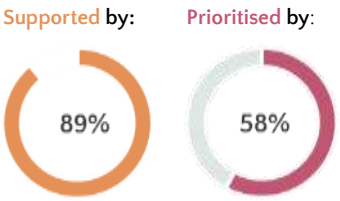
> *"If the directive is too high a level, it gets bogged down and becomes slow and ineffective. If you want to be able to react and make decisions quickly […] you need the decision-making to be empowered at a lower level. It should be broad strokes at a higher level: more strategic than operational."*

Reducing Health Inequalities in Scotland: Ambitions & Priorities

The panel and research team also worked together in small-group discussions to draft a series of statements of ambition relating to action that could be taken to tackle health inequalities in Scotland. Panel members voted on the extent to which they would support each proposal and were invited to choose and prioritise those that they believed would do most to reduce health inequalities in Scotland.

Each ambition is presented below in order of prioritisation, with the proportions supporting and prioritising each one detailed alongside, and a brief discussion of the rationale behind each ambition.

INCREASE INVESTMENT, SPENDING AND CAPACITY IN THE NHS IN SCOTLAND

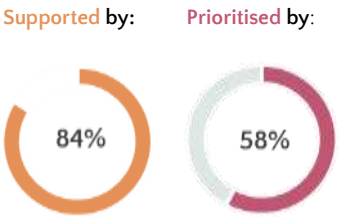


There was widespread concern at the current state of the National Health Service, with many panel members citing resource and staff-shortages. Investment was seen as crucial to deliver high-quality and timely healthcare.

In the eyes of the public, healthcare appeared inextricable as a concern from the concept of health inequalities, with sustained attention to this throughout and across the panel. Public services were broadly seen to be under strain and therefore unable to adequately respond to people's needs.

> *"The other [point] I had was general public sector funding, I feel that's having a huge impact on everything. That all comes down to health, whether it be the alcohol and drugs, the support for people, but with everything I feel that the funding is generally disappearing."*

MAKE THE TAX SYSTEM MORE PROGRESSIVE, SPREADING THE TAX BURDEN MORE EVENLY AND FAIRLY ACROSS WEALTH AND HIGH INCOMES, IN ORDER TO REDUCE INEQUALITY AND FUND HIGH-QUALITY PUBLIC SERVICES



The existing tax system was seen to be, in various ways, defective, with perceived shortcomings around regressive and outmoded direct taxes and council taxes, as well as a perception of widespread tax avoidance.

> *"With the tax rises, [the government] should make it more progressive so that those at the bottom who, at the moment, pay quite a bit of tax... The lowest end is like 20% plus national insurance – that's a large chunk of their income gone."*

"You've got to tackle the loopholes and the tax avoidance though [...] it is appalling and happens even though they know it's happening. I don't know how the government gets away without doing something about it."

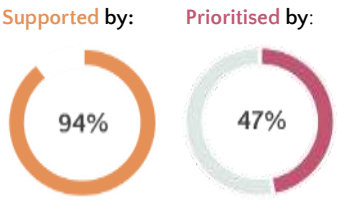
A number of panel members suggested that inequality has become too pronounced and that higher taxes should be used to redistribute wealth and resources from the better off to the worse off in society.

There was also widespread concern that key public services, and particularly the NHS, are under-resourced and struggling. There was a broad and strong appetite for greater spending and investment in public services to reduce inequitable and unfair health outcomes, and a broad acceptance that taxes would have to rise to bring about progress on strengthening public services and reducing health inequalities.

"It's unavoidable. An increase in income tax certainly must happen in Scotland if you're going to have [positive] changes, so I think starting a conversation and putting it out there sooner rather than later so that people understand why and how it's going to work [...] People would probably rather pay an extra 1% tax if it was creating a positive change."

Some panel members believed that Scotland would benefit from having greater control over a wider range of tax powers (such as capital gains tax or inheritance tax) but there was a parallel appetite for a greater use of existing powers. Panel members pointed to income tax, council tax, and land taxes as levers by which to raise extra revenue.

ENSURE A FAIR AND EQUITABLE SPREAD/DISTRIBUTION OF GP PRACTICES AND PRIMARY HEALTH FACILITIES THAT IS REFLECTIVE OF LOCAL NEED AND DEPRIVATION, TO ENSURE RELIABLE AND TIMELY ACCESS FOR ALL



Throughout the life-course of the panel, access to healthcare and local primary care services was a recurring and key concern. There was evident concern at a perceived postcode lottery, with panel members suggesting that at present, such access is varied and often inadequate.

"I think having the GP practices in the right places with the right capacity is something that we're not doing well at all just now."

A number of panel members voiced concern at a failure of primary health services to keep pace with growing and aging populations, especially in areas of rapid expansion and in more remote rural areas.

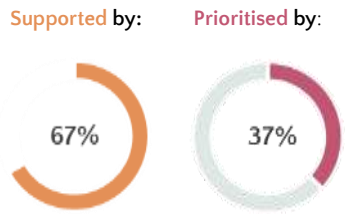
"It would be best if you say to builders 'Yes, you can build on this greenspace, but by the way, you've got to put in a doctor's surgery and facilities for a pharmacy."

"Providing more healthcare facilities in local [or] less urban areas is vital because there are thousands of GP practices across the big cities but if you go to the highlands or islands there's maybe one GP practice for the whole island."

There was concern that this shortage of primary care appointments could cause health problems to build up and become worse before people could secure treatment.

"It might be worthwhile looking into preventative healthcare as well, which would maybe help with the waiting lists because you'll get to grips with some of the medical conditions early on, so it doesn't progress to a point where they have to go into hospital and get these tests. So, it's a combination of more services, and that'll link back to what's also been pointed out where, depending on where you live, your services are a bit patchy. So, if we had an NHS which is efficient and actually providing healthcare centres as well as hospitals with enough staff to cover the area they're in..."

USE THE SOCIAL SECURITY SYSTEM TO TACKLE POVERTY AND INSECURITY, AND ENSURE THAT NOBODY FALLS BELOW A REASONABLE MINIMUM STANDARD OF LIVING



There was a broadly held belief and principle that nobody should go without their basic essentials in a wealthy, modern country. For most participants, it was immediately and easily apparent how this would impact negatively on people's health outcomes, and why this was unfair.

"We should be judged as a society by how we look after the more vulnerable."

There was a broad perception that more should be done to reduce poverty in Scotland, that inequality has grown too wide, and that the existing social safety net is not fit for purpose. A few participants spoke about the stigma and stress of claiming Universal Credit, while others suggested that it simply fails to provide responsive or stable finances amid growing insecurity, and that it serves to effectively subsidise low-paying employers.

"I think part of the problem is the demonisation of poorer people, so the way people feel if they're on benefits and the way we're all set up against each other.

"At the moment we seem to have a system where [...] you just give someone the bare, bare minimum so they're just scraping through in life."

A number of panel members called for a fundamental rethink of the social security system, with suggestions of implementing a universal basic income or a minimum income guarantee to ensure that everybody can attain their basic needs and lead a healthy life, and to build a sense of social solidarity and cohesion.

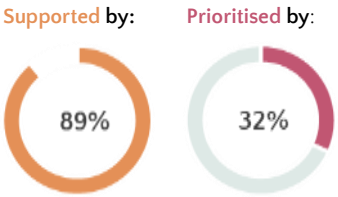
> *"Hopefully people will either have the living wage or a universal citizen's income which should hopefully help people to access things like good quality food to keep them healthy and all of the other things that come with having a bit more of an equal society."*

> *"I think, we as a collective, should be supporting each other on a level to better ourselves. […] If we supported each other, we'd be a better society and get more of what we want."*

There was some disagreement, however, over how this should be achieved. Some favoured a universal approach – variously, to ensure that nobody falls through the cracks, to account for growing precarity, and to build social solidarity – while others expressed a preference for more targeted means-testing, suggesting that it maximises impact and ensures that the worst off are supported most.

While this ambition enjoyed marginally lower support overall from panel members, there was an evident strength of feeling behind it, and for many it appeared an obvious and highly effective way to reduce health disparities.

EMPOWER AND ENCOURAGE ALL INDIVIDUALS TO LEAD A HEALTHY LIFE, BY ENSURING THEY HAVE ACCESS TO ALL THEIR RELEVANT NEEDS, INCLUDING EDUCATION ON HEALTHY LIVING, AFFORDABLE NUTRITIOUS FOOD, GREEN SPACE, AND A DECENT INCOME



Early discussions of health determinants exhibited a high degree of 'lifestyle drift', but as the panel progressed, discussions of individual behaviours became more conscious of the ways in which wider factors and circumstances could inform and constrain choices. The onus therefore moved, at least in part, from one of individual responsibility to a focus on empowering people to lead full and healthy lives.

There was a clear preference for positive approaches to changing behaviour, using incentives rather than disincentives. Many spoke, for instance, of the role of education in instilling positive behaviours, while others expressed scepticism at discouraging negative behaviours through, for instance, the tax system.

"You've got to persuade people not to do these things [through education]. Trying to use tax to change behaviour doesn't work: people will spend a larger proportion of their income on alcohol and tobacco products, and you'll actually leave them poorer in real terms. "

Resource constraints and inequitable access to relevant facilities/services were seen to limit opportunities for healthy living or actively push people into unhealthy lifestyles, and certain behaviours – such as drug and alcohol consumption – were increasingly seen as a political challenge than an individual failing.

However, individual responsibility remained an important principle for a number of panel members. There was a strong appetite for educational efforts to instil positive healthy behaviours in people from an early age, though education was also increasingly seen to have a broader empowering purpose in terms of instilling a sense of autonomy in people.

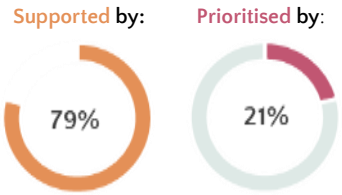
"A greater understanding of what causes poor health has always got to be a good thing because educated people make more educated decisions."

"Individuals, and not the state, are primarily responsible for their own health, hence people should be educated to lead healthier lifestyles and make better health choices."

Most panel members appeared to occupy a middle ground, whereby behavioural change plays a part in long-term improvements the health of the population, but that it reflects just one part of a much bigger puzzle, and that it is inevitably bounded by other factors.

"We agree that people need to take more personal responsibility for their own health by stopping smoking, drinking, taking drugs and eating healthily. We're not saying that's a solution [on its own] but we're saying government must continue to do that. Over the last four [sessions, some] people have been saying that's not enough, but it has to be part of it. So, government must provide people with the resources and education to make personal choices about health."

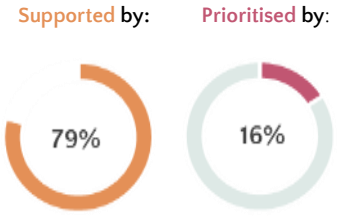
RETROFIT AND INSULATE OLD AND POOR-QUALITY HOUSING TO IMPROVE LIVING STANDARDS AND ENERGY EFFICIENCY



This was seen to reflect an obvious and simple solution to the problems caused by inadequate and unsuitable housing. Panel members suggested that much of Scotland's housing stock is of a poor standard, leading to health issues.

Retrofitting was seen as an obvious and efficient way to improve the housing stock without further encroaching on green space.

INVEST IN NEIGHBOURHOOD HEALTH INFRASTRUCTURE (INCLUDING CYCLE PATHS, LOW TRAFFIC ZONES, ETC), AND PROTECT AND EXPAND GREEN SPACE



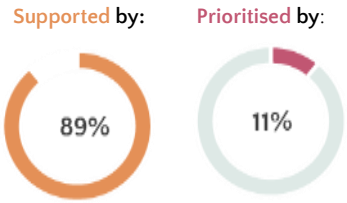
Exercise and healthy living were seen to rely on access to relevant spaces and facilities.

> *"For me, the most important thing is to improve healthy infrastructure [...] The more active you are obviously the more healthy you are likely to be."*

There were concerns at the dwindling access to green space, especially in areas that are growing rapidly, and the damage this could do to people's health. This was seen to impact negatively not only on physical health, but also mental health.

> *"There's a lot of places where there's not easy access within walking distance to playing fields or parks. They're living in a concrete jungle where there's nowhere to exercise or nowhere to play games. So, we need to stop building on green spaces. But then there's been no parks built into these massive housing estates that they've made, so that needs to be looked at"*

SUPPORT PEOPLE INTO GOOD-QUALITY EMPLOYMENT THROUGH ACCESSIBLE AND EFFECTIVE TRAINING, AND (DIRECT OR INDIRECT) JOB-CREATION



The stress and damage that poor-quality or insecure employment could impose on people was self-evident to many panel members. There was a broad perception that long-term changes in the economy and labour market have seen insecurity grow as an issue, and a number of panel members pointed to in-work poverty as a new and alarming development.

Good work was seen to provide stable, predictable, and decent incomes as well as a sense of purpose, all of which were seen to impact positively on physical and mental health. Conversely, there was frustration at the impression that the social security system was being used to subsidise low wages.

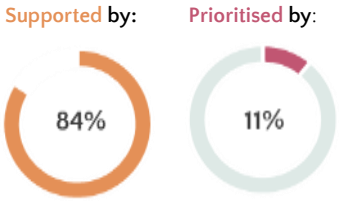
> *"You hear this thing about 'in-work benefits' and really, I think if someone is working 35 or 40 hours a week, they should be getting paid enough that they don't have to rely on benefits. And all the administrative costs and means-testing and whether people are on full uptake of those benefits. So, I*

think we need to get to a society where those people are paid an appropriate amount for the work they're doing."

There was broad support for wider labour market policies/reforms, such as introducing a real living wage to tackle in-work poverty, and some support for scrapping zero-hours contracts in order to ensure a decent and stable wage. While some acknowledged that flexible contracts can be beneficial for certain workers, there was a broad agreement that they can often be exploitative and damaging, and that this imbalance should be addressed.

"Obviously a decently set living wage so that no one is in [in-work] poverty […] so people aren't worrying where their next meal is coming from, and it means they're making healthier choices and have more time."

"I don't know if it's to save [employers'] money, I don't know how it all works – but I don't think zero-hour contracts should be allowed and I don't think that people should be left with zero income because they've not got a sufficient contract."



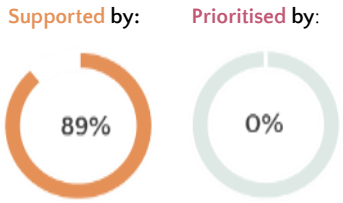
IMPOSE HIGHER STANDARDS (AND STRENGTHEN ENFORCEMENT) ON HOUSEBUILDERS AND LANDLORDS RELATING TO THE PHYSICAL STANDARDS OF NEW HOMES AND RENTED ACCOMMODATION, TO ENSURE A DECENT STANDARD OF LIVING FOR ALL

Housing was seen to have clear and significant implications for people's health outcomes, with a perception that much of Scotland's housing stock is dated and unsuitable. Throughout the panel, people drew attention to this, and flagged the poor conditions that people were living in.

"[A key driver of health inequalities is] housing being poor [or] having damp. There's not enough housing and some can be overcrowded."

There was a perception that many housebuilders and landlords do the minimum required of them to comply with current regulation and that this should be strengthened to drive up standards and to improve health outcomes.

INVEST IN AND EXPAND RELIABLE AND AFFORDABLE PUBLIC TRANSPORT TO ENSURE PEOPLE HAVE ACCESS TO THEIR MEDICAL AND NON-MEDICAL NEEDS (E.G. ACCESSING LOCAL HEALTHCARE AND/OR COMMUTING TO GOOD JOBS)



Access to local services – both healthcare services and wider community supports – was a consistent thread through much of the panel's discussions. This was seen to be especially relevant in worse connected and rural areas, where panel members regularly flagged concerns about access to primary care settings.

Conclusions

Key reflections from the research, and their implications for tackling health inequalities in Scotland.

Conclusions

Below we set out 10 key conclusions which the research team have reached from this study.

In our view, the combination of the deliberative approach to the research and the subsequent flow of findings drawn from the research participants provide a clear steer on public attitudes in Scotland, clarity on ideas that the public consider may help address the longstanding issues around health inequalities, and the barriers which need to be overcome for those ideas to be successfully implemented.

Taken together, the conclusions point to a range of opportunities for engaging the public in meaningful ways and for actions to be taken which will carry public support and make a difference in addressing health inequalities in Scotland.

1. There is considerable concern among the broad public at the scale of health inequalities in Scotland; this concern appears to grow when people are provided with detailed information and given access to expert opinion from a range of sources.

2. Alongside this concern, there is widespread support for action to address issues related to health inequalities; the nature of what the public sees as effective measures to address health inequalities changes as they gain more insight via exposure to information and expert opinion.

3. Evidence from the national survey and the initial qualitative discussions illustrate that the public tend to approach the issue of health inequalities instinctively through the prism of behavioural and lifestyle choices, focussing on these as the most significant factors behind health inequalities. This deliberative research has shown, however, that this is not insurmountable.

4. Through the deliberative workshops, we observed significant changes in the ways participants approach the issue of health inequalities, moving from an individualised language of 'responsibilities' and 'choices' to a more ecological view of the ways in which wider circumstances can inform or constrain choices.

5. The deliberative process provides significant and demonstrable evidence to illustrate that, especially when exposed to expert opinion and information, the public can develop sophisticated understanding of health inequalities and their determinants, as well as ways to tackle them.

6. By the end of the deliberative workshops, participants were more likely to identify high-level factors (including fundamental and socioeconomic drivers) as important determinants of health inequalities, significantly different from the beginning of the process where the focus was largely on behavioural and lifestyle issues.

7. In terms of interventions to help address health inequalities in Scotland, participants want to see greater investment in, and more equitable access to, the NHS and primary healthcare services, and a greater redistribution of wealth and resources through the tax and benefits system as their top priorities, as well as wider action on factors such as housing and employment.

8. In this regard, participants want to see a shift in the approach which policymakers have traditionally taken when dealing with health inequalities, moving from a risk-averse reliance on educational and behavioural programmes to more holistic and longer-term thinking aimed at addressing the root causes of health inequalities more concertedly and explicitly.

9. Despite lacking confidence in political leaders to make progress on tackling health inequalities, participants are keen to see a long-term cross-party strategy developed with all powers and resources required to make progress on tackling health inequalities effectively.

10. The deliberative process is both effective at giving participants the tools to explore the issues in greater depth and through alternatives prisms and is also seen by participants as being an enjoyable experience and an effective way of addressing complex issues. A similar dynamic and process, replicated at the national level, has an evident potential to improve public understanding of health inequalities and build support for meaningful and effective action to tackle these.

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Appendix

National Survey Topline Results

Technical details

- The survey was designed by Diffley Partnership. and invitations were issued online using the ScotPulse panel,
- Results are based on a survey of 1079 respondents aged 18 and over,
- Results are weighted to the Scottish population by age and sex.

Question 1

Thinking about people's physical and mental health in Scotland, how large an impact would you say the following have on people's health? Rate from 1 (small impact) to 5 (large impact)

Base: All (1074)	Average
(Access to and quality of) healthcare services	4.39
Lifestyle and individual behaviours	4.34
Financial and professional circumstances (e.g., personal finances, employment, and income)	4.29
Personal circumstances (e.g., friends, family life, relationships and upbringing)	4.29
Environmental factors (e.g., housing, neighbourhood, and green space)	4.12
Genetics and family medical history	3.85
Inequalities in political participation and representation (e.g., involvement in shaping policies, public views being reflected by politicians)	3.36
Luck/chance	2.75

Question 2

And from the following list, please select the 3 factors that you believe have the biggest impact on people's physical and mental health in Scotland

Base: All (1078)	Percentage
Their money & resources	79%
Work/employment	58%
Their friends & family	50%
Their surroundings and neighbourhood	40%
Housing	36%
Education	21%
The local community	7%
Their access to affordable and reliable transport	6%

Question 3

To what extent do you agree or disagree with the following statements:

Base: All (1078)	Strongly agree	Tend to agree	Neither Agree nor Disagree	Tend to disagree	Strongly disagree	DK
	%	%	%	%	%	%
People in better off areas in Scotland tend to be healthier than people in worse off areas in Scotland	46	40	7	3	1	3
The difference between the health of those living in better off areas and the health of those living in worse off areas is a big problem in Scotland	39	37	14	3	1	5
The Scottish and UK Governments should do more to reduce the differences in health between different groups and areas.	56	30	8	2	1	1
In general, it is more efficient to prevent illnesses and poor health than to treat them.	64	26	5	2	1	2
The COVID-19 pandemic has made me more aware of the ways that health problems impact differently on different groups of people.	30	41	17	6	4	2
The COVID-19 pandemic has made me more aware of the ways in which our social, economic and personal circumstances can affect our health	33	38	18	6	4	2

Question 4

'Health inequalities' refer to differences in the health status of different population groups. This includes, for example, differences in health between people in more affluent areas and people in more deprived areas. How effective or ineffective do you believe the following would be in reducing health inequalities in Scotland?

Base: All (1078)	Very Effective	Somewhat Effective	Not Very Effective	Not at all Effective	DK
	%	%	%	%	%
Initiatives to improve people's understanding of healthy living (e.g., anti-smoking and/or healthy-eating campaigns)	25	44	23	5	3
Investing in communities and tackling social exclusion (e.g., investing in community spaces, services and/or facilities)	38	45	10	2	4
Improving day-to-day living conditions (e.g., through improved housing)	51	39	6	2	2
Improving day-to-day working conditions (e.g., by making workplaces safer)	28	48	17	3	4
Policies to tackle poverty and income inequality (e.g., through tax policy and the benefits system)	44	31	13	7	5

From many voices to smart choices