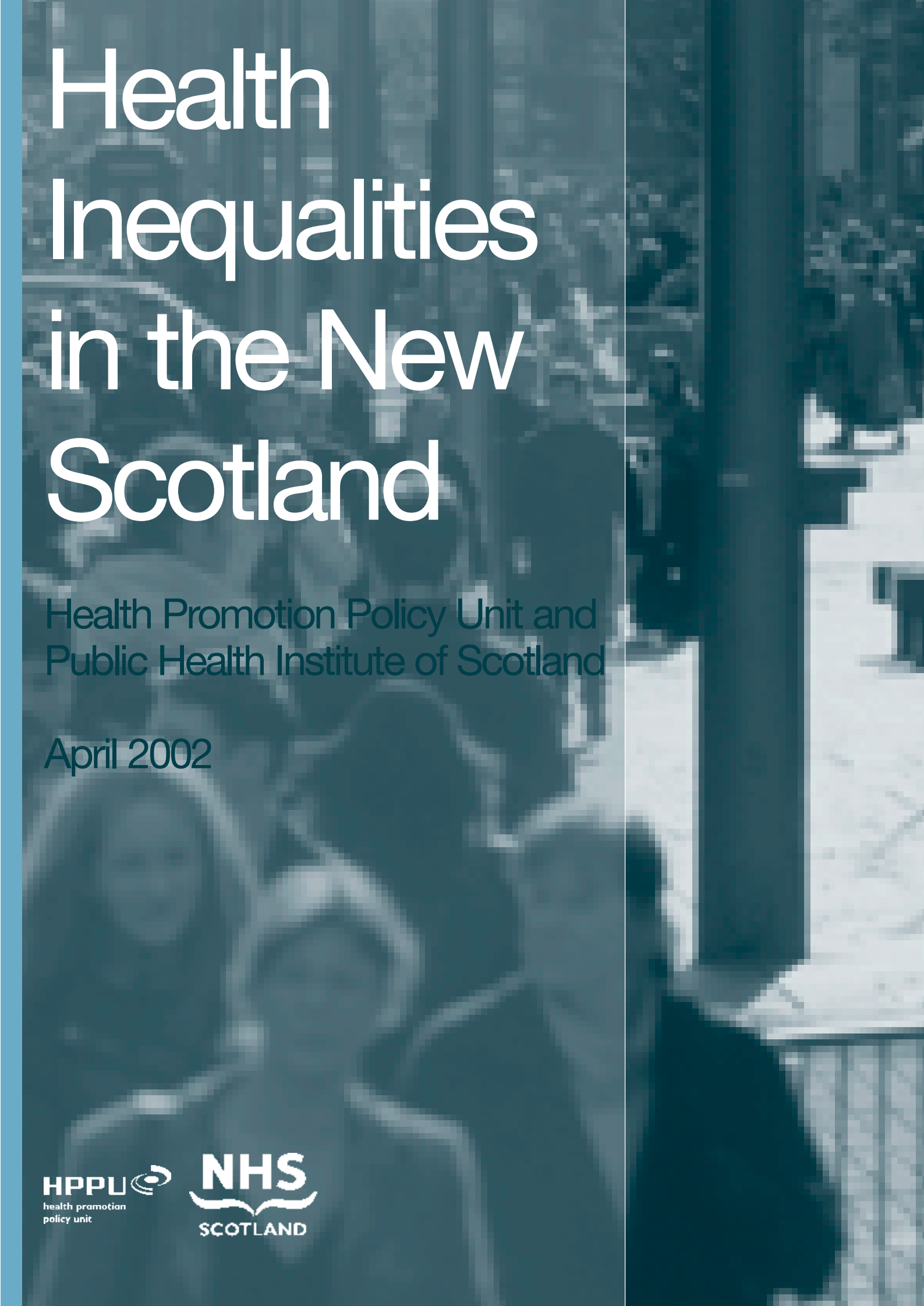
Health Inequalities in the New Scotland



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Health Inequalities in the New Scotland

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introduction

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The Scottish Executive is committed to taking action that will lead to a reduction in health inequalities. Such an approach is now central to their strategic policy direction. A clear set of actions is being put in place in response to the unavoidable fact that the poorest people living in the most disadvantaged circumstances suffer substantially more avoidable illness and disability and premature mortality. This is in direct contrast to the years following the publication of The Black Report (1980)[1] when inconvenient facts were largely neglected. For too long, health policymakers appeared to be more concerned with an obsessive search for value for money in the delivery of health care than in the promotion of population health. Now, the new emphasis on promoting social justice in general and reducing social-determined inequalities in health in particular is very welcome. Furthermore, it has been carried forward with great vigour. New policies have flowed thick and fast since 1997 with an additional momentum for positive change being provided by the establishment of the Scottish Parliament in 1999.

There can be no doubt that many of the commitments made by both the UK government and the Scottish Executive represent a substantial response to the diagnosis of the problem of health inequalities set out in official reports such as the Acheson Inquiry (1999)[2] and independent foundations such as the King's Fund (Benzeval *et al*, 1995)[3]. At the same time it is important to acknowledge that the evidence base for choosing to invest in one intervention rather than another is weak and that the results of action will take many years to unfold. Difficult choices between many desirable options have to be made in a world where uncertainty about the best course of action is endemic and where there are many competing values and vested interests clamouring for this or that preference to be made.

In these kinds of circumstances we believe that there is real merit in policy research groups making independent contributions to the process of analysis and monitoring that ought to be an increasingly important part of future policy review. That is why we have produced this report. We have tried to bring together a number of contributions that between them help to provide an overview of current patterns of inequalities in health in Scotland and the actions that are being to taken to reduce them.

The report begins with a context-setting piece by Avril Blamey and Jill Muirie, which defines what we mean by health inequalities and introduces the latest thinking about their causes and possible solutions. This is followed by a summary of the evidence about geographical and social inequalities in health in Scotland in the late 1990s compiled by Iain Paterson. The report then presents a number of personal perspectives by experts in different areas about patterns and trends in health inequalities and their determinants. Marion Bain reviews trends in health inequalities by reference to the targets set in the most important policy documents related to this area produced by the Scottish Executive. Robina Goodlad considers the approach to area deprivation in Scotland and assesses the potential of policies in such fields as housing and regeneration to contribute to tackling health inequalities. David Bell then turns his attention to labour market policies to reduce poverty in the expectation that this must be an important part of any strategy to bridge the health divide. Deirdre Elrick discusses recent policies aimed at reducing the extent of child poverty. Finally, Ken Judge and Iain Paterson undertake a preliminary assessment of the extent to which important elements of the Scottish social justice strategy are making progress, and employ a range of indicators of trends in health inequalities to assess whether this problem is getting worse or not.

One important part of this report, which follows some brief reflections about the key messages emerging from contributors as a whole, is a digest or calendar of key events – in or about Scotland and related directly or indirectly to health inequalities – that took place between the establishment of the Scottish Parliament and the end of the calendar year 2001. This provides a tangible testament of the extent to which actions are being taken to deliver on commitments made in this area. The future intention is to update this on an annual basis.

We commend this report to the many colleagues who are concerned about and are engaged in action to reduce the problem of health inequalities in Scotland. Above all we hope that it will be accepted as an even-handed, albeit modest, contribution to the existing debate about how to improve the health and welfare of **all** Scots regardless of their social circumstances.

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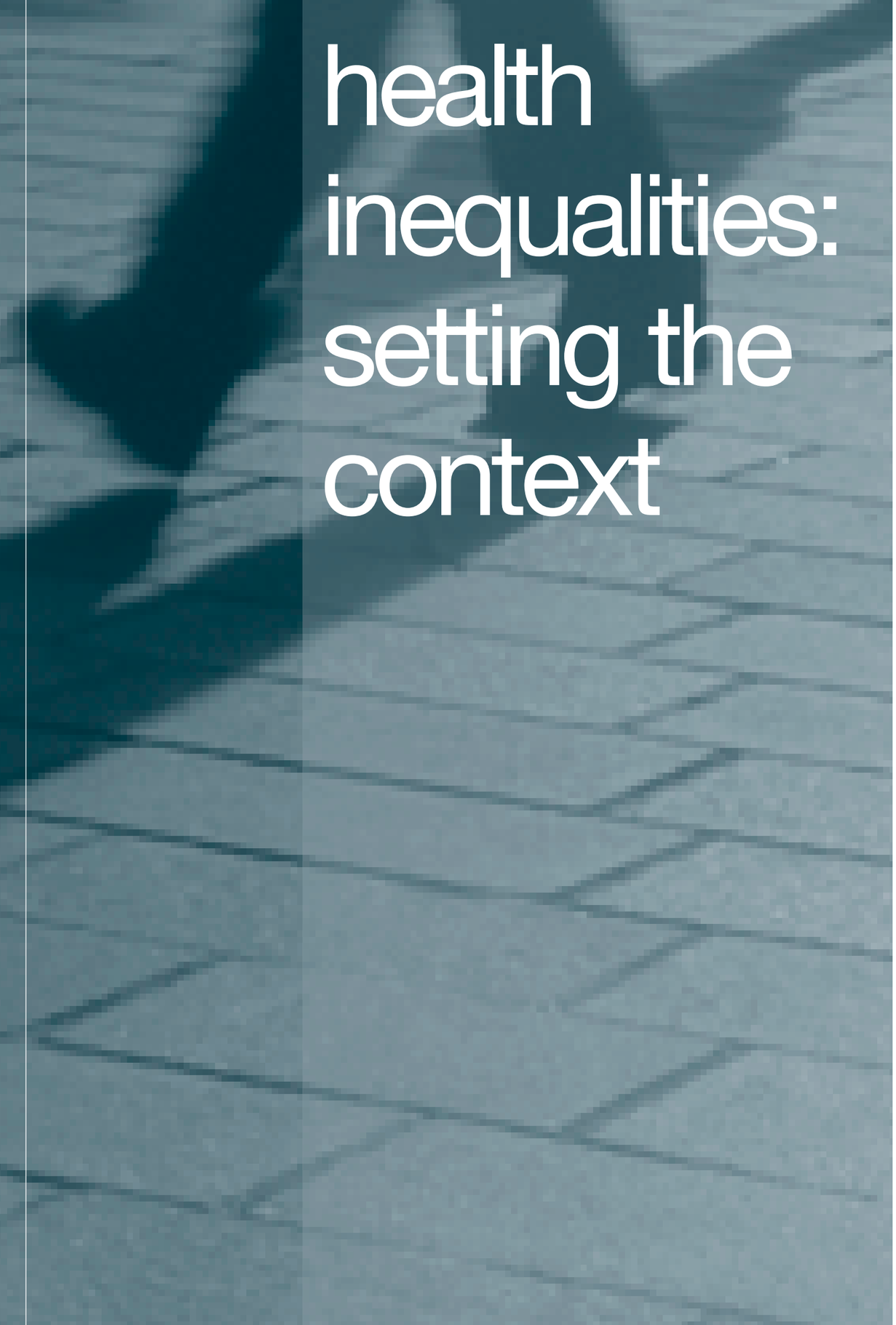

health inequalities: setting the context

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This paper aims to define the concept of socio-economic health inequalities and explain what we mean by that term within this publication. It aims to highlight current thought on the main causes of inequalities in health and on where the consequent solutions might lie in terms of health policy and interventions. It will also comment on some of the current debates about health inequalities.

What are health inequalities?

'Health inequalities' are the differences found in various aspects of health between different groups in society. The focus of this publication is on the differences in health between those who are best and worst off in society (in relation to socio-economic circumstances such as employment, income, housing and social support). Over the last twenty years, in general population terms, life expectancy and prosperity have increased and death rates from major diseases have fallen. However, despite this, the gap between those at the top and bottom of the socio-economic spectrum has persisted and has in fact increased in Scotland and the UK during the late eighties and early nineties'. This health gap between socio-economic groups exists virtually irrespective of the type of health indicator and socio-economic measures chosen for comparison and analysis. More over, those who benefit most from social, fiscal and health advances are generally not those who are in greatest need.

How do health inequalities manifest themselves?

Inequalities in health are observed for a wide range of health outcomes. They are found in self-reported health measures, objective measures such as death and illness and in access to services. They are also evident across the lifespan throughout childhood, adulthood and old age.

The Black Report[2], published in 1980, was the first report to gain international recognition of the extent of, and the increasing trends in, inequalities within the UK. These findings were reinforced in 1987 with the publication of The Health Divide[3]. Numerous other publications added further weight to these findings, confirming that substantial health inequalities exist between individuals, groups, social classes, income brackets, races and genders and across geographical locations (e.g. north and south of the UK and within cities).

In 1997 the Labour government established an *Independent Inquiry into Health Inequalities* chaired by Sir Donald Acheson. This inquiry report[4], published in 1998, reinforced the fact that health inequalities in the UK were still widening and evident across all aspects of health, all stages of life, and across various social and geographically defined groups. A few examples of the range and extent of these inequalities taken from Shaw *et al*[1] are detailed below. More detailed analyses of current health inequalities in Scotland are included in the subsequent papers by Ken Judge and Iain Paterson and Marion Bain.

- In terms of life expectancy in the UK (1992-96), the difference between men in social class I (professionals) and social class V (unskilled) was 9.5 years (6.4 years for women)[5].

- During the period 1991-95, residents in areas that make up the 10% of the UK with the worst health record[a] were more than twice as likely to die as a result of CHD before age 65 than those living in the areas that constitute the 'best health' 10%[6].

- In 1981-85 the standardised mortality ratios (SMR) in the 'worst health'[b] constituencies was 155[c], this rose to 178 in 1991-95. During the same period in the 'best health' constituencies it fell from 76 to 68[7].

What are the causes of these inequalities in health?

There are several potential explanations for the associations found between socio-economic status and health.

One explanation is that the association occurs simply as a result of the way in which health, social class and other variables of socio-economic status are gathered and analysed. In other words, according to this line of explanation, the association between poor health and lower socio-economic status would be an artefact of measurement. However, the associations that have been found[8] have been remarkably consistent in shape and size across many studies, methodologies, and timescales and in relation to many plausible variables. They are, therefore, very unlikely to be a result of data collection and analysis techniques.

A second explanation suggests that the association exists because of selection: people who have poor health are likely to be found in lower social classes and be living in poverty because their poor health has impacted on their educational attainment, employment prospects and their subsequent income, housing status and physical or geographical environment. The opposite of this would be expected for those with good health. Research studies have followed people over long periods of time to gauge the likely direction of influence between health and employment, education or income, for example. Findings from this research have indicated that selection cannot be solely responsible for the levels of association found[8].

A third explanation proposed for the association between poor health and socio-economic status is that it results from behavioural factors

a Shaw *et al*[1] split age-sex adjusted standardised mortality ratio (SMR) data for Britain into deciles for analysis (p121).
b Shaw *et al*[1] calculate SMRs for the 1 million people living in constituencies with the worst health and the best health respectively to draw comparisons (p11).
c The UK average mortality ratio = 100. A mortality ratio of 155 would therefore be 55% greater than the UK average.

such as smoking, inactivity and poor diet among those in lower social classes. While there is evidence that the impact of lifestyles goes some way to explaining some of the association (such as that between smoking and lung cancer) there have been many studies that have controlled and accounted for the influence of high risk health related behaviours and, despite this, have still found very strong associations. For example a study by Lantz *et al* in 1998[9] indicated that as little as 10-30% of the gradient between health and socio-economic status could be explained by behaviour.

The above explanations all have a number of limitations and the vast majority of recent research evidence clearly indicates that the major causes of health inequalities are related to socio-economic factors, such as income, education and employment, and the subsequent impact that these factors will have on the material environment that a person experiences, such as their working environment, housing, transport and nutrition. The health impact of these socio-economic inequalities can be further exacerbated through their interactions with race and gender inequalities. Experiences such as migration, racism and single parenthood (predominantly among women) can interact with socio-economic status to compound inequalities. The interplay of all these different factors over an individual's life course appears to be complex. An example of how this might work is illustrated in Box 1.

Box 1
An individual's health is likely to be influenced by their material circumstances and physical environment (e.g. if they have sufficient income, are unemployed or have a hazardous occupation or if their home is damp). To a more limited degree it will be influenced by their lifestyle and behaviours, which are likely in turn to have been influenced by the social norms and family history that they have experienced. Psychosocial factors such as the degree of control they have over their work, the amount of social interaction and support they experience and the subsequent stress that may result from this will also play a part in determining their health. Each of these experiences can act on health independently but in combination the impacts are likely to interact and further compound the experiences and mechanisms that lead to poor health. In other words, children born into low income families are more likely to live in overcrowded houses, to exist in an environment where smoking is the norm (so suffer passive smoking and be more likely to smoke themselves) and if they gain employment it is more likely to be in a hazardous work environment (e.g. factory) in comparison to individuals born into wealthier homes.

In addition to the individual factors that influence health, there is some evidence that a geographical or area effect can have an impact on health over and above that explained by the socio-economic factors related to the individuals who inhabit that area. Some of the mechanisms by which the place that one lives can have an impact on health include aspects of the infrastructure, such as transport limiting access to services, retail provision impacting on access to healthy food, fear of crime in a local area influencing freedom of movement and the social structures or networks dictating opportunities for socialising and community involvement.

Why have health inequalities increased?

Inequalities in health have widened in a manner that parallels the social inequalities that have resulted from recent economic change. In the late 1990s, unemployment among unskilled manual workers was 20% compared to 1% in professional groups[11]. Educational achievement has improved overall but again the gap between high and low achievers is growing. Throughout the 1990s there has been a dramatic rise in homelessness and people living in temporary accommodation and 60% of people living in social housing are economically inactive[11]. In the mid 1970s, only 7% of households were defined as living in poverty. This rose to 25% in the mid 1990s. Thirty-five per cent of children were believed to be living in poverty in the UK in 1990[12]. All of these factors are strongly associated with differences in health outcomes as illustrated below.

- In 1991 people living in the worst health areas earned on average only 65% of the income of those in the best health areas (this is likely to be a substantial underestimation of the actual differences due to limited data availability)[13].

- In the period 1991-95, the areas with the 'worst' health outcomes had more than four times as many households with children living in poverty in them than the areas with the 'best' health outcomes[14].

- The mortality rate in the 10% of UK constituencies with the lowest incomes was 27% above the average for Britain in the early 1980s but was 34% above the average in the early 1990s[15].

Further research is required to fully explain the complex pathways by which these various mechanisms can influence health and the degree to which each is responsible for different health outcomes across social groups and individuals. There is, for example, some debate about the degree to which absolute and/or relative poverty influences health and whether the mechanisms for this are material deprivation and/or psychosocial factors about one's perceived status relative to others. There is, similarly, a lack of clarity as to whether the focus of policies to improve health should take an individual or area focus. Robina Goodlad discusses the success of area-based policies in her subsequent paper.

Despite these debates it is overwhelmingly clear that inequalities in health exist, have widened and that they must be tackled by social policies which focus on the wider socio-economic determinants of individual and population health, if the health of all citizens is to be improved.

What is the current status of health inequalities in Scotland?

The following statistics demonstrate that Scotland has a relatively heavy burden of ill-health compared to other areas of the UK. More detailed analysis of this burden is contained in Iain Paterson's subsequent paper.

- 52% of the 'worst off million' people in the UK in terms of health live in Scotland[16].

- By 1998 the mortality rates in Scotland's three 'worst health' local authority areas (West Dunbartonshire, Inverclyde and Glasgow City) had risen to be twice the average rate for Britain as a whole[17].

- The premature death rates for men (<65) in the UK fell by more than 10% between 1991 and 1998. The corresponding decrease in the three Scottish local authority areas with the lowest rates was only 6%, and in the three wards with the worst rates there was no fall[17].

Not only does health in Scotland fare badly compared to other UK countries, but there are substantial inequalities *within* Scotland. These are detailed further in the subsequent paper by Marion Bain.

- In Scotland over the 1990s, the gap between districts with high rates of premature death and those with low rates has widened[17].

- For lung cancer, the incidence rates among people living in the most deprived areas of Scotland are three times higher than the rates in the least deprived areas. (Lung cancer is the commonest cancer in men and the second most common in women in Scotland)[18].

- Those in the most deprived areas have a 2.5 times greater risk of dying from coronary heart disease (CHD) than those in the least deprived areas. (This association is most obvious in the under-65s)[18].

- The percentage reduction in mortality from CHD in the most deprived areas during 1990-99 was 34% compared to a decrease of 38% in the least deprived areas[18].

- Over the last ten years suicide rates among the most deprived groups have increased by 26% (The average increase was 19%)[18].

Some variances in inequalities in health are perhaps unavoidable due to genetic inheritance, exposure to certain environments, individual choices and chance[3]. In order to be acceptable, however, such variation must be randomly distributed across social groups. If such variations are unequally distributed across gender, ethnic or socio-economic groups or are associated with levels of education, income, occupation or access to services, then these should be considered to be unethical and therefore unacceptable to a modern society.

How can inequalities be tackled?

Whitehead[19] suggests there are four main levels of health policy action that are commonly found. These are:

- Strengthening individuals;
- Strengthening communities;
- Improving access to essential facilitates and services; and
- Encouraging macroeconomic and cultural change.

Many of the policies that have the greatest potential impact on health have traditionally been outside the influence of the health sector (e.g. pensions, housing, transport). These policies have been introduced primarily for other reasons and this has consequently meant that their health and particularly their health inequalities impact have rarely been fully evaluated. Despite the lack of full health impact assessments of policies there is some evidence that policies at each of the above levels can help to improve health. Governments, however, must be aware that some policies will work better than others at reducing health inequalities. They must ensure that improving the health of some of the population does not happen at the expense of others and lead to a widening of the health inequalities experienced[20]. The sensible policy response is one that is multifactorial in order to address material deprivation as well as inequalities in income and access, and to avoid focusing on one life stage (eg childhood) to the exclusion of others. Some overall lessons from Whitehead[19] appear to be that:

- policies and interventions may need to be specifically targeted at those in greatest need;
- policies aimed at changing individual and group behaviour will have only limited success amongst deprived groups unless backed by economic and structural change to create supportive environments;
- change is likely to require long-term commitment to policies;
- interventions that are found to be successful need to be applied to large sections of those in need; and
- the greatest effects are likely to result from policies that provide adequate support for those in poverty and promote the redistribution of income and opportunities in relation to education and training which may prevent poverty.

What is the Scottish Parliament doing to address health inequalities?

The Chief Medical Officer (CMO) for Scotland in his recent report 'Health in Scotland 2000'[19] stated in the foreword that,

"With deprivation comes a higher burden of disease, poorer uptake of services and worse outcomes of care … I very much welcome, therefore, the Executive's determination to put the social justice agenda at the heart of health policy. Tackling exclusion: economic, social, cultural and geographic, is a key theme of our National Health Plan, a plan for action, a plan for change".

The policy response of the current government in Scotland has broadly mirrored that of Westminster in terms of taking a three-pronged approach:

- Area based initiatives to improve services and opportunities in the more deprived communities.
- Macro-societal approaches to tackle, for example, early life influences; and
- Individual lifestyles interventions to allow people to make informed choices about the behaviours that will influence their health.

There appears to be a clear commitment within the Scottish Executive to tackle the determinants of poor health in an attempt to address health inequalities. There is a range of current policies that work within and across the range of levels described by Whitehead[19]. Some examples of these are listed in Box 2. A more detailed listing of all policies and interventions is contained in the *Calendar of Events*.

Box 2

Strengthening individuals
- New Deal
- Free nursery places
- Cubie Report
- Smoking cessation services

Strengthening communities
- Healthy Living Centres
- National Health Demonstration Projects
- Social Inclusion Partnerships

Improving access to essential facilities and services
- Housing policy (transfer)
  (See *Calendar* April 11th 2000)
- 'Fair Shares for All'
  (See *Calendar* Sept 7th 2000)

Encouraging macroeconomic and cultural change
- Tax policy
- Minimum wage

How will we know if these policies are successfully reducing health inequalities?

In order for both the government and the electorate to monitor the government's stated aim to reduce inequalities, it is necessary to have valid, reliable and appropriate measures that indicate both short and medium term progress as well as long-term success. Finding such measures can prove challenging particularly when seeking to determine issues such as levels of social cohesion and changes over time. Even measuring deprivation requires the use of a particular definition or set of criteria which may seem arbitrary or may not be appropriate for all sections of the population. As an example, car ownership is a useful proxy for deprivation in urban areas but in rural areas, where car ownership is often a necessity, such a measure is less appropriate. The different measures currently in use along with their limitations are discussed in a subsequent paper by Marion Bain.

What progress has been made by the Scottish Executive in tackling inequalities?

The subsequent papers in this publication attempt to address this question and to illustrate and discuss the progress that has been made to date both by the new Scottish Parliament and through the relevant policies that are still under the authority of Westminster. The papers attempt to provide fuller detail and analysis of the current position of health inequalities in Scotland and the impact of area-based, work-related and child-focused policies on this picture. The articles also consider the degree to which the new parliament in Scotland has achieved its own health related social justice milestones.

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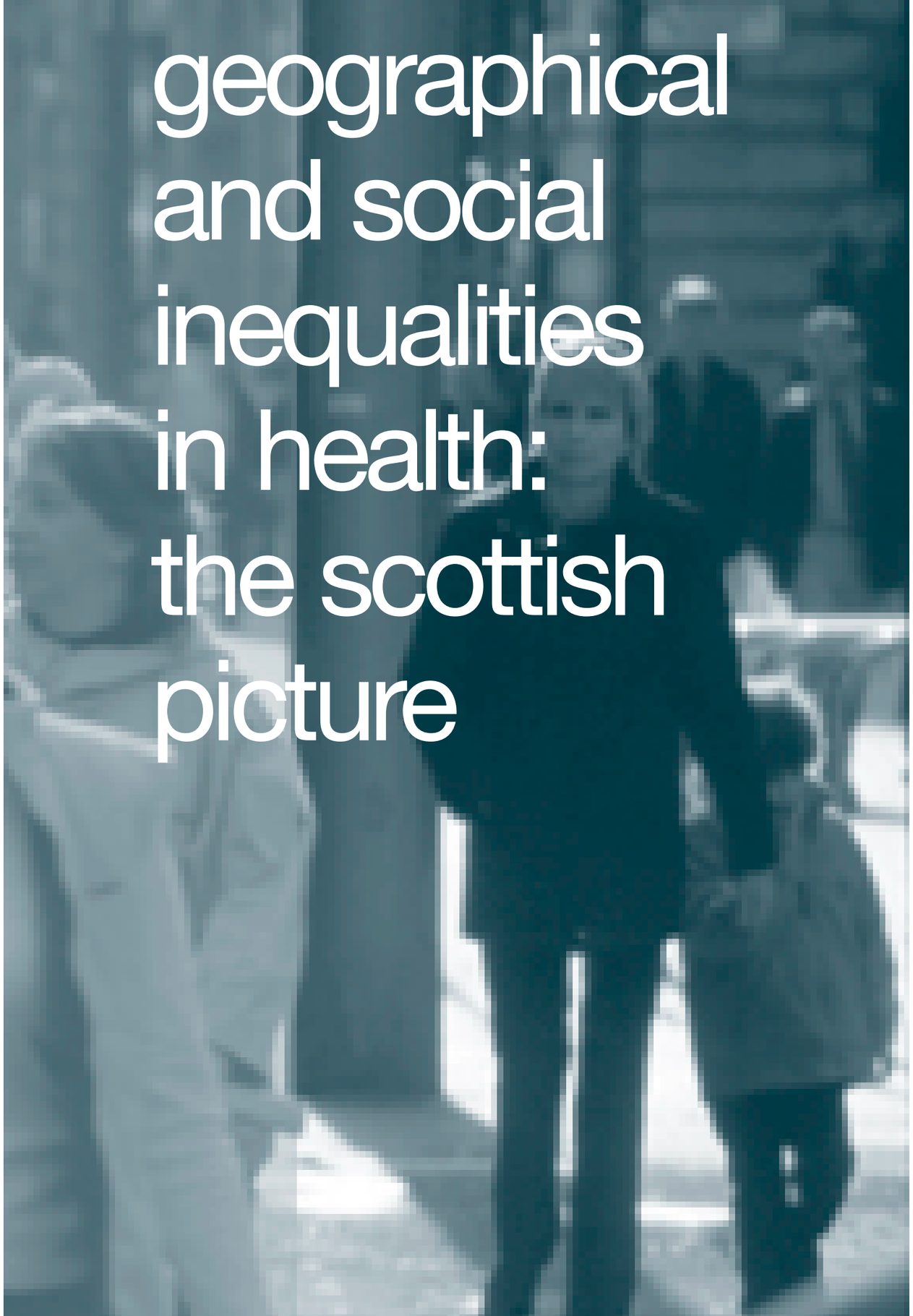

geographical and social inequalities in health: the scottish picture

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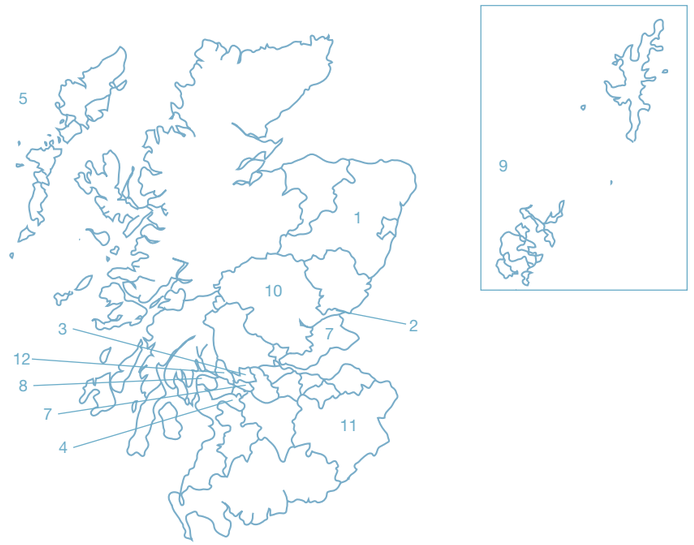
This section provides some evidence of geographical and social inequalities in health in modern Scotland. Sharp variations in health outcomes are seen at a number of area levels: between Scotland and the UK, between Scottish local authorities and between Scottish and English parliamentary constituencies. Social inequalities in health can also be established between individual Scottish households using social class as the discriminator. Avril Blamey and Jill Muirie's introductory paper provided some conceptual explanations for the links between poverty and health. Here the associations between both area and individual level poverty and health outcomes are presented.

Scotland and the UK

Scotland recorded a standardised mortality ratio (SMR) of 116 in 1998 (see Table 1). This means that mortality in Scotland was 16% above the UK average after accounting for any variation in the age and sex distribution. Of the 32 Scottish local authorities, only two recorded a ratio below the UK average; these figures were only marginally lower (East Renfrewshire and East Dunbartonshire both at 97). Surveying the selected local authorities listed in Table 1, the overall Scottish picture is quite poor compared with the UK average. Four local authorities record ratios of at least 30% above 100. Glasgow City recorded the highest SMR in the UK during 1998 at 139[1].

The disparity between Scotland and the UK average follows a very similar pattern for both male and female life expectancy. Based on three-year averages between 1997 and 1999, a Scottish male could expect to live 2.3 years less than the UK male average, while his female counterpart could expect to live 1.9 years less than the corresponding average (see Table 1). Only women located in East Renfrewshire could expect to live longer than the UK female average, and only by a few months. A Glaswegian female could expect to live 4.5 years less, while a Glaswegian male could expect to live a substantial 6.2 years less. Overall, seven of the worst ten UK local authorities for male life expectancy were in Scotland, as were four of the worst five authorities for female life expectancy. At this level, therefore, Scotland is clearly burdened with massively disproportionate poor health relative to its population size within the UK[2].

Table 1: Health Outcomes in Selected Scottish Local Authorities – how they fare against UK average



	Selected local authority	Male life expectancy 1997-99 (compared to UK average)	Female life expectancy 1997-99 (compared to UK average)	Standardised Mortality Ratios (UK = 100) 1998
1	Aberdeenshire	75.1 (+0.2)	79.8 (-0.1)	+1
2	Dundee City	71.4 (-3.5)	77.6 (-2.3)	+20
3	East Dunbartonshire	76.0 (+1.1)	79.3 (-0.6)	-3
4	East Renfrewshire	76.3 (+1.4)	80.5 (+0.6)	-3
5	Eilean Siar	70.9 (-4.0)	79.4 (-0.5)	+13
6	Fife	73.8 (-1.1)	78.9 (-1.0)	+11
7	Glasgow City	68.7 (-6.2)	75.4 (-4.5)	+39
8	Inverclyde	69.6 (-5.3)	77.3 (-2.6)	+34
9	Orkney Islands	73.4 (-1.5)	79.4 (-0.5)	+15
10	Perth and Kinross	74.9 (=)	79.3 (-0.6)	+3
11	Scottish Borders	75.1 (+0.2)	79.6 (-0.3)	+1
12	West Dunbartonshire	69.6 (-5.3)	76.3 (-3.6)	+30
13	West Lothian	72.0 (-2.9)	76.5 (-3.4)	+31
	Scotland	72.6 (-2.3)	78.0 (-1.9)	+16
	UK	74.9	79.9	100

Health outcomes *within* Scottish local authorities

Table 1 also highlights health inequalities within Scotland. These inequalities do not necessarily exist between East and West, or North and South, rather they can vary greatly between neighbouring authorities in particular areas of the country. The most dramatic examples occur in the heavily populated Clydeside conurbation. Glasgow City – the local authority with the poorest health outcomes in Scotland by far – is bordered by the two local authorities that record the best health outcomes – East Dunbartonshire and East Renfrewshire. These two authorities also neighbour West Dunbartonshire and Renfrewshire respectively, which also record health outcomes among the worst in Scotland. On the East coast, there are significant health differences recorded between Dundee City and neighbouring Angus, where the former records an SMR of 120 and the latter only 107, and where the life expectancy gap between authorities for men is 3.4 years.

It is vital to understand the reasons behind these stark health inequalities if they are to be reduced. The introductory paper cites evidence that health inequalities are underpinned by variations in socio-economic deprivation. Given this, it is useful to study the strength of the association between health outcomes and markers of deprivation in those local authorities that are of greatest concern.

Deprivation and health *within* Scottish local authorities

A database has been constructed consisting of the health outcomes plotted in Table 1 plus indicators of deprivation for all 32 Scottish local authorities. Three indicators of deprivation are used for illustrative purposes:

- the proportion of the working-age population claiming a key social security benefit;
- the proportion of dependent children reliant on key benefits; and
- the proportion of pupils eligible for free school meals.

The first and second indicators are based on UK government estimates from the end of 1999 and the third is based on Scottish Executive figures from 1999-2000.

The *strength of the association* between indicators of deprivation and health is established by calculating the correlation co-efficient. This co-efficient (represented as *r*) is the measure of a *linear* relationship between two variables and ranges from -1.0 to 1.0. In a graphic representation of the association between two variables (in this case deprivation and health), if all points (the 32 local authorities) appear exactly on a straight line then *r* will be either 1.0 or –1.0, depending on whether the relationship is positive or negative. If the points are randomly scattered then *r* will be zero. The stronger the association, or 'better the fit', the greater the magnitude of *r* (i.e. the closer *r* will be to –1 or +1).

Figures 1 and 2 show the shape and strength of the association between the proportion of the working age population claiming a key social security benefit and life expectancy for males (figure 1) and females (figure 2). Both graphs show that a strong negative association exists (*r* = -.827 for males and *r* = -.835 for females). In other words, the higher the rate of benefit dependency in a local authority, the lower the life expectancy of the people that live there.

Figure 1:Association between working-age benefit claimants and male life expectancy

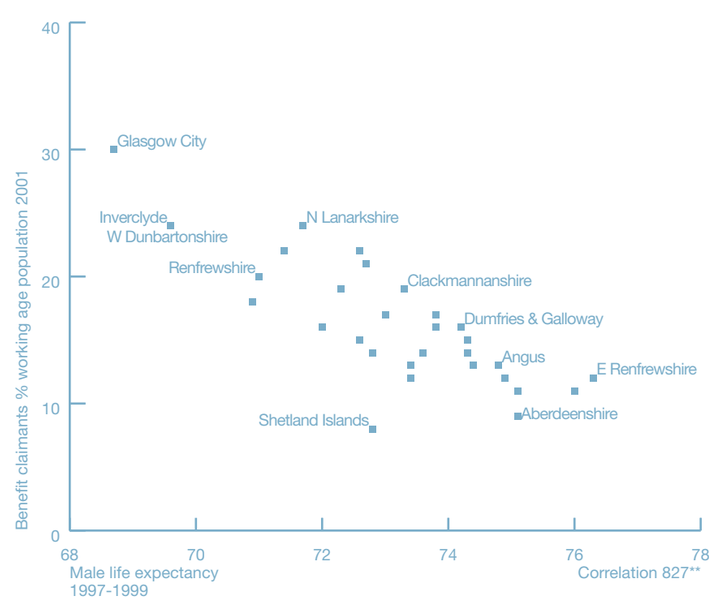
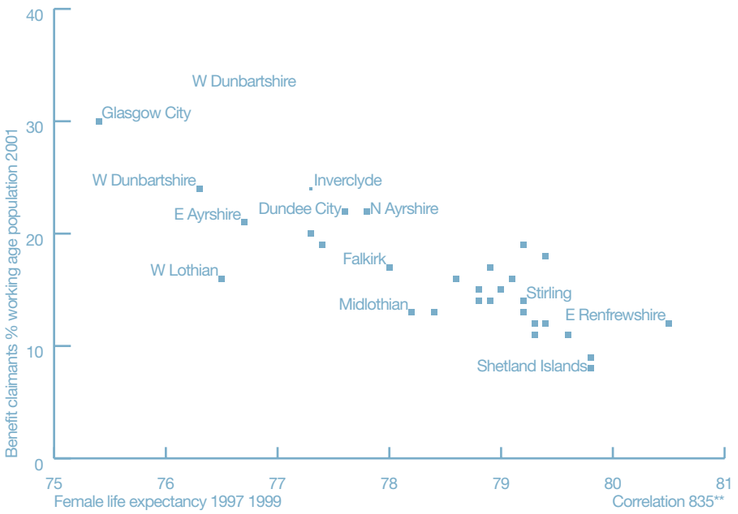


Figure 2: Association between working-age benefit claimants and female life expectancy



All three indicators of deprivation were correlated with Standardised Mortality Ratios and male and female life expectancy. The strengths of the associations are presented in Table 2.

Both male and female life expectancies are strongly negatively associated with all the markers of deprivation. The standardised mortality ratio also has a strong positive association with all three – the higher the deprivation in local authorities, the higher the age-adjusted mortality rate.

Table 3 presents these data in terms of health and deprivation for what can be identified as the eight 'best' and eight 'worst' Scottish local authorities. These authorities are not ranked within each category, but show consistently better or worse outcomes across most, if not all, deprivation and health indicators compared with other authorities. The only authority that can be said to have a clear rank is Glasgow City, which records the highest scores in all deprivation indicators and the poorest outcomes in all health indicators. Overall, the data presented in Table 3 place the worst health outcomes within the most deprived authorities, while the most affluent authorities are also the healthiest. That said, there are a couple of qualifications to be noted. First, the low male life expectancy rates and reasonably high SMRs recorded for the affluent Orkneys

Table 2: Correlations between indicators of health and deprivation at local authority level

	% working-age population claiming key social security benefit 1999	children of key benefit claimants as % of dependent children 1999	% children entitled to free school meals 1999 –2000
Standardised Mortality Ratios 1998	.741**	.718**	.739**
Male life expectancy 1997-99	-.827**	-.761**	-.788**
Female life expectancy 1997-99	-835**	-.865**	-.846**

** Correlation is significant at the 0.01 level (2-tailed)

and Shetlands. Rather than being associated with deprivation levels, population health in these islands could be linked instead to factors associated with isolated rural communities. Second, the SMR of 131 recorded in West Lothian during 1998 – the third highest in Scotland (see Table 1). This is despite the fairly average levels of deprivation recorded in the area (not presented).

Deprivation and health at parliamentary constituency level in Britain

While a clear link exists between deprivation and health at local authority level in Scotland, it is worth attempting to identify similar links using smaller comparator areas. Twenty-eight of the 32 local authorities recorded populations of at least 80,000 in 1998. A lot of these authorities are likely to contain smaller neighbourhoods with marked differences in deprivation levels and hence health outcomes. These may be overlooked as they disappear when the averaging out effect of calculating the overall area health status occurs. Fortunately, data on poverty and mortality has recently been released at parliamentary constituency level for the whole of Britain[3]. The 72 constituencies in Scotland are more likely to be socio-economically homogenous than the larger, less numerous local authority areas. Researchers have compared the one million people living in constituencies with the 'worst health' with the one million people in constituencies with the 'best health'. Table 4 lists the 15 parliamentary constituencies that contain the one million people aged under 65 with the highest age-sex-standardised mortality ratios in Britain between 1991 and 1995. The percentage of

Table 3: Deprivation and health indicators for selected Scottish local authorities

Local authority	% working-age population claiming key social security benefit 1999[a]	children of key benefit claimants as % of dependent children 1999[b]	% children entitled to free school meals 1999-2000[c]	Male life expectancy 1997-99	Female life expectancy 1997-99[d]	SMR (UK=100) 1998[e]
Worst						
Glasgow City	30	38	42.3	68.7	75.4	139
Inverclyde	24	21	24.6	69.6	77.3	134
W Dunbartonshire	24	26	29.9	69.6	76.3	130
Dundee City	22	25	27.0	71.4	77.6	120
North Lanarkshire	24	26	25.4	71.7	77.3	121
Renfrewshire	20	22	24.9	71.0	77.3	126
East Ayrshire	21	27	21.9	72.7	76.7	118
North Ayrshire	22	22	25.7	72.6	77.8	116
Best						
E Renfrewshire	12	12	10.1	76.3	80.5	97
E Dunbartonshire	11	9	9.5	76.0	79.3	97
Aberdeenshire	9	10	6.4	75.1	79.8	101
Perth & Kinross	12	10	8.0	74.9	79.3	103
Scottish Borders	11	13	8.6	75.1	79.6	101
Moray	13	16	10.2	74.4	79.2	105
Orkney Isles	12	12	8.2	73.4	79.4	115
Shetland Isles	8	10	7.2	72.8	79.8	118

a National Statistics. Regional Trends 2000 Edition. Figures for November 1999. Key benefits are Jobseeker's Allowance, Incapacity Benefit, National Insurance Credits (only through Jobseeker's Allowance and Incapacity Benefit), Severe Disablement Allowance, Disability Allowance and Income Support.
b Department of Work and Pensions Analytical Services Division. Figures for February 1999. Caseload figures are based on a 5% sample and percentages are subject to a high degree of sampling error and ought to be used only as an indication of the true picture.
c Scottish Executive statistics. Pupils whose parents are in receipt of income support or income-based jobseeker's allowance or who is him/herself in receipt of that benefit.
d Life expectancy for both males and females from Health Statistics Quarterly 11, Autumn 2001 (National Statistics).
e National Statistics. Regional Trends 2000 Edition.

households living in poverty in each constituency is listed alongside (see Appendix B of Shaw *et al* 1999[3] for details of the poverty score). The column '% of avoidable deaths' refers to the percentage of premature deaths that would not have occurred during the period of study if that constituency had the mortality rate of the best off health million.

The table clearly indicates that the clustering of the 'worst health' areas of Britain is in Glasgow. The chances of dying at any time under age 65 in Glasgow Shettleston are 2.3 times the national average. Had the mortality ratios of this constituency been the same as for those of the 'best health' one million people, 71% of the deaths of constituents under 65 would not have occurred during the period of study. Even among these 'worst health' one million people, there is evidence of a north-south gradient in mortality ratios, ranging from 2.3 times average at their worst in Glasgow, to 1.6 times the average in the London constituency of Southwark North & Bermondsey. Overall, 52% of the worst off million people in terms of health live in Glasgow and neighbouring Greenock & Inverclyde. By contrast, the 13 constituencies with the lowest mortality ratios are, apart from Sheffield Hallam, all in the south of England and mainly in suburban and rural areas.

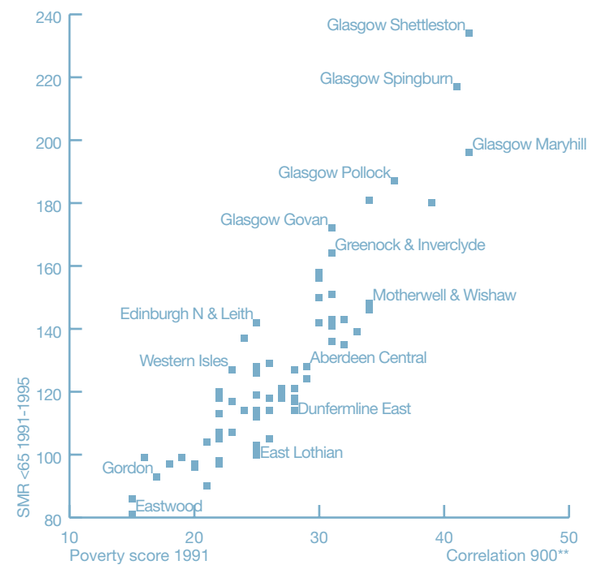
On wider inspection, we find that several other constituencies in West Central Scotland follow closely behind those listed among the worst 15. Indeed, 16 constituencies located in the Clydeside conurbation make the worst 30 constituencies for health in the whole of Britain. Overall, one half of the 72 Scottish constituencies are located within the first 9 'population million' categories in terms of premature mortality out of a total of approximately 47 'population million' categories of Britain (see Appendix A of Shaw *et al* 1999)[3]. Comparisons between Scottish and British health outcomes at constituency level are therefore very consistent with those made at local authority level.

It is important to measure the strength of the relationship between premature mortality and poverty at this level. The correlation co-efficient for this relationship for all British constituencies is such that $r = 0.85$. Taking the Scottish constituencies alone, the association between premature mortality and poverty is even stronger at $r = 0.90$. Figure 3 demonstrates the strong positive relationship between poverty levels and the likelihood of premature mortality. There is a very good 'fit' indicated by the degree of linearity – stronger than any such association at the larger local authority area unit.

Table 4: Mortality and poverty among constituencies with the worst health in Britain

Constituency	SMR<65 1991-95	% of households in Poverty 1991	% avoidable deaths
Glasgow Shettleston	234	42	71
Glasgow Springburn	217	41	69
Glasgow Maryhill	196	42	65
Glasgow Pollok	187	36	64
Glasgow Anniesland	181	34	63
Glasgow Baillieston	180	39	62
Manchester Central	173	40	61
Glasgow Govan	172	31	61
Liverpool Riverside	172	39	61
Manchester Blackley	169	34	60
Greenock & Inverclyde	164	31	59
Salford	163	34	59
Tyne Bridge	158	37	57
Glasgow Kelvin	158	30	57
Southwark North & Bermondsey	156	38	56
Worst health million	178	37	62
Best health million	68	13	0
Britain	100	21	32

Figure 3: Association between poverty and premature mortality at parliamentary constituency level

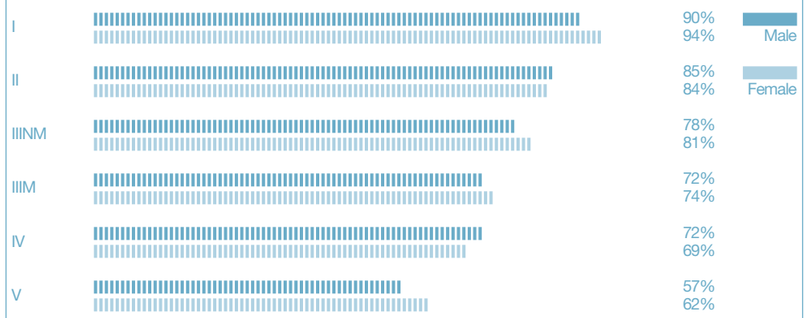


Deprivation and health at *individual / household* level

Correlations at both local authority and parliamentary constituency level show very close area-level relationships between high rates of deprivation/poverty and poor health outcomes. Such close relationships may go some way in explaining health inequalities between different parts of Scotland, and between Scotland and other parts of Britain. However, it is also important to consider individual level data on poverty and illness. As Marion Bain points out in her following paper, research suggests that up to half of the most deprived individuals in Scotland may in fact live outside the most deprived areas. Information on self-rated health and smoking is presented below to demonstrate the links at individual/household level. This information is disaggregated by 'social class of chief income earner' in households sampled by the Scottish Health Survey of 1995 and 1998.

Figure 4 is based on data from the 1998 survey, and shows the distribution of respondents who rated their health 'good' or 'very good' by gender and the social class of the chief income earner in the household. There is a clear gradient across the six social class categories; those living in households whose chief income earner is located in social class I (professional) are the most likely to rate their health good or very good. This response level steadily decreases down the class categories, with those respondents associated with the lowest class rank V (unskilled) least likely to report good health. This gradient is consistent among both males and females, with the latter slightly more likely to report good health in all social class categories except IV (semi-skilled). Therefore inequalities in self-rated health – or morbidity – are shown to exist by household social class.

Figure 4: Very good/good self-assessed health by social class of chief income earner

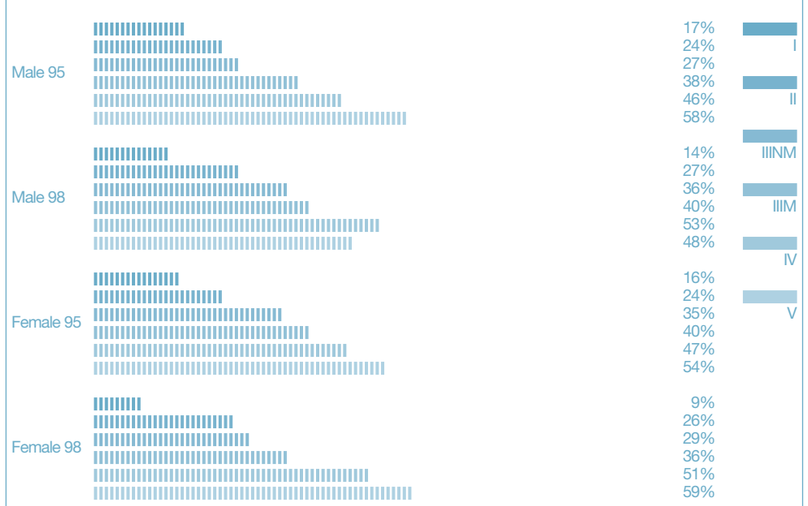


Source: Scottish Health Survey 1998

Figure 5 indicates the percentage of respondents who considered themselves smokers at the time of the 1995 and 1998 surveys by gender. The social class gradient is more apparent among women for both survey years; women in the lower social ranks are more likely to smoke than those at the upper end. This situation appears to have sharpened between 1995 and 1998 as a larger gap appeared between social classes IV and V and the rest. Indeed, smoking rates among females fell in all other categories except social class II. There was a clear social class gradient in smoking rates among men in 1995, but the pattern had changed by 1998. Smoking rates increased in social classes II, IIINM, IIIM and IV, but dropped in social classes I and V. The latter is surprising given the rises elsewhere; by 1998 men in social class IV were more likely to smoke than those in the lowest social class. Despite this, notable social inequalities in smoking rates were shown to exist for both genders during the late 1990s.

Disaggregation of dietary information by social class of chief income earner also reveals notable inequalities in the consumption of fruit and vegetables. It is important to note that these analyses are not the same as those presented by Marion Bain, who has disaggregated health behaviours such as smoking, diet and alcohol consumption by Carstairs deprivation quintiles (i.e. by area, and not individual deprivation). Nevertheless, it is interesting to note that in her subsequent paper the gradients of such health behaviours by individual social class and by area deprivation are quite similar.

Figure 5: Current smokers by gender, year of survey and social class of chief income earner



Source: Scottish Health Surveys 1995 & 1998

Summary

The data presented in this chapter demonstrate that health inequalities clearly exist between both areas (local authorities and constituencies) and individuals in Scotland. Furthermore, poverty is strongly associated with area-level health and social class is clearly linked with individual health. Establishing the existence of health inequalities is the simple part; explaining them, as Avril Blamey and Jill Muirie describe, is a more complex task. Contemporary research is beginning to locate individuals in the places in which they live and to suggest that both individual factors and area influences have their part to play in the causation of health inequalities. Results suggest that, while area differences in health are mainly attributable to the individual socio-economic characteristics of residents, where people live also matters for health. In other words, poorer people may have poorer health partly because they have to live in places which are health damaging[4]. Certainly, areas such as Glasgow, Inverclyde, West Dunbartonshire, North Lanarkshire and Ayrshire have all suffered acute economic decline over the past three decades through the demise of heavy industry. This might have impacted on population health status over and above the aggregate health status of poor individuals living within these areas. As Marion Bain advocates in her article, greater investment is required in data that measure exactly how poverty impacts upon health in order to better inform the Scottish Executive of interventions that could reduce health inequalities. As it stands, the Executive has embarked on a social justice strategy incorporating commitments to both deprived individuals and deprived areas/communities. These are outlined by the *Calendar of Events* and explored in detail in the following papers.

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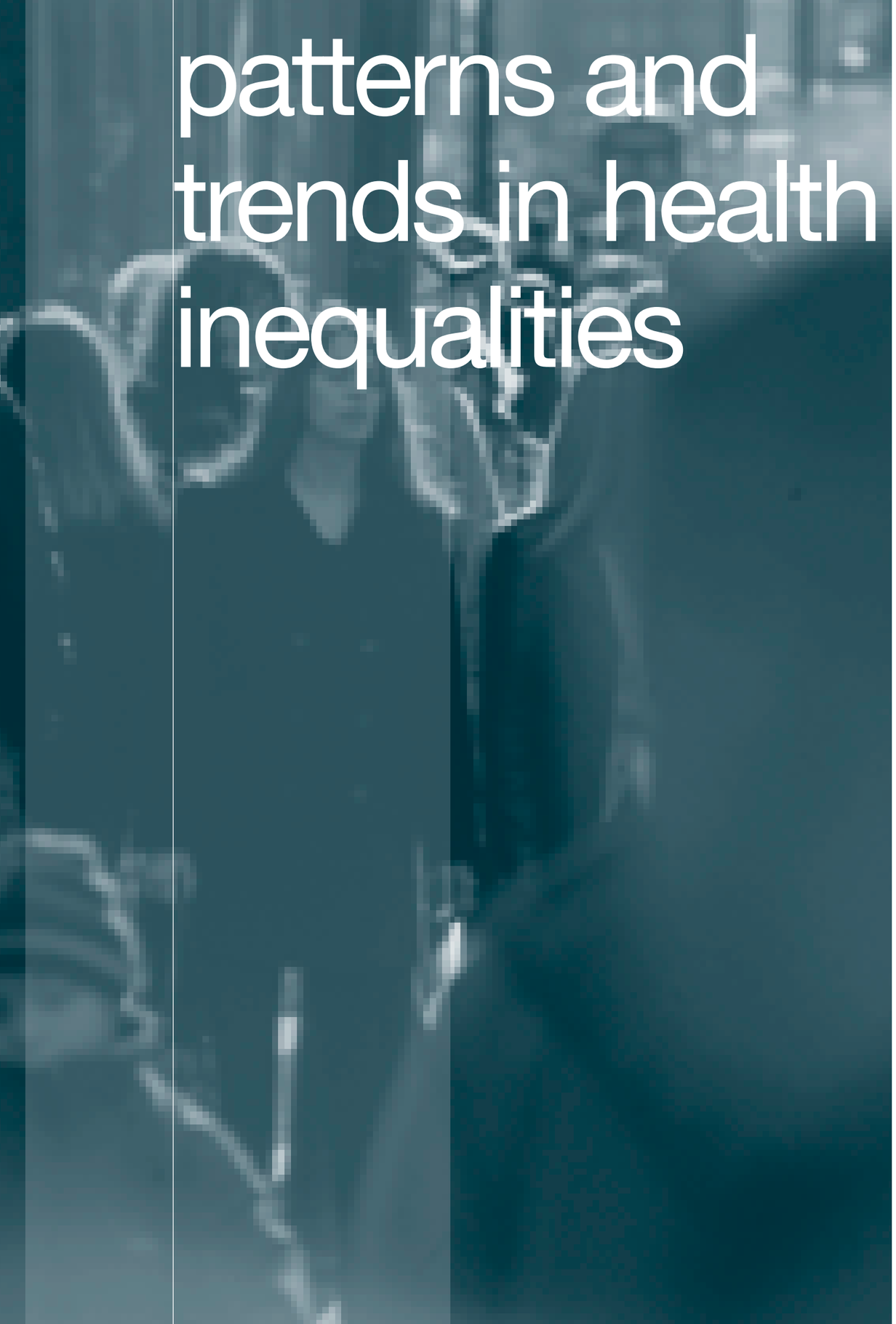

patterns and trends in health inequalities

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Towards a Healthier Scotland (1999) set out a range of indicators and targets for Scotland at the national level. The targets included disease specific targets and lifestyle targets. In 1999 the Scottish Executive also published the *Social Justice Strategy, Social Justice … a Scotland where everyone matters.* This set out 10 long-term targets for the achievement of Social Justice, with 29 milestones marking progress towards the targets, four of which specifically related to health. This chapter discusses current health inequalities and recent trends in key areas identified as targets in these two major policy documents.

Monitoring progress

The assessment of the impact of recent government policies on socio-economic inequalities is not straightforward. Much of the routine data on which to base progress is not timely enough to assess very recent impacts. For example, mortality data for the year 2000 has only recently become available, and because of a change in coding practice reliable comparisons can only currently be made to 1999. Cancer registration data will shortly be complete to 1998. National lifestyle information comes mainly from the *Scottish Health Surveys*[1,2]. The most recent survey relates to 1998. In addition, as the first survey was conducted in 1995, there is only a limited amount of information on trends from this survey. Finally, many of the policy interventions would not actually expect to result in rapid changes in disease incidence and mortality for the major health problems identified but would expect slower, longer-term change. However, it is possible to look at the current situation in Scotland and recent trends in order to consider the environment in which current policies are working.

Measuring deprivation

The most common routinely used measure of deprivation in Scotland is the Carstairs and Morris index, and it is this measure that is used in this chapter[3]. This is an area-based measure that uses four indicators (collected at the time of the 1991 census) that are related to material deprivation. These indicators are combined to create a composite score for each postcode sector in Scotland. The score can be divided into quintiles (with deprivation quintile 5 representing areas of high deprivation and quintile 1, low deprivation), with each quintile containing one fifth of the population. Using this measure allows the pattern of diseases and lifestyles between people living in areas of differing socio-economic deprivation to be described.

Health inequalities and recent trends in the key health priority areas

Three major health priority areas identified in *Towards a Healthier Scotland* were cancer, coronary heart disease and mental health. Coronary heart disease, and mental health milestones were also set in the *Social Justice Strategy.*

Cancer (Box 1)

Cancer is one of the greatest health problems facing Scotland. In 1997 over 25,000 cases of cancer were diagnosed in Scotland, and in 2000 almost 15,000 people died of the disease. By the age of 74 approximately 1 in 3 men and 1 in 4 women can expect to have been diagnosed with cancer.

For many cancers, incidence and mortality are higher, and survival is lower in people from more deprived areas. Looking at the incidence and mortality from all cancers combined gives an indication of the extent of the inequalities. Lung cancer is the commonest cancer in men and the second commonest cancer in women in Scotland. Lung cancer is more than twice as common in those from deprived areas.

Box 1: Inequalities in cancer

All cancers combined		
	Incidence*	14% higher in the most deprived
	Mortality*	40% higher in the most deprived
Lung cancer		
	Incidence*	215% higher in the most deprived
	Mortality*	220% higher in the most deprived
Trends in all cancers combined death rates		
1991-1997		8% fall in the least deprived
		5% fall in the most deprived
1991 Ratio of most deprived to least deprived:		1.4
1997 Ratio of most deprived to least deprived:		1.5

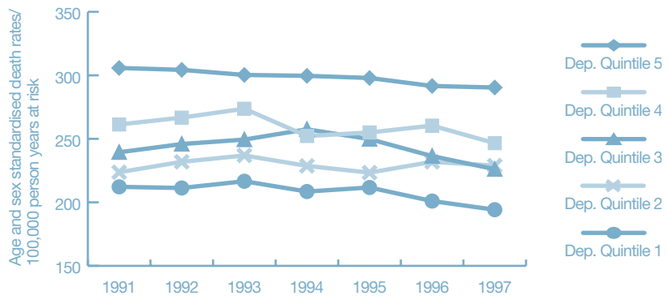
* Based on 1991-1997 data combined.

The year 2000 target for cancer was to reduce mortality from cancer in people under 65 by 15% between 1986 and 2000, and this has been met. A new target, to reduce mortality in people aged under 75 by 20% between 1995 and 2010, has been set in *Towards a Healthier Scotland.* There has, however, been little evidence of any impact on inequalities in mortality from cancer. Figure 1 shows the trends in death rates from cancer since 1991. People from all deprivation groups have seen a decline in rates, but the gap between those in the most deprived and least deprived areas remains. In fact, the ratio of death rates between the most and least deprived has increased slightly over the period.

Coronary Heart Disease (Box 2)

Coronary heart disease (CHD) is a major cause of death in Scotland, accounting for over 13,000 deaths each year. Scotland has one of the highest death rates from CHD in the world. However, there has been some significant progress in tackling this disease. The mortality rates from CHD have been declining steadily over the last 20 years or so. The year 2000 target set for CHD (to reduce mortality among people under 65 by 40% between 1990 and 2000) has been met, and a new target, to reduce rates by 50% between 1995 and 2010 in those under 75, has been set in *Towards a Healthier Scotland.* Reducing mortality from CHD has also been included as a milestone within the Social Justice framework.

Figure 1: Trends in death rates from cancer by deprivation quintile



Box 2: Inequalities in coronary heart disease

Mortality:*			
Age less than 65 years		240% higher in the most deprived	
Age 65-74		164% higher in the most deprived	
Trends in death rates for under 65 year olds 1990-1999	1990-1999	38% fall in the least deprived 34% fall in the most deprived	
		1990 Ratio of deaths in most deprived to least deprived:	2.3
		1999 Ratio of deaths in most deprived to least deprived:	2.4
Trends in death rates for 65-74 year olds	1990-1999	40% fall in the least deprived 31% fall in the most deprived	
		1990 Ratio of deaths in most deprived to least deprived:	1.4
		1999 Ratio of deaths in most deprived to least deprived:	1.6

* Based on 1991 - 1999 data combined.

There is a clear gradient of increasing incidence and mortality from coronary heart disease with increasing deprivation. The correlation is most marked in those aged under 65. All groups of the population have enjoyed falling death rates from coronary heart disease over the last ten years (Figure 2). The absolute fall in numbers has been greatest in those from the most deprived areas. However, the percentage fall has been greater in those from the less deprived areas and the ratio of deaths between the most and least deprived has increased.

Inequalities in health are often less evident in older people. There is, however, a clear relationship between coronary heart disease and deprivation for those aged 65 to 74 years, although it is not quite as marked as at the younger ages. The percentage reduction has again been less in those from more deprived areas.

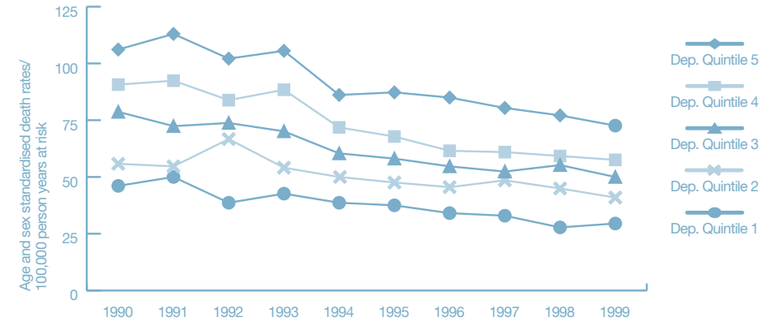
Mental health

Mental health problems are one of the commonest causes of ill health in Scotland. On average in Scotland, there are over 300 consultations for mental health problems for every 1,000 people in a general practice during a year. There is less evidence of an increasing gradient with increasing deprivation. Rather, the rates are fairly similar in most areas except those living in the most deprived areas where the rates are considerably higher[4]. Incidence rates, based on general practice consultations, for anxiety and depression in those from the more deprived areas of Scotland are around twice as high as rates in the least deprived areas.

It is difficult to find valid, available measures of mental health. Reducing suicides in young people was chosen as one of the Social Justice milestones. Suicidal behaviour is related to a complex mixture of behavioural, emotional, interpersonal and social factors, and cannot be used as a direct measure of mental health[5]. However, suicide is an important cause of premature death, especially among young men, and mental illness is an important causal predictor to some suicides, although other factors are also important[6].

Through the 1990s suicide rates in young men have steadily increased. For young women the rates are much lower and have stayed relatively constant over the last 20 years. There is a strong association between suicides and deprivation, with twice as many suicides occurring in those from the most deprived areas of Scotland. Over the last ten years the rates have also increased more in those who are most deprived.

Figure 2: Trends in death rates from coronary heart disease in under 65s



Box 3: Inequalities in suicide rates in men aged 15-29

Suicide rates*	179% higher in the most deprived	
Trends in suicide rates	1991-1999:	20% increase in suicide rates in young men in Scotland 38% increase in men from the most deprived areas
	1991 Ratio of most deprived to least deprived:	1.4
	1999 Ratio of most deprived to least deprived:	2.1

* Based on 1991-1999 data combined.

Lifestyles inequalities and trends

Lifestyle influences on health have also been included as national targets. *Towards a Healthier Scotland* and the *Social Justice Strategy* both included targets and milestones relating to smoking, diet and alcohol consumption. Current inequalities relating to socio-economic circumstances, and recent trends in these lifestyle factors are considered here.

Smoking (Box 4)

Smoking is a major contributor to ill health in Scotland. It increases the risk of many diseases, in particular coronary heart disease and many cancers[7]. For adults aged 16-74 the *1998 Scottish Health Survey* suggests that 34% of men and 32% of women in Scotland are cigarette smokers. There is a strong correlation with deprivation.

Smoking is also an important and preventable cause of harmful effects on the unborn baby[8, 9]. Information from routine maternity statistics suggest that currently around 27% of pregnant women in Scotland are smokers at the start of their pregnancy. This has seen little change over the last seven years. Smoking during pregnancy shows a clear correlation with deprivation.

Between the two *Scottish Health Surveys* the smoking rates in the least deprived have changed very little. There has been a small increase in the percentage of men from the most deprived areas smoking, and a small decrease in women from the most deprived areas. Over the last seven years there has also been an overall small, but encouraging, decrease in the numbers of women from the most deprived areas smoking during pregnancy, despite negligible changes in rates for women in the other deprivation categories.

Diet (Box 5)

Poor diet contributes to a range of ill health[10]. An indication of the quality of the diet can be obtained from looking at consumption of fresh fruit and vegetables. The *Scottish Health Survey* again shows significant variation related to deprivation.

Figure 3 shows the percentage of adults who eat fresh fruit once a day or more. As deprivation increases the percentage of adults eating fresh fruit regularly decreases. Figure 3 also shows the changes between 1995 and 1998. Since 1995, the percentage of the population regularly eating fresh fruit has increased. However, it has increased more in those from the least deprived areas than in those from the most deprived areas.

Box 4: Inequalities in cigarette smoking

Men aged 16-74*		49% in the most deprived areas 26% in the least deprived areas
Women aged 16-74*		43% in the most deprived areas 24% in the least deprived areas
Pregnant women**		40% in the most deprived areas 14% in the least deprived areas
Change since 1995		Up by 2% in men in the most deprived areas Down by 4% in women in most deprived areas
Changes 1993-1999 in pregnant women		Down by 4% in the most deprived areas

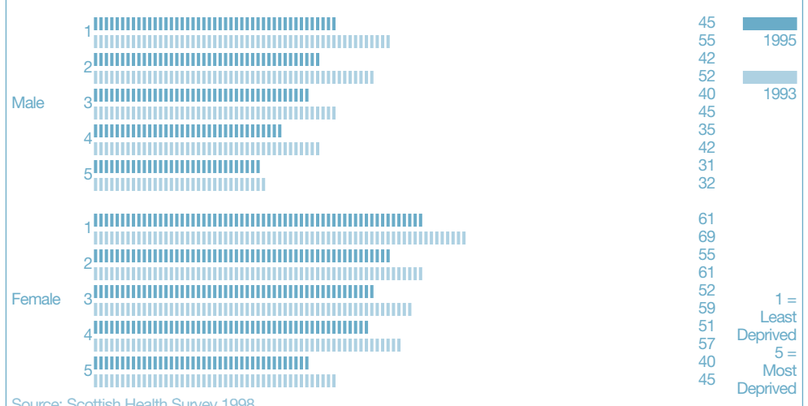
* Based on 1998 data. ** Based on 1999 data.

Box 5: Inequalities in diet

Fresh fruit daily*	Men	32% in the most deprived areas 55% in the least deprived areas
	Women	45% in the most deprived areas 69% in the least deprived areas
Change since1995	Gap between most and least deprived increased by:	9% in men 3% in women
Green vegetables daily*	Men	17% in the most deprived areas 32% in the least deprived areas
	Women	23% in the most deprived areas 39% in the least deprived areas
Change since 1995	Gap between most and least deprived increased by:	4% in men 8% in women

* Based on 1998 data.

Figure 3: Percentage of adults aged 16-64 years eating fresh fruit once a day or more by deprivation quintile



Source: Scottish Health Survey 1998

Children's nutrition also has important effects on health. At the earliest stage breastfeeding provides the best start. Increasing the proportion of mothers breastfeeding is included as a milestone within the Social Justice framework. The percentage of mothers breastfeeding their babies at six to eight weeks old is available from child health surveillance data. It is currently 35%, and this has risen slowly through the late 1990s. Over the last five years there have been small improvements in breastfeeding. However the current rates in the most deprived areas are only 22%, which is still less than half the rates in the least deprived areas.

Box 6: Inequalities in alcohol consumption

Percentage exceeding recommended limits*	Men	39% in the most deprived areas 32% in the least deprived areas
	Women	13% in the most deprived areas 19% in the least deprived areas
Change since 1995		Up by 3% in men from the most deprived areas Up by 5% in women in the least deprived areas

* Based on 1998 data.

Alcohol (Box 6)

Excessive drinking contributes to a range of diseases as well as accidents, antisocial behaviour and crime[11]. Alcohol consumption information is collected in the *Scottish Health Survey*. It shows the percentage of adults reporting drinking more than the current recommended limits in 1998 to be higher in men from the most deprived areas. The gap between the least deprived and the most deprived has increased since 1995. However, for women, in contrast to the pattern seen for most other adverse lifestyle factors, high alcohol consumption is more common in those from the least deprived areas than those in the most deprived areas.

Discussion

Routine mortality statistics suggest that although health generally is improving, we are making little progress in tackling inequalities. For most of the major causes of mortality, the gap between the least deprived and the most deprived has remained the same or widened over the last ten years. The processes for diseases like coronary heart disease and cancer start long before death. Therefore, we cannot expect recent initiatives to show immediate impacts. However, lifestyles may be influenced in the short term and will influence future health. There have been some small, but encouraging reductions in smoking prevalence in women from the most deprived areas of Scotland in the late 1990s. The next *Scottish Health Survey*, which is due to be undertaken in the near future, will show whether these improvements are sustained. However, other lifestyle statistics are less promising. In particular, differences in diet appear to be increasing. Therefore, the challenge to the Scottish Executive, and to all those involved in tackling health inequalities, is considerable. Changes need to be made against a background of existing significant inequalities, and increases in these inequalities over the 1990s.

There are also a number of challenges in monitoring success in this area. Firstly, we need more clarity about the aims of policies designed to reduce inequalities. While *Towards a Healthier Scotland* identified tackling inequalities as an overarching aim, and the *Social Justice Strategy's* stated aim is tackling poverty and injustice, neither of these policies identified any specific targets relating to reducing inequalities. However, there is a commitment in *Our National Health: a plan for action, a plan for change*, published in 2000, to develop health indicators to track progress in tackling health inequalities. The development of indicators and targets is welcome. It will help in defining specific objectives for tackling health inequalities in Scotland.

Secondly, we need to do better than just measuring what is currently measurable. Targets do need to be measurable, and it is for this reason that many of the current mortality targets have been chosen. However, mortality targets will be very slow to reflect progress. In addition, mortality reflects the end result of a range of factors that policies may be trying to influence. If mortality and/or relative inequalities change, it is very difficult to tell what has caused this. We need to plan ahead and decide what other measures would be useful. Then we can put in place the mechanisms to collect these. This would allow us to develop better indicators in the future, including measures of morbidity and positive health.

Thirdly, we need to find better ways of assessing short-term progress. The milestone approach adopted in the Social Justice framework is helpful and could be used as a basis for monitoring progress in tackling health inequalities too. Monitoring of changes in lifestyles will provide useful milestones towards progress. However, we know that the causes of health inequalities reflect social and material circumstances as well as lifestyles. We need to consider the policies that are intended to improve social and material circumstances for the most deprived in our society. Within these, we need to determine whether there are potential milestones for monitoring progress towards reducing health inequalities. In some cases, published evidence will suggest what may be used as a milestone. Alongside this, interventions based on limited evidence need to include a thorough evaluation so that their impact on health inequalities can be assessed, and the impact of different factors can be considered.

Finally, we need to keep developing ways of assessing deprivation to ensure that we can measure progress in tackling health inequalities accurately. The current Carstairs Index is useful but it does have important limitations. It reflects areas of deprivation rather than *individuals* who are deprived. It has been suggested that up to half of the most deprived individuals in Scotland may live outside the most deprived areas[4]. The Carstairs index is also known to lack sensitivity in measuring deprivation in rural areas and it is only updateable at the ten yearly census. A reliable, valid and updateable individual measure of deprivation needs to be developed. A range of useful socio-economic variables are collected routinely in the *Scottish Household Survey*. Scotland has developed expertise in linking different datasets[12]. Linkage of *Scottish Household Survey* data (which would provide individual socio-economic measures for those included in the survey) to the routine health data could provide a cost-effective mechanism of monitoring changes in health inequalities in Scotland. Alongside this, other routine data that have been used to illustrate the impact of poverty, such as those held by the Benefits Agency, councils and education authorities and the Inland Revenue are worth exploring as alternative ways of routinely assessing deprivation.

Conclusions

Health inequalities, with the most deprived experiencing significantly poorer health than those who are affluent, are evident in all the common diseases that affect people in Scotland. As the Scottish Executive attempt to tackle this problem they do so against a background of increasing health and lifestyle inequalities over the 1990s. As policies specifically designed to tackle this problem are implemented we need to ensure that we are in a position to monitor changes, to assess impacts and to ensure that Scotland invests in interventions that make a difference.

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area policies and inequalities in scotland: 1999-2001

The Scottish Executive's commitment to resolving Scotland's health problems is reflected in social justice policies emphasising that inequalities reflect economic, social, cultural and geographic exclusion. This chapter considers the Executive's approach to tackling area deprivation, concentrating particularly on regeneration and housing. It considers the potential of these and other area policies to contribute to tackling health inequalities and comments on the distinctiveness of Scottish area policy.

Does geography matter?

Whether geographical concentrations of deprivation should be a focus of policy is disputed. Broadly, some commentators argue that the key instruments in reducing deprivation are fiscal, taxation and employment policies combined with welfare provision such as income support and health (see the subsequent article by David Bell). Area concentrations of deprivation are seen as having their origins elsewhere – there is more deprivation outside such areas than within them and area-based action serves a symbolic function only and is marginal against structural forces.

Another view is that alongside national economic policies and welfare services, recognition is needed of the adverse way that local factors can mediate the delivery and take-up of services in certain areas; that certain services and investments require to be targeted and deprivation is the best criterion for that; that deprived areas suffer from poor environmental conditions and these require targeted intervention; and that the deprivation suffered by residents of deprived areas is compounded by the effects of stigma.

The Executive has clearly been convinced by the second set of arguments. As the first Social Justice report says:

"The strength and well-being of communities and neighbourhoods is vital because this is where we live together … For too many of Scotland's communities, there is a concentration of linked problems – high unemployment, poor health, poor services, poor quality of environment, inadequate housing and high crime ... We will tackle the problems in the worst of these areas and prevent others from becoming disadvantaged"[1].

The long-term targets set for such deprivation are to "reduce inequalities between communities"; and to "increase residents' satisfaction with their neighbourhoods and communities." The means to achieve this are the targeting of resources to improve standards in 'priority areas' and for particular groups facing disadvantage; the organisation of services "around the needs of individuals" rather than service providers; the involvement of communities in renewal; and the better delivery of mainstream programmes. Six "indicators of progress" chosen to monitor progress are concerned with reducing unemployment rates, drug misuse and crime rates; increasing the quality and variety of homes and the number of people volunteering; and accelerating access to the Internet[2].

Area Regeneration

The key 'priority areas' are the 48 Social Inclusion Partnerships (SIPs), 46 of which were designated in 1999. SIPs are in direct line of succession from the four 1988 *New Life for Urban Scotland* partnerships and the 12 Priority Partnership Areas (PPAs) and 10 Regeneration Programmes established in 1997. All unsuccessful bidders for a PPA in 1996 achieved "at least a partial share" in a SIP in 1999[3] as do all but 6 local authorities (out of 32 in Scotland). SIPs are a mix of 34 traditional 'area based' partnerships and 14 local theme or issue based initiatives intended to assist young people, care-leavers and other disadvantaged groups. The key focus of area SIPs is deprived neighbourhoods within urban areas, but the programme and choice of language – area regeneration – encompasses rural areas and small towns too. Other small scale area initiatives include the Coalfields Regeneration Trust; 13 *Working for Communities* Pathfinders, which are innovating in service provision; and *Initiative At the Edge*, launched in 1997 as a multi-agency programme aimed at reversing decline in some very remote areas.

Regeneration policy has been located administratively within the Scottish Development Department, close to housing and social justice policy teams. It moved on 1st November 2001 to Communities Scotland, a new executive agency directly accountable to ministers with a remit for neighbourhood renewal and community empowerment that combines the functions of area regeneration, regulating the social rented sector (housing associations and local authority landlords) and funding housing associations in areas where local authorities remain landlords. Communities Scotland is expected to continue the focus on priority areas and will establish a 'neighbourhood renewal centre' to develop policy and encourage good practice.

The SIPs programme is based on principles familiar to public policy analysts, such as a co-ordinated, multi-agency approach; community involvement; and a long-term strategy with commitment from local partners. SIPs are usually composed of local authorities, health boards, the employment service, Scottish Homes, local enterprise companies, community and voluntary sector representatives and local business interests. They typically have a more active health service involvement than previous area initiatives and almost all have strategic health objectives. SIP areas are intended to receive priority in local spending programmes and have received some priority in a number of

quango budgets. There is early evidence of budgetary information sharing, "bending the spend" and joint funding[4]. A core staff usually provide support for the development of strategies, co-ordinate the efforts to consult and involve the public (for which ear-marked funds have been made available on a substantial scale) and administer the allocation of SIP funds. SIPs directly target relatively small amounts of money (typically with budgets between £250k and £1m per annum) to projects that complement or supplement the mainstream activities of partners. Many have been active in supporting community health work. Additional funds have been allocated specifically for drug related action.

Although it is too early for systematic evaluation, early indications suggest a mixed pattern of good partnership working in some SIPs, not necessarily those based in areas with a history of priority status. But elsewhere progress may be slower, with some continuing distrust and frustration. In particular, it is hard for SIPs to match in practice the rhetoric about community involvement. The factors that lead people to participate and make them feel it is worthwhile are complex and include educational background, a belief that the area is improving and the availability of structures for participation, such as community-based housing associations, that engender a sense of inclusion[5]. These factors range beyond the immediate control of SIP managers and partners.

Housing

The Scottish Executive's recognition of decent housing as a factor in health and wellbeing has led to targeting capital grants and consents to deprived areas, through Scottish Homes and local authorities, with particular emphasis on council housing, where evidence of poor conditions has grown in recent years. One third (34%) of houses in the public rented sector (25% in Scotland as a whole) suffer dampness and condensation and just over one in six council houses (16%) are in poor repair (visible repair costs greater than £1,200)[6].

The key policy instruments are the Scottish Homes development funding programme which supports housing association activity and the £323 million New Housing Partnership (NHP) programme in which council housing has to change ownership, mainly to non-profit 'community ownership' bodies such as housing associations, in order to secure the necessary mix of NHP and private finance. Many of the SIP areas contain poor quality council housing occupied by tenants suffering high levels of unemployment, poor health and isolation. The NHP programme has targeted such areas supplementing local authority with Scottish Homes and private funds in support of renovation or new building, including some private development for owner occupation.

Another type of neighbourhood with poor housing conditions is predominantly privately owned, found in inner urban areas and in some cases contains concentrations of ethnic minorities or privately rented housing. A Housing Improvement Task Force has been established to report in 2002 and a review of housing policy for ethnic minorities has recently affirmed the priority attached to areas with the highest concentrations of minority ethnic communities[7]. This builds on innovations such as schemes for extended families by housing associations in Charing Cross and Govanhill, Glasgow, funded by Scottish Homes, and adds a commitment to pursuing good racial harassment and access policies in the regulation by Communities Scotland of housing associations and local authority landlords.

Two other housing initiatives are contributing to reducing area inequalities. First, the Rural Partnership for Change initiative is boosting the availability of decent, affordable housing in the Highlands. Second, a central heating initiative is providing £2,500 on average to all households in the social rented sectors, by 2004, and to older householders in the private sector, until 2006. This area-blind programme is likely to favour deprived areas because of the present skewed distribution of central heating. It complements a commitment to end fuel poverty within 15 years, a strategy for which is now being developed.

Finally, the Scottish Executive has undertaken that no one should have to sleep rough by the end of the Scottish Parliament's first term in 2003. Although also area-blind, the Rough Sleepers Initiative (RSI) is providing £36 million over five years to 2002, with Glasgow and Edinburgh receiving over one-third of the funds. Additional allocations have been made for hostel replacement in Glasgow (£2 million) and for health-related services, delivered through Primary Care Trusts with the involvement of local RSI partnerships (£4 million). Projects often involve partnerships between housing, social work, health and voluntary organisations to deliver services to groups such as prisoners, young people, hostel residents and people who are sleeping rough. Most projects address drug and alcohol misuse, family breakdown and poverty and many assist people to access services from which they have felt or been excluded.

Conclusions

Although this chapter has no space to provide a comprehensive listing of all area policy initiatives even within the two fields of regeneration and housing, it is in these two fields that area targeting is most apparent. (Some recent policies are listed in the *Calendar of Events*). Generally, the Scottish Executive's unambiguous commitment to tackling area deprivation has seen an expanded budget and focus on a bigger number of priority areas than before 1997 and in housing, particularly, deprived areas have achieved priority through a combination of area targeting and the application of apparently area-blind policies that have differential effects in deprived areas. No significant opposition to priority areas has emerged, possibly because of the obeisance to rural interests which may have had the effect of building support for targeting priority areas while diverting relatively few resources from the largest concentrations of deprivation.

Regeneration policies have many parallels with developments in England and Wales – the SIP programme's nearest equivalent in England, the National Strategy for Neighbourhood Renewal[8], is only now getting underway and builds on earlier area programmes such as the Single Regeneration Budget. The use of 'neighbourhood', however, conveys insensitivity to rural deprivation in a way that Scottish policy discourse has avoided. In housing policy, Scotland continues to be distinctive[9], in particular in its commitment to improving the worst areas of council housing through community ownership and improving the prospects for homeless people. Overall, the Scottish Executive's overarching commitment to social justice appears to provide a more coherent and integrated area focus than the apparently more *ad hoc* approach taken in England by the Social Exclusion Unit and several government departments.

For the future, there are two issues that continue to engender debate. The first is whether all relevant areas of public policy are as involved as they should be in implementing the area dimension of social justice policy. A review might look particularly at *social problems* such as drug misuse and truancy and measures to prevent them; and *policy fields*, such as economic development and education. Three factors seem to limit area targeting. There is resistance to devoting new resources only to areas of concentrated deprivation, even when, as in the case of new community schools for example, social inclusion is a key aim. There is also a belief in some policy fields that success (in attracting private investment, for example) will come more easily in areas not suffering from deprivation. In addition, there are many legal, administrative and political obstacles to area targeting that can subvert it even when other obstacles are overcome.

Secondly, the impact of area targeting needs to be examined more closely in relation to the effect on surrounding areas. The largest concentrations of economic deprivation are much larger than the size of SIP neighbourhoods. This means that the designated priority areas in the worst local authorities, Glasgow in particular, are surrounded by or are close to areas with characteristics of deprivation that might qualify them for special attention elsewhere in Scotland. If area priority is not coupled with adequate priority in Scottish resource distribution to the city or regional level, the effect of some local targeting to priority areas is to take from the poor to assist the poorest. Whether this is happening is not clear and will be examined in the current Scottish Executive review of Scotland's cities.

Finally, it is implicit in this chapter and in Scottish Executive policy that area targeting benefits health and well-being in the long run through a complex process of multi-directional causal influences, as argued in *The Possible Scot*[10]. The Executive's approach to area deprivation does not depend on demonstrating a direct causal link from deprived area to poor health. It acknowledges the variety of aspects of people's lives, including area of residence, that working together can deprive them of social justice. The various forms of exclusion have to be tackled simultaneously, providing coincidentally a defence against the accusation that the devolved government of Scotland has no effective role in social welfare.

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labour market policies to reduce poverty

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The UK is the world's fourth largest economy with a Gross Domestic Product (GDP) of $1.4 trillion. During the 1990s, it experienced one of the longest continuous spells of growth in its history and in 2001 its unemployment rate hit a 20 year low of 4.2%. Yet the apparently buoyant state of the labour market masks the serious problems that particular groups experience in accessing and retaining the benefits of labour market participation. In Britain, exclusion from the labour market is the principal route into poverty. There is a wealth of literature showing that poverty has an adverse effect on all kinds of life experience and in particular on the health of the workless household. It is widely assumed therefore that attempts to reduce health inequalities must have anti-poverty strategies such as active employment policies at their heart.

Concentrations of deprivation and poverty exist within such a seemingly healthy economy because the UK has among the most unequal distributions of income in the industrial world. Figure 1, which plots the ratio of the 90th to the 10th income percentile on a consistent basis across a group of major industrial countries shows that only in the USA and Italy is income inequality greater than in the UK.

High levels of inequality inevitably result in a high degree of relative poverty. In the UK, one common definition of poverty is a level of net income below 60% of median income. Net income is used – taxes are deducted and benefits added. Stephen Jenkins' work with the British Household Panel Survey (BHPS)[1] showed that during the 1990s, about one-third of the population experienced poverty one year in four, while about a seventh of the population experienced more or less continuous poverty – being recorded as poor on at least three occasions in a four year period.

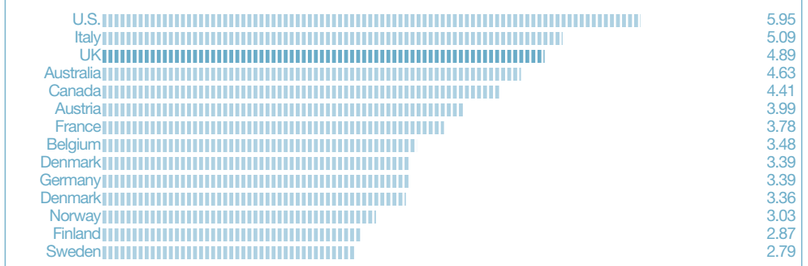
The BHPS can track an individual household's experience of poverty through time. Until recently, the sample size was too small to construct comparable measures for Scotland[a]. Cruder 'snapshot' measures suggest that poverty rates in Scotland are similar to those in the UK as a whole. For example, a simple snapshot of poverty in Scotland for 1996/97[b] showed that around 25% of all individuals and 34% of children belonged to households where net income was less than half of average income.

Jenkins' work on transitions shows that the labour market is the most important route into and out of poverty. Decreases in earned income accounted for 62% of entries to poverty while increases accounted for 44% of exits. Such changes in income can arise both from changes in jobs and/or from changes in earnings within a job.

There are substantial differences in the length of time that individuals from different kinds of household can expect to spend in poverty. An individual from a household with two workers and no children starting a poverty spell would expect to spend no more that 1.3 years out of the next eight in poverty. But the length of poverty spells increase with age. Someone aged 60–64 starting a spell of poverty could expect to experience a further 3.5 years from the next eight in poverty, even when someone in the household is working. For lone parents the situation is even worse: those with one child spend 3.5 years on average in poverty and 4.2 years if there are two children.

Children are particularly affected by poverty. British children are over-represented at the lower end of the income distribution, with over a quarter of children belonging to the poorest fifth of households. Individuals in families with children are more likely to experience low income than those in childless families. Britain comes out poorly in international comparisons of child poverty. From directly comparable estimates based on the Luxembourg Income Survey, Britain had the third highest child poverty rate from 19 major industrial countries.

Figure 1: Inequality measured as ratio of 90th to 10th Income Percentile



Source: Luxembourg Income Study

Policy Responses

There are two obvious policy responses. The first is to improve and assist the operation of the main route out of poverty – the labour market. The second is to provide those in poverty with sufficient income to directly alleviate its adverse consequences. The latter will be more expensive to the public purse: once individuals enter the labour market, the need for direct state payments is much reduced.

Further, the issue of incentives is important in determining the balance between the two types of policy. Overgenerous benefits, or penal rates of withdrawal of benefit as earned income rises, reduce the incentive to find work. But failure to provide a minimal safety net for the poor not only exacerbates the real hardships that some experience, but may also store up problems for the longer term. These dangers are particularly acute for children because failure to acquire both educational and health capital reduces their chance of escaping poverty and limiting illness in later life[2].

a The Economic and Social Research Council funded an extension to the Scottish sample from 1999 which will soon enable study of movements into and out of poverty in Scotland.
b Source: Department of Work and Pensions

Other governments have come to broadly the same conclusions, particularly in respect of the need to improve employment opportunities for those on the fringe of the labour market. During the last two decades many governments have introduced Active Labour Market Policies (ALMPs), which comprise a mixture of 'carrot and stick' approaches to labour market participation. Making social insurance conditional on job search activity or providing tax credits for those on low incomes are typical examples.

The Earned Income Tax Credit (EITC) in the USA provides a significant boost to the incomes of poorer *working* families, particularly those with children. Households receive a credit, payable monthly or at the end of the year, with the size of the credit depending on the level of income and number of children. With a maximum subsidy of $3756 to the poorest families with most children, the total cost of the programme in 1999 was $26.3bn. France introduced a rebate in social security contributions for those with earnings up to 30% above the minimum wage in 1996. The rebate is proportional to hours worked and so favours full-time workers relative to part-timers. In 1997 it covered more than 5 million workers and cost the French government 0.6% of GDP. Both the US and French schemes share the feature that they are aimed at the *working* poor. By providing credits to boost income, the intention is not only to directly remove such families from poverty, but also to increase the relative benefits of being in work compared to unemployment.

The UK government has introduced a number of ALMPs. The Working Families Tax Credit (WFTC) was introduced in 1999 and is designed to ensure that low-income families that have at least one adult working for more than 16 hours a week have a minimum weekly income of £200. Payments increase with the number of children. There are also special provisions for lone parents – one of the groups most likely to be affected by poverty. For example, if there are two children in the household, a 70% subsidy on childcare costs up to £150 per week is payable. From April 2003, the government will extend WFTC to low income workers without children, through a new tax credit for work.

WFTC is withdrawn at a much slower rate than the benefit it replaces – Family Credit – and so should maintain the incentive to work as earnings increase. Many lone parents had poor incentives to progress in work prior to the introduction of WFTC because of the penal withdrawal rates of benefit that they faced: with Family Credit, around 250,000 lone parents stood to lose at least 70p in tax and benefits for each extra £1 they earned. After the introduction of WFTC only 60,000 face such high withdrawal rates. There are around 1.5 million recipients of WFTC and it costs around £5bn – 0.66% of GDP.

Another much-vaunted ALMP in the UK is the New Deal for Young People (NDYP), which is mainly aimed at the young unemployed. Since April 1998 all individuals aged between 18 and 24 claiming unemployment benefit ('Job Seekers Allowance') must enter the New Deal programme. It comprises two stages. In the 'Gateway' stage, a personal adviser gives the claimant intensive help with job search. If no unsubsidised employment results from this process, the claimant then enters the second stage where a number of options are available. These options comprise:

- Subsidised full-time training/education;
- Wage subsidy paid to employers willing to hire the claimant;
- Voluntary work; or
- Environmental Task Force (government provided employment).

Failure to progress through the scheme can result in sanctions – mainly in the form of benefit withdrawal. Job search is also monitored. There is no option to remain on benefit. US evidence[3] suggests that assistance with job search is an effective method for increasing labour market participation. Van Reenan[4] argues that the sanctions embodied in the New Deal programme have not deterred participants.

So far NDYP has helped around 333,000 young people back into work, 38,000 of these in Scotland. In September 2001, there were 80,100 participants in NDYP in Scotland (see Table 1). The New Deal also comes in a number of other flavours, including New Deal for those aged 25+, 50+ and Lone Parents. These follow the same pattern as NDYP but exist on a much smaller scale. Table 1 also shows the proportion of jobs found by New Deal participants in Scotland as a share of those in Great Britain (GB). With a population share of 8.8%, but an 11.5% share of unemployment in GB, the proportion of jobs as a share of GB (where available) more closely mirrors Scotland's unemployment share.

Van Reenan's detailed cost-benefit analysis of the scheme suggests that its social benefits modestly outweigh its costs. This contrasts with the analysis of similar US schemes, although these perhaps deal with a more disadvantaged segment of the population than the New Deal in the UK.

A recent development in ALMP is the creation of fifteen 'Employment Zones'. These were established in April 2000 in areas of GB with persistently high unemployment. Employment zones target participants aged 25 years and over who have been receiving income-based Job Seeker's Allowance for a long period of time – the long-term unemployed. Participation is mandatory. The only such zone in Scotland is located in Glasgow City, although similar initiatives such as Action Teams for Jobs and StartUp are being piloted elsewhere (see *Calendar of Events*). The Glasgow Employment Zone targets those unemployed for 18 months or more. It is run on a commercial basis by a partnership which includes the private sector. Organisations such as Ernst and Young have been involved to take account of their expertise in skills and recruitment. The target in Glasgow is to make 5000 placements in jobs. It is too early to come to a judgment about the success of this form of ALMP. But it too fits into the mould of trying to move people out of poverty by encouraging them to find work through a variety of 'carrot and stick' incentives.

Table 1: New Deal Participants and Outcomes for Scotland

New Deal Programme[c]:	Participants	Jobs	Jobs as Share of GB	Sustained Jobs
Young People (18-24)	80,100	38,400	11.5%	29,100
Lone Parents	10,100	9,700	10.0%	
25 Plus[d]	1,400	6,900		5,500
50 Plus		6,300	12.3%	

c Source: The Scottish Executive (2001) 'New Deal For Unemployed People In Scotland: Statistics To End September 2001'.
d The 25+ data relate to pre April 2001, since when the scheme has changed somewhat. Because of these changes, some figures are incomplete.

The final component of the government strategy to make work pay is the introduction of the minimum wage. Currently workers aged 18-21 are paid a minimum of £3.60 per hour, while older workers are guaranteed £4.20 per hour. Although it is early to evaluate its full effects, the minimum wage has not had the negative effects on the labour market that some predicted. Employment in low paying sectors has generally risen and unemployment has fallen. Two-thirds of the beneficiaries are women and two-thirds are part-time workers. Scotland has one of the highest rates of compliance with the minimum wage: in 1999, only 1-2% of employees earned below the minimum wage[5]. For single people working full time and two earner married couples, the minimum wage can make a substantial impact on net income, particularly in conjunction with the WFTC.

Although the government has tried to shift the balance towards ALMPs, there is still a range of 'passive' benefits available, payment of which is not contingent on individuals' action. These payments form the other component of the anti-poverty strategy – trying to alleviate the impact of poverty on adults and, in particular, on children. These include Housing Benefit, Child Benefit and Council Tax Benefit. The total value of these benefits is around five times larger than payments for ALMP schemes. Although ALMPs provide important levers to assist people to escape poverty, the direct assistance that they provide is still dwarfed by welfare payments that are not conditional on labour market activity.

Summary

Where therefore does the UK stand in respect of policies to alleviate poverty? This paper has highlighted the two main planks of its approach. The first is a number of ALMPs that are mainly designed to make work pay. Similar policies are being implemented in other industrial economies. What is noticeable is that there is a much greater emphasis on *evidence* rather than ideology in their design. The UK has neither a long nor a distinguished record of using evidence-based policy. This is perhaps changing, but the UK is still well behind the USA in properly analysing the effectiveness of ALMPs. This is particularly important in the context of reducing health inequalities because the worst problems are to be found in those areas where a long history of economic decline suggests that a range of supplementary efforts to create a level field in relation to labour market opportunities might also be required.

The second plank is the system of social security benefits that do not require individuals to take particular actions in order to qualify. Most but not all of these policies are means tested: Child Benefit and the old-age pension are obvious exceptions. Social security benefits are still vastly more expensive than ALMPs, but play a vital role in alleviating the immediate and long-term consequences of poverty. A budget-constrained government will seek to target these as closely as possible in order to control its spending. Its ability to do so depends on its capacity to maintain a social compact whereby those on high earnings are willing to accept *targeted* transfers to the poor through the tax system, rather than seeing their taxes as a form of savings that will eventually be repaid through a system of *universal* benefits.

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new beginnings: policies for healthy children in scotland

The joy of when you see this wee tiny baby, this perfect wonderful thing. It's wonderful.

(New mum, Inverclyde)[a]

The joy described above is shared by around 60,000 people in Scotland every year. What, however, are the opportunities for the well-being of these new babies in a devolved Scotland?

If they are lucky they are not starting their lives in poverty, although nearly one in three have a chance of living in households that have less than £200 per week[1]. If they are lucky they will have a strong network of family and friends to help their mothers (and fathers) to deal with the day-to-day difficulties of child rearing and to provide them with the social networks that will stimulate and support their growth. If they are unlucky they will be underweight, living in areas of concentrated deprivation, where food poverty has already affected their mother's nutritional level during pregnancy and their housing will have an impact on their future well-being. If they are unlucky their mother will be isolated and depressed with no obvious social support system. At this stage in their lives their well-being is very much dependent on their family circumstances.

Current statistics show:[2]

- 31% of Scottish children live in poverty;
- 12,000 children are 'Looked After';
- 72,457 children are referred to the Children's Hearing System; and
- 100,000 children live in families affected by domestic violence.

These figures demonstrate the size of the task the Scottish Executive is faced with in creating a Scotland where children's life chances are not prescribed by where they are born, their family circumstances or their personal needs.

a All research quotes are from the Scottish Council Foundation's Early Endowment study, of 2000 and 2001, working with small groups of new mums and pregnant women to establish their needs and interested at this point in their child's life. J McCormick, 2001[7].

European indicators of inclusion currently being developed include indicators on: income poverty and its persistence; income inequality; long-term unemployment and joblessness; health; education; and, regional cohesion (unemployment)[3]. These indicators show a broad base of policies that need to be addressed to support the Prime Minister's commitment in 1999: "to be the first generation to end child poverty forever". The requirements of such a goal will require linked European, Westminster and Scottish Parliament policies. This is an essential element of any development that will improve the early life chances of the youngest members of our society. The Scottish Executive's Social Justice Milestones for children recognise the need for this broader policy context.

Box 1: Social Justice Milestones[4]

- Reducing the proportion of our children living in workless households
- Reducing the proportion of our children living in low income households
- Increasing the proportion of our children who attain the appropriate levels of reading, writing and maths by the end of P2 and P7
- All of our children will have access to quality care and early learning before entering school
- Improving the well-being of our young children through reductions in the proportion of women smoking during pregnancy, the percentage of low birth-weight babies, dental decay among five year olds and by increasing the proportion of women breastfeeding.
- Reducing the number of households, and particularly families with children, living in temporary accommodation.

Importance of early intervention

The links between poverty and life chances come from a growing understanding that the early years have an important influence on health, well-being and learning of children in the short and longer term[5]. Small babies are more at risk of poor health and death during the first year of life according to the work of the Scottish Low Birth Weight Study Group. While low birth weight can have other explanations (physical characteristics like ethnic origin or mother's own size and weight) as an indicator it can provide us with a reasonable starting point for exploring the health needs of children in low income communities. Research in Gary, Indiana indicated that additional income for pregnant women on low incomes had an impact on birth weights[6], while more recent research in the UK identified that income support levels do not meet the cost of an adequate diet for expectant mothers. The poorest tenth of households spend up to 30% of their disposable income on food; and, women on low incomes often reduce the quality and quantity of their own diet to feed their children[7].

If Scottish children are to experience healthy starts and the opportunities for a long, healthy and fulfilling life, it is essential that policies across all levels of government work towards this end.

The Policy Dimension

Because I was pregnant again we got a grant. I applied for it. You had to get your certificate off your midwife. And I put in for it and I got a cheque for £300. And I bought my twin buggy with it.

(New mum, Inverclyde)

Practical help with the cost of a new baby can make an immediate difference to a child's life. The UK and Scottish Parliaments have begun to focus practical support for young children that is specifically aimed at tackling poverty and exclusion for low paid families with children and for lone parents. Figure 2 lists the policy changes since 1997[7], showing a consistent targeting at low pay, unemployment and integrated services to help bring children out of poverty. Although the trend has reversed, with the number of children in workless households down from 19% to 15%[8], that still leaves Scotland with around 200,000 households with children in that position.

Economic Policies

You think of all the nice things you have got like the cot and the pushchair, but it's all the wee things like socks and vests and baby clothes and bottles, even sterilising packs and things like that eat up the money.

(New mum, Coatbridge)

The day-to-day expense of meeting a baby's needs, as well as the initial outlay on larger items like the pram and the cot, can stretch budgets. The additional support identified in the Scottish Council Foundation Early Endowment research[7] provided through the Sure Start Grant was seen as positive, but there were issues identified around the loss of Income Support, to the amount of the Family Allowance payment, by one participant in a workless household. Economic concerns also undermined interest in the availability of non-paid paternal leave, where the additional costs of a new baby meant that losing a partner's wage, even for a week, was not felt to be feasible.

The option of increased Family Allowance starting during the pregnancy and to between 6 and 18 months were identified as an effective way of helping to support a new baby[7].

Integrated Planning and Delivery

Take family support if you've got it, especially in the early days, housework and that or even just take them for a walk, whenever you can and take a break.

(New Mum, Inverclyde)

The information and support needs during pregnancy and the early months of a baby's life are diverse and immediate and cannot be provided by a single agency. Concerns about benefits, childcare, exhaustion, looking after older children, emotional and health information and support were all cited by participants in the Scottish Council Foundation study[7], indicating that all round support requires a multi-agency approach. Initiatives developed to provide focused support to children that are built on multi-disciplinary planning and delivery, and joint budgeting include Sure Start Scotland, which is funded through local authorities. They work with the health service, voluntary sector organisations and local service providers to plan and deliver services, designed at the local level, with a focus on families in areas of deprivation. Multi-agency approaches to health promotion, education and services, parenting skills and support, educational opportunities, social work and childcare services, through Family Centres and New Community Schools, seek to address the needs of "each child as well as their family and community"[9].

One approach to integrated support provided in the Netherlands, which has been a core part of their health care service since the 1950s, provides intensive home-based support, with the aim of helping both mother and father to adapt to a new baby. This is a model of support that could provide practical information and support to families, designed with the parents to help fulfil their needs[7].

Figure 2: Policy changes since 1997 that may impact on child health

Policy	Reform	Eligibility	Comments
Child Benefit	Raised by 26% in real terms to £15.50 a week for the first child (£10 for others).	Universal payment for families with children.	Universal payment continues and made more generous despite speculation that Child Benefit would be taxed back from top earners; continuing problem of off-setting with Income Support.
Children's allowance in means-tested benefits	Raised by 80% for children aged under 11 from 1997-2001.	Means-tested addition for families on Income Support and income-based Job Seekers Allowance.	Considered as 'quiet redistribution' in favour of the poorest families, especially towards those with children aged under 11.
Children's Tax Credit	Tax credit worth up to £500 per year. A new 'Baby Credit' will be paid to the mother, worth £1,000 in the baby's first year.	Means-tested payment to families on low and middle incomes.	Replaces Married Couples Allowance; further step towards integration of taxes and benefits; horizontal redistribution towards families with children; reaches a fair distance up the earnings ladder; potential problems of take-up.
Sure Start Scotland	Integrated services, delivered mainly through Family Centres to provide low-income families with one-stop childcare and health service support.	Targeted services available to families with children from birth to three years in some disadvantaged neighbourhoods.	Aim of joining-up health, care and education services for families with youngest children, to be within 'pram-pushing distance' of home; likely extension to other areas; the Starting Well Demonstration Project in Glasgow pushes the boundaries further.
Sure Start Maternity Grant	Grant worth £300 since Dec 2000 payable from birth, will rise to £500 following 2001 Budget.	Means-tested grant for lower income families.	Targeted support has more than doubled in recent years, replacing the Maternity Payment; linked to 'early health care, check ups and expert support'.
Working Families Tax Credit (WFTC)	Tax credit paid to families typically with one earner - income guarantee of £208 a week for families with one full-time earner.	Means-tested in-work support, paid through employer with earnings.	WFTC replaces the less generous Family Credit and is available to more families higher up the earnings ladder – higher maximum payment and lower taper; potential problems of take-up.
Child Trust Fund	Savings account to be established on birth, with state credits and parental top-ups.	All families to have a Baby Bond, with credits on a sliding scale; accessible from age 18 or 21 for a defined range of purposes.	Announced as a 'big idea' for Labour's second term, based on the Institute of Public Policy Research's 'baby bond' proposal; manifesto commitment in 2001 election following Treasury consultation process to refine the detail.
Parental leave	Mothers to become entitled to up to 52 weeks rather than 40 weeks (extended) maternity leave, typically 26 weeks paid and 26 weeks unpaid. Men to gain a new entitlement to two weeks paid leave.	Changes announced in the 2001 Budget to come into effect in April 2003.	Ability of parents to make full use of leave entitlement depends on earnings and flexible working conditions being in place All mothers will be entitled to at least 14 weeks leave; extended leave is based on having worked for the same employer for at least two years.
Maternity pay	Increase in Statutory Maternity Pay (SMP) from £60 to £75 and then £100 a week from April 2003. Entitlement extended to 26 weeks.	Entitlement to SMP depends on length of employment (at least 26 weeks with the same employer) and paying National Insurance; Maternity Allowance payable to most who are ineligible for SMP and earn at least £30 a week.	Changes announced in the 2001 Budget to come into effect in April 2003. For the first time these entitlements (leave and pay) will apply fully to parents who adopt children.

Social Change

See the thought of me breast-feeding - can you just imagine me with three of them sitting saying 'what are you doing mum?'

(Expectant mum, Inverclyde)

Although there has been a gradual increase to 35% in women breastfeeding six weeks after birth, babies in social class I households are three times more likely to be breastfed than babies in social class V households[10]. The numbers of women smoking at the start of their pregnancy have fallen slightly to 25% but women in deprived areas are three times more likely to smoke than those in the least deprived areas[8]. The media campaigns and policy initiatives around breastfeeding and reducing or stopping smoking and improving diet and lifestyle are a starting point for the kind of social changes that can support women and help to improve the life chances of babies and young children.

Discussions about the possibility of a 'New Mum's Loyalty Card' through pregnancy and early childhood during Scottish Council Foundation research were positive, with participants identifying the retail sector, as well as government departments, as one way of funding it. Some initiatives on the possibility of encouraging changes in behaviour or providing additional support to provide healthier options for mothers and babies involve mothers, retailers, health services and local authorities. For instance, Blantyre/North Hamilton SIP are considering the provision of £50 a month worth of nutritional food to expectant mothers. This might be extended for 3 months after the birth if the mother chooses to breastfeed. This would provide a direct link between lifestyle, money and breastfeeding. Wider initiatives around smoking may provide the additional psychological support required by smokers[11] and could be integrated into a support plan for the well-being of mother and baby that explores some of the social pressures that undermine progress.

The Future

There's no respect given for the job of childraising and I think that's a lot of the reason for society's problems. When you think that the mother bringing up the child is one of the most important jobs you'll ever have, because they're the people who are going to do all the future jobs. It's a job and people get paid to do childcare ... It's women who know where all the other mothers are coming from. The big onus is on going back to work quickly – I know the strain that put on my own marriage, you were tired from your shifts, tired from looking after the kids … I just don't feel it's seen as an important role nowadays by the government. Everything's geared to getting the woman back to work and nothing lets them be at home for the children.

(Expectant mum, Inverclyde)

While breaking the cycle of deprivation is very much focused on enabling parents to work, providing economic incentives, supporting families with increased childcare resources and access to initiatives like homework and breakfast clubs in schools, the Scottish Council Foundation study indicated that there are some fundamental assumptions that need to be explored in designing and delivering effective family policies. Abolishing child poverty is a strategic intent that requires integrated policies at all levels of government. This in turn needs co-ordinated service provision and that requires a process involving parents and children in the identification of the needs and issues that face people as they move through their lifecourse. The value we place on children, the social and economic capital they provide, and the choice of parents on how to balance care and employment are important aspects of the policy directions that can help refine and define how the children of Scotland will be best served for the future.

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social justice and health inequalities: monitoring trends

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The purpose of this article is to make a contribution to disseminating knowledge about trends in health inequalities and their determinants in Scotland. As a result we hope to stimulate debate about the direction and effectiveness of policies that are being put in place to promote social justice.

The widespread existence of avoidable health inequalities in the UK is not a new phenomenon. The problem was recognised more than 150 years ago, and it has been discussed extensively in the past quarter-century. Yet it was not until the late 1990s that health and social policy was focused on this issue in any coherent and persuasive way. A commitment to reducing inequalities in health as part of a wider determination to promote social justice for all citizens is now a central feature of policy across the UK, and it is especially prominent in Scotland. As a result it is becoming more important to monitor trends in health inequalities and their determinants so that the policy response can be retuned.

Relatively little attention has been paid by the health inequalities community to what might constitute indicators of success or progress in tackling this problem. It is essential that this deficit is addressed as soon as possible. We share the view of John Lynch, an eminent public health researcher in the USA, that:

an inequality or disparity or variation in health can be defined unambiguously as an arithmetic difference in rates, proportions, means, etc between two or more socially defined groups. The size of this difference depends on how it is measured and which group is chosen as the comparison (that may already involve value judgements). From a public health perspective, whether we define such differences as large, small, unfair, unjust, inequitable, avoidable, etc involves some process of social discourse that establishes criteria for those judgements to be made and they will involve values, ethics, morals etc. By so doing, we participate in social dialogue about what sorts of societies we want to live in.

(personal communication)

The primary aim of this paper is to contribute to the process of dialogue that we want to see in Scotland and the wider UK about the extent to which progress is being made in relation to reducing health inequalities. We start from the assumption that answering seemingly simple questions such as this is actually a good deal more complicated than it appears at first sight. One of the major limitations is the lack of good data about the health experiences of different social groups over time that would allow trends and patterns to be clearly identified. This paper represents a first step. We hope that it will stimulate further analyses and discussion and that it will draw attention to some of the complexities that have to be considered.

The paper focuses attention on the latest annual Social Justice report produced by the Scottish Executive. It summarises some of the evidence contained in the report in relation to the key health determinants and outcomes associated with health inequalities, and it then provides an independent critical appraisal of the progress that is being made.

Social justice in Scotland

The Social Justice 2001 Annual Report contains a 'scorecard' with which the Scottish Executive rates its progress made towards the 29 milestones set out in its 1999 policy document, *Social Justice … a Scotland where Everyone Matters.* We have chosen to focus on the 14 milestones most closely related to health inequalities in Scotland.

For the purpose of this analysis we present data organised in three different ways as shown in Table 1. We distinguish between five target groups – children, young people, families, older people, and communities – and for each of these where possible we identify the most relevant milestones either as health determinants (n=10) or health outcomes (n=4). The numbers in Table 1 correspond with the numbers assigned to these selected milestones in the Social Justice Annual Report. Note that there is no health outcome milestone for communities.

Table 1: Selected Social Justice milestones and their relation to health

Target Group	Health determinants	Health outcomes/behaviours
Children	1, 2	5
Young People	9, 10	11
Families	13, 14	18
Older People	19, 23	22
Communities	24, 27	—

Using the same data that the Executive uses in the Annual Report we:

- independently assess the progress made in relation to the health determinants milestones and compare this to the Executive's own self-assessment;
- assess the progress made in relation to the health outcomes and behaviour milestones; and
- conduct further analysis on the health outcomes and behaviour milestones in relation to the Carstairs deprivation index to estimate trends in health inequalities over time.

Comparison of the self-assessed and independent assessments of progress in relation to the health determinants milestones

Listed below is summary information on the Scottish Executive's self-rated performance for each of the 10 health determinant milestones, our own corresponding independent ratings, plus a brief explanation of our justification for each rating. The Executive's 'scorecard', to which we adhere, is as follows:

✓ : data moving in right direction
✗ : data moving in wrong direction
= : data broadly constant, no clear trend

We also assign an additional score of '?' to a milestone if we have been unable to draw any conclusion based on the data. The summary information is set out in Table 2. The comprehensive list of health determinant milestones ranges from child poverty and educational attainment to unemployment, security in old age and community regeneration. The Executive's score for each milestone is listed adjacent to our own corresponding score. Space does not allow a detailed description of why we have reached a particular decision, although we briefly justify our decision based on the data sources from the *Social Justice Indicators of Progress* listed in the last column.

Table 2 indicates that the Executive believes progress is being made in five milestones and that there are no convincing signs of change in a further five. Based on the same data used by the Executive in the Social Justice report, we identify progress in only four areas. We acknowledge stability in a further two, but deterioration in two as well. We cannot reach a judgement on the remaining two milestones. Overall, we have reached agreement with the Executive in six of these ten milestones – 1, 2, 9, 13, 19 and 23. However, one of the problems we encountered in making these rather crude judgements is that it is not always clear what the appropriate time period for assessing trends should be. We note that the Executive usually chooses the year(s) 1996-1997 for its baseline but are also aware that a baseline as recent as 1999 has been used for some measures.

Table 2: Summary and assessment of health determinant milestones

Milestone		SE rating	Our rating	Reason	Source
1	Reducing the proportion of our children living in workless households	✓	✓	15% of dependent children lived in workless households in 2001, a steady decline from 17% in 1999 and 19% in the baseline year of 1997	Table 1b
2	Reducing the proportion of children living in low income households	✓	✓	Proportion has dropped by 5% since 1996/97 baseline year	Table 2d
9	Bringing the poorest performing 20% of pupils, in terms of Standard Grade achievement, closer to the performance of all pupils	=	=	Absolute gap between bottom 20% and all S4 pupils has widened between 1995 and 2000, but the relative difference has narrowed	Table 9d
10	Reducing by a third the days lost every year through exclusion from school and truancy	=	✗	Truancy rates have increased since 1996/97. Pattern in the rate of temporary exclusions is inconclusive	Tables 10c, 10e
13	Reducing the proportion of unemployed working age people	✓	✓	The Executive presides over the lowest recorded rate for a long time. 2001 figure is a fall of 3% since baseline year	Chart 13b
14	Reducing the proportion of working age people with low incomes	=	?	17% in 1997/98, 19% in 1998/99 and 20% in 1999/00. After some initial improvement, this rate is moving in the wrong direction	Table 14d
19	Reducing the proportion of older people with low incomes	=	=	Trend has been consistent at 25-26% between 1997/98 and 1999/00	Table 19d
23	Reducing the fear of crime among older people	✓	✓	Three indicators derived from the Scottish Crime Survey all show improvements	Tables 23a,b,c
24	Reducing the gap in unemployment rates between the worst areas and the average rate for Scotland	=	✗	The relative gap has widened since the mid 1990s	Table 24b
27	Increasing the quality and variety of homes in our most disadvantaged areas	✓	?	We cannot reach a judgement given lack of SIP or local authority data on quality and variety of housing	Tables 27a-o

The analyses of health inequalities are described in relation to these three measures. We rate progress towards both the Executive's milestones and towards the reduction of health inequalities using the scoring system outlined earlier.

Progress in relation to the milestone for children

Milestone 5: Improving the well-being of young children through reductions in the proportion of women smoking during pregnancy, the percentage of low-weight babies, dental decay among 5 year olds, and by increasing the proportion of women breastfeeding.

The following data[a] were considered in relation to milestone 5, children:

- The percentage of women who self-reported at their first antenatal visit to the hospital that they smoked rose from 28% in 1993 to 29.9% in 1996. There appears to be a downward trend from 1996 to the Executive baseline year of 1999 to 27.1%. The provisional figure for 2000 has been put at 25.1%.
- In terms of low birth weight babies (< 2,500kg), the Executive reports that the percentage of singleton (i.e. non-twin) low births has remained fairly stable at around 2.5% of all singleton full term births since 1975/76.
- On average, around 40% of 5 year olds were free from dental caries during the 1990s. The figure fell to around 38% in 1993/94 but has gradually risen to 45% in 1999/2000.
- Information about the percentage of women breastfeeding after 6-8 weeks was submitted by 9 of the 15 Health Boards and the Executive are right to warn of drawing robust conclusions based on the data. The trend indicates that since 1995 the percentage of women breastfeeding after 6-8 weeks has risen each year from 29% to a provisional figure of 35.4% in 2000. Information on the levels of breastfeeding on or around the 7th day after birth is collected nationally through the Guthrie card, which is completed when babies are screened for a range of metabolic diseases. The national trend between 1995 and 2000 shows a slow but steady increase from 40.5% to 43.6% of babies being breastfed at 7 days of age.

Assessment of progress and analysis of trends in health inequalities in relation to health outcomes / behaviour milestones

We now concentrate on the four health outcome/health behaviour milestones that target children, young people, families and older people. We first describe progress made in relation to these milestones (three of which contain more than one health condition) in similar fashion to the assessments made in Table 2, although in more detail. We then analyse the data to uncover any trend in health inequalities for each indicator using the Carstairs and Morris index of deprivation.

The Carstairs index is composed of four indicators judged to represent material disadvantage in the population using census data at postal sector level. The four indicators (overcrowding, male unemployment, head of household in social class IV or V, households without a car) are combined to create a composite score that can be divided into quintiles ranging from high to low deprivation. The Scottish Executive comments on the difference in health outcomes by most deprived and least deprived areas, but it does not consider how the distribution of health may have altered over time between deprivation quintiles. Using the same data, we have calculated three scores that partially measure the trend in health inequalities: the absolute rate gap between Carstairs deprivation quintiles 1 and 5 for each year; the relative rate ratio between deprivation quintiles 1 and 5 for each year; and the co-efficient of variation, which measures the degree of dispersion around the mean for each year. We think that it is important to include a measure of the relative variability (or dispersion) of health status between all deprivation quintiles, rather than limiting the analysis to the best and worst quintiles (and in effect to just 40% of the country). In due course it will be important to extend this form of analysis and to examine the full range of indicators as recommended by Kunst and Mackenbach[1].

Assessment of progress on milestone 5: children

For milestone 5 (children) the Executive cites progress in three out of four health outcomes: women smoking at start of pregnancy, children free from dental caries, and rates of breastfeeding. Given the incomplete information available on the latter, however, we would prefer to identify progress in two and maybe three. As it appears that progress has been made in at least half the indicators, we will conditionally uphold the Executive's assessment.

Scottish Executive rating for milestone 5: ✓
Our rating: ✓

Table 3: Trends in inequalities in smoking rates during pregnancy

	94	95	96	97	98	99	00
absolute rate gap	4.00	5.80	3.60	4.30	4.00	6.00	8.00
relative rate ratio	1.61	1.95	1.55	1.73	1.73	2.33	2.90
co-efficient of variation	16.92	22.71	15.81	21.75	23.93	31.24	34.86

a Information on smoking, low birth weight and breast feeding comes from the Information and Services Division (ISD) of the National Health Service in Scotland, while dental caries information is supplied by the University of Dundee.

Analysis of health inequalities progress in relation to milestone 5: children

All four health outcomes can be disaggregated by Carstairs deprivation quintiles.

Smoking during pregnancy:
Table 3 presents three measures of inequality in smoking rates during pregnancy by deprivation to illustrate our analysis.

Table 3 shows that the absolute rate gap between deprivation quintiles 1 (most affluent) and 5 (least affluent) fell to a low of 3.60 in 1996, rose the following year to 4.30 and then dipped slightly to 4.00 in 1998. Since then however, the gap has increased steadily to 6.00 in 1999 and to 8.00 in 2000. In other words, the absolute rate gap between most and least deprived areas doubled between 1998 and 2000. It is also clear that the relative rate ratio between quintiles 1 and 5 has also risen significantly since 1996, and reached its highest point of 2.90 in 2000. The coefficient of variation has consistently risen since 1996 and its rate of change increased dramatically between 1998 and 1999. By 2000, it was over twice that of 1994. All three measures therefore indicate that the inequalities trend in smoking while pregnant has worsened over the period in question: inequalities in health behaviour have clearly widened by deprivation category.

Our health inequalities rating for smoking during pregnancy: ✗

Live singleton low birthweight babies:
As Table 4 indicates, the absolute rate gap rose steadily between 1991 and 1995, experienced some fluctuation and then reached heights of 2.12 in 1998 and 2.23 in 1999. It had fallen slightly to 1.89 by 2000. The relative rate ratio has also experienced a similar pattern. The co-efficient of variation rose between 1991 and 1995, fell between 1996 and 1998, but rose to its highest level of 32.3 in 1999. It had dropped to 28.3 by 2000. Overall, no clear trend emerges.

Our health inequalities rating for low birth weight: =

5 year olds free from dental caries:
The absolute rate gap widened slightly between 1993 and 1999 as did the relative rate ratio. The co-efficient of variation dropped from 31.04 in 1993 to 23.76 in 1995 but rose to 28.33 in 1999. Based on the results in Table 5, we identify little change in health inequalities between deprivation quintile.

Our health inequalities rating for dental caries: =

Table 4: Trends in inequalities in low birthweight babies

	91	92	93	94	95	96	97	98	99	00
absolute rate gap	1.49	1.99	2.01	1.96	1.88	1.97	1.64	2.12	2.23	1.89
relative rate ratio	1.81	2.14	2.42	2.44	2.12	2.22	2.04	2.54	2.57	2.22
co-efficient of variation	24.8	29.9	29.9	30.9	30.1	29.2	25.5	31.9	32.3	28.3

Table 5: Trends in inequalities in dental caries

	93	95	97	99
absolute rate gap	34.9	28.2	32.0	35.6
relative rate ratio	0.40	0.49	0.46	0.42
co-efficient of variation	31.04	23.76	24.57	28.33

Table 6: Trends in inequalities in breastfeeding

	94	95	96	97	98	99
absolute rate gap	34.08	36.61	34.71	36.77	34.97	33.95
relative rate ratio	0.31	0.32	0.36	0.35	0.37	0.39
co-efficient of variation	39.32	37.89	34.55	35.87	33.86	32.24

Breastfeeding at 6-8 weeks:
The three indicators for this outcome show different trends. The absolute rate gap between quintiles 1 and 5 fluctuated between 1994 and 1996 but narrowed between 1997 and 1999. On the other hand, the relative rate ratio increased quite markedly, which is a sign of progress. The co-efficient of variation gradually declined between 1994 and 1999, except for a very small rise in 1995. Overall, we are inclined to view these data as representing progress between 1994 and 1999.

Our health inequalities rating for breastfeeding: ✓

Overall health inequalities rating for milestone 5: children

Our assessment of health inequalities relating to children suggests the following conclusions. The health gap for smoking at pregnancy is widening, there is no good evidence of improvements for low birthweight babies and children free from dental caries, but there is some evidence of improvements in the distribution of breastfeeding rates by deprivation quintile.

Health inequalities ratings:
Smoking at pregnancy: ✗
Low birthweight babies: =
Dental caries: =
Breastfeeding at 6-8 weeks: ✓

Progress in relation to the milestone for young people's health

Milestone 11: Improving the health of young people through reductions in smoking by 12 - 15 year olds, teenage pregnancies among 13 - 15 year olds, and the rate of suicides among young people.

The following data[b] were considered in relation to milestone 11, young people:

- While the trend in the percentage of 12-15 year olds who considered themselves to be regular smokers has dropped from 14% in 1996 to 10% in 2000, girls are consistently more likely to smoke, and the drop since the baseline year of 1998 is entirely due to the drop in the level of boys smoking. More data is required to see whether this is a continuation of the long-term trend or a fluctuation.

- Data on teenage pregnancies is given as rolling three-year averages owing to the small counts in individual years. Between the mid 1980s and mid 1990s, the rate of teenage pregnancies per 1,000 females aged 13-15 increased relatively steadily, and since 1996 has flattened out at 9 per 1,000. The rate has fallen slightly between the baseline year of 1998 and 1999, but once again, more data is required to determine a trend or a fluctuation.

- Suicide rates among young people (aged 11-24) are aggregated and also presented as rolling three-year averages. Over the period 1976 to 1999, suicide rates for males have shown a steady increase up to 1994 and, after a slight decrease, the rate has increased rapidly since 1997 to the point of being the highest in 25 years at 16.9 per 1,000. The rate of female suicides is much lower and more stable, although there is evidence of a small gradual rise since the early 1990s, from 2.3 per 1,000 in 1991 to 4.2 per 1,000 in 1998. The numbers are indeed small, but this nevertheless represents the rate of female suicides almost doubling over the last decade.

b Information on smoking is taken from a biennial National Centre for Social Research survey, data on teenage pregnancies is supplied by the Information and Services Division (ISD), and data on suicides is supplied by the General Register Office for Scotland (GROS)

Assessment of progress on milestone 11: young people

The Executive reports a positive rating overall for milestone 11 (young people) by suggesting that two of the three indicators show data moving in the right direction. Yet smoking among young females is not improving and must be a major concern, while the data on teenage pregnancies tends to show stability in the last few years with slight improvement indicated by the most recent year only. As a result, we are inclined to the view that there has been no real improvement in the health outcomes of young people.

Scottish Executive rating for milestone 11: ✓
Our rating: =

Analysis of health inequalities progress in relation to milestone 11: young people

The three-year averages for teenage pregnancies and suicides can be disaggregated by Carstairs deprivation quintiles, and so we are able to monitor the trend in health inequalities.

Teenage pregnancies (13 - 15 years of age):
The absolute rate gap between quintiles 1 and 5 rose steadily from 8.70 in 1991-93 to 11.20 in 1995-97. Since then however, the rate gap has been reduced to 10.60 in 1997-99 and 9.60 in 1998-2000. The relative rate ratio has also followed this pattern, declining from 3.60 in 1995-97 to 3.09 in 1998-2000. The co-efficient of variation rose to a peak of 38.27 in 1995-97, declined to 37.32 in 1997-99 and has remained fairly stable since. Overall, there are signs of modest improvement in terms of the distribution of teenage pregnancy rates by deprivation quintile since 1995-97.

Our health inequalities rating for teenage pregnancy: ✓

Suicides (ages 11-24):
The trend in suicide rates by deprivation quintile has significantly worsened during the 1990s. The absolute rate gap between quintiles 1 and 5 doubled from 4.00 to 8.00 between 1995-97 and 1997-99 and the relative rate ratio has also increased since the mid 1990s. The co-efficient of variation has risen since 1994-96 with a very sharp increase from 23.93 in 1995-97 to 31.24 in 1996-98. It rose even further to 34.86 in 1997-99.

Our health inequalities rating for suicides: ✗

Overall health inequalities rating for milestone 11: young people

Our health inequalities analyses shows that variations in teenage pregnancy rates by deprivation quintile appear to be improving slightly, but those of suicide rates are worsening over time and this is a clear problem.

Health inequalities ratings:
Teenage pregnancies: ✓
Suicides: ✗

Progress in relation to the milestone for family health

Milestone 18: Improving the health of families by reducing smoking, alcohol misuse, poor diet and mortality rates for coronary heart disease.

The following data[c] were considered in relation to milestone 18, family health:

- The percentage of men smoking cigarettes in 1998 was estimated at 36% compared to 33% for women. This is a rise among men by 2% since 1995 and a decrease of 3% among women.

- The percentage of men drinking more than the recommended weekly level of alcohol was 33% in both 1995 and 1998. The figure for women rose slightly from 13% in 1995 to 15% in 1998.

- Between 1995 and 1998, the percentage of men and women consuming fresh fruit once a day increased, from 39% to 45% and from 52% to 58% respectively, but the percentage consuming cooked green vegetables once a day remained static (26% for men and 30-31% for women). Clearly, women are more likely than men to eat fresh fruit and cooked green vegetables.

- There has been a sustained decline in the rate of mortality from coronary heart disease (CHD) since 1975. Men are significantly more likely than women to die from CHD and the 2000 figure of just under 92 out of every 100,000 men is still higher than the figure for women in 1975. The male figure for 1975 was around 230 per 100,000.

Assessment of progress on milestone 18: families

The Executive reports overall progress despite updated data only being available for CHD mortality. Data for smoking, alcohol misuse and diet is only available for 1995 and 1998, and only the results of the 2002 Scottish Health Survey would confirm whether there were any notable trends. As there is only current confirmation of progress in one out of four indicators, we cannot uphold the Executive's self-assessment, although neither is there evidence that any situation is worsening. As a result, we cannot reach a judgement.

Scottish Executive rating for milestone 18: ✓
Our rating: ?

Table 7: Trends in inequalities in teenage pregnancies

	91-93	92-94	93-95	94-96	95-97	96-98	97-99	98-00
absolute rate gap	8.70	7.40	8.20	9.40	11.20	10.70	10.60	9.60
relative rate ratio	3.02	2.64	2.82	3.24	3.60	3.33	3.16	3.09
co-efficient of variation	35.3	32.3	33.7	36.2	38.3	37.6	37.3	37.7

Table 8: Trends in inequalities in suicides

	91-93	92-94	93-95	94-96	95-97	96-98	97-99
absolute rate gap	4.00	5.80	3.60	4.30	4.00	6.00	8.00
relative rate ratio	1.61	1.95	1.55	1.73	1.73	2.33	2.90
co-efficient of variation	16.92	22.71	15.81	21.75	23.93	31.24	34.86

c The Scottish Health Surveys of 1995 and 1998 provide figures for smoking, alcohol consumption and diet, while coronary heart disease rates per 100,000 population are supplied by the General Register Office for Scotland (GROS).

Table 9: Trends in inequalities in coronary heart disease by gender

	Males			Females		
	91-93	94-96	97-99	91-93	94-96	97-99
absolute rate gap	119.41	107.73	93.65	54.62	35.18	35.94
relative rate ratio	2.36	2.55	2.49	3.18	2.49	3.30
co-efficient of variation	29.07	30.81	29.33	38.93	32.70	36.84

Analysis of health inequalities progress in relation to milestone 18: families

An analysis of the indicators by Carstairs deprivation quintiles is once again possible. Trends in the absolute rate gap for smoking, alcohol use, diet and CHD mortality have been studied by Marion Bain elsewhere in this volume. We have analysed the distribution of CHD mortality rates by deprivation quintile over time for males and females aged between 16 and 64.

Having calculated three-year averages for CHD mortality rates in order to smooth out the trends, we find that the absolute rate gap between quintiles 1 and 5 has declined quite significantly for both males and females. The relative rate ratio for men has fluctuated from 2.36 in 1991-93 to 2.55 in 1994-96 and then down to 2.49 in 1997-9. We find a converse pattern for females in that the ratio declined between 1991-93 and 1994-96 but rose to 3.30 in 1997-99. Differences by gender also become apparent after calculation of the co-efficient of variation: it appears very stable for men over the period, but among females it fell from 38.93 to 32.70 and then increased to 36.84 in 1997-99. The results indicate that, while the absolute rate gap of CHD mortality has fallen, the relative rate ratio between quintiles 1 and 5 has increased for both genders. On the other hand, trends in the co-efficient of variation are more difficult to interpret.

Overall health inequalities rating for milestone 18: families

While there does appear to be some improvement in terms of absolute CHD mortality rates by deprivation quintile, the relative rate ratio between best and worst quintiles is worsening and the dispersion of rates between all deprivation quintiles has not improved. Overall, no clear trend is evident. We do not make any judgement on the position of inequalities in relation to smoking, drinking and diet because of data limitations.

Health inequalities rating: CHD mortality: =
CHD mortality: =

Progress in relation to the milestone for older people's health

Milestone 22: Increasing the number of older people taking exercise and reducing the rates of mortality from coronary heart disease and the prevalence of respiratory disease.

The following data[d] were considered in relation to milestone 22, older people:

- The physical exercise indicator measures people who take at least 30 minutes of moderate activity at least five days a week. 12% of men and 7% of women met this criterion in 1998.
- The trend in mortality from CHD closely mirrors that of the general population although the rates are much higher. Men are around twice as likely as women to die of CHD. Whilst there has been a considerable decrease in the rate, from 1,935.7 per 100,000 males in 1975 to 969.1 per 1,000 males in 2000, this is still higher than the figure for women in 1975.
- The national estimates of the prevalence of chronic respiratory disease are based on a sample of activity from General Practices across Scotland, so the figures are broad estimates of the national picture. Between 1996 and 2000, there was an erratic trend for both men and women within the range of around 82 per 1,000 and 96 per 1,000 with both falling between 1998 and 1999 then both rising between 1999 and 2000.

Assessment of progress on milestone 22: older people

The Executive identifies only one of the three indicators that indicates improvement, with one lacking data and one showing no clear trend. We endorse their assessment of this milestone.

Table 10: Trends in inequalities in coronary heart disease among older people

	Male			Female		
	91-93	94-96	97-99	91-93	94-96	97-99
absolute rate gap	663.3	514.4	476.8	384.6	277.7	284.2
relative rate ratio	154.14	146.32	151.98	171.55	157.79	173.70
co-efficient of variation	13.99	12.73	13.24	18.49	17.89	18.69

Scottish Executive rating for milestone 22: =
Our rating: =

Analysis of health inequalities progress in relation to milestone 22: older people

Due to lack of trends available for inequalities in physical exercise and the erratic trends established after analysis of inequalities in respiratory disease, we present trends by coronary heart disease only.

CHD mortality (ages 65-74):
The analysis is based on three-year averages. The absolute rate gap between quintiles 1 and 5 has fallen steadily among men from 663.3 in 1991-93 to 476.8 in 1997-99. The rate gap among women however follows a slightly different course, rising moderately between 1994-96 and 1997-99, despite a significant fall earlier in the decade. For both males and females, the trend in relative rate ratios and the co-efficient of variation are also curved, falling between 1991-93 and 1994-96 but rising thereafter. Overall, the absolute rate gaps between the most affluent and the least affluent areas for both genders are much lower now than the early 1990s. The Executive is right to claim that the decrease in mortality rates has been marked in the most disadvantaged areas, but the distribution of mortality between all deprivation quintiles has returned to the pattern of the early 1990s, despite signs of improvement in the mid-part of the decade. Given this, we are inclined to think that health inequalities in this area have remained fairly constant.

Overall health inequalities rating for older people

In terms of the monitoring of health inequalities, while we accept that improvements have been made in terms of CHD mortality in disadvantaged areas, other measures of inequality suggest that the overall distribution of mortality has changed little during the 1990s.

Health inequalities rating:
CHD mortality: =

d The Scottish Health Survey supplies information on physical exercise, the GROS provides data on mortality from CHD, and the ISD supply information on chronic respiratory disease. In all cases, older people are defined as being aged between 65 and 74 years.

Summary

This paper summarises evidence in relation to three key sets of indicators. First, we review trends for ten determinants of health such as child poverty and worklessness (Table 2). We agree with the Scottish Executive that progress is being made in relation to four of these targets and that trends for a further two show no real change during the 1990s. However, in two areas (milestones 10 and 24) we believe that there are signs of things getting worse whereas the Executive suggests no change, and in a further two areas we think that the data are not sufficient to allow judgements to be made.

Secondly, we examine the extent to which progress is being made in relation to the four milestones within the Social Justice strategy that capture health outcomes (see Table 11). The Scottish Executive reports improvements for three of the milestones and stability in the fourth. But we think that this assessment is too optimistic. We acknowledge that progress is being made in relation to child health outcomes and that trends for older people are broadly stable. However, we are not convinced that overall improvements are discernible for young people and the data for family health are insufficient and inconclusive.

The third and probably the most important contribution of this paper reviews trends in relation to inequalities between areas for eight specific health outcomes (see Table 12). In presenting data about these indicators we are following the logic outlined by Sally MacIntyre in her personal contribution to the Social Justice Annual Report 2001[2]. She suggests that: "Well-intentioned health promotion policies may actually increase, rather than decrease, inequalities in health … Although there have been marked improvements in the overall health of the population in the last few decades, the benefits have been experienced unequally; death rates, other health indices and health risk behaviours have tended to improve faster among more privileged social groups." (pp.118-119)

Of the eight health outcomes where data in the Social Justice report permit judgements about inequalities between area to be made, we find evidence of improvements in relation to two of them, relative stability for six and definite signs of deterioration for two.

The overall impression that we want to convey is that assessing trends in relation to health inequalities and their determinants is not a simple matter. We very much applaud the fact that attempts to reduce health inequalities are high on the policy agenda in Scotland. There are many good signs of determined attempts to promote social justice. But in these circumstances it is time to give more careful consideration to success criteria and to the availability of data to monitor any progress or lack of it. One further implication of the findings in this paper is that more attention needs to be given to distributional aspects of social justice milestones. Perhaps it is time that Scotland developed its own targets for specific aspects of health inequalities.

Table 11: Assessment of health outcome/behaviour milestones

Milestone		SE rating	Our rating	Reason	Source
5	Improving the well-being of young children through reductions in the proportion of women smoking during pregnancy, the percentage of low-weight babies, dental decay among 5 year olds, and by increasing the proportion of women breastfeeding	✓	✓	We identify progress in two - maybe three – of these four indicators	Tables 5a,d,e,j,k
11	Improving the health of young people through reductions in smoking by 12 - 15 year olds, teenage pregnancies among 13 - 15 year olds, and the rate of suicides among young people	✓	=	Smoking among young females is not improving. Teenage pregnancies tends to show stability in the last few years with slight improvement indicated by the most recent year only	Tables 11f, 11g, 11h
18	Improving the health of families by reducing smoking, alcohol misuse, poor diet and mortality rates for coronary heart disease	✓	?	Up to date trend available in only one out of four indicators. Inconclusive.	Tables 18a,b,c 22b,f
22	Increasing the number of older people taking exercise and reducing the rates of mortality from coronary heart disease and the prevalence of respiratory disease	=	=	Improvement in one indicator, one lacking data, and one showing no clear trend	

Table 12: Health inequalities assessment of Scottish Executive health milestones

Target group		Rating
Children	Smoking at pregnancy	✗
	Low birthweight babies	=
	Dental caries	=
	Breastfeeding at 6-8 weeks	✓
Young people	Teenage pregnancies	✓
	Suicides	✗
Families	CHD mortality	=
Older people	CHD mortality	=

References

1 Kunst A.E. and Mackenbach J.P. *Measuring socio-economic inequalities in health.* World Health Organization. Copenhagen: Regional Office for Europe, 1995.

2 MacIntyre S., Socio-economic inequalities in health in Scotland. *Social Justice … a Scotland where everyone matters (Annual Report 2001).* Scottish Executive 2001:116-120.

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conclusion

The Public Health Institute of Scotland was established to work with public health experts throughout Scotland to provide, amongst other things, the evidence base for effective actions to improve health in Scotland. This publication is part of this stream of work and has been a collaborative exercise led by Professor Judge and his team. It provides an important perspective on health in Scotland and it is vital that the results presented in this Report are widely debated and acted upon.

What is most striking about this Report?

First, the complexity of the challenge comes through with clarity. The wide-ranging nature of inequalities and the interactions between broader inequalities and inequalities in health are clearly illustrated. What is encouraging, however, is the fact that the Executive and the work of the Parliament shows an appreciation of this complexity and the range of actions and activities enumerated in the report which have been carried out by the Executive and Parliament are truly impressive. From the point of view of public health professionals working in Scotland the current approach of the Executive to inequalities in health is most welcome. The second striking feature of the Report is the importance, and the difficulties, of measurement. It is only by measuring the determinants of health, key health behaviours and disease outcomes, that we obtain a picture of how inequalities in health are changing in Scotland. However, several authors have pointed out that we need to become broader in our measurements so that we can capture more positive dimensions of health and not simply disease. Also, the less optimistic conclusions drawn in the report of the progress towards social justice targets illustrates how important analysis and debate are once measurements have been made.

What should we take from the Report?

The Report has many messages but two simple points should be emphasised. First, inequalities in all their manifestations are a key issue for the whole of Scottish society. Second, unless inequalities can be confronted, Scotland's health will continue to lag behind the rest of the United Kingdom and many of our European counterparts.

What next?

It would be exceptionally disappointing if the main reaction to this Report was a debate about whether the Executive has been more optimistic than it should have been about progress towards the social justice targets. The fact that this report was produced by independent academics gives it a certain authority but careful reading will reveal that conclusions about the degree to which social justice targets are improving come down to a matter of a judgement. It is clear that the whole of Scottish society needs to engage in a debate about inequalities and become much more aware of how trends are moving. If we are to confront inequalities in general (social justice targets) and inequalities in health in particular we will need to, as a society, engage in a cycle of measurement followed by action followed by further measurement. To this end we intend to produce an annual publication to update and add further texture to the analysis contained in this report. We would welcome views from readers as to which dimensions of inequalities they might wish future reports to focus upon.

Please respond with views on this or any other reactions to the report to the addresses below.

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calendar of events

This section chronicles the launch of policies and initiatives, important announcements, and the publication of key documents, which together have formed the overarching strategy to tackle health inequalities in Scotland during the first two and a half years of devolved power. While space does not allow us to detail the abundance of relevant local activities taking place, all major Scottish Executive and UK government-led activities are documented, as are important pilot initiatives at the local level. Policies and initiatives designed to tackle the social determinants of ill health - such as child poverty, worklessness, lack of education and skills, poor housing and neighbourhood exclusion - are listed, as are health service-led initiatives that attempt to improve access to health care for deprived people and improve facilities in deprived areas. The calendar is wholly based on national and local press releases from the Scottish Executive, the Scotland Office, HM Treasury, Department of Work and Pensions, Department of Education and Skills, Glasgow City Council and Greater Glasgow Health Board.

1999

July 1
The Scottish Parliament, elected on May 6, receives its full legislative powers. Devolved powers include health, education and training, local government, social work, housing, planning, the environment, law and home affairs, some aspects of transport, sport and the arts, and agriculture, forestry and fishing. Notable areas reserved with Westminster include social security, fiscal, economic and monetary policy, trade and industry, employment legislation, equal opportunities, and constitutional matters.

The Scottish Executive introduces the Warm Deal scheme, which allows for a package of energy efficient measures up to a maximum of £500 to be installed in low-income households. The scheme is also designed to provide employment opportunities for the long-term unemployed through New Deal.

July 26
Scottish Health and Community Care Minister, Susan Deacon, announces the second round of pilot schemes under the Primary Care Act Initiative. GPs and other care professionals are to be offered flexible contract options to address recruitment and retention issues in Scotland. A particular aim is to develop services in areas where access is limited, such as deprived inner cities; to provide better support for single handed GP practices, to improve services in remote and rural areas; and to fill vacancies in practices where recruiting a GP partners has proved difficult.

July 28
Minister for Communities, Wendy Alexander, launches the Shelter Families Project. The project will provide one-to-one support for homeless families as they move to permanent accommodation.

September 10
The Beattie Commission's Implementing Inclusiveness – Realising Potential report is published. The Committee, set up in April 1998, investigated post-school provision for young people who need the additional support to make the step from school into further education, training or employment. Recommendations include: the establishment of a national 'Implementing Inclusiveness' network at national and local level; improvements in guidance and support arrangements during transition to post-school learning or employment; and the development of inclusiveness policies in FE colleges and training providers.

September 14
A Waiting Times Support Force is set up to advise the Health Minister on setting targets to help speed up treatment for patients. Its remit includes looking at ways of ending the inequity in waiting times between Health Board areas.

September 16
Communities Minister, Wendy Alexander, announces a new package of measures to fight homelessness at a key debate in the Scottish Parliament. On top of additional funding for the Rough Sleepers' Initiative, the recently-convened Homelessness Task Force is to examine time limits on councils dealing with rough sleepers, draw up proposals on how current homelessness legislation can be made more effective, and eventually draw up long-term measures for tackling the underlying causes of homelessness. Local authorities themselves will be expected to develop comprehensive homelessness strategies. The Executive pledged that no one should have to sleep rough by the end of the Parliament's first term.

September 21
The UK government's anti-poverty strategy, Opportunity for all – tackling poverty and social exclusion, is launched by the Department of Social Security. The publication, which outlines the government's strategy to tackle the causes of poverty and social exclusion among children, young people, working people, older people and communities, is to be followed by the publication of annual progress reports.

October 5
The Working Families Tax Credit (WFTC) is introduced in the UK. The WFTC, the replacement to Family Credit, is designed to encourage parents without work to move into employment and to help those in relatively low-paid jobs to increase their earnings. It is available on application to families, either couples or lone parents, who: have one or more children; work at least 16 hours a week; are resident in the UK and entitled to work here; and have savings of £8,000 or less. The Scottish Executive estimates that WFTC will benefit around 140,000 families in Scotland through an average increase of £25 per week. It also contains a childcare tax credit component, where working families on low incomes can receive up to £70 per week for one child and £105 per week for two children or more.

November 3
Plans are announced to develop a loan fund, as recommended by the independent Social Inclusion Strategy Action Team report *Local Anti-Poverty Action*. The Scottish Community Investment Fund is planned in order to bring in up to £10 million from banks and private and public sector sources to give community-based projects - such as food co-operatives, community health projects, fuel poverty initiatives, childcare schemes, credit unions, and training and employment schemes - better access to funding. The Scottish Executive is to back the preparation of a business plan to attract financial contributions to the scheme.

November 9
The UK government's Pre-Budget Report is delivered by the Chancellor of the Exchequer. It is announced that any real terms increase in tobacco revenues will be allocated for spending in the NHS. Eligible pensioners will immediately receive a £100 winter fuel payment on an annual basis, and every household with a pensioner over the age of 75 will receive a free TV license from Autumn 2000.

November 17
At a Parliamentary debate on the government's childcare strategy, Minister for Children and Education, Sam Galbraith, announces that local authorities will receive higher allocations of funding in 2000 to provide more childcare places, particularly for children in deprived and rural areas, and with special needs. The government's strategy was set out in the 1998 Green Paper *Meeting the Childcare Challenge: A Childcare Strategy for Scotland*. The Executive has pledged to provide out of school care places for 100,000 children by 2003.

November 22
First Minister Donald Dewar launches the policy document *Social Justice … a Scotland where everyone matters*. The statement contains a set of ten long-term targets for 2020 and 29 more immediate milestones in tackling poverty and delivering social justice and equal opportunity. It also commits the government to an annual Social Justice Report from 2000 onwards, which will measure progress against these targets and milestones. Details of the targets and milestones can be found later in this publication.

Minister for Children and Education, Sam Galbraith, announces that every council is to receive increased resources for the Sure Start Scotland initiative in 2000. Sure Start is a UK-wide initiative and a key element of the social inclusion strategy, aimed at promoting the physical, intellectual and social development of pre-school children in disadvantaged areas. Local authorities, voluntary agencies, health services and existing child support networks are encouraged to work together to provide family support, advice on childcare and nutrition, access to health services and early learning facilities. £42 million was announced as part of the Comprehensive Spending Review in July 1998 to fund the initiative over 3 years in 500 Sure Start areas around the UK. Funding is distributed to local authorities weighted to reflect population, rurality and deprivation.

December 2
The Scottish Executive agrees to COSLA's proposals for a review of the allowance made for deprivation in the arrangements for distributing grants to Scotland's councils. The planned review (to be completed in autumn 2000) will look at whether more weighting should be given to the allowance than currently exists to reflect the additional cost to local authorities of providing services for relatively poor and deprived areas and households. Nearly £72 million total Grant Aid Expenditure is currently distributed in this way, with Glasgow receiving £44 million of it.

The Safer Routes to School initiative is launched to encourage more children to walk, cycle or take public transport to school, in order to benefit their health and the environment, encourage active lifestyles, and increase child independence and confidence. The initiative will also fund local authorities to develop areas sensitive to child road safety such as 20mph zones, controlled crossings, cycle lanes and footpaths. The Executive has pledged to reduce by 50% the number of child road accident victims by 2010.

December 20
Review of the Public Health Function in Scotland report published. The Review began in December 1998 with the aim of re-assessing the role, relationship and locus of public health medicine and to ensure optimal use of all available resources in the drive to safeguard Scotland's health. Its recommendations include: the establishment of a Public Health Institute for Scotland to serve as an authoritative source of advice to the Scottish Executive; measures to develop public health working between Health Boards and local authorities; and the development of managed public health networks.

2000
January 13
Figures released indicate that more than 3,000 lone parents have found work through New Deal. By the end of October 1999, 9,719 lone parents had joined New Deal for Lone Parents and 3,029 jobs were obtained. The NDLP programme, launched nationally in October 1998, is a voluntary programme for lone parents on income support whose youngest child is aged over five years and three months. Participants are paid income support for their first two weeks in work, provided that work is expected to last at least five weeks. They also keep maximum Housing Benefit and Council Tax Benefit for their first four weeks in work.

Funding is provided to set up a measurement framework to enable the Scottish Executive to monitor the effectiveness of anti-poverty and regeneration strategies in deprived areas. Each of the 32 area-based Social Inclusion Partnerships, 14 thematically-based Social Inclusion Partnerships, and the two New Life Partnerships will use the funding to provide extra IT support for existing monitoring processes, or to buy in external assistance to help develop monitoring plans.

January 25
The Cabinet of the Scottish Executive agrees to present new arrangements for the funding of higher and further education to the Scottish Parliament, following consideration of the recommendations published in the Cubie Report of December 1999. The package includes: the abolition of tuition fees for all Scottish full-time higher education students in Scotland from Autumn 2000 (a year earlier than the Cubie recommendation); the abolition of tuition fees for all Scottish full-time further education students in Scotland; access payments of up to £2000 targeted at students from low income families; and a Graduate Endowment of £2000 to help fund more maintenance for students currently under represented in higher education. Almost 50% of students will be exempt from the Endowment repayments including all mature students, lone parents, the disabled and HND/HNC students, and no graduate will pay more each month in loan and endowment payments than they do now.

January 27
Minister for Lifelong Learning and Enterprise, Henry McLeish, claims that New Deal has created 20,000 new jobs for the young unemployed. The latest figures indicate that by the end of November 1999, 43,100 young people in Scotland had joined New Deal 18-24. Of this total, 15,000 had gone into sustained employment but a further 5,600 had entered employment lasting less than thirteen weeks. New Deal for the Young Unemployed (New Deal 18-24) was introduced into Scotland in April 1998, as part of the government's Welfare to Work strategy. The scheme is mandatory for those aged 18-24 who have been claiming Job Seekers' Allowance for more than 6 months. The programme has been funded from the windfall levy on the profits of the privatised utilities.

February 2
Communities Minister Wendy Alexander announces that the New Opportunities Fund will allocate substantial funding over three years through its Community Access to Lifelong Learning Programme to: improve access to information and communications technology in a range of learning centres across Scotland, with the focus on excluded adults and communities; create websites and services providing local information for adult learners; and support the Peoples Network to link every public library to the internet, community websites and the National Grid for Learning. The announcement coincides with figures showing less than 1 in 20 households in Scotland's most disadvantaged communities having access to the internet.

February 15
The Low Pay Commission report on the National Minimum Wage (NMW) published. The government announces that the NMW for workers aged 18 to 21 will increase from £3.00 to £3.20 per hour in June 2000, and the NMW adult rate will increase from £3.60 to £3.70 per hour in October 2000.

February 25
Three successful bids to develop the Health Demonstration Projects, as outlined in the 1999 White Paper *Towards a Healthier Scotland*, are announced. Glasgow Healthy City Partnership's 'Starting Well' project will aim to promote better health among the under 5s in areas of deprivation; Lothian Health's 'Healthy Respect' project will aim to foster responsible sexual behaviour among teenagers; and Paisley Local Health Care Co-operative's 'Have a Heart Paisley' project will focus on preventing heart disease. The Scottish Executive is to invest £15 million in these community-based projects over three years to provide 'test beds' for national action and learning resources for the rest of the country.

March 13
Three initiatives to support community regeneration and community projects are launched. Scottish Homes is to provide funds to support 43 community regeneration projects; the Scottish Executive is to support the start-up costs of the re-named Social Investment Scotland, which is expected to raise loan funding available to community projects (see Nov 3 1999); and £1 million is set aside to pilot people's panels and juries as part of the drive to empower local communities.

March 21
The Chancellor's Budget 2000 announcement. The basic rate income tax is cut to 22p (the lowest basic tax rate for 70 years) with the starting band fixed at 10p (for the first £1,520 of income after personal allowance). Child Benefit is increased to £15 for the first child and £10 for subsequent children, the under-16 child credit component of WFTC rises by £4.35 per week, the Winter Fuel Payment is increased to £150, and the Minimum Income Guarantee for Pensioners goes up in line with earnings, to at least £78.45 for single pensioners and £121.95 for couples.

New Deal 50+ is launched throughout the UK, following piloting in nine Pathfinder areas. The programme offers assistance to those aged 50 or over on benefits, who have been out of work for six months or more to move into, or back into, employment. This includes a cash employment credit of £60 per week (£40 for part-time work) for up to one year for those returning to full or part-time employment or self-employment.

March 23
The biggest ever investment in health improvement and public health in Scotland is announced. As revealed in the Chancellor's Pre-Budget Report (see 9 Nov 1999), £26 million, raised directly from extra tobacco taxes will be invested in the current year to: create a Health Improvement Fund; create a National Strategy Group to take forward the Scottish Executive's work on public health; step up anti-smoking measures; extend screening into new areas of disease and across wider age groups; and step up vaccination programmes to protect the vulnerable and prevent the spread of illness.

March 27
The Sure Start Maternity Grant is introduced. Replacing the existing Maternity Payment, the grant will be available nationally with payments of up to £200 for mothers who are: in receipt of benefits; who can provide evidence that health advice has been received from an approved health professional; and whose child is due on or born after 11 June 2000. The grant can be claimed at any time from the 29th week of pregnancy until the child is three months old.

April 11
Glasgow City Council, the Scottish Executive and Scottish Homes launch a joint proposal for the UK's biggest ever regeneration project by unveiling a £1.6 billion housing stock transfer strategy. Under the proposal, housing would be transferred from the City Council into community ownership through the establishment of 14 Area Housing Partnerships and £900 million council debt would be cancelled. The transfer, it is claimed, will lead to damp-free modernised housing, create around 3,000 jobs in construction and allied industries, and could guarantee rents linked to inflation for at least five years. Glasgow tenants are to be consulted on the proposals, culminating in a citywide ballot in early 2002. The other councils considering the transfer of housing stock are Aberdeen, Dumfries & Galloway, Scottish Borders, Western Isles, Shetland and Orkney.

May 30
The second phase of the Primary and Community Care Premises Modernisation Programme begins. The programme began in February 1999 to fund community-based capital projects whose bids could demonstrate that the money would support improved and/or extra services in areas of deprivation. 31 projects based at GP surgeries and health centres were successful in bidding for the second phase funding, taking the total number in Scotland to 69.

June 7
The Scottish Network for Access and Participation (SNAP) is launched to provide a national platform for the higher education sector to share best practice on improving access and participation. The Executive has pledged to increase the proportion of students from under represented, disadvantaged groups and areas in higher education compared with the overall student population in higher education.

June 26
The Scottish arm of the Child Poverty Action Group is launched, to raise the profile of child poverty issues and provide information and advice on welfare rights and benefits. Communities Minister Wendy Alexander claims that the target of lifting 100,000 children out of poverty by 2002 will be met, through a combination of the UK government's tax and benefit reforms and initiatives including Sure Start Scotland, Starting Well, funding for pre-school education, and increased spending on school education.

The Child Health Support Group is set up, bringing together a range of experienced child health professionals from across Scotland. The Group's tasks include: supporting health boards and NHS trusts in the preparation of their Improvement Programmes, Trust Implementation Plans and contribution to Children's Services Plans; and assisting in the identification of innovation and improvements in services nationally and locally, and providing advice on the evaluation of these services.

Proposals for the Housing Bill is published. Key elements of the Housing Bill proposals include: the reform of tenant rights and obligations; a modernised right to buy process; giving Scottish Homes a broader regeneration role, working with Social Inclusion Partnerships and other local initiatives to rebuild communities; a commitment to tackle fuel poverty; measures to tackle anti-social behaviour; and implementation of the recommendations of the Homelessness Task Force (see Sep 16 1999).

August 14
The Dental Action Plan is launched. Children under 12 months and infants in deprived areas are to receive free toothbrushes and toothpaste; fissure sealant programmes will begin; and short term funding for local dental initiatives and practice improvements will be available.

September 7
The final report of *Fair Shares For All: The National Review of Resource Allocation for the NHS in Scotland* is published. The report sets out proposals for a new funding formula for the allocation of over £4 billion of NHS funds between Health Boards in Scotland. The National Review of Resource Allocation, or the 'Arbuthnott Review' (the first since the SHARE formula was introduced in 1977), commenced in December 1997 under the chairmanship of Professor Sir John Arbuthnott. The final report sets out revised conclusions and recommendations following a period of consultation. The new formula uses four key elements to determine each health board's relative need for funding: the share of the population living in the health board area; the age structure of the population and relative number of males and females; the level of health board area deprivation; and the proportion of people living in remote and rural areas.

September 13
Opportunity for All, the second report on the UK government's anti-poverty strategy is published (see Sep 21 1999).

October 2
The first of the Health Demonstration Projects, 'Have a Heart Paisley' is launched (see Feb 25 2000).

October 6
First Minister Donald Dewar confirms that tobacco advertising will be outlawed in Scotland, despite a European Court ruling the previous day that overturned a directive intended to phase out all tobacco advertising and sponsorship across Europe by 2006.

October 26
New Deal for the Long-Term Unemployed (New Deal 25+) figures released for Scotland. Since the launch of New Deal 25+ in June 1998, a total of 30,000 people had joined the scheme, with 4,800 going into jobs. Of these, 900 entered jobs lasting less than 13 weeks. Those aged 25 and over who have been claiming Job Seekers' Allowance continuously for 2 years become eligible for New Deal. At that point, their participation is mandatory.

November 3
Scotland's first four Healthy Living Centres (HLCs) are announced. The Inverkeithing Project and the New Ways Project, both in West Fife, the Health Hit Squad in East Ayrshire, and the Stirling Health Hub are the first of a network of HLCs across Scotland funded by £34.5 million over three years by the New Opportunities Fund. The centres are designed to provide a focal point for communities to develop better health at the local level while also paying particular attention to areas of social and economic deprivation within their respective localities.

November 4
The Kickstart Programme is launched. The initiative will fund eight development workers who will work across all 34 area-based Social Inclusion Partnerships to help community groups gain the skills to develop local projects, identify funding strategies and deal with application processes, effectively manage any funds awarded, and forge links with Councils for Voluntary Service and Scottish Business in the Community.

November 8
The Pre-Budget Report is delivered by the Chancellor of the Exchequer. Winter Fuel Payments are increased to £200 with immediate effect. Single pensioners and married couples are to receive a £5 and £8 a week increase in their pensions from April 2001, and the Minimum Income Guarantee will increase to £92.15 for a single person and £140.55 for a couple.

November 10
The Executive respond to the consultation on student support, *Scotland the Learning Nation – Helping Students* (published in May 2000), and announces proposals to target support more closely on those from the lower income backgrounds and on groups currently under-represented in higher education. The number of students receiving full support will be increased by raising the allowable earnings of parents by 12%, a Mature Students' Bursary Fund will be introduced, as will a new School Meals Grant for the children of higher education students in receipt of the Dependant's Grant from the Student Awards Agency for Scotland.

November 13
Social Justice … a Scotland Where Everyone Matters: Annual Report 2000 is published. The Executive sets out its progress (along with that of the UK government) in relation to the targets and milestones set twelve months ago to tackle poverty and social exclusion (see Nov 22 1999). The document also outlines the Executive's plans for future initiatives or expansion of existing initiatives relating to social justice in Scotland.

Health Demonstration Project, Lothian's 'Healthy Respect', is launched (see Feb 25 2000).

November 17
Susan Deacon announces that the Scottish Executive is to provide funds over three years from January 2001 to ensure reduced priced milk is still available at nurseries and primary schools following a cut in the EU School Milk Subsidy Scheme.

'Starting Well' in Glasgow becomes the third Health Demonstration Project to be launched (see Feb 25 2000).

November 30
Speaking at the 'Get into Enterprise' National Conference in Glasgow, new Minister for Enterprise and Lifelong Learning, Wendy Alexander, unveils an action plan to return Scotland's workforce to full employment. Pledges include: strengthening and extending the New Deal in Scotland; charging the new Scottish Labour Market Unit with identifying skills shortages; a 50% increase in Further Education funding during the lifetime of the Parliament; creating 40,000 extra FE places and more funds to assist the cost of childcare; and doubling the number of modern apprenticeships over the same period.

December 1
The first ever targets for reducing drug abuse are set. The targets, which span enforcement, education, treatment and rehabilitation, include: reversing the upward trend in drug related deaths and reducing the total number, by at least 25% by 2005; increasing the number of drug misusers in contact with drug treatment and care services in the community by at least 10% every year until 2005; and reducing the proportion of drug misusers who inject by one fifth by 2005. By 2002 all schools are to provide drug education to every pupil, all local authorities must draw up comprehensive written drug policies, and local policies are to be in place to support drug-using parents and their children.

December 14
Our National Health – A plan for Action, a Plan for Change is published. The report sets out plans and proposals to improve standards of health and healthcare in Scotland. The core aims are to "build a national effort to improve health" and to "close the health gap between rich and poor". Specific action outlined to tackle health inequalities and to work in partnership with communities includes: each NHS Board identifying the action it is taking to reduce inequalities; NHS Boards working with local authorities to route Health Improvement Fund money (£100 Million between 2000-01 and 2003-04) into Social Inclusion Partnership areas; developing health indicators within the Social Justice framework of targets and milestones to track progress in tackling health inequalities; establishing a Health Promoting Schools Unit and encouraging every school to become a Health Promoting School; increasing the funding for Scotland's Health at Work (SHAW) scheme to enable more employers to develop health-promoting workplaces; increasing funding for the Scottish Community Diet Project to allow it to help at least 50% more projects from 2001; and launching a Physical Activity Task Force in 2001 to promote and encourage exercise and physical activity. The report also contains plans for NHS management reform and pledges to improve patient care, including: nobody waiting longer than 9 months for treatment in hospital by 2003; national standards of care, quality and cleanliness being set for all hospitals to end the "postcode lottery of care"; and ensuring access to an appropriate member of the primary care team within 48 hours.

December 15
East Ayrshire Community Hospital opens, the first of eight new hospital developments pledged by the Scottish Executive to be completed by 2003. The other hospital developments, funded publicly and through Public Private Partnerships, are the New Royal Infirmary of Edinburgh, Wishaw General, Hairmyers Hospital, Glasgow Royal Infirmary, Western General in Edinburgh, Southern Isles Community Hospital, and Aberdeen Children's Hospital.

December 18
The Scottish Executive is to set up a Sounding Board to take stock of the prospects for Scotland's cities and inform future policy proposals, based on the recognition of how the cities impact upon economic competitiveness, social justice and environmental quality. The Sounding Board will be made up of expert advisers in a range of disciplines and representatives from Glasgow, Edinburgh, Aberdeen and Dundee and will report back to the Executive in Autumn 2001. Currently, one third of the population live in the cities, which account for 75% of Scotland's GDP and 75% of Scotland's energy consumption and pollution.

December 19
The Housing Bill is introduced into the Scottish Parliament (see Jul 3 2000).

December 27
A pilot initiative is launched in Ayrshire and Tayside enabling patients who are exempt from prescription charges (including a variety of low income groups) to obtain certain over-the-counter medicines from their community pharmacy, without the need of a GP prescription. The initiative is designed to test the benefits to patients in terms of access to advice and services, equity of services, and quality of care, and to GPs in terms of the extra time created for treating patients. It will begin in April 2001.

2001
February 3
The third phase of the New Community Schools pilot project begins, taking the total number in Scotland to 47 projects across 31 educational authorities and involving more than 200 schools. The initiative has been designed to create a community resource that promotes social inclusion among both children and adults, by providing a range of services including education, social work, family support and health education services.

February 15
The consultation exercise on the Changing Children's Services Fund begins. The Fund will be designed to provide children and young people with integrated education, social work, housing and health services. The consultation will identify how statutory agencies can work with the voluntary and independent sectors, and across professional boundaries, in order to best combat child poverty. Where local authorities, health and the voluntary sector together produce proposals for better integrated and preventative services they will receive additional funding.

February 19
A three-year £18.5 million investment is announced that will fund up to 50 GP posts in deprived and rural areas. For the first time, Primary Care Trusts will be able to employ salaried GPs directly on a permanent basis to address recruitment and retention problems in deprived and remote and rural areas. The new arrangements, known as Personal Medical Services (PMS), were initially piloted in five understaffed practices serving deprived communities. All have now been made permanent, and the PMS option will be available to GPs and Primary Care Trusts from April 2001, where there is a case that the arrangement would be of benefit to patients.

February 23
The UK Fuel Poverty Strategy is launched, with the main target "to end the blight of fuel poverty for vulnerable households by 2010". For its own part, the Scottish Executive has set a target to "ensure that all pensioner households and tenants in the social rented sector will live in a centrally heated and well insulated home by 2006". £350 million of funding was announced by the then First Minister Donald Dewar in September 2000 to install central heating and insulation in all pensioner homes and all those in the social rented sector who do not have any central heating.

February 26
The Children's Traffic Club in Scotland is re-launched to provide free membership to all three year olds, support packs for every health visitor in the country, and to encourage parental involvement and awareness raising initiatives from health boards. The re-launch follows the Scottish Executive-commissioned 'Research on Road Accidents and Children Living in Disadvantaged Areas' project of 2000, which found that child pedestrians from disadvantaged areas are four times as likely to be killed as children from the highest socio-economic group. Their injuries are also likely to be more severe.

March 3
Caring for Scotland: The Strategy for Nursing and Midwifery in Scotland is published. The strategy is designed to produce more highly trained nurses and midwives with greater responsibilities for changing and improving Scotland's health and health services. One of the new roles for nurses will be "working to promote social justice in communities". Public Health Departments of NHS Boards and Local Health Care Co-operatives (LHCCs) will identify opportunities where nurses and midwives can promote health and improve access to health for socially excluded groups, by 2002. Furthermore, directors of nursing services, individual nurses and midwives and local managers will promote examples of effective practice that can inform policy on social justice, by 2002.

March 6
Deputy Health Minster Malcolm Chisholm announces the appointment of Sue Irving, Scotland's first Health and Homeless Co-ordinator at the Health Inequalities Seminar in Edinburgh. Her post will involve helping Primary Care Trusts and Health Boards to develop strategies to tackle the health needs of Scotland's homeless, and to build links between statutory and voluntary agencies, homeless people and their representative groups. Such work will be supported by guidance issued to ensure that the provision of health services for homeless people form part of the overall advice given to the NHS on tackling health inequalities.

March 7
The Chancellor's 2001 Budget announcement places a strong emphasis on families and children. Measures include: the Children's Tax Credit (replacement of the Married Couple's Allowance) being introduced in April 2001 at up to £10 per week, up from the original £8.50 intended; the basic adult credit on WFTC and Disabled Person's Tax Credit will rise by £5 per week from June 2001, giving families a minimum income of £214; up to £94.50 will be claimable via the Childcare Tax Credit component of WFTC and disabled credit for one child families, and £140 for two or more; maternity pay will be increased and extended from April 2003; and a two-week paternity leave for working fathers will be paid at the same flat rate as statutory maternity pay.

March 13
An action plan to expand the credit union movement in Scotland is announced in a joint statement between the Scottish Executive and Scotland Office. *Unlocking the Potential – An Action Plan for the Credit Union in Scotland* sets out objectives to develop sustainable credit unions and to increase membership across Scotland from less than 1% to 5%. Credit unions are not-for-profit co-operatives, owned and controlled by individual members, which offer services such as low cost loans and accessible savings to people without access to financial services in disadvantaged areas.

Nursing for Health, A Review of the Contribution of Nurses, Midwives and Health Visitors to Improving the Public's Health is published. New initiatives set out include the employment of over 80 'public health practitioners' based within Local Health Care Co-operatives (LHCC's), who will be handed a roving brief to assist families and communities in making improvements to their health. The school nursing service will also be revitalised, with investment to boost training for up to 200 school nurses and health visitors, enabling them to address major health problems like diet, drug misuse, alcohol and smoking. Extra support for the most vulnerable families is set out in the shape of Family Health Plans, to be developed jointly between families with young children and health professionals.

March 14
National No-smoking Day. Susan Deacon announces that all nicotine patches, inhalers and gum will be available on NHS prescription from April 2001, resulting in some 750,000 people in Scotland being able to receive nicotine replacement therapies free of charge. The announcement follows a Health Department consultation on proposals to make NRT available on GP prescriptions.

March 22
At the annual COSLA conference in Crieff, Perthshire, Susan Deacon announces new Executive funding to boost the health improvement role of local authorities. Every local authority and health board will be invited to put forward proposals for innovative and sustainable joint working. The Executive will fund 50% of each initiative, with local authorities and health boards expected to match this commitment.

The Scottish Higher Education Funding Council (SHEFC) earmarks specific allocations for widening access to higher education for under-represented groups. An additional 800 places will be targeted at disadvantaged groups, with extra funding for colleges to recognise the actual cost of recruiting, supporting and retaining students from non-traditional backgrounds.

The Coalfields Regeneration Trust funds 11 outreach projects designed to tackle poverty and exclusion in ex-mining areas. These include employment initiatives, credit unions, health facilities and community advice centres.

March 26
Minister for Enterprise and Lifelong Learning, Wendy Alexander, announces that the Education Maintenance Allowance scheme will be extended to Glasgow, Dundee and West Dunbartonshire in August 2001. The scheme, first piloted in East Ayrshire, is designed to encourage young people from low income households to remain in post-compulsory education. Eligible students receive up to £40 per week cash, with bonuses of £75 for attendance and £50 for achievement also available.

April 10
Health Boards are informed of the increases in funding they will receive to support patient care in 2002-3 and 2003-4. Every board will receive increases of at least 6.5% in 2002-3, and 7.4% the following year. The implementation of the 'Arbuthnott' formula (see Sep 7 2000) means that Health Boards with deprived and rural communities will receive higher increases in recognition of their extra needs.

April 30
Alternatives to School Exclusion is published by HM Inspectorate of Education. The report evaluates a range of approaches developed by 18 education authorities between 1998 and 2000 to reduce the need for exclusion from school. Funding is now continuing on a substantially enhanced basis for all 32 education authorities through the Alternatives to Exclusion Grant Scheme funded by the Scottish Executive's Excellence Fund. The Executive has pledged to reduce exclusions by one third by 2002 across Scotland and provide a full time and appropriate education for all those who are excluded for over three weeks.

June 13
Speaking at the Fit for Future 2001 Primary Care Trusts Conference in Edinburgh, Susan Deacon announces a four-point "contract for change" with primary care services in Scotland, involving: an increased role for Local Health Care Co-operatives; new investment, agreed with LHCC's, to improve services and widen access; the creation of a high-level Primary Care Modernisation Group to draw together all the current initiatives to produce by the end of 2001 a set of clear targets, milestones and investment priorities for improved services and; new guidelines which help Unified NHS Boards develop the full potential of LHCCs. These measures will aim to provide patients access to an appropriate member of the primary care team within 48 hours, as pledged in the NHS Plan (see Dec 14 2000), and support a bigger role for primary care professionals in improving community health.

June 21
The UK government accepts the Low Pay Commission's recommendations of an increase of the National Minimum Wage for young people, rising from £3.50 to £3.60 from October 2002. The NMW rose from £3.20 to £3.60 on June 1.

June 27
The Communities First initiative is launched. Beginning in April 2002, the initiative will identify and assist 50 of the most deprived areas in the UK, which have also fared poorly in past Lottery distribution. The initiative, which will direct £150 million over three years, will be jointly run by the Community Fund and the New Opportunities Fund.

July 2
The Executive announces a new package of initiatives to encourage lone parents into colleges and universities by making it easier for them to meet childcare costs. A £1000 childcare grant for lone parents in full-time education will be introduced, funding will be provided to FE colleges to widen childcare provision to meet locally identified needs, and extra funding will be allocated to local authorities to increase their support for out-of-school clubs in disadvantaged areas.

July 18
Three more successful bids for the Healthy Living Centres are announced: Gorbals Healthy Living Project and the East End Healthy Living Project, both Glasgow, and the Eoropie Dunes Project in the Western Isles (see Nov 3 2000).

The Housing (Scotland) Bill, the largest and most technical Bill to go through the Scottish Parliament so far, receives Royal Assent and becomes law (see Jul 3 2000).

August 15
It is announced that NHS 24's first telephone advice service will be set up by Grampian Health Board in Aberdeen, followed by centres in Tayside, Highlands, Orkney and Shetland, and the Western Isles (see Dec 13 2000). The Grampian service will not be available for patients until Spring 2002.

September 18
Glasgow City Council and Greater Glasgow Health Board launch the Fruit Plus programme, which will provide youngsters aged between 3 and 12 with a piece of fresh fruit three times a week. The programme is to be rolled out to all 380 city-managed primary schools, nursery schools and pre-5 establishments following a successful three - month pilot project in 12 primary schools and nurseries.

September 19
Opportunity For All, the third Annual Report measuring the progress of the UK government's anti-poverty and social exclusion strategy is published (see Sep 21 1999).

Key Public Health professionals and practitioners gathered at the Healthy Scotland Convention to consider the future direction of Public Health policy in Scotland.

October 15
Two new Action Teams for Jobs – designed to offer help to people from areas of lowest unemployment – are launched in Dundee and North Lanarkshire. Delivered by the Employment Service and its partners, the Action Teams for Jobs Initiative is already operating within the local authority areas of East Ayrshire and West Dunbartonshire, the Glasgow Employment Zone and the Highlands and Islands Special Programme area.

November 11
A panel is set up to devise national nutritional standards in Scottish schools, to improve the appeal of school meals, and to maximise the uptake among children from low income households eligible for fee school meals. The panel will report its findings and recommendations in May 2002.

November 26
The *Social Justice Annual Report 2001* is released. The Report contains a scorecard indicating progress on the 29 Social Justice milestones set in the 1999 report (see Nov 22 1999). Data is "moving in the right direction" in 16 out of 29 Social Justice milestones, "data broadly constant, no clear trend" in eight, "insufficient data" to measure progress in four, and "moving in wrong direction" in one. For an independent assessment of progress made see Judge and Paterson in this volume.

The Breakfast Service Challenge Fund is launched by the Executive to expand services targeted at improving the diet of children in the most disadvantaged parts of the country.

November 27
Pre-Budget Report published. Key announcements include: the introduction of an integrated system of income-related support for families and children in the new Child Tax Credit and Working Tax Credit from 2003; the introduction of a new Pension Credit from 2003; a rise in the annual basic state pension of £100 for a single pensioner and £160 for couples in 2003-04 and a rise of 2.5% each year thereafter; and the provision of an additional £1 billion to the NHS in 2002-03.

November 28
The StepUp programme is launched by the Department of Work and Pensions for those unemployed who have not been able to secure full-time work after New Deal and who require more intensive support. It will guarantee participants a job paid at the national minimum wage with the same in-work benefits as all employees. The Scottish pilots will begin in 2002 in Dundee and East Ayrshire.

December 13
Chancellor Gordon Brown launches the strategy paper *Tackling Child Poverty: Giving Every Child the Best Start in Life*. Its four key strands are: to provide more support for family finances; to give priority to children's services, especially health and education; to offer support to parenting for life; and to pursue a partnership with the voluntary and community sectors. At the same event £10 million is provided for new Sure Start pilots to help make existing services more accessible.

December 20
The Better Neighbourhood Services Fund allocates funding to 9 Scottish Local Authorities for pathfinder projects. The Fund, set up through the Executive's commitment to improving services in the most disadvantaged neighbourhoods, has accepted proposals from Authorities with higher than average proportions of Income Support, together with high levels of population dispersal.

December 27
The UK government launches an implementation strategy to meet its commitment to reduce the unemployment gap between disadvantaged areas – the 30 local authority areas with the poorest initial labour market position – and the rest of the UK. Stakeholders include the Employment Service, Department of Work and Pensions and the Scottish Executive.

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