The Annual Report of the Director of Public Health

NHS Highland na Gàidhealtachd

2024

Health Inequalities

Acknowledgements and List of Contributors

Thanks are due to the following colleagues for their contributions to this year's report:

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Contents

Introduction

This is my fifth annual report as Director of Public Health for Highland and Argyll and Bute. The focus this year is on health inequalities, and this is one of the two strategic priorities for public health within NHS Highland. The other strategic priority is prevention which was the subject of the report for 2022. At its heart, tackling health inequalities is about fairness and about ensuring that everyone has the best chance of a long and healthy life. No one ever goes to their health professional and complains of having a health inequality. People have poor health. When that poor health results from a lack of fairness or a lack of opportunity then we need to tackle that inequality.

My first report as a Director of Public Health was in 2002 in Yorkshire and I have been looking back at previous reports and reflecting on similarities and differences. There have been some encouraging changes such as the decline in smoking and its harmful effects. Life expectancy has shown increases, but in recent years this has stopped. One thing that has changed little has been the importance of health inequalities. The differences in health between communities, rich and poor, advantaged and disadvantaged, have formed a constant theme over the years and some of these inequalities have been getting worse. That is why it is important to have health inequality as the theme for this year.

This report cannot hope to cover the full range of health inequality and equity issues and can only begin to raise questions and prompt actions. There are wide areas not covered such as the poor health and low life expectancy of people who have a serious mental illness or people who are in prison. Similarly, inequalities in access owing to rural or island location are not a focus. However, I hope that the report raises the importance of tackling health inequalities and increasing fairness in Highland and Argyll & Bute. We need to take action to reduce inequalities and if there is one overall recommendation from this report it is that we all take health inequalities seriously.

Dr Tim Allison MD MRCP FFPH

Director of Public Health and Health Policy, NHS Highland

Ro-ràdh

Seo an còigeamh aithisg bhliadhnail agam mar Stiùiriche Slàinte Poblach na Gàidhealtachd agus Earra-Ghàidheal is Bhòid. Am-bliadhna tha am fòcas air neo-ionannachd slàinte, aon den dà phrìomhachas ro-innleachdail airson slàinte a' phobaill taobh a-staigh NHS na Gàidhealtachd. Is e am prìomhachas ro-innleachdail eile ro-casg, a bha mar chuspair na h-aithisg airson 2022. Aig a chridhe, tha dèiligeadh ri neo-ionannachdan slàinte mu chothromachd agus mu bhith a' dèanamh cinnteach gu bheil an cothrom as fheàrr aig a h-uile duine air beatha fhada agus fhallain. Cha bhi duine sam bith a' dol dhan neach-slàinte phroifeiseanta aca agus a' gearan gu bheil neo-ionannachd slàinte orra. Bidh droch shlàinte aig daoine. Nuair a tha an droch shlàinte sin ann mar thoradh air dìth cothromachd no dìth chothroman feumaidh sinn dèiligeadh ris an neo-ionannachd sin.

Bha a' chiad aithisg agam mar Stiùiriche Slàinte a' Phobaill ann an Siorrachd Iorc ann an 2002 agus tha mi air a bhith a' coimhead air ais air aithisgean a sgrìobh mi roimhe agus a' meòrachadh air coimeasan eatarra. Tha atharrachaidhean brosnachail air a bhith ann, mar eisimpleir, crìonadh ann an smocadh agus san droch bhuaidh a th' aige. Tha àrdachadh air a bhith ann a thaobh na ùine a thathar an dùil a bhios daoine beò, ach tha am fàs seo air stad sna beagan bhliadhnaichean mu dheireadh. Aon rud nach eil air atharrachadh gu mòr, sin cho cudromach 's a tha neo-ionannachdan slàinte. Tha na h-eadar-dhealachaidhean ann an slàinte eadar coimhearsnachdan, beartach is bochd, fo chothrom is fo ana-cothrom, air a bhith seasmhach fad nam bliadhnaichean agus tha cuid de na neo-ionannachdan sin air a bhith a' dol am miosad. Sin as adhbhar gu bheil e cudromach gu bheil neo-ionannachd slàinte againn mar thèama am-bliadhna.

Chan eil e comasach dhan aithisg seo dèiligeadh ris an làn fharsaingeachd de chùisean neo-ionannachd agus cothromachd slàinte agus chan urrainn dhi ach tòiseachadh air ceistean a thogail agus gnìomhan a bhrosnachadh. Tha raointean farsaing ann air nach eilear a' coimhead leithid droch shlàinte agus dùil-beatha ìosal aig daoine air a bheil droch thinneas inntinn no daoine a tha sa phrìosan. Mar an ceudna, chan eil neo-ionannachd ann an ruigsinneachd air sgàth suidheachadh dùthchail no eileanach nam fòcas. Ach, tha mi an dòchas gun seall an aithisg cho cudromach 's a tha e a bhith a' dèiligeadh ri neo-ionannachd slàinte agus a bhith a' cur ri cothromachd air a' Ghàidhealtachd agus ann an Earra-Ghàidheal is Bòd. Feumaidh sinn ceumannan a ghabhail gus neo-ionannachdan a lùghdachadh agus ma tha aon mholadh fharsaing san aithisg seo 's e gun tuig sinn uile cho cudromach 's a tha neo-ionannachd slàinte.

Dr Tim Allison MD MRCP FFPH

Stiùiriche na Slàinte Phoblach, Bòrd Slàinte na Gàidhealtachd

Summary

This report sets out information about the health and wellbeing of people in Highland and Argyll and Bute and focuses on health inequalities. It starts with information about the overall health of the population including people's life expectancy and how things have changed over several years. Then there is a chapter about health inequalities, what they are and how they affect local people. This is followed by a section about ways of tackling health inequalities. The remainder of the report consists of chapters looking at different groups of people or different factors that relate to health inequalities including chapters on children, on vaccination, on the effects of alcohol and on under-represented groups. There are recommendations for action which are designed to help us all work to reduce inequality.

Geàrr-chunntas

Tha an aithisg seo a’ cur air adhart fiosrachadh mu shlàinte is sunnd dhaoine air a’ Ghàidhealtachd agus ann an Earra-Ghàidheal is Bòd agus a’ cur fòcas air neo-ionannachdan slàinte. Tha i a’ tòiseachadh le fiosrachadh mu shlàinte an t-sluaigh san fharsaingeachd, a’ gabhail a-steach dùil-beatha dhaoine agus mar a tha cùisean air atharrachadh thar nam bliadhnaichean. An uair sin tha caibideil ann mu neo-ionannachdan slàinte, dè a th’ annta agus mun bhuaidh a bheir iad air daoine san sgìre. Tha seo air a leantainn le earrann mu dhòighean gus aghaidh a chur air neo-ionannachd slàinte. Anns a’ chòrr den aithisg, tha caibideilean a’ coimhead air diofar bhuidhnean de dhaoine no diofar nithean co-cheangailte ri neo-ionannachd slàinte, a’ gabhail a-steach caibideilean air clann, banachdach, buaidh deoch làidir agus air buidhnean nach eil air an riochdachadh gu leòr. Tha molaidhean ann airson gnìomhan a tha air an dealbh gus ar cuideachadh uile gus neo-ionannachd a lùghdachadh.

Recommendations

This section brings together all of the recommendations from each of the chapters of this report into one place. You can also find each of these recommendations at the end of the relevant chapter within the report.

Health Inequalities

- NHS Highland and its partners should regularly review and monitor progress in reducing health inequalities.

Approaches to Health Inequalities

- Highland and Argyll and Bute Community Planning Partners should consider the best ways to tackle local health inequalities and how to learn from models such as Collaboration for Health Equity and place-based approaches.

Child Health

- NHS Highland and partners should evidence compliance with the UNCRC and increase completion rates for Equality and Integrated Impact Assessments by March 2026.
- NHS Highland and partners should deliver the actions set out in local child poverty action reports by November 2026.
- NHS Highland should work with local authority partners to deliver on The Promise Plan 24-30 to improve outcomes for care experienced children by 2030.

Immunisation

- NHS Highland should continue work to improve vaccination uptake especially among disadvantaged groups.

Minorities or Underrepresented Groups

- Public sector organisations in Highland and Argyll & Bute should acknowledge the poor health experienced by underrepresented groups and address these health inequalities with help from the skills and resources of the groups. This includes building strong collaborative relationships with those in positions of trust within communities.
- Organisations and individuals should take action to address stigma and discrimination by adopting clear and inclusive language, supporting staff to be aware of unconscious bias, challenging discrimination wherever it is seen and supporting staff to undertake training on equality and diversity, anti-racism and cultural awareness.

Alcohol

- Alcohol and Drug Partnership member organisations should consider and implement the most effective and efficient ways to reduce the harms and health inequalities caused by alcohol.

Cancer

- NHS Highland should ensure that health inequalities are actively monitored as part of cancer management and across all services.
- NHS Highland should address health inequalities across the entire cancer pathway from prevention to rehabilitation.physically.

Progress on recommendations from the 2023 report

Last year's report presented information about the health of the population of NHS Highland then gave examples of how medication affects public health. Since the publication of the report there have been the following developments:

NHS Highland and its partners should ensure that planning addresses the change in demography and ageing population.

Update: Understanding of population change and future health and wellbeing needs is included in needs assessments that inform the future planning of primary care services, adult health and social care services and alcohol and drug partnership priorities.

NHS Highland and partners should prioritise tackling health inequalities and the causes of those inequalities.

Update: This report addresses health inequalities and the importance of taking the issue seriously as a priority. Examples of activity over the past year include: the publication of Child Poverty Action updates for Highland and Argyll and Bute; the work of the Welfare and Health Partnership, funded by the Improvement Service; interventions as part of the NHS Highland Screening Inequalities programme; completion of a local Highland Gypsy/Traveller asset-based health needs assessment.

NHS Highland and those prescribing medicines should prioritise actions which will reduce the impact of medicines on the environment.

Update: The NHS Highland Realistic Medicine action plan focused on medicines waste last year. There are many initiatives taking place to decrease medicines waste by applying the principles of Realistic Medicine including considering non-pharmacological interventions. The NHS Highland Treatments and Medicines (TAM) group considers the environmental impact of medicines for new applications to the formulary. One example has been the use of dry powder inhalers instead of metered dose inhalers for asthma where it is clinically appropriate to do so.

Citizens should take up actions which will reduce the impact of medicines on the environment.

Update: NHS Highland organised a pharmaceutical waste campaign asking citizens across the Badenoch and Strathspey and Mid Ross areas to return unused or expired medicines to their local pharmacy for safe disposal instead of putting them in their domestic bins or flushing them down the toilet. Research has been undertaken with citizens across Highland better to understand their need for information and resources about the environmental impact of medicines. This work is to be published in the BMJ in early 2025. The NHS and Scottish Water have co-branded the Nature Calls campaign to raise awareness of and reduce the impact of inappropriately flushing items such as wet wipes and medicines down the toilet.

NHS Highland work to eliminate Hepatitis C should promote the effectiveness of new medication and so encourage more people to be tested and successfully treated.

Update: Many different activities have been progressed to support elimination of Hepatitis C including case-finding, testing, awareness-raising, access to care and research and monitoring. A communications plan encourages early testing and effectiveness of new medicines. NHS Highland is on track to achieve the elimination target set by Scottish Government.

NHS Highland should increase the number of health and social care staff who are aware of social prescribing by developing and promoting a social prescribing network and a Directory of Services and by creating targeted messaging through staff and service newsletters, bulletins and social media.

Update: The network regularly produces newsletters. A directory of services is to be launched early in 2025.

NHS Highland and partners should improve the knowledge and skills of health and social care staff in relation to social prescribing by providing learning and development opportunities.

Update: Work is being undertaken as part of the social prescribing network to develop resources to improve knowledge around social prescribing. Development of an online module is planned as part of the learning offer to staff. A social prescribing section has been developed on the NHS Highland website and is updated and promoted.

NHS Highland and partners should improve the infrastructure and availability of social prescribing by embedding link workers in a range of health and social care services and increasing use of the community benefits gateway through public sector procurement and commissioning processes.

Update: The Community Link worker service in Highland has been expanded in 2024 to include all GP practices. Further development of the service in Argyll and Bute is also under way. From September 2024 Waiting Well Link workers employed by My Self-Management and funded by NHS Charities Together are offering social prescribing support to patients on NHS Highland waiting lists. The Community Benefits Portal continues to be promoted.

Alcohol and Drug Partnership members should support further work relating to opioid and analgesic prescription, including needs assessment and development of alternative programmes for chronic pain.

Update: Highland ADP and Argyll and Bute ADP are updating the needs assessment which will be a key factor in the development of the strategic plan and action plan. Alternative programmes for pain include primary care prescribing of a range of physical and social activities such as a green gym and nature prescriptions. The third sector continues to build capacity around self-help and self-management.

Alcohol and Drug Partnership members should continue to support the delivery of the Medicines Assisted Treatment (MAT) standards and the increased choices offered to individuals through the Opioid Substitution Therapy programme.

Update: Implementing the MAT standards is progressing. Every year information is collected from services and reviewed by the national support team (MAT Standards Implementation Support Team) and by local services. Improvement plans are agreed.

1. Epidemiology and Trends

- Introduction
- Demographic Trends
- Characteristics of NHS Highland
- Health Status

Epidemiology and Trends

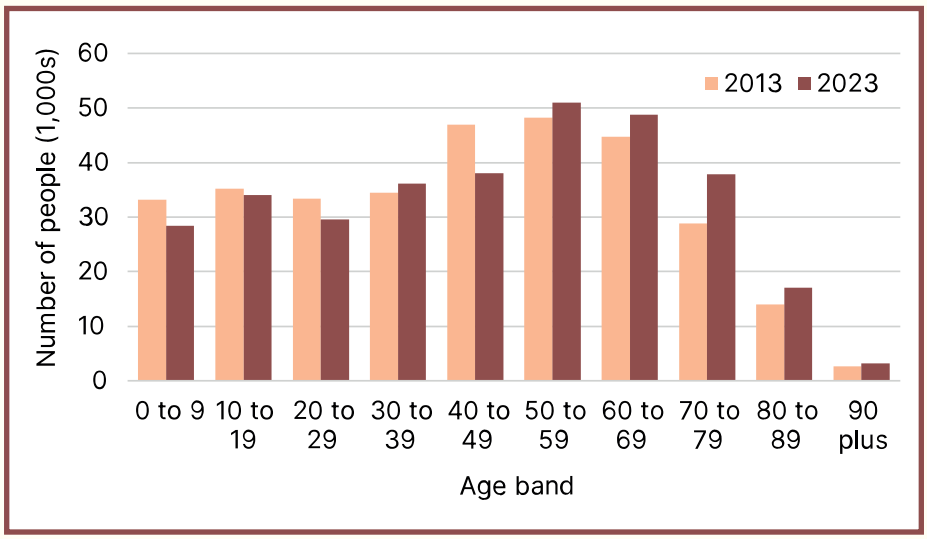
Introduction

This chapter of the Annual Report sets out overall figures and trends for people and their health in Highland and Argyll and Bute. It is important to have this presented every year and it acts as a helpful reference point for consideration of how we can improve health and wellbeing. There is some information on health inequalities in this chapter, but most is contained the next chapter and within each of the chapters on specific areas.

Demographic Trends

There are an estimated 324,140 people living in NHS Highland, the highest ever number reported[1]. The population has increased by 0.8% over the previous ten years. By age band, the number of people in the oldest age groups increased the most, with decreases in age-bands below 50 years old. Population change was experienced differently in NHS Highland council areas; the population of Highland council area increased by 1.4% to 236,330 people whereas the population of Argyll and Bute decreased by 0.7%, to 87,810 people.

Figure 1.1: The number of people resident in NHS Highland by ten-year age band, 2013 and 2023

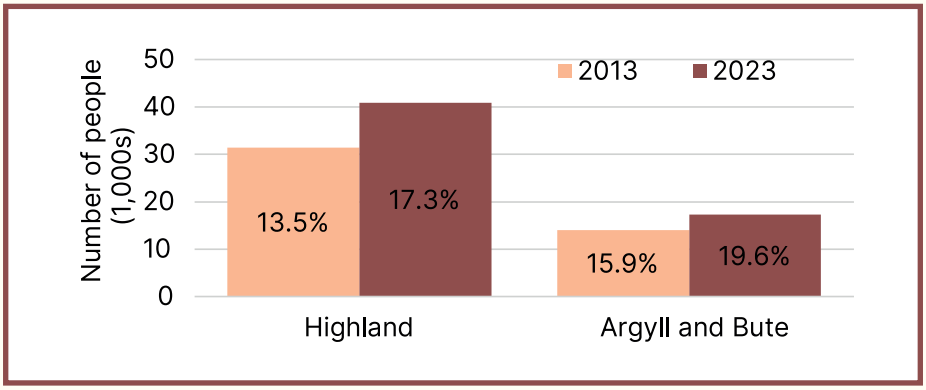


Source: National Records of Scotland mid-year population estimates

The number and percentage of people aged 70 and over has increased in both Argyll and Bute and Highland and comprises 17.9% of the population of NHS Highland. Population projections indicate the number of people aged 70 and over will continue to increase over the next ten years[2]. Numbers of deaths are projected to increase alongside greater need for end-of-life care[3].

Double click with a mouse or double tap on a touch screen to zoom in/out where necessary.

Figure 1.2: The number and percentage of people aged 70 and over resident in NHS Highland council areas has increased between 2013 and 2023

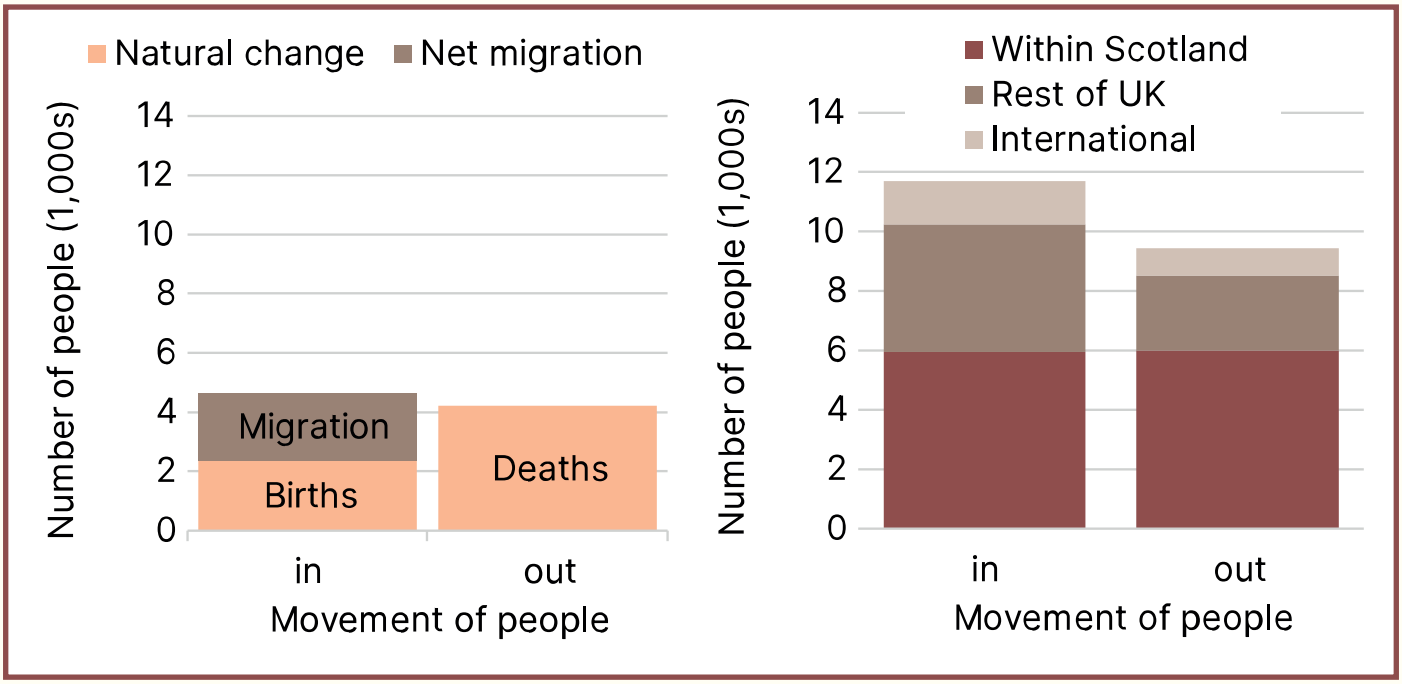


Source: National Records of Scotland mid-year population estimates

Numbers of deaths of NHS Highland residents are higher than numbers of births, generating a natural decrease in population; migration is therefore responsible for the rise in the population in NHS Highland. Although the highest movements of people in and out of NHS Highland have occurred between different parts of Scotland, recent net in-migration has been driven by movement from the rest of the UK and, to a lesser degree, internationally.

Figure 1.3: Causes of change to the size of the population of NHS Highland between 2022 and 2023

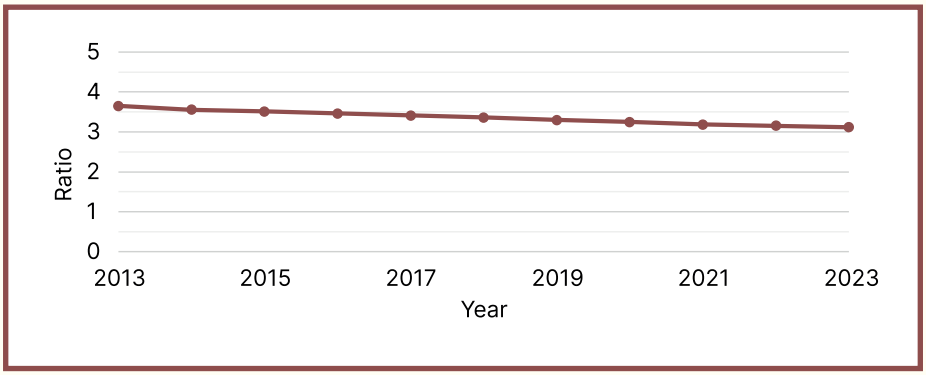
Number of people moving in and out of NHS Highland between 2022 and 2023, by area migrating to and from



Source: National Records of Scotland mid-year population estimates

Migration has not occurred equally in all age groups; NHS Highland has consistently experienced net out-migration of those age 15-19 and there have been lower movements of those aged 70 and over[4]. Along with natural aging and deaths, this creates changes in the number of people in each age band. The ratio of those aged 16-64 to those 65 and over has decreased year on year over the past ten years. Although crude, this provides an indication of the challenge facing NHS Highland, along with Scotland and the UK, with higher health and care needs observed in older age groups but proportionately fewer people of working age.

Figure 1.4: Ratio of people aged 16-64 (approximately of working age) for each person aged 65 and over has decreased between 2013 and 2023



Source: National Records of Scotland mid-year population estimates
Ratio: People aged 16-64/People aged 65 and over

Characteristics of NHS Highland

Characteristics such as housing, travel infrastructure and the economy influence population health. These are sometimes referred to as the wider determinants of health. When people across NHS Highland experience these differently they can produce or contribute to health inequalities. NHS Highland contains areas with multiple deprivation within urban areas and towns. Health inequalities by deprivation have been demonstrated in many measures of health, including life expectancy. NHS Highland has a substantial remote, rural and island geography. Whilst there are many positive aspects to this, including access to green and blue spaces, there is significant deprivation in access to services. Higher costs of living in remote, rural and island areas can compound difficulties in accessing services and be a barrier to healthy lifestyle choices.

As with wider determinants, individual characteristics impact on life experience and influence individuals' health. Underrepresented groups can have specific difficulties in participating equally in society and can experience significant inequalities in health. This is explored in more detail later in the report.

Double click with a mouse or double tap on a touch screen to zoom in/out where necessary.

6700 (4.2% vs.1.6% in Scotland) people aged 16+ worked in agriculture, forestry and fishing and 15,000 (9.4% vs. 6.9% in Scotland) in accommodation and food services reflecting higher reliance on seasonal industries, particularly in some communities.[a]

30% live in an urban area in Inverness, Nairn, Fort William and Helensburgh, 21% live in small towns between 3,000 and 10,000 people in size, and 49% live in rural areas. 41% live in very remote areas more than 60 mins drive from an urban area and an additional 17% live more than 30 mins drive from an urban area.[b]

Multiple Deprivation

30,419 (9.3%) people live in areas in areas in the 20% most deprived in Scotland (by population).[c]

25,898 (8.0%) people live in areas in the 20% least deprived in Scotland (by population).[c]

25,931 (8.1%) people live on one of 50 inhabited islands. Four islands (Mull, Islay, Skye and Bute) had a population of over 1,000 people, ten islands had no usual residents, and 33 islands had a population of under 200 people.[a]

161,979 (50.0%) people live in an area in the 20% most access deprived in Scotland.[d]

35,054 (10.8%) people live in areas in the 20% least access deprived in Scotland.[d]

13,034 children (2022/23) live in poverty, after housing costs in NHS Highland 3,258 (23.5%) in Argyll and Bute and 9,776 (23.3%) in Highland.[e] Lone parent families, minority ethnic families, families with a disabled adult or child, families with a younger mother (under 25), families with a child under one, and larger families (3+ children) are at higher risk of experiencing poverty.[f]

33% of households in Highland and 32% of households in Argyll and Bute live in fuel poverty, compared to 24% in Scotland. This includes 22% of Highland and 19% of Argyll and Bute households in extreme fuel poverty, compared with 12% in Scotland.[g]

Sources: a) National Records of Scotland Census 2022[5], b) Scottish Government Urban Rural Classification 2020 (SGUR)[6], c) Scottish Index of Multiple Deprivation 2020 (SIMD), Public Health Scotland[7], and National Records of Scotland 2021 Mid-year estimates, d) Scottish Index of Multiple Deprivation 2020 (SIMD) and National Records of Scotland 2021 Mid-year estimates, e) End Child Poverty Coalition[8], f)Scottish Government[9], g) Scottish House Condition Survey (SHCS) 2017-2019[10].

Protected Characteristics and under-represented groups in NHS Highland

Religion[a]	Num.	%
No religion		**52.76**
Christian		**39.78**
incl. Roman Catholic		**7.04**
Buddhist	915	**0.28**
Hindu	421	**0.13**
Jewish	183	**0.06**
Muslim	1,455	**0.45**
Sikh	102	**0.03**
Pagan	1,756	**0.55**
Other	796	**0.25**

Sexual orientation (aged16+)[a]	Num.	%
Gay or lesbian	3,033	**1.1**
Bisexual	3,298	**1.2**
'Other' sexual orientation	952	**0.4**

Trans status or history (aged 16 +)[a]		
Trans or have a trans history	920	**0.34**
Incl. non-binary	357	**0.13**

Sex[b]	Num.	%
Female	164,573	**51**
Male	159,567	**49**

Looked after children[d]		
Argyll and Bute	144	**1**
Highland	426	**1**

Main Language (aged 3+)[a]		
English		**97**
Scots	508	**0.16**
Gaelic	759	**0.24**
Sign language	114	**0.04**
Other	9,140	**2.91**

Learning disability (adults)[c]		
Argyll and Bute	330	**0.45**
Highland	1,028	**0.52**

Sensory impairment[a]	Num.	%
Blind or partially vision impaired	8,318	**2.6**
Deaf or partially hearing impaired	26,836	**8.4**

Armed forces veterans (aged 16+)[a]		
Veterans	14,725	**5.4**

Ethnicity[a]	Num.	%
White		**97.49**
incl. White Scottish		**75.40**
and incl. White gypsy traveller	347	**0.11**
Asian	3,492	**1.09**
African	567	**0.18**
Caribbean or Black	293	**0.90**
Mixed or multiple ethnic groups	2,606	**0.81**
Other ethnic groups	1,104	**0.34**

Country of birth[a]	Num.	%
UK, Channel Islands and Isle of Man		**92.90**
Europe	12,393	**3.86**
Africa	140	**0.04**
Middle East and Asia	3,677	**1.14**
Americas and Caribbean	2,406	**0.75**
Antarctica and Oceania	1,201	**0.37**

Language skills (aged 16+)[a]	Num.	%
Speak, read and write English		**97.04**
No skills in English	194	**0.07**
Speaks but does not read or write English	2,747	**1.01**
Full/partial loss of voice or difficulty speaking	996	**0.31**

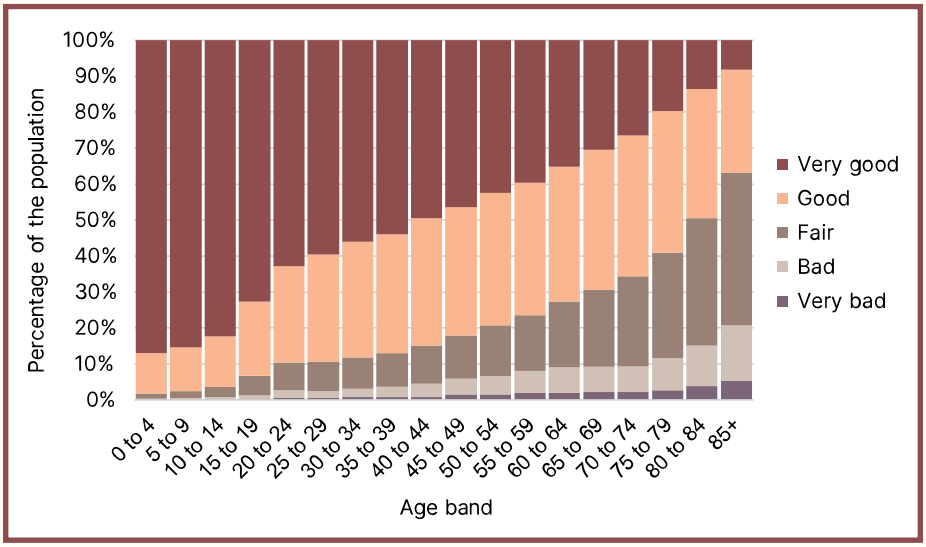
Unpaid care (aged 3+)[a]		
Any unpaid care	36,483	**11.6**
50+ hours a week	8,521	**2.7**
Aged 2 to 15	968	**2.3**
Aged 50-64	14,341	**18.6**

Sources: a) Census 2022, National Records of Scotland b) National Records of Scotland 2023 Mid Year Estimates, c) 2019, Learning Disability Statistics Scotland, Scottish Commission for People with Learning Disabilities d) July 2023, Scottish Government Children's Social Work Statistics 2022-23

Health Status

In the 2022 Census, 79% of the NHS Highland population reported their health to be 'good or 'very good'. This percentage was highest in younger age groups and decreased with increasing age (Figure 1.5). 14% self-reported their day-to-day activities being limited a little and a further 10% reported they were limited a lot, with higher proportions in older age bands. 22.5% of the population of NHS Highland reported a long-term illness, disease or condition, 9.5% a mental health condition and 9.5% a physical health condition.

Figure 1.5: Good and very good self-reported general health decreases with increasing age band



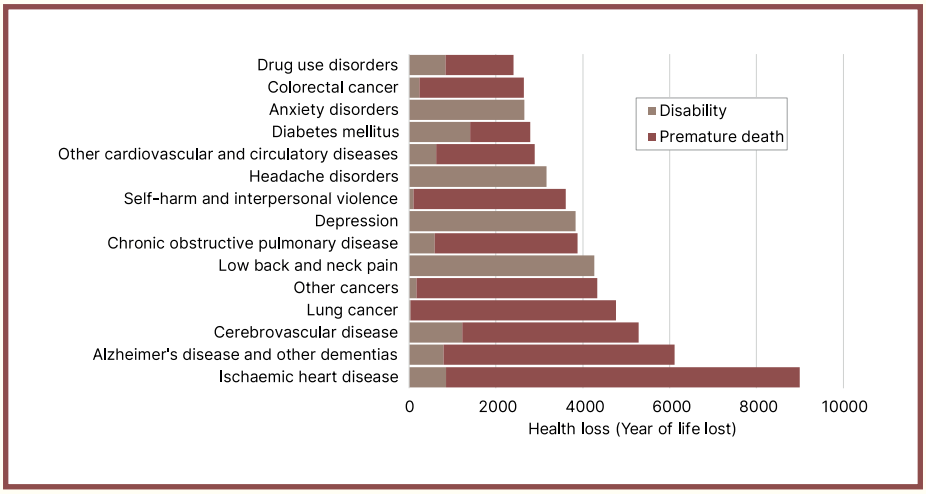
Source: Census 2022, National Records of Scotland

Loss of health can be measured using early (premature) death or loss of quality of life and these are combined to calculate Disability Adjusted Life Years (DALYs). Common causes of ill-health in NHS Highland are associated with risk factors such as smoking, poor diet and physical inactivity. The greatest health loss in NHS Highland is caused by cardiovascular (including heart disease and stroke) diseases, Alzheimer's and other dementias, and cancers. These conditions are also the leading cause of years lost due to early death. Chronic Obstructive Pulmonary Disease and self-harm and interpersonal violence also contribute substantially to health loss through premature death. Mental health conditions such as depression and anxiety are amongst the leading causes of health loss due to disability. Substantial disability likewise occurs due to low back and neck pain and headache disorders.

The most common causes of health loss vary by age with higher health loss per population in those aged 85+ than in younger age groups. Alzheimer's disease and other dementias are the leading causes of health loss in those aged 85+ with ischaemic heart disease the lead cause in those aged 45-64. In adults aged under 45 the leading cause of health loss is self-harm and interpersonal violence whereas in children it is congenital birth defects. As the numbers of the oldest people increases, it is expected that more people will present with dementias, frailty and multiple coexisting conditions (known as multimorbidity).

Double click with a mouse or double tap on a touch screen to zoom in/out where necessary.

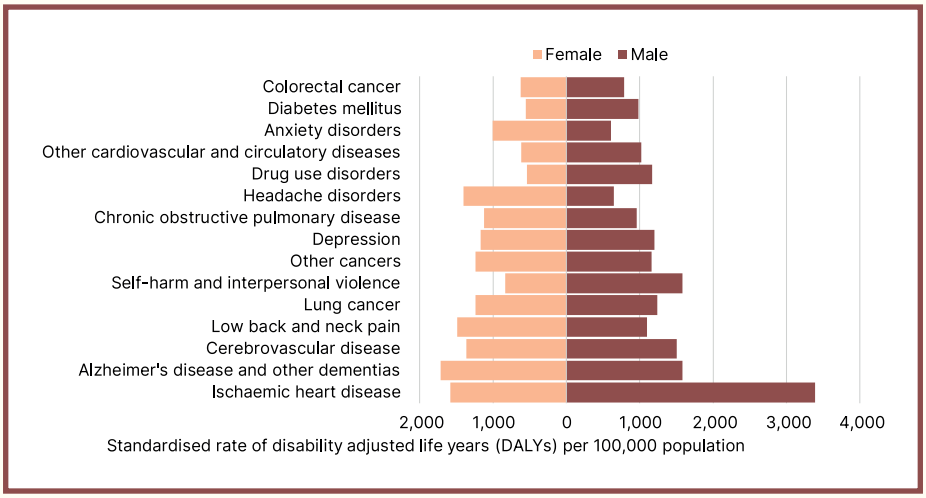
Figure 1.6: Leading causes of health loss in NHS Highland, 2019



Source: Scottish Burden of Disease Study, 2019, Public Health Scotland

Males, compared with females, experience higher health loss in NHS Highland due to ischaemic heart disease, self-harm and interpersonal violence and drug use disorder (Figure 1.7). Reasons for these differences are complex but are not solely explained by underlying difference in sex.

Figure 1.7: Years of life lost per 100,000 population by sex for leading causes of health loss

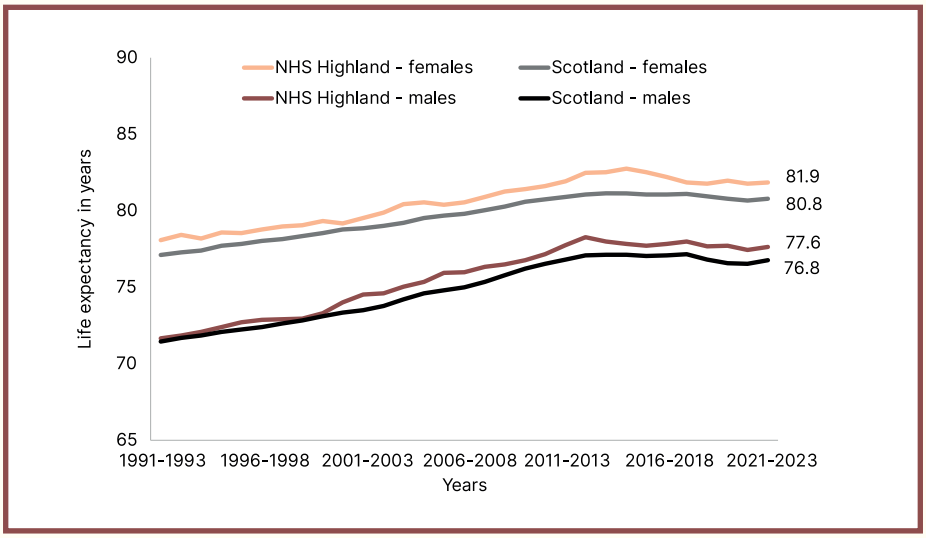


Source: Scottish Burden of Disease Study, 2019, Public Health Scotland

Life expectancy at birth is an important measure of population health, derived from age at death. Life expectancy is higher in NHS Highland than in Scotland[11] but it is considerably lower than for England and Wales (79.0 and 83.0 for males and females respectively in 2021-2023)[12]. Female life expectancy is consistently higher than male life expectancy, highlighting an inequality between the sexes. Historically, life expectancy has improved over time, but this stalled around 2012-14 in NHS Highland, along with the rest of the UK. Despite a slight increase in the most recent time period, it has not reached the level expected had the previous trajectory continued.

Double click with a mouse or double tap on a touch screen to zoom in/out where necessary.

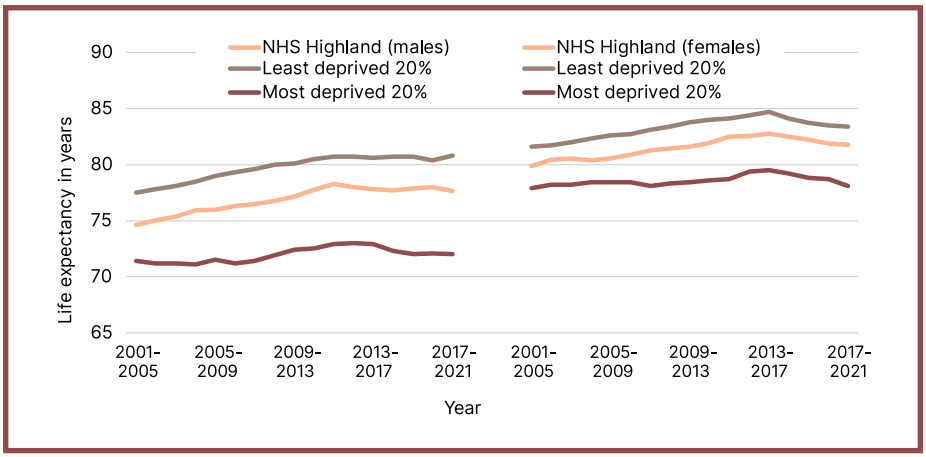
Figure 1.8: Increases in life expectancy have stalled in NHS Highland and Scotland, for males and females



Source: National Records of Scotland

Males in the least deprived areas live 8.8 years longer and females 5.3 years longer than those in the most deprived areas of NHS Highland. This inequality in life expectancy has increased over time from 6.1 years for males and 3.7 years for females in 2001-2005. Life expectancy in the least deprived areas has increased to a greater extent than in the most deprived areas, reflecting widening inequality. Since 2013-2017 both male and female life expectancy in the most deprived neighbourhoods decreased.

Figure 1.9: Life expectancy is lower in the most deprived compared with the least deprived areas in NHS Highland, by local SIMD quintile



Source: National Records of Scotland, Scottish Public Health Observatory (ScotPHO) online profiles tool[13]
Scottish Index of Multiple Deprivation (SIMD) 2020v2 within NHS Highland quintiles

Double click with a mouse or double tap on a touch screen to zoom in/out where necessary.

2. Health Inequalities

- What are Health Inequalities?
- Trends in Health Inequalities
- Premature Mortality
- The Inverse Care Law
- Selected Health Outcomes
- Health Inequalities Measures
- Summary
- Recommendation

Health Inequalities

What are Health Inequalities?

Health inequalities are the systematic, avoidable and unfair differences in people's health outcomes across the population or between social groups within the same population[1,2]. Unfair differences in health outcomes can be experienced by people by a range of inter-related factors including:

- protected characteristics such as sex, ethnicity or disability
- socioeconomic status and deprivation
- disadvantaged or excluded groups of society
- geography and place.

Health inequalities are not caused by a single issue but are the result of a complex mix of factors which play out in local areas and generate a social gradient. People experience different combinations of these factors, which is often referred to as intersectionality.

The existence of health inequalities means that the right to the highest possible standard of physical and mental health is not being achieved equally for people in NHS Highland[3].

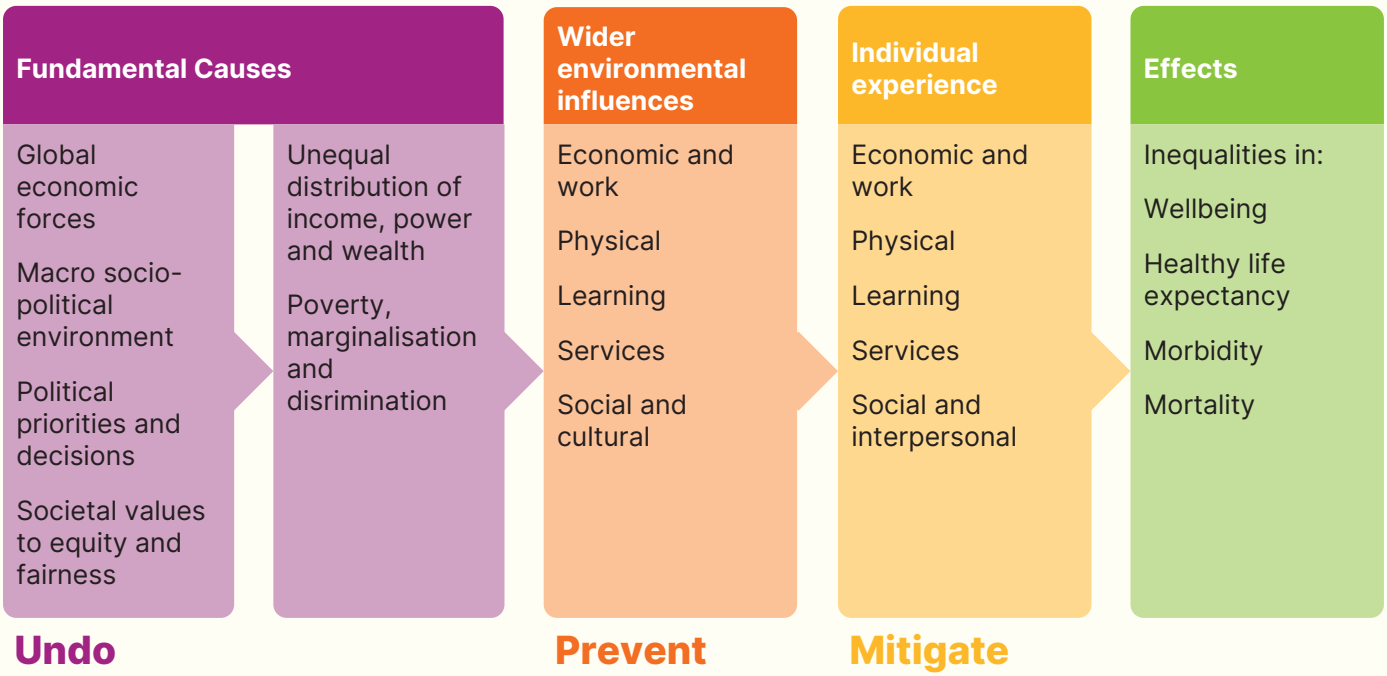
Dimensions of health inequalities

Protected Characteristics	Socio-economic deprivation	Geography and place	Under-represented groups
e. g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, religion or belief, sex (gender), sexual orientation	e.g. poverty, unemployment, low income, multiple deprivation	e.g. urban, rural and island communities and neighbourhoods	e.g. homeless people, people living in prison, people with problem substance use, people with mental health problems

Public Health Scotland highlights a cause of health inequalities as the unequal distribution of income, power and wealth[4]. This can lead to poverty and marginalisation of individuals and groups, and affects the distribution of wider environmental influences, such as good housing, work and education. In turn, these influences can shape individual experiences, for example of poverty, discrimination, poor housing, and access to services. It is the social and environmental conditions in which people are born, grow, live, work and age, alongside behavioural risk factors, which mostly shape health and wellbeing for people and communities.

Double click with a mouse or double tap on a touch screen to zoom in/out where necessary.

Fundamental causes of health inequalities



Source: Public Health Scotland[4]

Trends in Health Inequalities

This section of the report highlights key trends in health inequalities using the Scottish Index of Multiple Deprivation. The most deprived and least deprived 20% of areas refer to local areas within NHS Highland (see following).

Area-based Measures of Deprivation

It is frequently demonstrated, using the Scottish Index of Multiple Deprivation (SIMD), that measures of health and wellbeing are poorer in the most deprived areas compared with the least deprived areas. SIMD is an area-based measure.

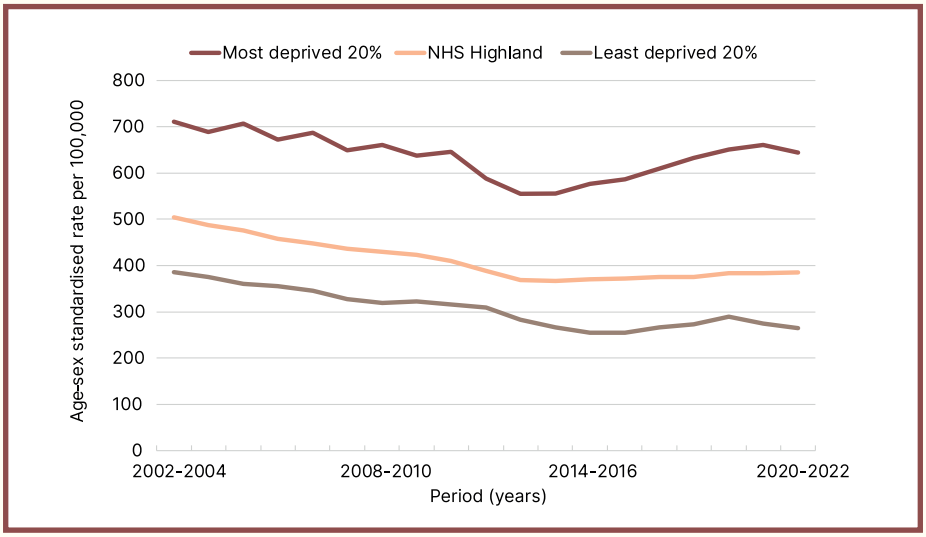
Deprivation indices classify small areas based on factors like income and employment, health, access to services and education. The Scottish Index of Multiple Deprivation (SIMD) ranks small areas in Scotland from most to least deprived, weighting income and employment deprivation most prominently. The most and least deprived 20% of areas (quintiles) are used to describe health inequalities where it is not possible to use an individual measure of deprivation.

It is important to understand that not every person living in the most deprived quintile experiences deprivation and, conversely, deprivation is experienced by some people living in the least deprived areas.

Premature Mortality

Early death in people aged under 75 is a Scottish Government headline indicator of health inequalities[5]. The chart shows the difference in premature mortality rates between the most and least deprived areas of NHS Highland. People living in the most deprived areas are more likely to die early than people in the least deprived areas. Premature mortality rates decreased to 2012-14 but then increased, particularly in the most deprived areas. The gap in premature mortality between the most and least deprived areas widened and inequality in early deaths has increased.

Figure 2.1: Premature mortality rate (under 75) in NHS Highland



Source: National Records of Scotland, Scottish Public Health Observatory online profiles tool

Trends in premature mortality are similar to those observed for life expectancy, showing widening of inequalities by deprivation from 2012-14. This corresponds with austerity and changes to the welfare system in the United Kingdom. Median income, adjusted for inflation, has failed to increase in line with trends from 1997-2007[6]. Those living in the most deprived areas are likely to be more significantly impacted by these changes[7].

Selected Health Outcomes

Trends in health inequalities are not increasing in every indicator. Figure 2.2 shows health inequalities in four different indicators of morbidity and mortality. Early deaths from coronary (ischaemic) heart disease and cancers are the most common causes of premature mortality in NHS Highland. Both conditions have wide gaps in outcomes between areas. The pattern of inequality in coronary heart disease (CHD) deaths has increased over the last decade, whereas gaps in early cancer deaths have declined over time. This is due to increases in CHD deaths in the most deprived areas but decreases in cancer mortality across all areas. Further detail on inequalities in cancer are provided in section 8.

The Inverse Care Law

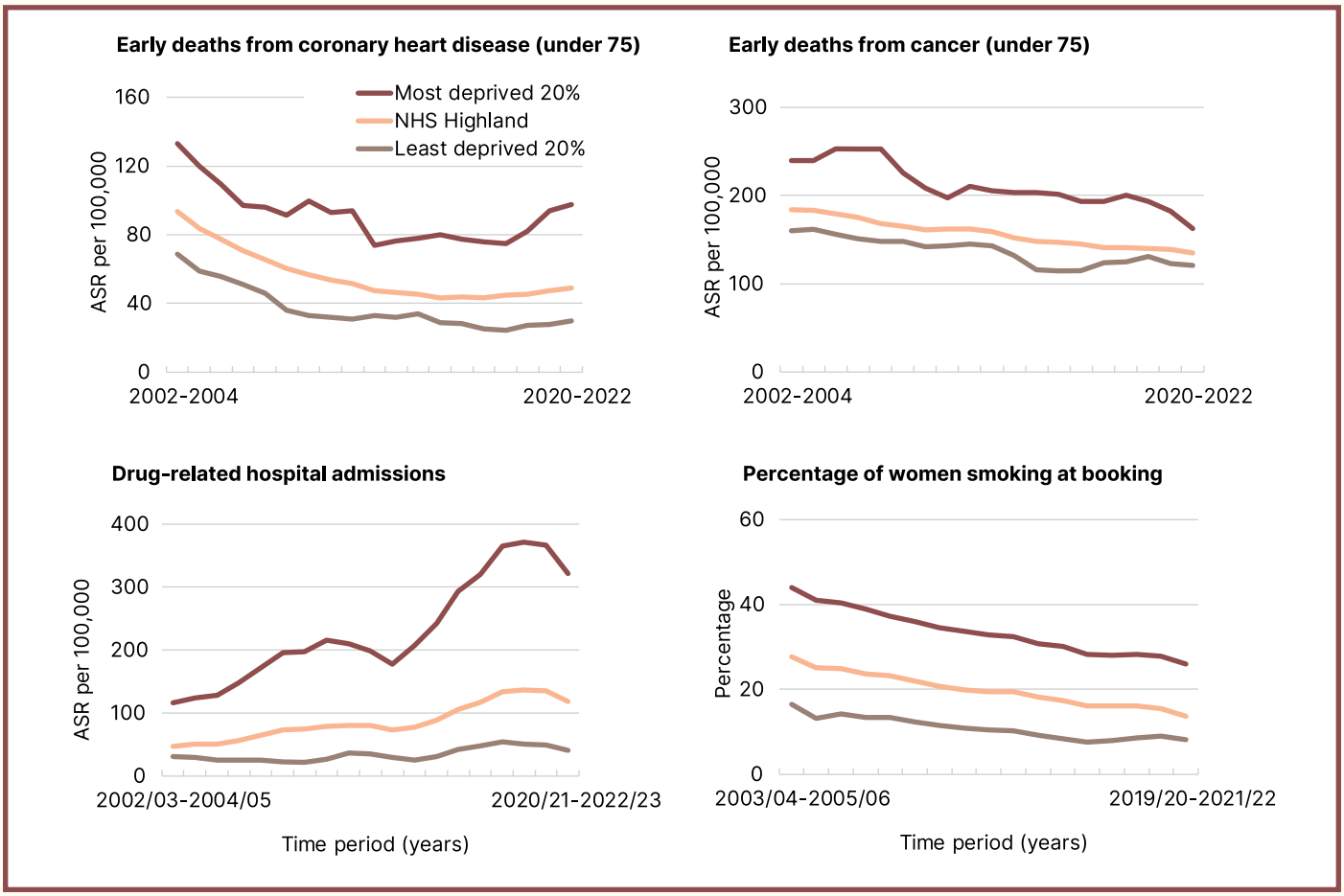
"The availability of good medical care tends to vary inversely with the need for it in the population served"[8].

This is the inverse care law, and it is an important concept in addressing health inequalities. It is not a law, and it relates to more than care, but it will help us think about the issues and what we can do. The idea was developed by Julian Tudor Hart who was an academic and general practitioner in the South Wales valleys and was published in a paper in The Lancet in February 1971. The idea is timeless and suggests that those most in need are the least likely to have that need met. It should make us consider how the provision of services relates to need and inequality whenever we undertake planning or reviewing.

Drug use and smoking are two risk factors associated with poorer health outcomes. Rates of drug-related hospital admissions and the percentage of women smoking at booking (for maternity services) are strongly patterned by deprivation with higher values in the most deprived areas. Drug-related hospital admissions have increased over time with the greatest rises in the most deprived areas.

Smoking at booking has decreased in all areas, but the most deprived neighbourhoods still have higher rates of smoking in pregnancy than observed in the least deprived neighbourhoods over fifteen years ago. Inequalities in child health are further explored in section 4 and inequalities in alcohol-related harm in section 7.

Figure 2.2: Trends in health inequalities in NHS Highland



Source: Scottish Public Health Observatory online profiles tool. ASR: Age-sex standardised rate.

Health Inequalities Measures

Some readers will be interested in more detail and in different ways of presenting the level of health inequality (see 'Measuring Inequalities on the following page). This section is designed for those with a particular interest in health inequalities information.

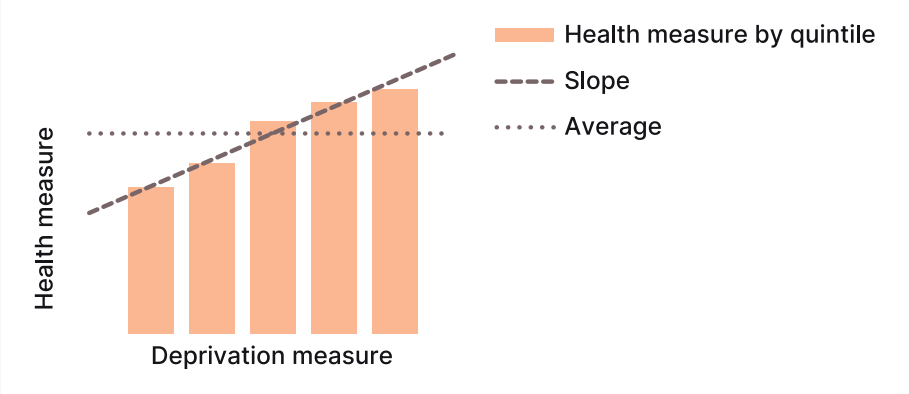
Measuring inequalities

Inequalities in health can be summarised in different ways[9]. Most simply, the range between the least and most deprived areas can be presented e.g. there were 8.8 years difference in life expectancy between males living in the most and least deprived quintiles in NHS Highland in 2017-2021. This is an absolute measure of inequality; absolute measures have the same units as the health indicator itself.

Relative measures of inequality are a proportion or percentage. They quantify the scale of the absolute inequality relative to the health indicator e.g. male life expectancy was 1.12 times higher in the most compared to the least deprived SIMD quintile in NHS Highland.

Calculating the range only uses data in the least and most deprived quintiles. To use more of the information available, the slope index of inequality (SII) can be determined. Commonly, a linear relationship is assumed between the health indicator e.g. life expectancy and the characteristic e.g. SIMD.

This is then used to evaluate the SII across SIMD quintiles. The SII for male life expectancy in 2017-2021 was 11.1 years compared to 7.1 years for females.

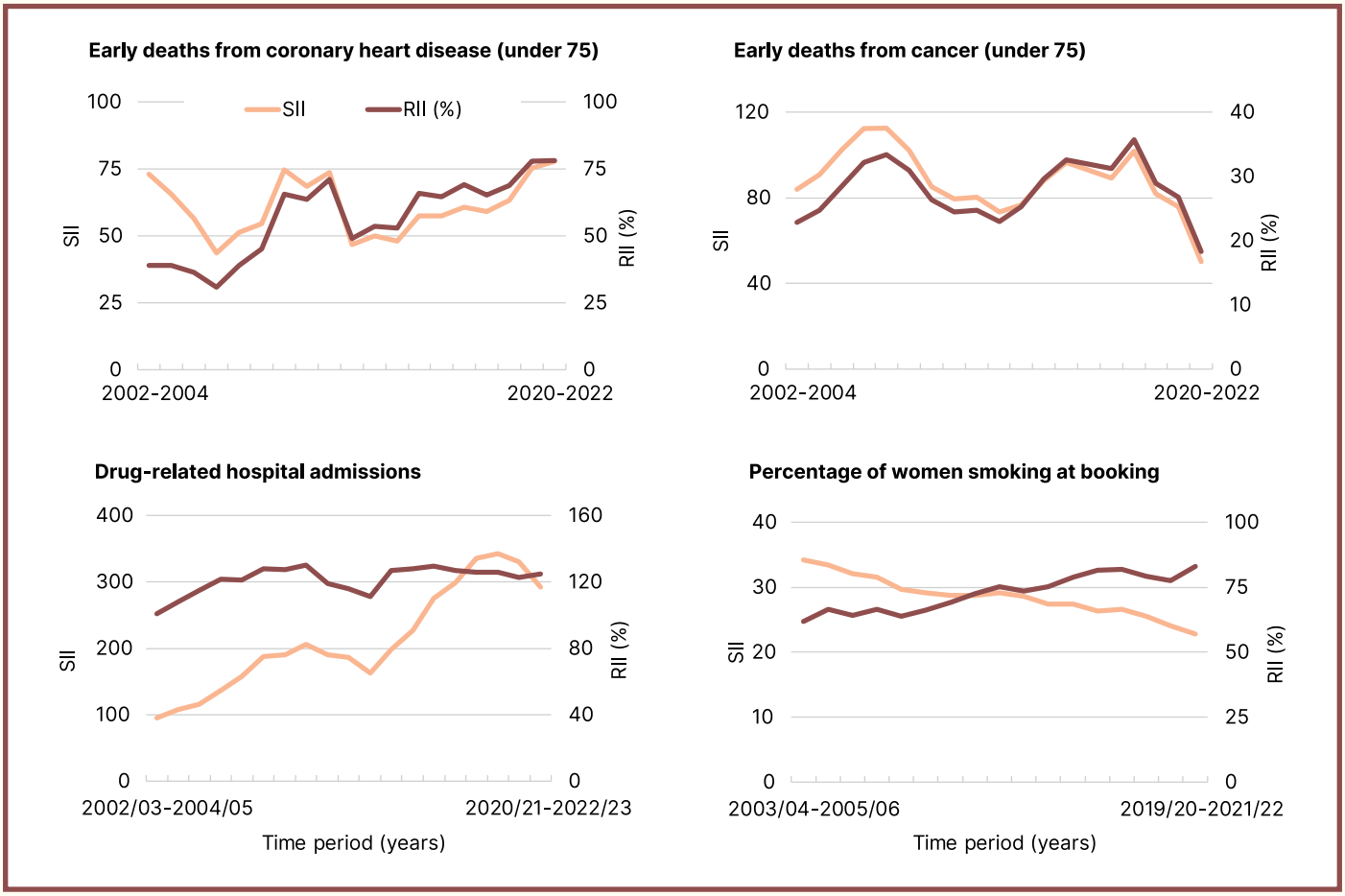


The relative index of inequality (RII) is a relative measure calculated by dividing the SII by the average value e.g. 11.1 years divided by the average of 77.7 years male life expectancy gives a RII of 0.14. The RII can be converted to the percentage difference between the most deprived SIMD quintile relative to average. This is 7.1% for male life expectancy in 2017-2021 and 4.3% for females.

Summary measures of inequalities are useful to monitor inequalities over time. Absolute measures of inequality can decrease alongside improvements in health whilst the relative inequality remains relatively constant. It is therefore helpful to consider both absolute and relative measures of inequality. Increases in both or either measure can indicate increasing inequality. Both absolute and relative measures of inequality in male life expectancy in NHS Highland have increased.

Figure 2.3 shows trends in absolute inequalities (Slope index of inequality, SII) and relative inequalities (Relative index of inequality, RII) for the same indicators displayed in Figure 2.2. They show different patterns of health inequalities in NHS Highland.

Figure 2.3: Trends in summary measures of health inequalities in NHS Highland



Source: Scottish Public Health Observatory online profiles tool. SII: Slope index of inequality. RII: Relative index of inequality.

Early deaths from coronary heart disease (under 75) have increased over the last ten years with an increase in the absolute and relative inequality. This situation is extremely concerning and suggests a need for prevention across the whole population but with a focus on the most deprived areas.

Early deaths from cancer (under 75) have decreased over the last 18 years with a recent decrease in absolute and relative inequality. This is excellent progress, but inequalities persist and action to tackle them should continue.

Drug-related hospital admissions have increased over the last ten years with an increase in absolute inequality, but with little change in relative inequality. The relative inequality is the highest of the measures shown and demonstrates a very large difference between the most and least deprived areas.

The percentage of women smoking at booking has decreased over the last 15 years with a decrease in absolute inequality but an increase in relative inequality. This suggests that, although it is a success that smoking rates are reducing, still more needs to be done to reduce gap between most and least deprived areas.

Summary

The charts in this report clearly show the level of health inequality and the importance of reducing inequalities in NHS Highland. Improving the health of our population requires a shift towards prevention across the whole population and mitigating the underlying issues that can impact on health, such as poverty and deprivation.

Recommendation

- NHS Highland and its partners should regularly review and monitor progress in reducing health inequalities.

3. Approaches to Health Inequalities

- Introduction
- Collaboration for Health Equity
- Place and Wellbeing
- Place Based Example – Shaping Places for Wellbeing - Dunoon
- Recommendation

Approaches to Health Inequalities

Introduction

Health inequalities and equity in health can be approached in many ways and some different approaches are shown in various chapters of this report. This chapter presents some approaches to tackling health inequalities and improving health equity which are being implemented place by place.

Collaboration for Health Equity

A programme led by the UCL Institute of Health Equity (IHE) has built on work led by Sir Michael Marmot and the report on health equity in England in 2010. The work recognises that the social determinants of health mostly influence and drive health outcomes[1]. The IHE has identified eight priority areas or principles to reduce health inequalities[2].

1. Give every child the best start in life.
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives.
3. Create fair employment and good work for all.
4. Ensure a healthy standard of living for all.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill health prevention.
7. Tackle racism, discrimination and their outcomes.
8. Pursue environmental sustainability and health equity together.

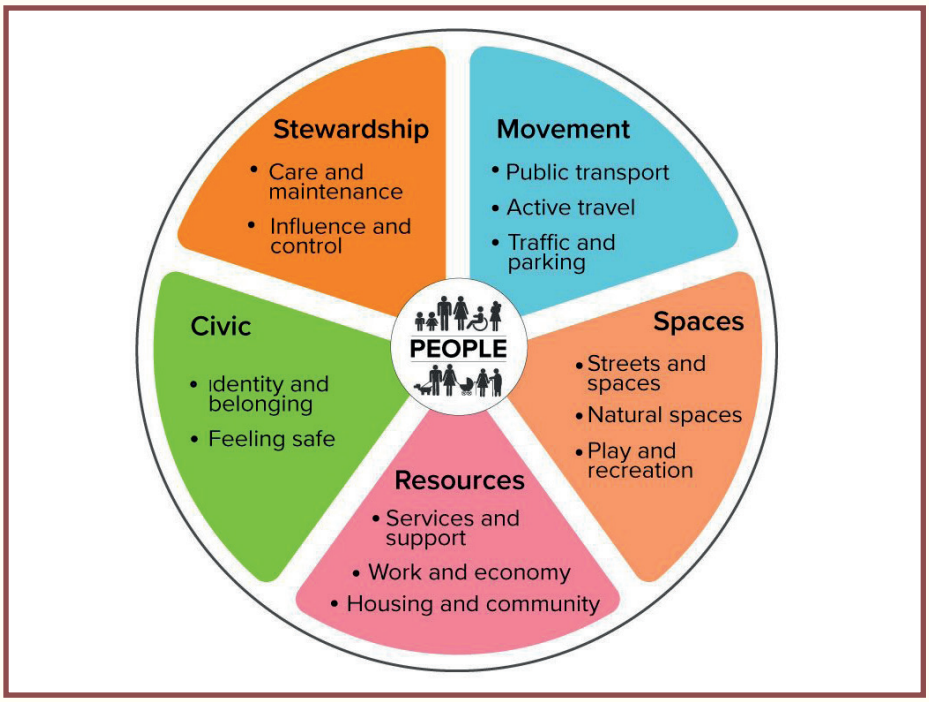
Based on these eight principles, a Marmot approach involves places and communities in the identification of local priorities and works to develop and embed interventions and policies to improve health equity in local systems. The Marmot approach is known as proportionate universalism. This means it applies policies to all but with services and support increasing at a scale and intensity proportionate to the degree of need. The aim is to raise overall levels of health at the same time as flattening the gradient in health. The IHE argue that focusing on one group of individuals or a few geographical areas will not deliver long-term, whole-system change. This approach is being piloted in Scotland and there are likely to be many opportunities for learning and putting lessons into practice.

Place and Wellbeing

A Scotland where we live in vibrant, healthy and safe places and communities is one of the six Public Health priorities in Scotland. There is growing evidence on how differences in the design and function of neighbourhoods impacts on health and wellbeing and contributes to inequalities.

To tackle these inequalities, it is necessary to consider action beyond the health and care system. Place based approaches to improve health and wellbeing and reduce health inequalities acknowledge the link between the physical and economic environment and its impact on the people who live, work, play and learn there. This affects different groups in different ways and therefore requires interventions to be based on an understanding of people and the place itself. The elements within a place that are likely to help improve health and wellbeing, and tackle inequalities are described in a set of Place and Wellbeing Outcomes[3]. We need to focus on these areas of policy and practice to improve health and wellbeing and tackle inequalities in our communities.

Figure 3.1: Place and wellbeing outcomes



Source: Improvement Service

The quality of our neighbourhoods varies from place to place. This variation contributes to increasing inequalities[4]. People living in our most deprived areas are more likely to experience poor quality buildings and community spaces. These neighbourhoods are more likely to have gambling outlets and outlets that sell alcohol, tobacco and fast food making it easier to access health harming products and services[5].

Taking a place-based approach can identify the causes of inequality and target action at the specific challenges for individual places. This requires a co-ordinated and joined up approach with public and third sector partners working together to improve the quality of our places and communities and ensure investment in places with greatest need. The key areas for action in taking a place-based approach include:

- Community Planning Partnerships taking a lead role in developing and implementing a place-based approach in our communities.
- Assessing the wide range of policies that contribute to better places such as local development plans, transport plans, housing plans transport and economic plans for their impact on health and inequalities.
- Tracking progress on improving the quality of our local places through use of tools such as the Place Standard[6].
- Embedding the Place and Wellbeing outcomes into policy and decision making and taking action on each of the elements that a local place needs to support health and wellbeing and reduce inequalities.

Place Based Example – Shaping Places for Wellbeing - Dunoon

The *Shaping Places for Wellbeing Programme* was a collaborative initiative led by the Improvement Service and Public Health Scotland, in partnership with local authorities and health boards. The programme aimed to enhance Scotland's overall wellbeing by tackling health inequalities and addressing environmental challenges. This was achieved through three core activities:

- Supporting place-based 'Local Project Action'.
- Sharing insights via 'Local Learning Cohorts'.
- Guiding national strategy through a 'National Leadership Cohort'.

These programmes of work put place at the heart of planning with the intention to support communities to flourish.

Dunoon was one of seven areas selected for the programme and had dedicated support through a Project Lead and Community Link Lead to assist in local implementation. The focus of this support was to deepen understanding of three key aspects of a place-based approach:

1. Understanding community experiences through data.
2. Identifying the necessary features for a thriving place, using the Place and Wellbeing Outcomes.
3. Integrating data and outcomes into decision-making processes.

The work was rooted in the *Place and Wellbeing Outcomes*, which define the essential conditions for a place where both people and the planet can flourish. As part of this, the Project Lead worked with Public Health Scotland Data Analysts to create a *Quantitative Data Profile* and a *Quantitative Data Infographic* for Dunoon. The primary focus was on addressing inequality, particularly in relation to:

- People living in poverty.
- People experiencing deprivation.
- People with problematic alcohol use.

A central component of the programme was Place and Wellbeing Assessment, which brought together key stakeholders (either virtually or in person) to evaluate how a policy, plan, or proposal might impact a place and its people.

These assessments used the *Place and Wellbeing Outcomes* framework to guide discussions, with a strong emphasis on reducing inequality. Following each assessment, a report was produced summarizing key recommendations for advancing a more place-based approach to improving wellbeing. For more information on the Dunoon programme please visit the Dunoon Project Town section on the Improvement Service website.

Recommendation

- Highland and Argyll and Bute Community Planning Partners should consider the best ways to tackle local health inequalities and how to learn from models such as Collaboration for Health Equity and place-based approaches.

4. Child Health

- Introduction
- Child Poverty
- Early Child Development
- Care Experienced Children and Young People
- Children’s Rights
- Recommendations

Child health

Introduction

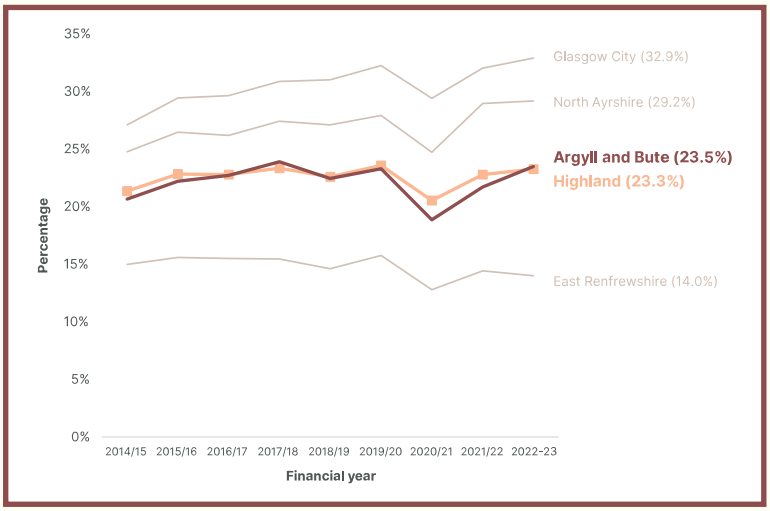
Health equity work has highlighted the importance of health inequalities among children as both important in its own terms and as a determinant of future health and wellbeing. This chapter presents some examples of child health inequality and the importance of action to tackle it.

Child Poverty

Inequality starts before birth and is driven by social, economic and environmental factors that become entrenched throughout childhood and persist across the life course, often passed between generations. Child poverty is part of family and community poverty. Poverty is the primary driver of health inequalities, with children living in poverty more likely to experience adverse health outcomes, including a higher risk of mortality and physical and mental health problems[1].

There are currently 13,000 children in NHS Highland who are growing up in poverty, which is almost 1 in 4 children in both Highland and Argyll and Bute HSCPs. (Figure 4.1). The number is increasing, with children more likely to live in poverty if they are from a lone-parent family, have a younger mother (under 25), are aged under one, or have two or more siblings. Minority ethnic families and having someone (child or adult) with a disability in the household also increases the risk. Previously, childhood poverty was linked to unemployment but increasingly, children in poverty live with at least one working parent with the current cost of living crisis putting more families into poverty[2].

Figure 4.1: Percentage of children living in poverty after housing costs by Local Authority area in Scotland



Source: End Child Poverty Coalition estimates of child poverty rates after housing costs (2024). A child is defined as aged under 15 or aged 16-19 and in full-time education.

The Scottish Government has prioritised eradicating child poverty and introduced the Child Poverty (Scotland) Act 2017 which sets interim and longer-term targets for 2030. These are to be met by implementing the second Best Start, Bright Futures (2022-2026) national delivery plan. Health boards and local authorities are legally required to jointly produce annual Local Child Poverty Action Reports that describe ongoing and planned activity. Most activities focus on three key drivers: improving income from employment; reducing living costs; increasing income from social security and benefits in kind.

Early Child Development

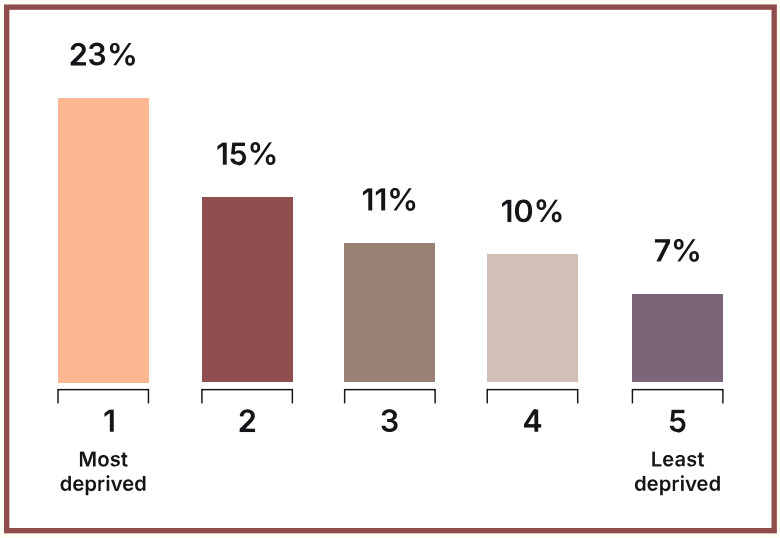
"Investing in the early years is one of the smartest investments a country can make to break the cycle of poverty, address inequality, and boost productivity later in life" - The World Bank[3].

Social and environmental influences such as parenting skills, play opportunities, and living in poverty, along with biological factors such as premature birth can impact child development. Identifying potential delays in development as early as possible is essential for ensuring children and families receive the support they need, when they need it to reduce the risk of any longer-term health and educational challenges.

The main supports for young children's healthy development include sensitive and responsive caregiving, play and stimulation, nutrition and health and safety from harm. We are now aware that growing up with adverse childhood experiences such as abuse, neglect, violence, poverty or living with adults with mental health or alcohol or drug problems can result in trauma that can affect children's development from an early age. The COVID pandemic has impacted negatively on child development due to reduced access to play, early learning opportunities and the increased stress placed on parent's mental health, with children and families living in poverty affected disproportionately.

There are inequalities in the proportion of children who are found to have a developmental concern. Compared to Scotland fewer children in NHS Highland tend to be identified with one or more developmental concerns during the 27–30-month review period. However, there are evident health inequalities that need to be tackled, with children in our poorest communities more likely to have developmental concerns than those living in more affluent areas. (Figure 4.2)

Figure 4.2: Percentage of children with at least one developmental concern at their 27-30 month review in NHS Highland by quintile of Scottish Index of Multiple Deprivation in the financial year 2023 – 2024



Source: Child Health Surveillance Programme (Pre-school)

Double click with a mouse or double tap on a touch screen to zoom in/out where necessary.

There are persistent inequalities in the proportion of children with developmental concerns at review.

At 27-30 months, this proportion is 3.3 times higher among children living in the most deprived areas of NHS Highland (23%) than those in the least deprived (7%), a wider gap than previously observed in 2022/23

Care Experienced Children and Young People

There are many reasons for children becoming care experienced which can include adverse childhood experiences and trauma, often aligned to challenging family circumstances. Many care experienced children also have a mix of protected characteristics which intersect to compound their experiences of inequalities. Care experienced children and young people have a risk of significantly poorer health and wellbeing outcomes compared with others[4].

Table 4.1: Differences in life circumstances and health status of the care experienced cohort from population-wide research carried out by Children's Health in Care in Scotland (CHiCS)

Measure	**Children** (Care experience)	**Children** (General population)
Born in areas of deprivation	59%	25%
Born to younger mothers (maternal age less than 25 years)	56%	26%
Parents who are unemployed, students, unknown employment status at birth	29%	7%
Risk of dying prematurely	5 times higher for care experienced children	
Higher prevalence of mental ill health	2.5 – 4 times higher for care experienced children	
Higher prevalence of hospitalisations for stress-related conditions	6 times higher for care experienced children	

Source: CHiCS Study[3]

Figure 4.3: The Promise

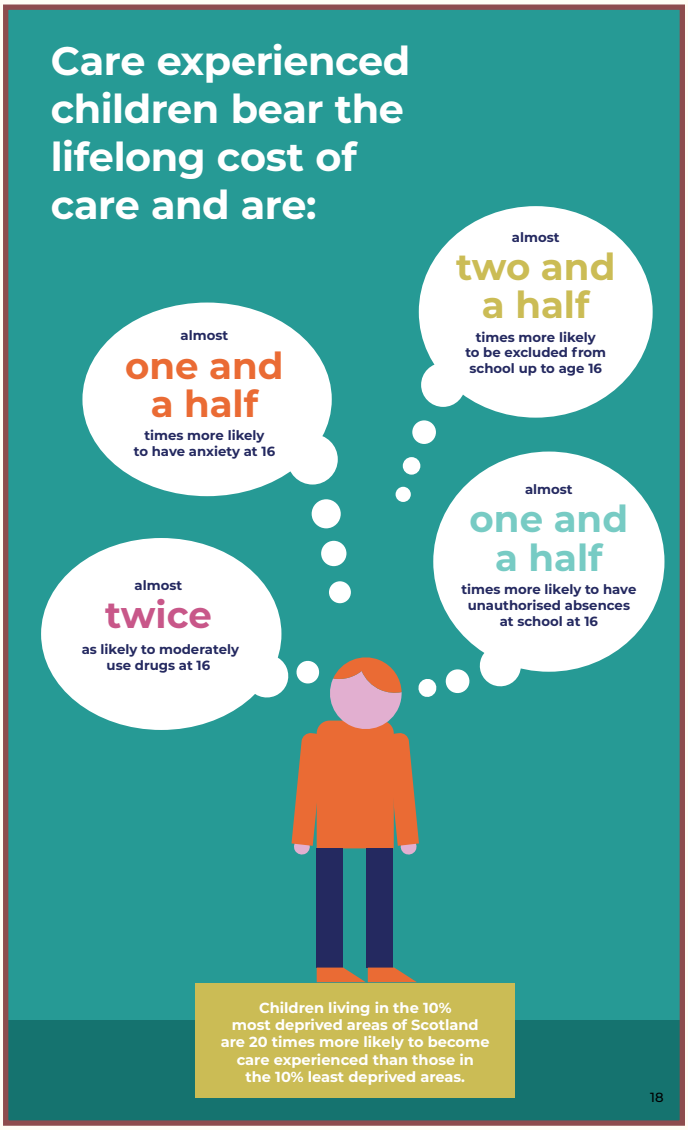
It is vital that the needs of care experienced children and young people are recognised, acknowledged and addressed to reduce the inequality in their health compared with others. This is encompassed within The Promise across Scotland, including Highland and Argyll and Bute so that children with care experience will grow up loved, safe and respected.

Vital to keeping The Promise is delivering on the five underpinning foundations:

- Voice
- Family
- Care
- People
- Scaffolding.

In practice, this means; helping families stay together wherever it is safe to do so, preventing children from entering the 'care system'; and ensuring children who do grow up in care, have opportunities to fulfil their potential. This involves services working together to build and maintain loving relationships as the basis on which to thrive.

Figure 4.4: Care Experienced Children



Source: Taken from Follow the Money, Independent Care Review (page 18)

Children's Rights

Central to the vision of a world where children feel loved, safe, respected and reach their full potential, is respect, protection and fulfilment of children's human rights. These include the right to be treated fairly, to be heard, to have an adequate standard of living and to be as healthy as possible. Realising children's rights is vital to achieving health equity by ensuring all children have the best start in life and have agency over their future.

Figure 4.5: United Nations Convention on the Rights of the Child

Incorporation of the United Nations Convention on the Rights of the Child (UNCRC) into Scot's law will drive a culture of everyday accountability for children's rights. The legislation means the public sector are required to take proactive steps to ensure compliance with children's rights. In practice, this means delivering plans and activity that incorporate children's rights into policy development, planning, delivery and evaluation of services as well as strategic, operational and budgetary decision-making. This can have a profound effect both on the health and wellbeing of children and young people as well as reducing inequalities now and in the future.

Recommendations

- NHS Highland and partners should evidence compliance with the UNCRC and increase completion rates for Equality and Integrated Impact Assessments by March 2026.
- NHS Highland and partners should deliver the actions set out in local child poverty action reports by November 2026.
- NHS Highland should work with local authority partners to deliver on The Promise Plan 24-30 to improve outcomes for care experienced children by 2030.

5. Immunisation

- Introduction
- Recommendation

Immunisation

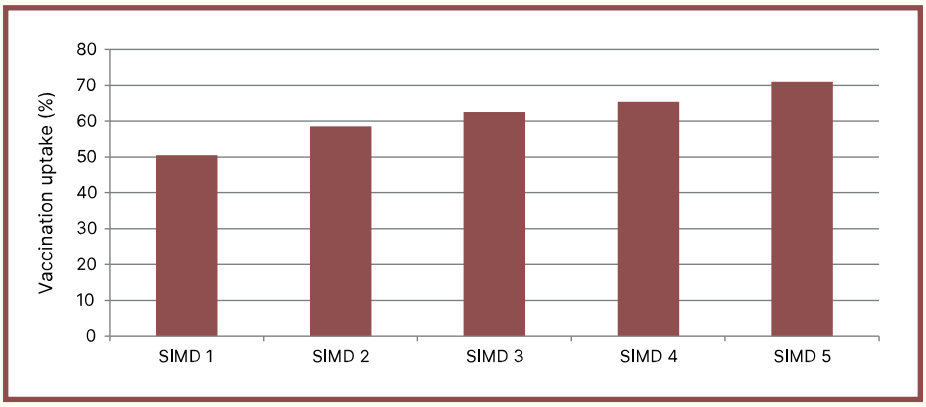
Introduction

Immunisation is one of the most effective interventions for preventing illness and death from infectious diseases[1]. As with most healthcare interventions, there are recognised inequalities with respect to immunisation programmes with uptake rates lower in more deprived communities compared with less deprived communities. So, in addition to the delivery of a safe, high-quality and efficient vaccination programme, reducing inequalities is a key aim for all involved in immunisation programmes. Inequalities are seen across all of the immunisation programmes from childhood through to programmes aimed at older adults.

Inequalities and Immunisation

The spring COVID-19 vaccination programme was delivered to those aged 75 years and over, residents in care homes for older adults and immunosuppressed individuals aged 6 months and over. As illustrated in Figure 5.1, there is a significant difference in vaccination uptake between those in our most deprived communities (50.4%) compared with our least deprived (70.9%). The difference in uptake of around 20% between our most and least deprived is seen across Scotland as a whole with vaccination uptake across Scotland for SIMD 1 being 51.5% compared with 71.5% for SIMD 5 for spring 2024.

Figure 5.1: COVID-19 vaccination uptake by SIMD for NHS Highland for the spring 2024 vaccination programme

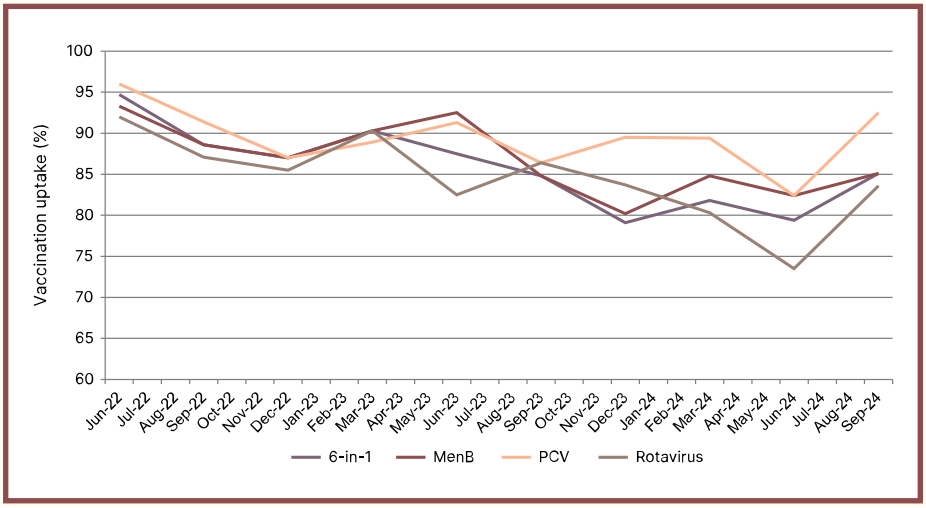


Source: Discovery website, Public Health Scotland, 2025

For childhood immunisation, there has been an overall decline in the uptake of vaccines, and it is important that action is undertaken to reverse this. In areas of deprivation the fall in uptake is most apparent and Figure 5.2 shows the uptake of the primary immunisations by 12 months of age for those children in SIMD 1 (most deprived) across NHS Highland. There is a declining trend in uptake over time with the vaccination uptake for all four vaccines being lower in the quarter ending September 2024 compared with the quarter ending June 2022. For the 6-in-1 vaccine the uptake has dropped from 94.7% in the quarter ending June 2022 to 85.1% in the quarter ending September 2024.

Double click with a mouse or double tap on a touch screen to zoom in/out where necessary.

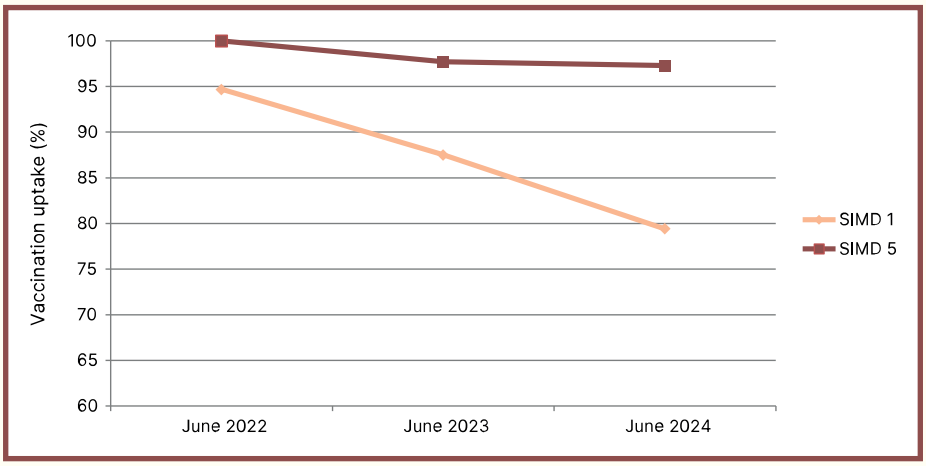
Figure 5.2: Uptake for childhood vaccinations by 12 months for SIMD 1 between quarter ending June 2022 & September 2024



Source: Discovery website, Public Health Scotland, 2025

The decline among least deprived areas is considerably smaller and so the inequality is increasing. Figure 5.3 shows how the gap in vaccination uptake for the 6-in-1 vaccination between the most and least deprived increased from 5.3 percentage points to 17.9 between the time points reviewed.

Figure 5.3: Vaccination uptake by 12 months for the 6-in-1 vaccination for SIMD 1 and SIMD 5 across NHS Highland



Source: Discovery website, Public Health Scotland, 2025

In addition to the impact of deprivation on uptake, uptake is lower for certain groups of people including Black, Asian, Eastern European and other minority ethnic groups. For the seasonal influenza campaign for adults in 2023, there was significant variation in uptake between different ethnic groups ranging from an uptake of 12.8% in Polish communities, 48.6% in Chinese communities and 56.3% in White Scottish communities across NHS Highland. The need to address inequalities and support more targeted work to increase uptake is a vital priority at the same time as improving overall uptake. There are examples of success, such as work with the Chinese community for COVID vaccination and work with people who use substances, but further and more comprehensive activity is needed.

Recommendation

- NHS Highland should continue work to improve vaccination uptake especially among disadvantaged groups.

6. Minorities or Underrepresented Groups

- Introduction
- Health and Illness in Underrepresented Groups
- Power: Relationship Building and Trust
- Stigma and Discrimination
- Accessibility
- Enablers
- Recommendations

Minorities or Underrepresented Groups

Introduction

Underrepresented groups are those with less presence, participation, or influence in areas like politics, business, education, or media, often due to systemic barriers. These groups, including ethnic minorities, women, LGBTQ+ individuals, and people with disabilities, face obstacles that limit their access to opportunities and power, which perpetuates inequality and reduces the diversity of perspectives in decision-making processes.

Imagine a place where everyone has equal access to support, systems and services. Where people weren't disadvantaged by stigma or communication challenges for example.

What would that look like?

Health inequalities in these groups are deep-rooted and complex, exacerbated by barriers such as communication difficulties, limited access to services, and stigma. These factors contribute to poorer health outcomes. Effective communication is key to navigating services and systems, but language and comprehension barriers often hinder access to essential services. Disparities in health education and literacy can further exacerbate these challenges, while a lack of representation among service providers may mean that their needs are not appropriately acknowledged.

Health and Illness in Underrepresented Groups

The following figures and charts show how different aspects of health can be poorer among people from underrepresented groups and these are just a few examples of far wider issues.

Table 6.1: Deaf and hearing impaired

Twice as likely to experience mental health problems. Rate of depression amongst deaf BSL users is double that of the general population.

More likely to have multiple medical conditions and **overall worse health** status compared to those without hearing loss.

Experience barriers to accessing health services including negative attitudes and behaviours from health professions and admin staff.

Source: Royal National Institute for Deaf People (RNID)[1]

Double click with a mouse or double tap on a touch screen to zoom in/out where necessary.

Table 6.2: Gypsy Traveller People

Lower life expectancy and **worse health** than any other ethnic group in Scotland, including White Scottish.

Higher risk of poor mental health, mental illness, and suicide.

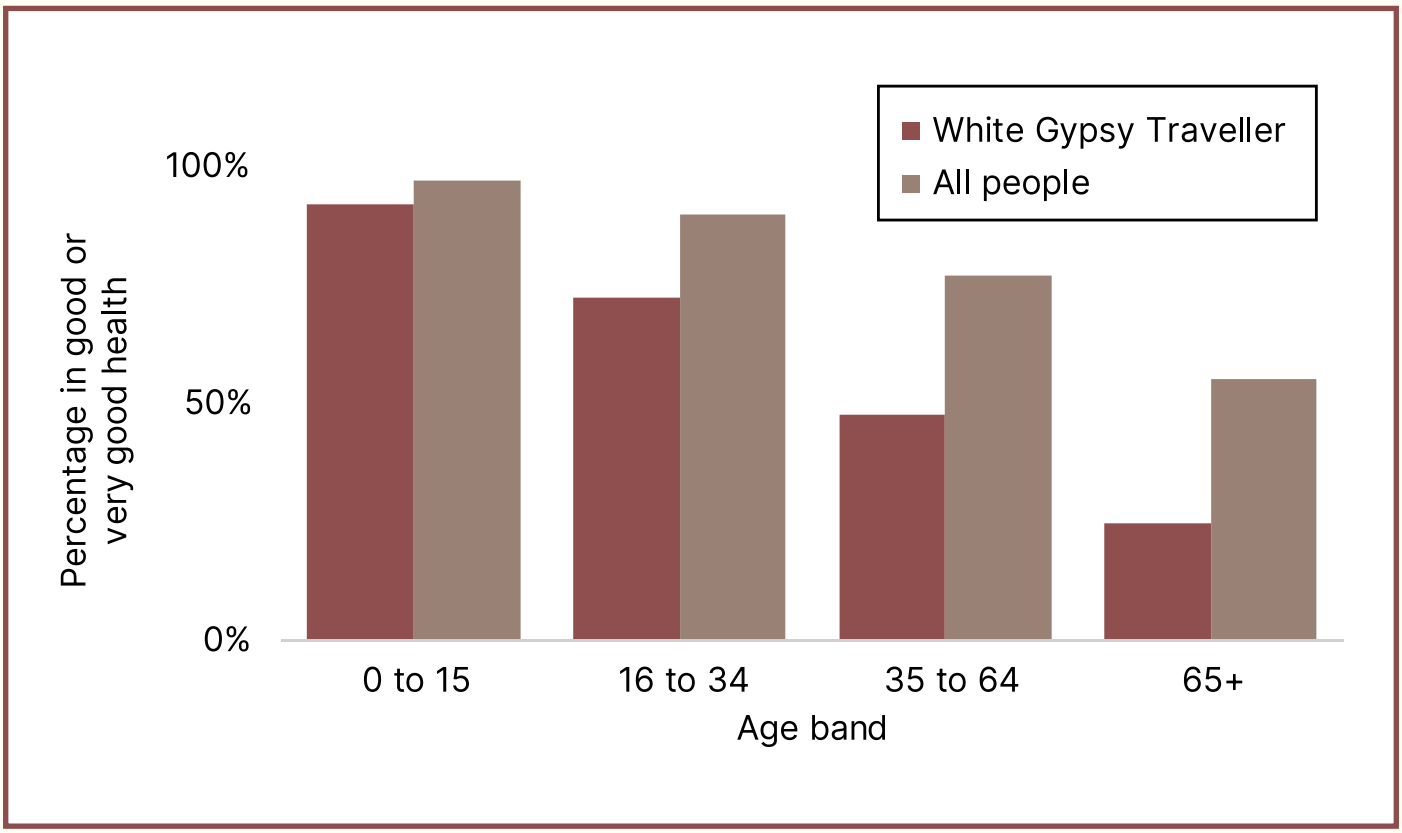
More likely to have one or more **long-term health condition** with higher than average levels of obesity, hypertension, risk factors for diabetes, heavy alcohol use and/or smoking, and risk of cardiovascular disease.

Barriers to **accessing health service** include temporary registration at GP practices, discrimination, lower literacy, and isolation from mainstream society. People are also more likely to receive a lack of continuity of care.

Vulnerable to poor health through high rates of homelessness, poor quality housing and living conditions, low educational achievement, social exclusion, and widespread prejudice and discrimination, including hate crime.

Sources: Gypsy/Travellers in Scotland: A Comprehensive Analysis of the 2011 Census[2]
Improving access for Gypsy/Travellers to the NHS and health and social care in Scotland[3]

Figure 6.1: Comparison of health between White Gypsy Traveller people and the general population



Source: National Records of Scotland, Census 2022

Table 6.3: People with learning disability

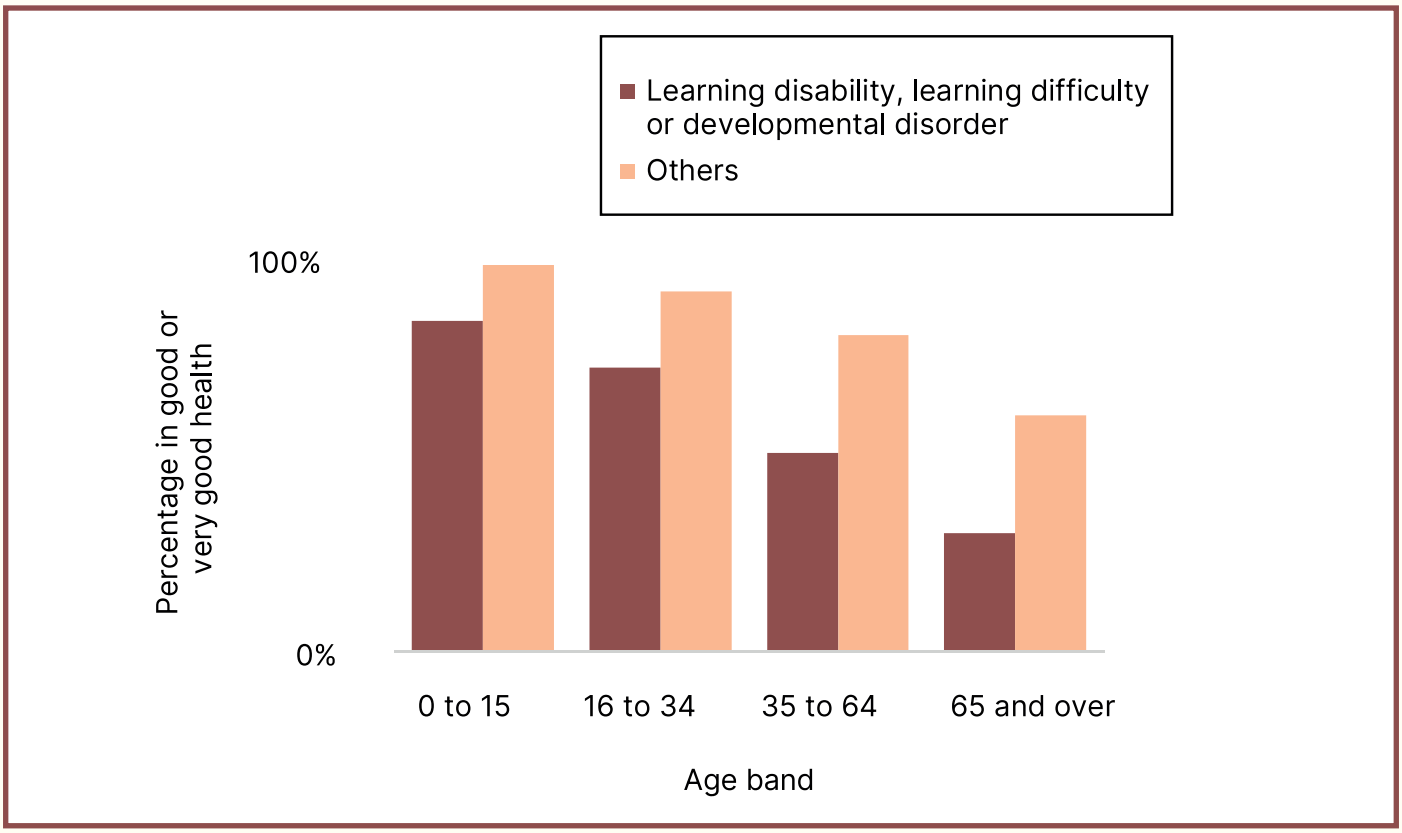
20 **years lower life expectancy** than people in the general population with worse health across all ages.

More likely to have one or multiple **long-term health conditions**.

Experience poorer management of long-term conditions and are more likely to be admitted to hospital and stay longer once there. Experience barriers to **accessing health service**.

Source: Scottish Learning Disabilities Observatory[4]

Figure 6.2: Comparison of health of people with learning disabilities, learning difficulties, or developmental disorders, and others



Source: National Records of Scotland, Census 2022

Double click with a mouse or double tap on a touch screen to zoom in/out where necessary.

Table 6.4: Lesbian, gay, bisexual, transgender and non-binary

59%	aged under 50 rated **general health** positively compared with **88%** aged 16-44 in the Scottish Health Survey. The poorest health was reported by transgender and non-binary people.
	Higher risk of **mental health problems** than heterosexual population. **54%** had depression/anxiety/stress. Linked to minority stress but compounded by discrimination, bullying, hate crime, and higher social isolation.
84%	LGBT **young people experienced mental health problems** and associated behaviours e.g., self-harm with transgender young people most at risk (96%).
	More likely to engage in some **health risk behaviors**, e.g. to smoke or use e-cigarettes, and to drink at problem levels than heterosexual people. Increased barriers to participating in physical activity include, laddish culture, communal changing, gender rules, and clothing.
	Problems in **accessing health services** include assumptions regarding gender and sexuality, confidentiality, inadequate knowledge or inappropriate questioning by staff, and long waiting times for specialist services.

Source: Health needs assessment of lesbian, gay, bisexual, transgender and non-binary people[5]

Power: Relationship Building and Trust

Building trust and improving relationships between service providers and underrepresented communities is critical to enhancing engagement and improving health outcomes.

The distribution of power, along with income and wealth, is a key driver of health inequalities. Power is the ability to act, influence, and control, and those with greater power often have better access to resources, social connections, and opportunities, which can protect their health. For underrepresented groups, understanding the relationship between power and health is crucial.

Power is relational and exists in interactions between people and groups. To address health inequalities in underrepresented communities, the imbalance of power must be examined as those with power can have better access to resources, live in healthier environments, secure better jobs, and access quality services.

Trust, like power, is unequally distributed and essential for building positive relationships between individuals and services. A power imbalance can hinder underrepresented groups from accessing services, as trust may be harder to establish when there is a history of trauma, inequality or exploitation. Trauma and adversity can significantly impact an individual's sense of power and trust, as research shows that experiences of harm or injustice often erode feelings of control and safety, leading to difficulties in forming trusting relationships and navigating power dynamics.

Trauma and adversity, beginning as early as pre-birth, significantly affect mental, physical, and emotional well-being throughout life. Chronic toxic stress can be transmitted across generations, leading to intergenerational harm. The Annual Report of the Director of Public Health 2018 highlights that individuals who have experienced trauma tend to have poorer outcomes compared to those who haven't.

An example is as follows:

Building trusting relationships within the Gypsy/Traveller communities

NHS Highland worked closely with Minority Ethnic Carers Of People Project (MECOPP's) Peer Led Community Health Worker Team, to help build trusting relationships and re-balance power to support delivery of initiatives to improve health and wellbeing. This included:

- Regularly meeting communities in places where they felt comfortable
- Asking communities about what was important to them
- Involving communities every step of the way
- Following through on commitments made

Stigma and Discrimination

Stigma and discrimination are significant factors affecting population health, with the World Health Organization (WHO) identifying "social inclusion and non-discrimination" as key social determinants of health. For individuals from underrepresented communities, stigma and discrimination contribute to "minority stress," reinforcing and exacerbating existing inequalities. Local Gypsy and Traveller communities report the profound impact of stigma on their lives with one survey in Scotland finding that 90% of Gypsy and Traveller children and young people experience racial abuse in schools. As a result, many families opt to home educate their children to protect them from this harm, but this choice often leads to lower levels of education and literacy, thus perpetuating the cycle of disadvantage.

2024 also witnessed coordinated outbreaks of racialised violence and racist abuse in parts of the UK, which threatened the safety and security of minority ethnic citizens. Although Highland has not experienced such violent incidents, there remains widespread concern about public safety, especially among minority ethnic communities across the UK.

Addressing stigma and discrimination, both within organisations and in communities, is critical to improving access to services, enhancing quality of life, and reducing health and social inequalities. Research published in 2024 highlights the importance of tackling stigma:

- The National AIDS Trust report, Mental Health and HIV: Beyond the Virus, identified tackling stigma as a key priority in improving access to care.
- The Equality Network's Scottish Trans and Non-binary Experiences Report found that 61% of trans and non-binary individuals had avoided at least one public service due to fear of harassment, being misgendered, or being outed. Furthermore, 54% reported having a negative experience when interacting with public services[6].

This underscores the urgent need to address stigma and discrimination to ensure equitable access to care and to reduce the health and social inequalities experienced by underrepresented communities.

Accessibility

Accessibility remains a significant issue, especially for underrepresented groups, such as people with disabilities who experience poorer access to services despite often needing them more frequently. For example, deaf and deafblind British Sign Language (BSL) users face communication barriers such as lack of interpreters and BSL information, leading to discrimination and poorer health outcomes.

Other important issues that support people to access services are literacy and health literacy. Good literacy and health literacy enable people to engage with services, make informed decisions, and participate in health and other programs. Groups with lower literacy/health literacy, such as people with learning disabilities or those who don't speak English as a first language, often face greater challenges to accessing services and experience poorer outcomes as a result. Improving literacy and health literacy can empower people improve health and reduce inequalities.

Addressing service accessibility requires a commitment to inclusivity, patient-centred approaches, and collaboration with affected communities to ensure that all individuals can access the care they need.

Enablers

Public Sector organisations play an important role in supporting environments and conditions that support the conditions for good health and wellbeing, for example by employing staff, by buying services, by owning buildings and assets and by examining the impact of decisions on marginalised groups. They act as anchor institutions for local communities.

Community Wealth Building (CWB) is an economic development approach that can create more equitable and sustainable local economies. It aims to retain wealth generated within communities to benefit local people and organisations, shifting economic power towards local institutions, individuals and communities. It aims to contribute to more equal distribution of wealth and power, and ensure that all members of the community, particularly underrepresented groups, have opportunities to participate in and benefit from the local economy.

Equality Impact Assessments (EQIAs) are an effective way to help address disparities in access and reduce inequalities. EQIAs help uncover disadvantages early on and allow for adjustments to reduce discrimination and any negative impacts of policy or plans. Undertaking EQIAs is an essential part of fulfilling obligations under the Public Sector Equality Duty (PSED) which requires authorities to give due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations when carrying out public functions. EQIAs demonstrate how this duty can be enacted by considering the potential impacts of policies, services, or functions on different groups, ensuring that all voices, especially those from marginalized communities, are heard and considered.

Recommendations

- Public sector organisations in Highland and Argyll & Bute should acknowledge the poor health experienced by underrepresented groups and address these health inequalities with help from the skills and resources of these groups. This includes building strong collaborative relationships with those in positions of trust within communities.
- Organisations and individuals should take action to address stigma and discrimination by adopting clear and inclusive language, supporting staff to be aware of unconscious bias, challenging discrimination wherever it is seen and supporting staff to undertake training on equality and diversity, anti-racism and cultural awareness.

7. Alcohol

- Introduction
- Epidemiology
- Consequences of alcohol
- Action
- Recommendation

Alcohol

Introduction

Health inequalities are apparent across a wide range of issues and groups of people. One significant area of concern is the relationship between inequalities and the harms caused by alcohol and that is the subject of this chapter.

This chapter starts with epidemiological data to show the inequality trends because of harms caused by alcohol. The next section explains some of economic, health and social consequences of alcohol consumption and the final section describe how health inequalities can be tackled locally and through policy.

It is well documented that people living in areas of known deprivation with a lower socio-economic status show a greater susceptibility to the harmful effects of alcohol, sometimes known as the alcohol harm paradox[1].

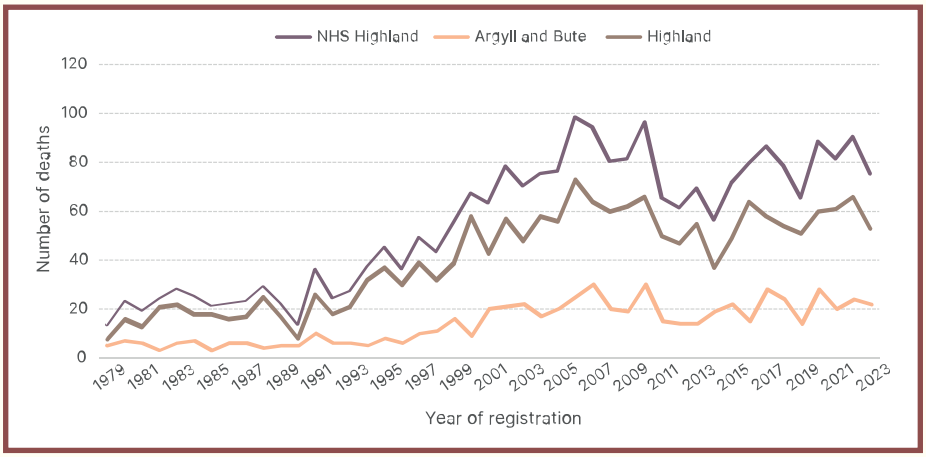
Epidemiology

This section outlines the impact of harm from alcohol in terms of deaths specifically caused by alcohol and hospital admissions directly related to alcohol, demonstrating the considerable inequality by deprivation. The effects of alcohol are much wider than this but information on this is less readily available. The data source is National Records of Scotland[2].

Alcohol Specific Deaths

Figure 7.1 shows the number of Alcohol Specific deaths registered by year 1979-2023; NHS Highland, Argyll and Bute, and Highland. There were 1277 alcohol specific deaths in registered in Scotland in 2023. For Highland this was 75 deaths; Argyll and Bute 22 deaths and Highland 53 deaths. The overall trend is upwards although current numbers do not exceed the highest recorded total in 2006 of Scotland 1417 deaths and 98 deaths NHS Highland.

Figure 7.1: Number of Alcohol Specific deaths registered by year 1979 to 2023. NHS Highland, Argyll and Bute and Highland

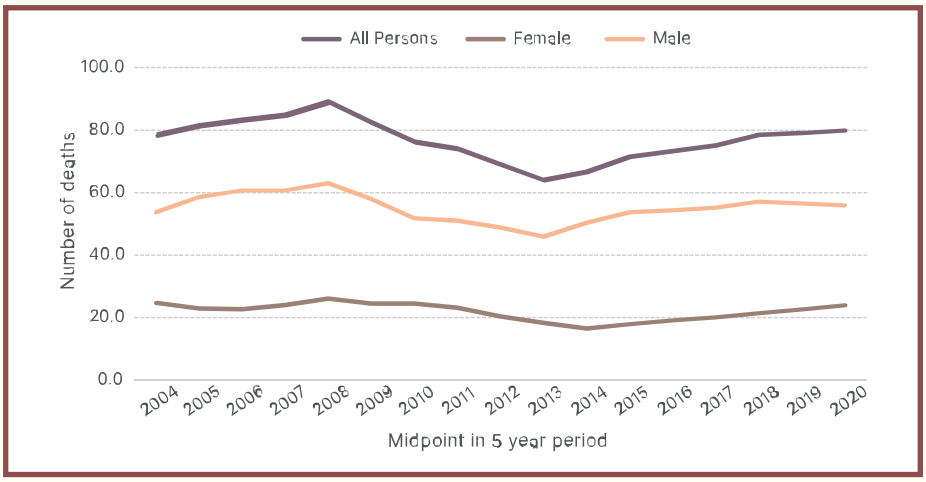


Double click with a mouse or double tap on a touch screen to zoom in/out where necessary.

Number of Alcohol Specific Deaths, Gender

Figure 7.2 shows the number of alcohol specific deaths registered, five year rolling annual average, by gender, 2002-2006 to 2019-2023, NHS Highland. This figure shows for NHS Highland, the time period 2018-2022, there are 55.8 for men and 24.2 for women deaths registered. The age sex standardised rate per 100,000 is male 31.4 and female 12.8.

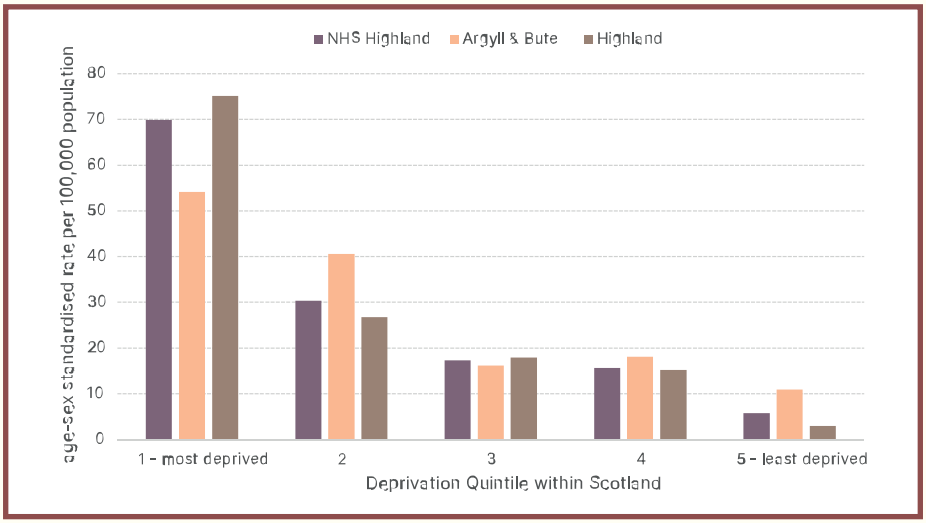
Figure 7.2: Number of Alcohol Specific Deaths registered: 5 year rolling average, by gender 2002-2006 to 2019-2023, NHS Highland



Alcohol Specific Deaths by Deprivation

Figure 7.3 shows alcohol specific deaths by deprivation standardised by age over 2018 to 2022 for NHS Highland, Argyll and Bute and Highland. There is a difference between the quintiles; NHS Highland AASR per 100,000 population for the most deprived quintile is 70 compared with 6 for the least deprived quintile.

Figure 7.3: Alcohol Specific Deaths by Deprivation within Scotland: 5 year annual average age-sex standardised rate per 100,000 population for 2018 to 2022. NHS Highland, Argyll and Bute, and Highland

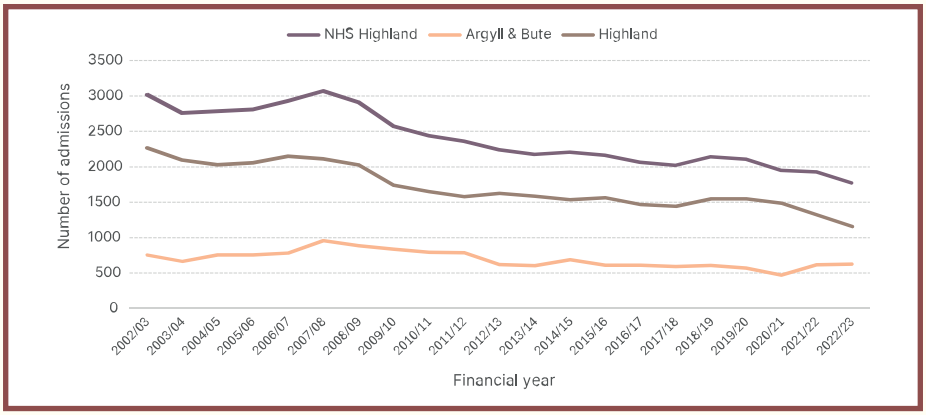


Double click with a mouse or double tap on a touch screen to zoom in/out where necessary.

Number of Alcohol Related Hospital Admissions

Figure 7.4 shows the number of alcohol related hospital admissions for the financial years 2002/03 to 2022/23 NHS Highland, Argyll and Bute, and Highland. The overall trend for the last twenty years is downwards although Argyll and Bute is showing a slight increase from 2021. This is in stark contrast to the increase in trend of alcohol related deaths over a similar time period.

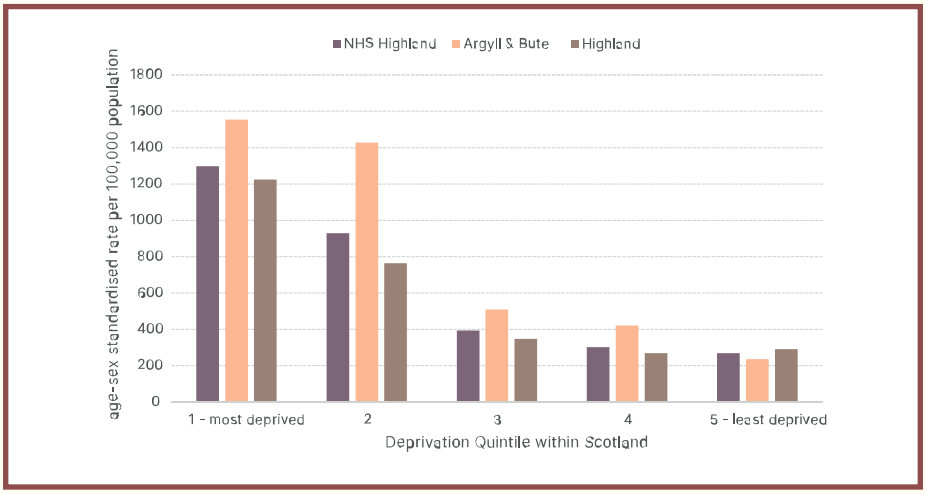
Figure 7.4: Number of alcohol related hospital admissions for the financial years 2002/03 to 2022/23 NHS Highland, Argyll and Bute, and Highland.



Alcohol Related Hospital Admissions by Deprivation

Figure 7.5 shows alcohol related hospital admissions by deprivation over the years 2018 to 2023 for NHS Highland, Argyll and Bute, and Highland. In NHS Highland, for the population living in the most deprived quintile their alcohol related hospital admissions rate is 1225 compared with the least deprived quintile of 291.

Figure 7.5: Alcohol Related Hospital Admissions by Deprivation within Scotland: 5 year annual average age-sex standardised rate per 100,000 population for 2018 to 2023 NHS Highland, Argyll and Bute, and Highland



Double click with a mouse or double tap on a touch screen to zoom in/out where necessary.

Consequences of Alcohol

Within the NHS Highland council area 20%[3] of people drink at or above the Chief Medical Officers' low risk guidelines; this is 14% of women and 26% of men. This compares with 23% of people in Scotland who drink above the guidelines[4].

Drinking excessively has the potential to cause harm with a range of economic, health and social consequences. Alcohol is rarely alone in causing health problems and is linked to a range of other factors: some individual, some such as metabolism or inherited genetic traits; other environmental, such as diet, smoking, access to healthcare or stress or experience of stigma. It is partly because the harmful effects of alcohol are linked to these other factors that we see a social gradient in alcohol harms.

Alcohol causes social harm and some of these are listed as follows:

- Crime
- Financial problems
- Career problems
- Work performance
- Family breakdown
- Domestic abuse/violence
- Homelessness
- Other harms such as loss of friends

The availability of alcohol is also important. There is often a far higher concentration of shops selling alcohol in the poorest neighbourhoods and research[5] has tended to find that higher levels of outlet density is linked to both higher levels of consumption and health harms. Throughout NHS Highland there are 1846 places to buy alcohol and of these places 1373 are on-sales premises (pubs and restaurants and 472 off sales premises (supermarkets and shops[6]. The availability of alcohol through internet sales (supermarkets/ specialist retailers) has also increased over the last decade making alcohol even easier to obtain throughout NHS Highland in particular rural areas.

Economic considerations are never far away from the agenda in NHS Highland and cannot be ignored. Within the Health Board area there are numerous distilleries that provide employment and contribute to tourism. However, the effects of alcohol on society, especially on those who are most deprived must be given proper weight.

Action

Harms caused by alcohol are largely preventable for the population as a whole and as part of a reduction in health inequalities. The World Health Organisation's best buys[7], Table 7.1, advocates for a whole system approach to tackling the harms from alcohol. The 'Hard Edges Scotland'[8] report also advocates for a whole system approach to tackling inequalities and multiple disadvantage. The following table shows examples of what is a 'best buy'. The left hand side of the table shows examples of the WHO 'best buys' and the right hand side shows what actions can be taken for Scotland and/or NHS Highland.

Table 7.1: World Health Organisation

WHO Best Buys	Action (Scotland or NHS Highland)
Increase excise taxes on alcoholic beverages	Minimum Unit Pricing (MUP) is not a tax, instead it sets a minimum price per unit of alcohol, and is currently set at 65p. Linking MUP to inflation is the next step to ensure ongoing effectiveness.
Enact and enforce restrictions on the physical availability of retailed alcohol	Via the Alcohol Licensing process for example the Highland Alcohol Over provision statement[9]. Part of Local Licensing Alcohol Policy.
Enact and enforce drink-driving laws and blood alcohol concentration limits via sobriety checkpoints	Local Police Force /Road traffic police. Run local seasonal campaigns in partnership with local radio. Increase testing over festive seasons.
Provide brief psychosocial intervention for persons with hazardous and harmful alcohol use	Population based approach – alcohol brief interventions can be targeted to settings. Alcohol and Drug Partnership strategy and action plans.
Enact and enforce an appropriate minimum age for purchase or consumption of alcoholic beverages and reduce density of retail outlets	Local Authorities employ Local Licensing Standards Officers whose role is to ensure license agreements/policy are adhered to. Part of Local Licensing Alcohol Policy.
Restrict or ban promotions of alcoholic beverages in connection with sponsorships and activities targeting young people	Local leadership and support for the Scottish Government 'Consultation on Restriction Alcohol and Advertising and Promotion'[10].
Provide prevention, treatment and care for alcohol use disorders and co morbid conditions in health and social services	Part of the recent Medication Assisted Treatment Standards[11]. NHS Highland and Local Alcohol and Drug Partnership planning.
Provide consumer information about and label alcoholic beverage to indicate, the harm related to alcohol	Put pressure on the alcohol industry to label products accurately and clearly. Local Alcohol and Drug Partnership planning.
KEY	
WHO best buys Effective interventions Other recommended interventions	

Recommendation

- Alcohol and Drug Partnership member organisations should consider and implement the most effective and efficient ways to reduce the harms and health inequalities caused by alcohol.

8. Cancer

- Introduction
- Cancer and Inequalities
- Tackling Cancer Incidence, Mortality & Inequalities
- Recommendations

Cancer

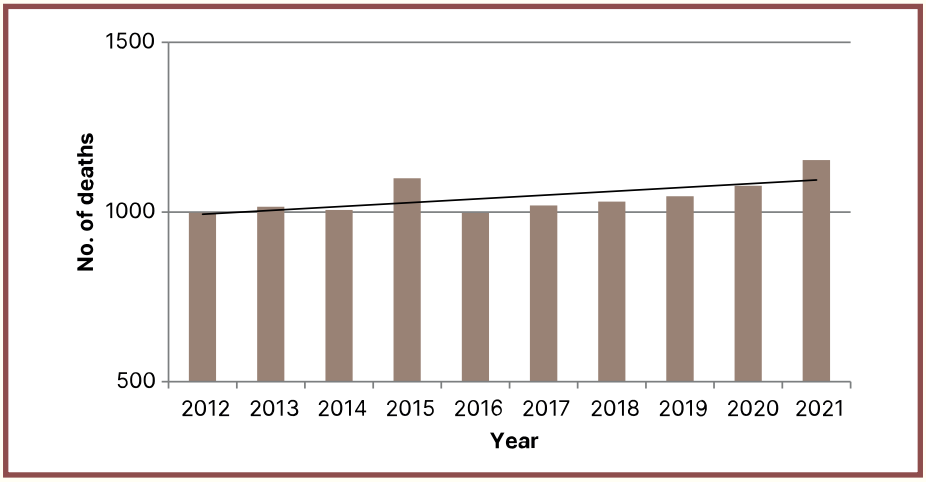
Introduction

Cancer is a significant public health issue. It is estimated that one in two people living in Scotland will develop some form of cancer during their lifetime[1]. Even if we are not affected ourselves, it is likely that someone close to us will be. As with other conditions there is an important relationship between cancer and health inequalities.

Cancer and Inequalities

The number of people dying from cancer each year is increasing as shown in Figure 8.1. This means that there is a growing demand on services for the treatment and the prevention of cancers.

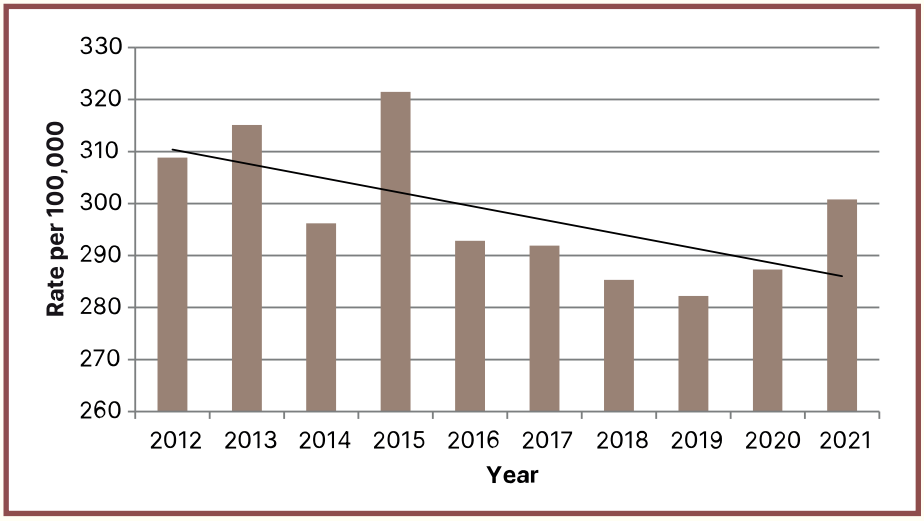
Figure 8.1: Cancer deaths in Highland, by year – all ages & all cancer types (excl. non-melanoma skin cancer)



Source: Public Health Scotland[2]

However, when we take the age of the population into account the picture is more positive, with a trend towards reducing death rates during recent years.

Figure 8.2: Cancer deaths in Highland, by year – age standardised mortality rates (EASR) per 100,000 person-years at risk, all cancer types (excl. non-melanoma skin cancer)



Source: Public Health Scotland [4]

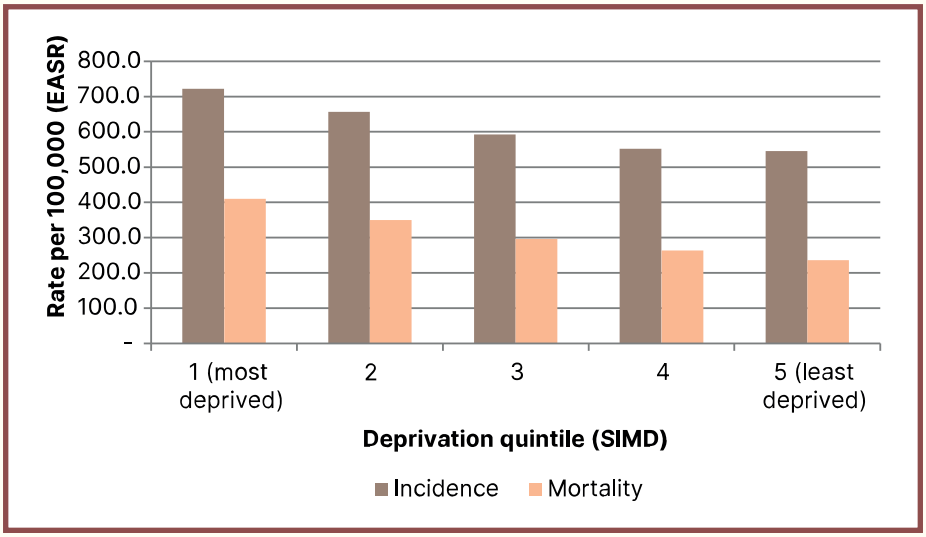
Double click with a mouse or double tap on a touch screen to zoom in/out where necessary.

This is believed to be due to a combination of[3]:

- Cancer prevention initiatives such as a reduction in smoking rates
- Diagnosing more cancers at an early stage when treatment is more likely to be successful, including participation in national cancer screening programmes, and
- More effective treatments

There are many different types of cancer and different cancers may be more or less common depending on the level of deprivation. So, for example, lung cancer tends to be much more common among people who are poorer, while breast cancer tends to be more common among those who are less deprived. However, overall being diagnosed with a cancer is more common among people living in more deprived areas as shown in Figure 8.3 for Scotland.

Figure 8.3: Cancer registrations (2016 – 2020) & deaths (2017 – 2021) in Scotland, by SIMD deprivation quintile – age standardised incidence & mortality rates (EASR) per 100,000 person-years at risk, all cancer types (excl. non-melanoma skin cancer)



Source: Public Health Scotland[4]

People living in our most deprived communities are more likely to be diagnosed with cancer and to die from the condition than individuals living in our most affluent areas.

In addition to diagnosis of cancer, survival from cancer is also related to deprivation. An analysis undertaken by Macmillan Cancer Support and NHS National Services Scotland demonstrated that for six tumour types (breast, colorectal / bowel, head and neck, liver, lung and prostate) across Scotland, survival rates were significantly lower among individuals living in our most deprived communities relative to those living in our most affluent[5].

Double click with a mouse or double tap on a touch screen to zoom in/out where necessary.

Tackling Cancer Incidence, Mortality & Inequalities

Smoking is recognised as being the dominant risk factor for cancer in the Scottish population, with estimates suggesting that it is responsible for 20% of cases[6]. While the proportion of people who smoke has declined in recent years, smoking rates remain higher among people living in our most deprived communities compared to individuals resident in our most affluent.[8] Initiatives to discourage people from taking up smoking are required, as well as programmes that support current smokers to quit. While aimed at the whole population, these should be particularly targeted at those living in our most deprived areas. Action at both a national level (e.g. tobacco pricing) and a local level is necessary.

Overweight and obesity are other significant cancer risk factors, responsible for approximately 7% of cases across Scotland each year. Adults living in the most deprived communities are at greater risk of being overweight or obese than those resident in the most affluent areas.[8] Furthermore, while estimates suggest that the proportion of the population living in our most affluent areas who are overweight and obese will decline by 2040, the proportion living in our most deprived communities is expected to increase.[8]

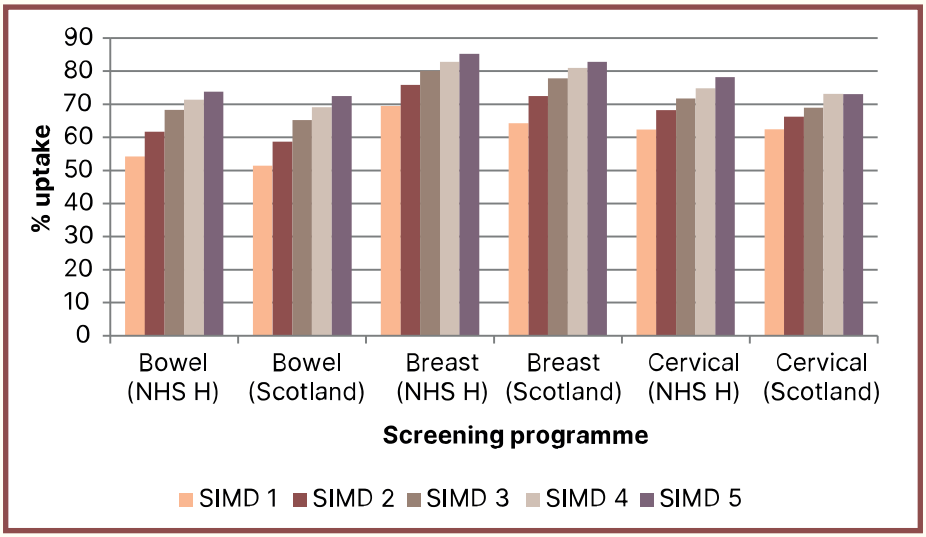
Initiatives to encourage people to achieve and maintain a healthy weight are required. Similarly to smoking, these should be aimed at the whole population but targeted at those living in our most deprived areas. Action at both a national level (e.g. regulation on food advertising and marketing) and a local level is necessary.

Treating cancer as early as possible and recognising the early signs of cancer or treating conditions that are likely to develop into cancer is of great importance. People who are from more deprived and excluded communities are less likely to present with symptoms early and it important that we encourage early diagnosis and referral in these communities. One example of this is participation in cancer screening.

Three national cancer screening programmes are currently available to people living in Scotland, covering bowel, breast and cervical cancer. These may help to prevent some tumours from developing by detecting changes before they develop into cancer. In addition, they can contribute to finding established tumours at an early stage when treatment is most likely to be successful.

Uptake of these national screening programmes within NHS Highland compares favourably with Scotland as a whole. However, for each programme, uptake among those living in our most deprived communities is lower than that among people living in our most affluent.

Figure 8.4: Uptake of bowel (2021-2023), breast (2020-2023) and cervical (2021-2022) screening, NHS Highland & Scotland, by SIMD quintile (1: most deprived; 5: least deprived)



Source: Public Health Scotland[10]

Recommendations

- NHS Highland should ensure that health inequalities are actively monitored as part of cancer management and across all services.
- NHS Highland should address health inequalities across the entire cancer pathway from prevention to rehabilitation.

Double click with a mouse or double tap on a touch screen to zoom in/out where necessary.

Notes

Endnotes

Epidemiology and Trends

1 Population estimates time series data. National Records of Scotland. © Crown copyright.

2 Population Projections for Scottish Areas 2018-based. National Records of Scotland. © Crown copyright.

3 Supporting end of life care in NHS Highland - Accounting for Value report. End of Life Care Together Partnership. Loynd M, Griffin SJ, Wilson T, Chumbley K. 2024

4 Local area migration. National Records of Scotland. © Crown copyright.

5 Scotland's Census. National Records of Scotland. © Crown copyright.

6 Scottish Government Urban Rural Classification. Scottish Government. 2020

7 Scottish Index of Multiple Deprivation. Scottish Government. 2020

8 Local Child Poverty Statistics. End Child Poverty Coalition. 2024.

9 Tackling child poverty priority families overview. Scottish Government

10 Scottish House Condition Survey. Scottish Government

11 Life Expectancy in Scotland. National Records of Scotland. © Crown copyright. 2021-2023

12 National life tables – life expectancy in England and Wales: 2021 to 2023. Office for National Statistics

13 ScotPHO profiles tool. Scottish Public Health Observatory.

Health Inequalities

1 What are health inequalities? Public Health Scotland.

2 Health inequalities, fundamental causes and power: towards the practice of good theory. McCartney G, Dickie E, Escobar O, Collins C. Sociol Health Illn. 2021;43:20-39.

3 Human rights and health. World Health Organisation. 2024.

4 Fundamental causes of health inequalities. Public Health Scotland. 2024.

5 Long term monitoring of health inequalities. Scottish Government.

6 Inequality Landscape: Health and Socioeconomic Divides in Scotland. Glasgow: The Scottish Health Equity Research Unit. 2024. Catalano A, Congreve E, Jack D, Smith K. 2024

7 Poverty in Scotland 2024. Birt C, Cebula C, Evans J, Hay D, McKenzie A. Joseph Rowntree Foundation; 2024.

8 The Inverse Care Law. Hart JT. Lancet. 1971;1(7696):405-412.

9 Measuring health inequalities. Scottish Public Health Observatory.

Approaches to Health Inequalities

1 Marmot review 10 years on. 2020. Marmot M, Allen J, Boyce T, Goldblatt P, Morrison J.

2 Institute of Health Equity. Marmot Places. 2024.

3 Seeds from the same tree: plotting the similarities and differences between the Place Standard Tool and the Place and Wellbeing Outcomes, E. Mackintosh and S. Whitmore. Improvement Service

4 Health equity in England: The Marmot Review 10 years on. London: Institute of Health Equity; 2020. Marmot M, Allen J, Boyce T et al.

5 Do 'environmental bads' such as alcohol, fast food, tobacco, and gambling outlets cluster and co-locate in more deprived areas in Glasgow City, Scotland? Health & Place 2018 51:224–231. Macdonald L, Olsen JR, Shortt NK et al.

6 The Place Standard tool is a way of assessing places.

Child Health

1 Child Health Inequalities Driven by Child Poverty in the UK - Position Statement Royal College of Paediatrics and Child Health (2024)

2 Child Poverty – Children and Young People's Health and Wellbeing Profiles: supplementary Report, Public Health Intelligence, NHS Highland (2024)

3 Early Child Development Transofrmational Change Programme Scottish Government (2023)

4 Cohort profile: The 'Children's Health in Care in Scotland' (CHiCS) study—a longitudinal dataset to compare health outcomes for care experienced children and general population children. Allik M, Brown D, Taylor Browne Lūka C, et al. BMJ Open 2021, Issue 11 Volume 9.

Immunisation

1 World Health Organisation. Immunisation. WHO, 2019 [Accessed 2 December 2024

Minorities or Underrepresented Groups

1 Royal National Institute for Deaf People (RNID)

2 Gypsy/Travellers in Scotland A Comprehensive Analysis of the 2011 Census

3 Improving access for Gypsy/Travellers to the NHS and health and social care in Scotland

4 Scottish Learning Disabilities Observatory Determinants of health and inequalities research

5 Health needs assessment of lesbian, gay, bisexual, transgender and nonbinary people. Prepared for: NHS Greater Glasgow & Clyde, NHS Lothian and Public Health Scotland. Traci Leven, Traci Level Research.

6 Scottish Trans and Non-binary Experiences Report

Alcohol

1 Bloomfield K (2020) Understanding the alcohol harm paradox: what next? The Lancet V5, Issue 6 E300-E301 June

2 Alcohol Specific Deaths, Scotland (2023) Alcohol Specific Deaths Scotland 2023

3 Scottish Health Survey (2022) Supplementary tables Alcohol Supplementary table: Alcohol

4 The Scottish Health Survey 2021 Alcohol Prevalence Estimates Scottish Health Survey 2021 [accessed 18.11.2024]

5 density

6 Alcohol Profiles 2024 Alcohol Focus Scotland Alcohol Profiles 2023 [Accessed 31 October 2024]

7 WHO Best Buys – alcohol Alcohol WHO best buys [Accessed 31 October 2024]

8 Hard Edges Scotland 2019 Hard Edges Report Scotland [Accessed 31 October 2024]

9 Highland Alcohol and Drug Partnership Alcohol Overprovision Statement Highland Directorate of Public Health and Policy Nov 2023

10 Scottish Government 2023. Consultation on Restriction Alcohol and Advertsing and Promotion.

11 Medication Assisted Treatment standards [Accessed 31 October 2024

Cancer

1 Illnesses and long-term conditions [Accessed 8 December 2024]

2 All Cancer Types - Scotland: trends in mortality 1996-2021 [Accessed 8 December 2024

3 Latest cancer research publications show decline in cancer deaths and where improvements in cancer care can be made [Accessed 8 December 2024

4 All malignant neoplasms excluding non-melanoma skin cancer - Scotland: age-standardised incidence and mortality rates (EASRs)2,3,4,5, by SIMD 2020 deprivation quintile [Accessed 8 December 2024]

5 Deprivation and cancer survival in Scotland - Macmillan Cancer. Authors: Authors: K Shiell-Davis[1], C Denny[2], J Mulligan[2], D Brewster[2], J Mabelis[1], H Storkey[2]. 1. Macmillan Cancer Support 2. Information Services Scotland (ISD), NHS National Services Scotland [Accessed 8 December 2024]

6 Cancer in the UK: Data and Research Deprivation and cancer inequalities in Scotland - Cancer Research UK [Accessed 8 December 2024]

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