CLOSING STATEMENT FOR MODULE 1

on behalf of

PUBLIC HEALTH SCOTLAND

Introduction

PHS has listened to all the evidence in this module. It adheres to the points it made in evidence, both in writing and orally. We reiterate what we said in our Opening Statement that PHS is driven by a desire to learn and do better for the people of Scotland.

In this Closing Statement PHS wishes to make certain limited observations about one topic, health inequalities.

In summary those observations are:

1. Professors Bambra and Marmot PHS identify the fact that in pandemic planning there was inadequate regard given to health inequalities.[1] PHS agrees with their analysis of the issues and acknowledges the recommendation they make. It considers their analysis to be a vital component in future pandemic preparedness.

2. PHS considers the inadequate consideration of inequalities in pandemic planning during the relevant period to be one of the most significant areas for learning.

3. PHS has reflected on what led to this position. In relation to Scotland, it believes there were two significant contributing factors: first, the academic and policy focus of health inequalities work; and second, the fragmentation of national public health organisations.

Professors Bambra and Marmot

Professors Bambra and Marmot discuss the five key pathways through which existing inequalities in the social determinants of health result in higher morbidity and mortality from an infectious respiratory virus (unequal exposure, unequal transmission, unequal vulnerability, unequal susceptibility, and unequal treatment). At paragraph 199.3, they set out their recommendation in

[1] See the discussion at paragraphs 180 to 189 of their Report and the recommendation at paragraph 199.3. See also the transcript of evidence, day 4, 16th June 2023.

relation to planning for future pandemics including the integration of a health equity lens across all aspects of the process.

Academic and Policy focus

Prior to 2020 there was little attention given to the unequal impact of infectious diseases by health inequality experts and academics. Research and writing in this area largely focused on the social determinants of health as they relate to life expectancy and actions to improve health and combat the impact of poverty and austerity on health (health improvement). That is no longer the case.[2]

The same was true of policies and strategies relating to the reduction of health inequalities. The focus of such policies tended to be – in line with the evidence – the fundamental drivers of poor health and health inequalities in Scotland.[3] We note that policies and strategies that have been produced since then have similarly focussed on reducing health inequalities through fairer health improvement as opposed to matters relating to health protection.[4]

Fragmentation of national organisations in public health

PHS considers the second contributory factor in relation to Scotland to stem from the way in which public health specialisms operated during the relevant period. In the most part, consideration of health inequalities was the purview of those working in health improvement. During the period in question, national leadership in this area was the responsibility of NHS Health Scotland. Pandemic resilience and preparedness (health protection) was the responsibility of Health Protection Scotland. As the Inquiry has heard, Health Protection Scotland was part of a separate Health Board during the time in question and had limited expertise around health inequalities.[5] NHS Health Scotland had neither the locus nor expertise around health protection and pandemic preparedness.

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[2] See the analysis at paragraphs 180 to 189 of Professor Marmot and Bambra's expert report and the articles referred to therein.

[3] For example, the focus of *Equally Well* in 2008 was on children, particularly in the early years, "killer diseases" such as heart disease, mental health and the harm caused by drugs, alcohol and violence.

[4] This is not in any way intended to imply that health improvement ought to be viewed with less importance. For PHS, health improvement has always been, and will continue to be, at the heart of what the organisation does.

[5] It was understood that clinically vulnerable people were likely to experience worse health outcomes in a pandemic, and that inequalities in vaccine update were likely with a lower uptake in deprived areas and amongst certain minority groups.

PHS believes that the fragmentation of national organisations in public health in Scotland in the period covered by Module 1 is likely to have been a contributing factor in the lack of sufficient consideration being given to inequalities in pandemic planning in Scotland.

As the Inquiry has heard, PHS was in part created to remedy this fragmentation and cement national leadership across the domains of public health. On a practical level, this has meant that there is now far greater collaboration between the experts across all the domains of public health.

Heath Inequalities and Lessons Learned

Perhaps unsurprisingly, since the start of 2020, PHS's work on inequalities focussed around health improvement and pandemic response, as opposed to pandemic preparedness.[6] However, in its Strategic Plan 2022 – 2025, PHS identifies various elements of work directed towards preparing for future pandemics. The work undertaken by experts like Bambra and Marmot, and the lessons to be learned from this Inquiry, will help ensure that future policies and strategies on health protection give due regard to inequalities relating to pandemics. PHS has already learned lessons listening to the evidence in this Module. For example, one of the recommendations in the Interim Report from the Standing Committee on Pandemic Preparedness was to produce proposals for a Centre of Pandemic Preparedness with the purpose of anticipating, preparing for, and responding to, pandemics. PHS is currently supporting Scottish Government engage with stakeholders and, as part of that, PHS has recently prepared a briefing for three stakeholder engagement events relating to this work. The briefing contains suggested preparedness themes potentially to form the basis of the Centre's work. One of the themes expressly identified in the briefing document is that of Inequalities with particular mention made to: the four harms context; socio-economically underserved population groups; support funding; and children and vulnerable adults.

Recommendations

We would respectfully suggest that the Chair might take account of the following in considering what recommendations she wishes to make.

1. PHS considers that in undertaking work in readiness for, and responding to, future pandemics, it is crucial that a wide range of input is obtained from across public health, research and academic communities, the wider NHS, and industry and Government. In relation to public health specifically,

[6] In its Module 2A Corporate Statement we discuss PHS's inequalities work in relation to pandemic response.

it is imperative that input comes from across two of the public health domains[7] (i.e. involves expertise in health improvement as well as health protection). All of this will help to ensure that the resulting judgements made are as informed as possible and will avoid the dangers associated with fragmented (working in silos) ways of thinking and working.

2. The assumption should be that whenever organisations address pandemic preparedness, inequalities should form part of that consideration. This should not be a tick box exercise. This will help to ensure that inequalities are placed at, and remain at, the centre of pandemic preparedness and resilience, something that has not been the case in the past as has so clearly been borne out by the evidence.

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[7] There are three public health domains: (1) health improvement, (2) health protection and (3) health and social care services.