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SPECTRUM response to Health, Social Care and Sport Committee inquiry on Health Inequalities in Scotland

What progress, if any, has been made towards tackling health inequalities in Scotland since 2015? Where have we been successful and which areas require more focus?

The recent *Long-Term Monitoring of Health Inequalities* report[1] indicates a mixed picture on the progress made in tackling health inequalities in Scotland since 2015. The Scottish Government has undertaken a number of initiatives along with local authorities, health boards and others to tackle poverty and other areas on inequalities. Nonetheless, the differences in health outcomes between people who are relatively economically advantaged and those who are economically disadvantaged remains significant and unacceptable.

Non-communicable diseases (NCDs), such as cancer, heart disease, diabetes, liver and lung disease and stroke are the leading cause of death and disability in Scotland. In 2020, they caused more than 62% of all deaths in Scotland with more than 40,000 lives lost[2]. Healthy life expectancy in Scotland is only around 62 years which lags considerably behind the rest of the UK and much of western Europe, with a 20-year gap between the most and least disadvantaged areas of the country[3].

Key to understanding health inequalities in Scotland is recognising the role of tobacco, alcohol and foods high in fat, salt and sugar (HFSS) play in the development of NCDs and as drivers of health inequalities. Consumption of these unhealthy commodities is driven by complex systems of production, distribution and promotion dominated by transnational companies. There are clear, evidence-based policy options available to reduce the burden of harm from NCDs, including measures to reduce consumption of health harming commodities by increasing the price, controlling availability and restricting marketing.

Scotland has already taken some bold policy action over the past twenty years through smoke-free legislation introduced in 2005 and Minimum Unit Pricing (MUP) for alcohol in 2012, but much more needs to be done to address the burden of harm from NCDs in our country. Scotland has set out ambitious plans to further its efforts to reduce NCDs with a vision for a tobacco-free generation by 2034, an ambition to halve childhood obesity by 2030, and an alcohol framework which seeks to reduce population-level consumption of alcohol through a wide range of evidence-based measures, including MUP.

Recently the World Health Organisation identified the commercial determinants of health (CDoH) as a key driver of inequalities[4]. CDoH are activities of the private sector which affect people's health for the better or for the worse. Through business and societal activities, private sector influence reaches across social, physical, and cultural

[1] Long-term monitoring of health inequalities: January 2021 report: https://www.gov.scot/publications/long-term-monitoring-health-inequalities-january-2021-report/
[2] https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/avoidable-mortality
[3] Key points - ScotPHO
[4] Commercial determinants of health: https://www.who.int/news-room/fact-sheets/detail/commercial-determinants-of-health

environments. This can happen through a wide range of circumstances and processes such as working conditions for employees, supply chain operations, product design and packaging in addition to research funding and lobbying and many more.

Scotland has made a good start in responding to CDoH in its commitment to addressing trade and working conditions through support for the minimum income of healthy living by updating the Scottish Living Wage in line with the annual, evidence-based recommendations, and through its emerging vision for trade that supports more just approaches. Its dignity-based approaches to benefits and move towards cash and housing first approaches reduce stigmatisation, reduce the risk of exploitation by unscrupulous companies and employers and help people move beyond ineffective, discriminatory, bureaucracy-led requirements to fulfil complex eligibility and means testing criteria.

Much more action is required in light of the agenda to build back better after the COVID-19 pandemic. This must include further development of the requirements for the awarding of public contracts. Private companies must be: registered for tax and other liabilities in the UK; meet ILO standards; whose premises are provide a safe, adequately ventilated and regulated physical and social environment, pay the Scottish Living Wage; demonstrate compliance with Scotland's equality outcomes; evidence a company-wide commitment to the sustainable development goals, demonstrate compliance with Nolan etc principles, including predatory marketing, lobbying and sponsorship including through front companies. There must also be a stronger commitment to testing and addressing loopholes in current regulations and guidance.

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

Addressing Scotland's high levels of non-communicable diseases (NCDs) is essential to tackling health inequalities in Scotland. NCDs including tobacco and alcohol use, cardiovascular health, cancer, obesity, diabetes, mental health, amongst others are key factors in driving the vast inequities in health in Scotland. It is important to recognise that NCD prevalence and health inequalities are strongly related to the social and commercial determinants of health and existed prior to the pandemic (which has clearly exacerbated them since). The social determinants model shows clearly that effective action on health inequalities requires structural changes that enhance the environments in which we live, work, play and grow older.

To achieve this, and to enhance health across all social and ethnic groups, it is vital to:

- Move away from the stigmatisation of the individual (for example, those with mental health illness or dependent drinkers) and focus on addressing the determinants of unhealthy behaviours, including the role of unhealthy commodity industries in creating and maintaining those behaviours, while investing in prevention and mitigation that is based on existing evidence or new approaches designed in partnership with communities to create new evidence.

- Plan for the short, medium and long term whilst undertaking transparent regular review of progress including collecting and sharing of data publicly. Utilising tools such as the Smoking Toolkit Study: Smoking in Scotland[5] dataset which is supported by SPECTRUM to gain insights in addition to data held by Public Health Scotland and others.
- Facilitate and nurture relationships across the sectors including national and local government, NHS academia and third party sector in addition to advocacy, voluntary and statutory sectors.
- Recognising that UCI/the private sector have an inherent conflict of interest when it comes to public health and so excluding them from decision making processes and limiting their role within policy discussions and options for delivery.

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

Health inequalities are underpinned by the unequal distribution of income, power and wealth; therefore, priorities need to include the development of more sustainable, equitable and healthier contexts for people to live their lives. Addressing the underlying causes of inequalities will require a whole system approach that rapidly reduces social and economic inequalities (including eradicating child poverty, educational disparities) as well as robust action on NCD prevention (including evidence-based public health interventions) and healthcare.

Increasing price, restricting marketing and controlling availability are recognised by the World Health Organisation (WHO) as three of the most effective and cost-effective approaches to reducing health harm[6]. To date, whilst some promising progress has been made in respect of pricing and marketing of unhealthy commodities in Scotland, more can and should be done:

Pricing: It is well established that increasing the price of unhealthy commodities has pro-equity effect on socioeconomic disparities in unhealthy behaviours, including smoking. There is an urgent need to consider innovative pricing options designed to address purchasing, consumption and availability including introducing a public health levy on businesses profiting from the sale of unhealthy products, raising the level of MUP for alcohol, and introducing a MUP for tobacco. There is evidence that introduction of minimum unit pricing (MUP) for alcohol in Scotland has reduced alcohol consumption levels and there was evidence of a reduction to the number of hospital admissions from alcohol-related liver conditions and a 10% reduction in alcohol related deaths in the year following the policy's implementation. The full implications and impact of the COVID-19 pandemic are not yet fully understood. However, in 2020, the number of alcohol specific deaths increased 17% to reach the highest level since 2008 and 1,190 people were reported to have died due to alcohol specific causes. Thus, the pandemic has potentially reversed some of the impact of MUP in Scotland. Researchers at the University of

[5] The Smoking Toolkit Study: Smoking in Scotland www.smokinginscotland.info
[6] https://www.who.int/ncds/management/WHO_Appendix_BestBuys_LS.pdf

Sheffield[7] have previously estimated that a minimum price of 60p would provide double the reduction in deaths and hospital admissions compared to a 50p MUP, and that 70p would deliver three times the effect. Based on the retail price index a minimum unit price of 50 pence in 2012 is equivalent to 61p in 2021. Action to review MUP in line with the Scottish Government promise to review it within two years of implementation is essential. The review, which has not yet taken place due to the pandemic, should consider uprating MUP to at least 65p.

Availability: Tobacco, alcohol and ultra-processed food products remain highly available in Scotland (e.g. 10,000 tobacco retailers across the country). The 'next frontier' of NCD prevention policies require robust action to reduce the availability of these products through e.g. the licensing of tobacco retailers, more robust implementation of overprovision policies in alcohol licensing, and the implementation of exclusion zones banning sales around 'child spaces', such as schools via the planning and/or licensing systems.

Marketing: The Scottish Government is limited to some extent with regards the action it can take on the promotion and marketing of unhealthy products such as tobacco, nicotine products, alcohol and unhealthy food. Some key aspects of the marketing mix are reserved to the UK Government such as television and broadcast marketing. Competency over digital marketing is currently a matter of dispute between the Scottish and UK governments. However, the Scottish Government does have competency over certain parts of the marketing mix and should take action to restrict the marketing of unhealthy commodities where it can. For example, outdoor advertising (on billboards, bus stops), advertising on transport and sports and events sponsorship. Scotland should also seek to support new legislation to restrict the marketing of unhealthy products at UK level, and push for the UK Government to go further where possible.
For example, On 28th December 2020, the UK Government announced new legislation implementing restrictions on promotions of HFSS (high in fat, sugar and salt) products by location and price in retail settings that sell food and drink in-store and online in England (UK Government, 2020[T]. The announcement outlined that retailers that sell food and drink will no longer be able to place HFSS products at store entrances, aisle ends, checkouts or online equivalents (entry pages, landing pages and shopping basket or payment pages). In addition, volume price restrictions will also prohibit retailers from offering price promotions such as 'buy-one-get-one-free' or '3 for 2' offers on HFSS products.

This new legislation is a move in the right direction, as it contributes to addressing the obesogenic food environment, moving the UK food environment away from one that pervasively promotes HFSS products. Although some supermarkets have already voluntarily removed HFSS products from checkouts (Ejlerskov et al., 2018), this new legislation ensures all medium and large retailers are bound by the same regulation. However, the development, implementation, monitoring and evaluation of such legislation must be robust and allow for amendments to be made as new evidence arises or as

[7] Model-based appraisal of the comparative impact of Minimum Unit Pricing and taxation policies in Scotland: https://www.sheffield.ac.uk/polopoly_fs/1.565373!/file/Scotland_report_2016.pdf

industry identify new ways to circumvent rules. The Scottish Government should take steps to support monitoring and evaluation where possible.

Although this policy is a promising step in the right direction, there are some concerns as to the scope of the policy, particularly the exemption of micro and small retailers from the legislation. If retailers employ less than 50 employees, even if this retailer is part of a medium or large brand, they are exempt from this new promotion legislation. This could result in continued, albeit less, exposure to promotions that encourage increased selection, purchasing and consumption of HFSS products, which would undermine the aim of the policy and broader public health goals. The Scottish Government should push the UK Government to keep this exemption under review and advocate for the inclusion of data and evidence on the impact of the exemption on policy implementation in any evaluation.

Conflicts of interest: The actions of unhealthy commodity producers can affect everything from consumption patterns of a particular product, to the social norms surrounding when and how much of it we use, to how normal and desirable children perceive products to be, to the tax and regulatory frameworks surrounding such products, the science regarding its harms and benefits, how policy-makers view the problem and its causes, and the framing of possible solutions in the mind of the public. Addressing NCDs requires an understanding of the CDOH and the actions of UCIs in driving them. It requires policy makers to be aware of attempts by UCIs to influence their decision-making and to actively manage conflicts of interest. The WHO Framework Convention on Tobacco Control (FCTC) Article 5.3 is the best international example of good practice in this area, intended to protect public health policy from the influence of the tobacco industry. A similar approach needs to be applied across other UCIs.

Research published by SPECTRUM and the NCD Alliance exposed UCI tactics during the COVID-19 pandemic, serving to illustrate UCI agility to use a global health crisis to promote brands, products and corporations whose economic interests frequently conflict with public health goals[8].
The report identified broad categories of strategic responses to the pandemic from UCIs:

- Adapting marketing and promotion of products;
- Corporate social responsibility and philanthropy;
- Pursuing partnerships and collaborations; and
- Shaping policy environments.

The report highlights the exploitation of the COVID-19 pandemic by UCIs to advance preferred policy positions, particularly as governments struggle to reconcile health objectives with economic and trade imperatives.
Key activities highlighted include:

- Lobbying to have unhealthy commodities designated as ‘essential’ products;
- Petitioning to accelerate the easing of lockdown;
- Working to undermine health and environmental regulations; and
- Attempting to shape strategies for economic recovery.

[8] Signalling Virtue, Promoting Harm: Unhealthy commodity industries and COVID-19: https://ncdalliance.org/sites/default/files/resource_files/Signalling%20Virtue%2C%20Promoting%20Harm_Sept2020_FINALv.pdf

We have seen clear examples of these activities here in Scotland and UK. The report highlights several Scottish case studies including the Scottish Food and Drink Federation publicly congratulating the Scottish Government's decision to withdraw a new bill introducing restrictions on junk food promotions in Scotland; and The Scotch Whisky Association calling for the Scottish Government to abandon proposed advertising restrictions on alcohol and offering to engage in "a sustained dialogue with government on smart taxation" in order to support the post-COVID-19 recovery.

These examples from Scotland, along with submissions from around the world, indicate an extraordinary range and scale of responses to COVID-19 from unhealthy commodity industries, reflecting extensive efforts on the part of these industries to be viewed as contributing to the pandemic response. These activities serve to promote these industries' core interests by promoting products, enhancing reputations, and building political influence. They distract from the role of UCIs in harming population health, which made us more vulnerable to COVID-19. Collectively, the actions outlined in the report raise concerns about the prospect of the involvement of unhealthy commodity industries in the pandemic response directing public policy efforts away from broader health and social goals and towards the entrenchment of industry interests.

Tobacco control: Whilst England and Wales aim to be smoke-free by 2030, the target in Scotland is to create a tobacco-free generation by 2034 and so protect children born since 2013 from tobacco so that when they start to turn 21 (from 2034) they will be tobacco-free and Scotland will remain tobacco-free for generations to come after is ambitious. Much progress has been made to date with respect to smoke-free environments however additional progress could be made by considering support for a UK-wide move to raise the age-of-sale from 18 to 21. This was reported to be supported by 54% of 18-24 year olds (and 63% of adults) and could reduce the number of smokers aged 18-20 by almost one third with the added bonus of a predicted associated cumulative reduction over time[5]. Provision of financial incentives for pregnant women to quit has proven to be a motivational tool for pregnant women and, as part of a comprehensive quit support package, is the only intervention which has impacted smoking rates in pregnancy in recent times as shown in Glasgow, Manchester and the North East[9]. Further research in Scotland found that those receiving financial incentives were more than twice as likely to succeed in quitting[10].

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

Please note, the Committee is interested in hearing about both positive and negative impacts.

[9] Evidence into Practice: Supporting smokefree pregnancies through incentive schemes. Smoking in pregnancy challenge group. https://smokefreeaction.org.uk/wp-content/uploads/2019/10/2019-Challenge-Group-Incentives-Briefing_v4-FINAL.pdf

[10] Financial incentives for smoking cessation in pregnancy: randomised controlled trial | The BMJ

The COVID-19 pandemic has bolstered and intensified existing health inequalities in Scotland. Many of inequalities experienced during the pandemic were pre-existing and the action to address them must recognise this.

The situation has been usefully characterised as a 'syndemic pandemic', i.e. a co-occurring, synergistic pandemic which closely intersects with, and aggravates, existing social conditions (e.g. economic/financial status, education, wellbeing, housing and environmental factors) and NCDs. This has resulted in a in an unprecedented fall in life expectancy since the start of pandemic. Further, minority ethnic populations are disproportionately affected by COVID-19 – specifically those of South Asian background who were around twice as likely to die from COVID-19 compared to white people. The reasons for this and action required have been set out in the reports produced by the Expert group; the underlying issues of systemic racism, precarious employment etc. and lack of data to identify and monitor inequity and harm must be addressed.

Prior to the pandemic, it was already recognised that those marginalised by society such as prisoners or the homeless, those living in poverty or in the most deprived areas experienced higher rates of non-communicable diseases and from a younger age. The Poverty Alliance and Get Heard Scotland undertook conversations with a number of families directly experiencing poverty in Scotland to understand what works, what doesn't and what needs to change to tackle poverty[11]. The report identified a number of challenges that were exacerbated by the pandemic across a range of areas including employment, education, health care and support structures.

Individuals who already had poorer mental or physical health are also more likely to have lower incomes and fewer social and material resources and as such felt the impact of the pandemic more keenly. The pandemic also interrupted the delivery of education at primary, secondary and tertiary levels for younger people and children. Those with additional physical or educational support needs and/or living in poverty felt this more keenly; arrangements to stop them falling behind varied between local areas, often between schools and colleges. This interruption led to challenges for working parents and guardians with the burden of supporting children mainly – but not always - falling on women. Loss of employment and income affected those in lower-paid jobs, those in precarious employment and in those in certain sectors more than others (such as tourism or hospitality).

Following the COVID-19 lockdown, smoking prevalence increased amongst younger adults although there was also an increase in the number of younger smokers attempting to quit. Higher levels of alcohol consumption amongst all adults was reported and in particular amongst women and those in less advantaged areas[12]. Those living in more advantaged areas were more likely to attempt to reduce their alcohol consumption levels. The introduction of minimum unit pricing (MUP) in Scotland has reduced alcohol consumption levels and there is evidence of a reduction to the number of hospital

[11] Living though a pandemic: Experiences of low-income families in Renfrewshire and Inverclyde https://www.povertyalliance.org/wp-content/uploads/2021/11/TPA_GHS_Project_Research_Report_FINAL_proof_02-1.pdf

[12] Jackson, SE, Beard, E, Angus, C, Field, M, Brown, J. Moderators of changes in smoking, drinking and quitting behaviour associated with the first COVID-19 lockdown in England. Addiction. 2022; 117: 772–783. https://doi.org/10.1111/add.15656

admissions from alcohol-related liver conditions and a 10% reduction in alcohol related deaths.

The full implications and impact of the COVID-19 pandemic are not yet fully understood. However, in 2020, the number of alcohol specific deaths increased 17% to reach the highest level since 2008 and 1,190 people were reported to have died due to alcohol specific causes. Thus, the pandemic has reversed some of the impact of MUP in Scotland. Researchers at the University of Sheffield[13] have previously estimated that a minimum price of 60p would provide double the reduction in deaths and hospital admissions compared to a 50p MUP, and that 70p would deliver three times the effect. Based on the retail price index a minimum unit price of 50 pence in 2012 is equivalent to 61p in 2021.

Research published by SPECTRUM and the NCD Alliance exposed UCI tactics during the COVID-19 pandemic, serving to illustrate UCI agility to use a global health crisis to promote brands, products and corporations whose economic interests frequently conflict with public health goals (see previous section). These tactics distract from the role of UCIs in harming population health, which made us more vulnerable to COVID-19. Collectively, the actions outlined in the "Signalling Virtue, Promoting Harm" report raise concerns about the prospect of the involvement of unhealthy commodity industries in the pandemic response directing public policy efforts away from broader health and social goals and towards the entrenchment of industry interests.

Access to effective healthcare is a determinant of health. Investment in prevention and in addressing health and healthcare inequalities had already been largely stagnant since the 2008 recession. The COVID-19 pandemic has compounded this, increasing the need for preventive and primary care services, increased the screening backlog and impacted on quality of life through delays to treatment for pre-existing and suspected new health conditions, including mental health problems, cancer and rehabilitation services -all of which provided examples of the inverse care law before the pandemic. There are insufficient data publicly available to determine if the existing healthcare inequities have worsened during the pandemic but ONS data on the increase in avoidable mortality indicates that this is likely.

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

N/A

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

[13] Model-based appraisal of the comparative impact of Minimum Unit Pricing and taxation policies in Scotland: https://www.sheffield.ac.uk/polopoly_fs/1.565373!/file/Scotland_report_2016.pdf

As outlined in previous sections, many of the health inequalities within Scotland existed prior to the pandemic and action should be prioritised as part of the aim to build back better.

A potentially unseen benefit of the pandemic has been a greater appreciation of nature and extent of health inequalities in Scotland. The pandemic has provided a public lens into the social, geographical and ethnic inequalities, and some of the underlying ecological drivers. Therefore this offers an opportunity for the development of new and effective public health policies designed to enhance the social determinants of health.

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

The Poverty Alliance and Get Heard Scotland undertook conversations with a number of families directly experiencing poverty in Scotland to understand what works, what doesn't and what needs to change to tackle poverty[14]. The report identified a number of challenges that were exacerbated by the pandemic across a range of areas including employment, education, health care and support structures. Ensuring that people have the minimum income required for healthy living in the short term, a mixture of cash, goods, services, affordable housing, improvement in employment conditions and practical support is required. This can be enabled through the provision of a real Living Wage to all workers. This requires urgent attention in the services that were essential during the pandemic.

As outlined in the Get Heard report, the pandemic has resulted in an increase in mental health issues. Support services and resources that are accessible and community based which address the needs of those on low incomes is strongly encouraged whist action to address stigma will make these services available to those that need them.

Significant drivers of health inequalities include inequitable exposure to unhealthy commodities such as alcohol, tobacco and foods high in salt, sugar and fat. Together with price, loopholes in regulation, marketing and advertising, these increase the inequalities in consumption.

The Government must do more to understand people's daily 'activity spaces' and how their experiences of alcohol, tobacco and food stimuli vary amongst different groups (e.g. young people, smokers), and the extent and nature of exposure to unhealthy commodity environments for more vulnerable populations (e.g. problem drinkers, poor mental health). In order to reduce consumption levels, the Scottish Government must focus on the availability, pricing and promotion of these goods in addition to setting clear goals and targets to protect young people and children from exposure to them.

Pricing & Availability

[14] Living though a pandemic: Experiences of low-income families in Renfrewshire and Inverclyde https://www.povertyalliance.org/wp-content/uploads/2021/11/TPA_GHS_Project_Research_Report_FINAL_proof_02-1.pdf

Policymakers must identify measures to counter industry tactics that enable the continued sales of cheap tobacco which encourages tobacco consumers with little or no disposable income living in the most deprived areas to continue to smoke – this contributes to health inequalities. Research undertaken by Professors Niamh Shortt and Jamie Pearce at the University of Edinburgh, in collaboration with colleagues from NHS Health Scotland, the University of East Anglia and the MRC/CSO Social and Public Health Sciences Unit at the University of Glasgow, investigated how tobacco price varied across 270 Scottish convenience stores[15]. The team analysed more than 120,000 purchases within those stores during one week in April 2018 and compared retail price with neighbourhood income deprivation and whether the shop was in a rural or urban setting.
The team discovered that the cost of tobacco varied markedly across neighbourhoods with the average purchase price found to be 50p less for a pack of 20 cigarettes, and 34p less for "roll your own" tobacco, in areas with highest income deprivation, compared with the most affluent neighbourhoods.

Therefore, the introduction of minimum tobacco pricing – and so increasing the price of the cheapest tobacco products - will support people in the most disadvantaged areas the most and potentially lead to the greatest health gains by preventing uptake and helping people to quit. It may also be beneficial to introduce a price cap in addition to MUP. Such a move would restrict the ability of tobacco companies to increase the price of expensive brands in order to maintain lower pricing for other brands (i.e. manage the tax rises in such a way as to retain an overall financial balance whilst retaining their customer base).

In Scotland, the average primary 6 age child will be within 10 meters of a shop selling tobacco around 43 times per week[16]. For those in the most deprived area, the actual figure is 149 times per week whilst those in the least deprived the figure is just 23. The research that uncovered these figures, also demonstrated that there are almost 3 times more tobacco outlets in the most deprived areas when compared to the least deprived. The team used GPS trackers which showed that, on school days, children were exposed to tobacco sales in newsagents and convenience stores and from supermarkets in the main on weekends. It is not known how often a child has to view tobacco consumption, advertising or sales before they accept it as a normal behaviour without realising the health harms it causes. Whilst point-of-sale advertising of tobacco products is banned, it has not removed all reference to these products and so children are still aware of it. This is key because availability is a factor in why people begin smoking and why it is hard to quit. Most adult smokers start when they are adolescent and so reducing exposure to children today will reduce the number of adult smokers in future.

Promotion & Regulation

Adverts for unhealthy products are ubiquitous whilst regulatory approaches are not. Research undertaken by Dr Alex Barker and colleagues at the University of Nottingham has shown that young people in the UK are being exposed to excessive alcohol

[15] Shortt NK, Tunstall H, Mitchell R, et al Using point-of-sale data to examine tobacco pricing across neighbourhoods in Scotland Tobacco Control 2021;30:168-176. Doi: 10.1136/tobaccocontrol-2019-055484)
[16] Caryl F, Shortt NK, Pearce J, et al. Socioeconomic inequalities in children's exposure to tobacco retailing based on individual-level GPS data in Scotland. Tobacco Control 2020;29:367-373. Doi: 10.1136tobaccocontrol-2018-054891)

advertisements during televised sporting events, which could lead to increased alcohol consumption in under 16s[17]. For example, during all 21 races in the 2018 F1 Championship, which aired on Channel 4, alcohol adverts were shown, leaving millions of children and young people exposed to alcohol imagery. Previous research[18,19,20] has shown that exposure to this type of imagery is associated with subsequent alcohol use among young people, and UK broadcasting regulations protect young people from advertising and alcohol content on UK television. The most prominent content was branding, occurring in 51% of race intervals and 7% of advertisement break intervals, appearing predominantly on billboard advertisements around the track, with the Heineken and Johnnie Walker brands being particularly prominent. The 21 races delivered an estimated 3.9 billion alcohol gross impressions to the UK population, including 154 million (95% CI 124 - 184) to children under the age of 16; and 3.6 billion alcohol gross impressions of alcohol branding, including 141 million impressions to children. Branding was also shown in race footage from countries where alcohol promotion is prohibited. However, alcohol promotion during sporting events is currently unregulated.

Further research from the University of Nottingham published in the Journal of Public Heath underlines the importance of the regulation of alcohol, tobacco and HFSS imagery in video-on-demand services[21]. These services are a known risk factor for the uptake and regular use of these products in young people. Following analyses of 11 original films released in the UK by Netflix and Amazon Prime Instant Video for alcohol, tobacco and junk food imagery, the results showed that alcohol content was most prevalent, appearing in 42% of the 5 minute intervals coded. HFSS imagery appeared in 35%, and tobacco in 27%.

When comparing original films across platforms, the results showed that exposure was similar between Amazon Prime Instant Video and Netflix. This is despite Amazon Prime Instant Video being subject to generally stricter regulation imposed by Ofcom, indicating that these measures are not enough to reduce exposure to alcohol, tobacco and HFSS imagery.

With the increasing popularity of VOD platforms among young adults, there is a clear need to regulation of tobacco, alcohol and HFSS imagery in original content in order to prevent youth exposure and limit future uptake.

Action should not be undertaken in partnerships with unhealthy commodities industries. For health, local authority, education and third sector organisations this could be added as statutory guidance as it is clearly not compatible with the legislation under which they are

[17] Barker A, Opazo-Breton M, Thomson E, et alQuantifying alcohol audio-visual content in UK broadcasts of the 2018 Formula 1 Championship: a content analysis and population exposureBMJ Open 2020;10:e037035. doi: 10.1136/bmjopen-2020-037035

[18] Chang F-ching, Miao N-fang, Lee C-mei, et al. The association of media exposure and media literacy with adolescent alcohol and tobacco use. J Health Psychol 2016;21:513–25

[19] Hanewinkel R, Sargent JD, Hunt K, et al. Portrayal of alcohol consumption in movies and drinking initiation in low-risk adolescents. Pediatrics 2014;133:973–82.

[20] Smith L, Foxcroft DR. The effects of alcohol advertising, marketing and portrayal on drinking behaviour in young people: systematic review of prospective cohort studies. BMC Public Health 2009;9:1–11.

[21] Khaldoon Alfayad, Rachael L Murray, John Britton, Alexander B Barker, Content analysis of Netflix and Amazon Prime Instant Video original films in the UK for alcohol, tobacco and junk food imagery, Journal of Public Health, 2021;, fdab022, https://doi.org/10.1093/pubmed/fdab022

established (noting the responsibility of Scottish Ministers 'to promote the improvement of the physical and mental health of the people of Scotland; https://www.legislation.gov.uk/ukpga/1978/29/section/1A. Particularly clear in areas where they have no competence, such as in developing or implementing health interventions or health-related policies. Furthermore, public bodies must not rely on information generated by unhealthy commodities industries to educate the public –as this would also be incompatible with their public task. The alcohol industry information, for example, filters promotion of less effective interventions through organisations like Drinkaware.

Scotland has made a good start by its adoption of the UNICEF Baby Friendly initiative and Code of Marketing for Breastmilk substitution. The support of CMO and CNO has helped remove sponsorship for health and related events by baby milk substitute producers and their parent companies (many of whom also manufacture other unhealthy commodities).

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

Tackling inequalities cannot be undertaken by one sector alone. It requires a whole system approach which includes representatives and stakeholders from across central and local government in addition to the NHS, advocacy and third sectors. Developing the skills to enable and facilitate collaboration by establishing communication channels which are clear and allow for the posing of questions which challenge the purpose and goals of the partnership. Placing an emphasis on co-production with and involvement of stakeholders in the co -design of solutions to address system challenges is key whilst also considering and amplifying of the voices of communities and marginalised populations most affected by health inequalities. Such action could help prevent new or emerging inequalities in the fast changing context of the aftermath of the COVID pandemic and generally uncertain context for low income households in particular.

Third sector and advocacy organisations require secure, long term funding so that their resources are not dissipated seeking multiple pots of short term funding on a competitive basis. The Community Empowerment Act and existing arrangements for acute crises could be deployed explicitly to address inequalities, given that, before the pandemic, the burden of disease associated with inequalities was equivalent (at time of analysis) to at least 5 pandemics[22].

Limited attention to the causes means that the adverse influence of powerful Unhealthy Commodity Industries (UCI) continues to pose a significant barrier to progress in public health policy. Recent examples of UCI actions during the COVID-19 pandemic serve to illustrate the vulnerability of public health policies to corporate capture. Policy makers must be aware of attempts by UCIs to influence their decision-making, exclude industry

[22] Wyper, G.M.A., Fletcher, E., Grant, I. et al. Inequalities in population health loss by multiple deprivation: COVID-19 and pre-pandemic all-cause disability-adjusted life years (DALYs) in Scotland. Int J Equity Health 20, 214 (2021). https://doi.org/10.1186/s12939-021-01547-7

from decision-making processes and actively manage conflicts of interest in public health policy.

While there is a clear evidence base on the most effective and cost-effective policy options to prevent and reduce harm from NCDs, there remain significant barriers and challenges to their implementation. If Scotland is to realise its public health ambitions, these barriers must be exposed, understood and adequately responded to at the national policy level.

The influence of powerful corporate actors on the policy process is one of the most significant barriers. Unhealthy Commodity Industries (UCIs), including industries that produce, promote and sell alcohol, tobacco and foods high in fat, salt and sugar (HFSS) are often involved in public health policy making, which usually results in weaker, non-evidence-based policies.

Commercial Determinants of Health (CDOH) are those activities of the private sector that affect the health of populations. These can be direct, such as the marketing of unhealthy products, or more indirect, like industry lobbying against duty increases, donating to political campaigns, funding dubious research, and generating doubt around product harms.

Until recently, except for the tobacco industry, the commercial determinants have remained largely absent from how we think about the social determinants of health. That is now changing, with a growing understanding of the core drivers of such companies, their strategies, the third parties they use, and their direct and indirect impacts on health and health inequalities.

The actions of UCIs can affect everything from consumption patterns of a particular product, to the social norms surrounding when and how much of it we use, to how normal and desirable children perceive products to be, to the tax and regulatory frameworks surrounding such products, the science regarding its harms and benefits, how policy-makers view the problem and its causes, and the framing of possible solutions in the mind of the public. Addressing NCDs requires an understanding of the CDOH and the actions of UCIs in driving them. It requires policy makers to be aware of attempts by UCIs to influence their decision-making and to actively manage conflicts of interest.

The WHO Framework Convention on Tobacco Control (FCTC) Article 5.3 is the best international example of good practice in this area, intended to protect public health policy from the influence of the tobacco industry. A similar approach needs to be applied across other UCIs. The role of the private sector must be solely on implementation of actions arising from policy decisions and implementation. They must have no role in the decision or policy making processes (see examples of UCI tactics described in the SPECTRUM and NCD Alliance report “Signalling Virtue, Promoting Harm” as outlined in previous sections).