Scottish Health Equity Research Unit
Insights, analysis and action on the socio-economic factors that shape health

Prevention Watch

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Public Health Scotland's 10-Year Strategy

Public Health Scotland (PHS) has published *Together We Can: Our 10-Year Strategy to 2035*, setting out how it intends to support the delivery of Scotland's Population Health Framework and wider public service reform over the coming decade. The strategy is explicitly framed around prevention, reducing health inequalities and strengthening the conditions for good health.

Driving Prevention: Setting Ambition and Tracking Progress

There is much to welcome. The strategy adopts a strong prevention focus, alongside commitments to deepen the Scottish Prevention Hub collaboration and to strengthen evidence on the social and economic determinants of health. PHS sets out ambitions not only to generate and synthesise evidence, but to "enable implementation" – providing practical tools, evaluation support, training and tailored advice to local systems. Given the constraints facing local public services, and the analytical capacity pressures we are observing in local areas, this offer of implementation support is significant.

A central quantitative ambition in PHS's strategy is to extend average life expectancy by at least one year by 2035, and to narrow the gap in life expectancy between the poorest 20% of areas and the national average. This gives the strategy a clear, long-term directional goal that aligns with the overarching aim in Scotland's Population Health Framework to improve both overall longevity and health equity over the decade to 2035. By anchoring the strategy to specific endpoints, rather than solely to processes or intermediate outputs, PHS underlines its intention to track substantive population-level change, not just organisational activity.

It also reflects the gravity of Scotland's current position: while recent data shows some uptick in life expectancy following pandemic disruptions, Scotland still experiences notably lower life expectancy compared with other UK nations, and stark geographic inequalities remain, with life expectancy differing by more than a decade between the most and least deprived areas of the country. Furthermore, unlike life expectancy, recent statistics on healthy life expectancy have not shown signs of recovery to pre-pandemic levels in the latest period. This suggests that a greater proportion of life is likely to be spent in poor health now than in previous years.

The scale of these targets presents both an opportunity and a challenge. Improving average life expectancy by a full year at a national level within a decade demands sustained, cross-sector action. The ambition to narrow the gap between the most deprived areas and the average also implicitly requires not just universal improvements over time, but greater improvements where health is worst – precisely where social determinants are most entrenched and service resources often most stretched. Achieving this also raises practical questions about how progress on these long-term life expectancy outcomes will be monitored, reported and mobilised in real time to inform corrective action – particularly given existing gaps in analytical capacity and outcome measurement at local levels.

Delivering Across Complex and Constrained Systems

A particularly significant element of the strategy relates to public spending. PHS states it will work in partnership to "identify, track, monitor and incentivise preventative spend" and, by 2028, aims for public bodies to have a shared approach to tracking and increasing the proportion of their expenditure on prevention. It also envisages public bodies being enabled, and held accountable for sustaining prevention spend. This aligns with longstanding calls for a shift in public spending priorities to better support prevention, and with commitments in the Population Health Framework to apply a stronger "public health lens" across government.

However, successful implementation of the strategy will depend on PHS having considerable leverage in this area. It is clear that PHS can redesign its own planning and budget cycles in line with public service reform principles. It is less clear how far it can influence the budgetary frameworks of the Scottish Government and local authorities. We are therefore interested to hear more about how this will work in practice. For example, if PHS intends to play a broader convening, influencing or monitoring role across the public sector, how will it interact with existing accountability structures?

Relatedly, the strategy commits to developing resources to ensure that national and local policies consider longer-term health and financial impacts. This resonates with ongoing Health in All Policies work and previous efforts to embed impact assessments. Experience with such tools suggests that the challenge is rarely their design, but rather how they are used. Without strong incentives and leadership, there is a risk that impact assessments become post-hoc tick-box exercises rather than drivers of substantive policy change. PHS's

focus on implementation and capacity-building is welcome but sustained political and institutional buy-in from others will be essential.

The strategy places welcome emphasis on delivering Scotland's commitments on child poverty and The Promise. PHS proposes to contribute policy and economic evidence on fair work, poverty reduction and affordable, quality housing, demonstrating equity effects and costs and benefits for physical and mental health. This is valuable. Yet it also raises a broader question about what additional evidence can achieve in areas where there is already substantial consensus about the direction of travel. For example, evaluations of Housing to 2040, The Promise, and child poverty delivery suggest that implementation barriers – systems design, funding mechanisms, performance management and cross-sector coordination – are at least as significant as evidence gaps. A key challenge for the strategy will therefore be how far PHS is able to support partners to address these systemic issues.

Community Planning Partnerships (CPPs) are identified as key local delivery vehicles for the Population Health Framework. However, previous assessments by Audit Scotland, What Works Scotland, and others have pointed to persistent challenges for CPPs, including unclear leadership, weak performance frameworks, and difficulties measuring impact on outcomes. If CPPs are to play a central role in prevention, PHS support to enable them to overcome these longstanding barriers will be critical– particularly around data sharing, analytical capacity and meaningful outcome monitoring.

Learning, Communities and Policy Development

Reassuringly, the strategy foregrounds evaluation and learning. PHS commits to supporting impactful child and family wellbeing interventions, implementing and evaluating whole-family approaches, and sharing actionable insights and emerging best practice. This emphasis on learning systems rather than one-off evaluations could be one of PHS's most important contributions, particularly in the context of constrained resources and the need to prioritise interventions with demonstrable impact.

The strategy commits to delivering the Collaboration for Health Equity in Scotland (CHES), applying learning from three initial areas to support action across the country. This place-based approach offers an opportunity to test more intensive cross-sector action on health inequalities and to generate practical insight to inform wider policy and practice. As the programme progresses, further detail on implementation, including what is changing in participating areas and how this is expected to lead to improved outcomes, will be important in demonstrating impact and supporting wider learning.

The strategy also highlights community engagement in its development and signals an intention to continue building relationships with communities. Ongoing attention to lived experience, and to incorporating qualitative and community-generated evidence alongside quantitative data, will be important if prevention efforts are to be responsive and equitable.

PHS sets out ambitions that, by 2028, new evidence-informed policies and actions will improve the affordability and availability of healthy food and reduce harm linked to inactivity, alcohol and tobacco. There is a strong focus on children in relation to affordability, availability and marketing. For adults, however, the emphasis appears to lean more heavily towards information campaigns and support services. While these are important components of a comprehensive approach, the evidence report supporting Scotland's Population Health Framework itself points out that it is structural measures that "*tend to have more inherently proportionate impacts, as they do not rely on individual agency*." The strategy is less explicit about upstream economic and regulatory levers for the adult population, despite clear social gradients and particular risks of preventable early deaths from alcohol, drugs and suicide among young adult men.

Looking Ahead

Overall, the strategy sets out a coherent and prevention-oriented vision. Its emphasis on implementation, prevention spend and cross-sector collaboration is welcome. Over the coming years, much will depend on how far PHS, working in partnership, is able to influence the design, funding and accountability frameworks that shape prevention, how it supports local systems facing capacity pressures, and whether it can help embed prevention as sustained, system-wide practice rather than an ongoing aspiration.

Parenting Across Scotland's report on young people's access to hobbies

In January, Parenting Across Scotland released a report collating how parents and carers feel about children's access to hobbies, digging into the barriers to leisure time activities that young people in Scotland face.

Participating in social activities is a vital determinant of health. People and regions with stronger social networks and higher levels of social inclusion often report notably better physical and mental health outcomes. For children, participating in leisure activities can have positive, lifelong effects, with studies finding that having hobbies (especially physical activity) in adolescence was linked to better mental well-being through adulthood. However, these activities come at a price, and there is a notable income gradient associated with social inclusion.

Unsurprisingly, parents were most likely to say that finances are one of the main barriers to their children's participation in hobbies. In Scotland, people from low-income backgrounds or living in deprived areas are more likely to experience loneliness and less likely to routinely see friends or family. This gap is an important aspect of health inequalities that Scotland's population faces. Reducing the gap in social participation early in life is crucial for improving population health.

Other issues that were commonly cited can also add to the cost of participation. These included parental concerns, such as a lack of available time, safety concerns, or a lack of family support or additional childcare needs; issues with the local availability of hobbies; and ease of access, including issues with public transport availability. Many parents, especially those in rural areas, cited how difficult it is to rely upon public transport, and how public transport timetables and links often fail to align with activities outside of working hours (an issue which we discuss below).

The report also asked if parents thought it would be a good idea for Scotland to have a free hobby provision model for children and adolescents. Around 90% of respondents supported this idea.

Given these findings, Parenting Across Scotland produced a range of recommendations, centring on the development of a National Hobby Framework, akin to provisions in other countries, such as Iceland, whose youth hobby model has been hailed as a landmark strategy for preventing poor health outcomes later in life. England also recently announced a National Youth Strategy, which we discussed in our previous Prevention Watch. In that edition of Prevention Watch, we highlighted that Scotland does not currently have a youth strategy, nor has Scotland made clear the funding or organisational changes that would be needed to improve access to recreational activities – an explicit goal of preventative policy documents such as the Population Health Framework.

Scotland has recently made some movement towards improving access to free after school activities; in January, the Scottish Budget increased its investment by £2.5million in the Extra Time Programme, which provides free before school, after school, and holiday activity clubs to primary school children in low-income families across 28 local authorities.

Ultimately, we welcome this publication from Parenting Across Scotland and strongly agree with a range of their recommendations. We are slightly sceptical of the call for a national framework for youth hobbies, however, given Scotland's history of creating frameworks without implementing an appropriate support structure. A national framework can only succeed if it is accompanied by the other actions that Parenting Across Scotland have outlined: securing sustainable funding; addressing inequity; implementing robust systems to monitor and evaluate outcomes; and importantly, working with parents, children, and communities to produce delivery models across the country. Therefore, a national framework in itself may not be essential if these actions are effectively implemented across existing programmes, such as the Extra Time Programme.

Public Health Scotland's transport poverty policy review

In 2024, PHS released a briefing defining transport poverty and the ways in which it links to health. Specifically, PHS defines it as *"the lack of transport options that are available, reliable, affordable, accessible or safe that allow people to meet their daily needs and achieve a reasonable quality of life."*

There are multiple ways in which access to transport interacts with personal and population health and can therefore be considered preventative. Transport poverty can reduce access to education and work; social engagement and engagement with leisure activities or public services; health services; and access to a nutritious diet. All of these can influence our health, and improvements across these dimensions can improve health long-term. Low-income households, people living in rural areas, disabled people, and women are the most likely to experience transport poverty, which can compound health and other inequalities faced by these groups.

In January, PHS released another briefing on transport poverty, this time reviewing the surrounding policy space and relevant data. This report reviewed 12 Scottish policies which address safety, accessibility, and affordability, and gave them a rating of High, Medium, or Low based on their potential impact on transport poverty for their target population.

PHS reviewed the following policies:

- Free bus travel aged <22
- Concessionary bus travel aged 60+
- Concessionary bus travel for disabled people
- "Kids for a Quid"
- Jobcentre Plus Travel Discount Card Scheme
- Disabled Persons Railcard
- Road Equivalent Tariff
- Air discount scheme
- Thistle Assistance Card
- Pavement parking ban
- Low Emission Zones
- 20mph speed limit

Of these, only the Thistle Assistance Card, which is a card or app that individuals can use to let transport staff know that they need support, was assessed to have a low impact, due to a low uptake or awareness of the scheme. The report offered a series of recommendations based on these findings, largely aimed at improving transport affordability and accessibility, especially for people with mobility and other support needs.

Two critical aspects of transport poverty went largely unaddressed throughout the report, however: reliability and availability (PHS's report acknowledged both the absence of these points and their importance, however). A report from last summer, published by Scottish Parliament's Cross Party Group on Sustainable Transport, found that people across Scotland reported poor connectivity, inaccessible services, and a lack of reliable and sufficiently frequent transport. This report found this issue to be both widespread and

largely overlooked, contributing to worsening inequality across the country. And, while issues with reliability and availability are especially concentrated in rural areas, a paper from 2023 found that large cities across the UK are also "*constrained by their limited transport infrastructure.*"

This is a significant gap in our understanding of transport poverty in Scotland. Measuring transport poverty is an important aspect of this gap; as the Sustainable Transport Cross-Party Group report noted, transport poverty is difficult to measure and there is insufficient data available for doing so. This initiative, at least, is being addressed by PHS, who are currently in the process of developing indicators across each transport poverty dimension. The Scottish Index of Multiple Deprivation (SIMD) also considers transport in its deprivation measure as part of the Geographic Access to Services dimension, looking at the time in minutes it takes to travel to GP surgeries, post offices, and retail services using public transport. The next iteration of the SIMD is due later this year, and while the Scottish Government has not provided any updates on the indicators they intend to use, we are keen to see how transport deprivation will be considered.

Recent work on preventing deaths from drugs, alcohol, and suicide among young adult men

In September, our annual report, the 2025 Inequality Landscape, discussed the role that social and economic conditions play in preventing deaths from drugs, alcohol, and suicide. In Scotland in 2023, men accounted for 70% of these deaths. While these and related deaths often occur later in life, prevention requires addressing the economic and social conditions that men experience earlier. Our focus, for that reason, was on men aged 18 to 44, who are most likely to experience related adverse outcomes (homelessness and criminal convictions peak among men in their 30s and 40s, for instance) before they experience these deaths.

A notable finding from the 2025 Inequality Landscape was that it is exceptionally difficult to trace these men in our available data. On average, men in this age range have high levels of income and employment, which can obscure the men that are doing poorly. Much of Scotland's poverty-related policy is focused on families with children or young adults as they transition out of school (generally aged 16-24). While both of these groups are crucial to preventing future adverse health outcomes, thousands of at-risk men in Scotland fall outside of either category, which we've highlighted as a key policy blind spot.

In the last month, we have progressed this body of work through a range of new publications and research.

First, we released a report in February which explores poverty rates among young adult men in Scotland. Poverty is a key driver of health inequalities more generally, and this report found that poverty among young adult men has increased sharply since the pandemic. This increase was not observed among young adult women, nor was it

observed to the same degree in any other UK region – with the result that young men are now more likely to be living in poverty in Scotland than anywhere else in the UK.

The analysis found that this increase was concentrated among young men aged 18-24, those who are out of work, and those who are single and without children but living with parents or housemates, pointing to a combination of economic and demographic factors. These results pose a major concern from a health equity perspective, providing an early warning sign of a further deterioration in outcomes among young adult men in Scotland.

Over the past year, we have also been conducting a series of Action Learning Sets, as part of a work package dedicated towards Strengthening Policy Implementation in Scotland. These sets involved a range of practitioners working across operational and strategic roles in Edinburgh and North Lanarkshire councils. Emerging evidence indicates that young men are overrepresented in crisis services but less present in early intervention work, reflecting broader system level challenges including policy attention and evidence usage.

While we are still in the process of collating the evidence from these sessions, we presented early findings at a series of roundtables in February and March, alongside findings from February's report on poverty among young men and produced a range of interesting discussions and insight.

Participants were particularly concerned about the transition out of school, and how this change affects men aged 16-24. This is a valid population to be concerned about. Previous research in Scotland found that people aged 16-19 who were not in education, employment, or training were likely to be less qualified, less likely to be in work, and have poorer health outcomes a decade later than those who had a positive destination after school. This relationship is complicated, however, as health conditions and disabilities can contribute to leaving school without a positive destination.

Educational gains among men, including improvements in positive school leaver destination rates, have generally not been matched by growth in employment rates or household income over the last decade. The pandemic also resulted in an increase in the proportion of students without a positive destination, and the long-term effects of this have yet to be understood.

Participants also discussed employment policy and how it relates to men. In particular, people highlighted the historical importance of trade union representation for protecting real incomes, and how regional sectoral differences need to be considered in policy. Often, men facing the worst outcomes in Scotland live in formerly industrialised regions, which have multi-generational cycles of worklessness.

More generally, participants discussed long-term impacts of austerity, especially the challenges with balancing trade-offs between preventative and crisis spending. Discussions also focused on the ways in which data sharing laws, such as GDPR, hamper efforts towards joined-up delivery.

Finally, we recently published a report which compiled findings from the Scottish Social Attitudes Survey, looks at public attitudes towards a range of issues, including deaths from alcohol, drugs, and suicide. The Scottish population as a whole felt that poverty reduction was the most effective way of reducing deaths from drugs and alcohol, whilst spending on mental health services was seen as the most effective way of reducing deaths from suicide. Men aged 16-44 were more likely than the general population to highlight the issue of poverty across both questions, again reflecting our findings across other reports.

Our next step for this work is still in development. We aim to publish a more in-depth recap of our findings from our roundtables in the coming weeks. Keep an eye out for reports on our Action Learning Sets and peer research later this year. We also welcome any thoughts on next steps for this research: feel free to email us at sheru@strath.ac.uk.

Scotland's Alcohol and Drugs Strategic Plan 2026–2035

Given the above work, it was encouraging to see the publication of Preventing Harm, Promoting Recovery: Scotland's Alcohol & Drugs Strategic Plan 2026–2035 on 10th March 2026. This sets out a joined-up approach to alcohol and drugs policy over the coming decade.

As with *Public Health Scotland's 10-Year Strategy*, there is much to welcome. The decision to develop a joint approach to substance use is a positive step, as is the Plan's emphasis on learning from Scotland's innovative harm reduction approaches, including the Thistle Safer Drug Consumption Facility, and its recognition of the complex, overlapping needs of many people who use substances. This includes trauma, mental health challenges and wider social vulnerabilities, including socioeconomic factors such as unemployment and homelessness. The focus on providing more holistic, person-centred support, alongside a strong human rights-based framing and attention to stigma, is therefore encouraging and provides an important foundation for efforts to reduce health inequalities.

It is also welcome that the Plan recognises the rapidly evolving nature of Scotland's drugs landscape. Rising injecting cocaine use, the emergence of potent synthetic opioids such as nitazenes, and the continued presence of novel benzodiazepines are changing the profile of risk and the challenges faced by services. The Plan's emphasis on maintaining a responsive, evidence-informed approach is therefore both timely and necessary.

However, as highlighted in our recent work on preventing deaths from drugs, alcohol and suicide among young adult men, the underlying social and economic conditions shaping risk remain critical drivers of harm. While the Plan clearly acknowledges both the unequal burden of harm (including among men) and the role of wider socioeconomic determinants, it does not set out a clear prioritisation or tailored response for the young adult men at greatest risk of deaths from drugs and alcohol. This represents a missed opportunity to more explicitly target action towards populations where preventable deaths from alcohol and drugs are most concentrated.

More broadly, much of the proposed response to the socioeconomic factors that shape harmful substance use is framed in terms of alignment with wider strategies, particularly the Population Health Framework. While this joined-up approach is welcome, the Population Health Framework itself currently lacks detailed implementation plans, creating a risk that action on the wider determinants remains diffuse.

As such, an important next step will be to translate these high-level ambitions into clear, deliverable actions that can meaningfully reduce inequalities and improve outcomes for those most affected. As Scotland moves into a new parliamentary term following the May elections, there will be an opportunity to strengthen cross-government leadership and ensure that action on alcohol and drugs is more fully integrated with wider efforts on poverty reduction, housing, employment and public service reform.