

A SUMMARY OF THE HEALTH OF THE NATION

Chief Medical Officer's Annual Report 2017-2018: ANNEX 1



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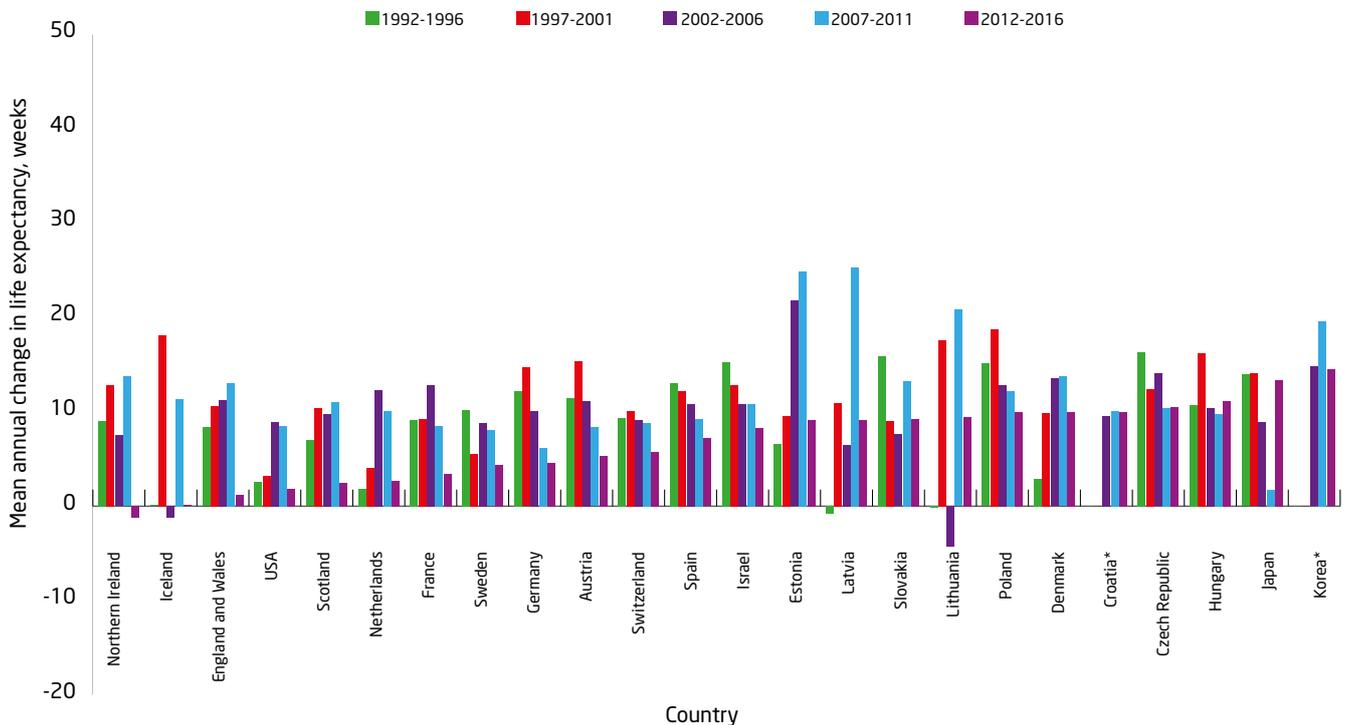
INTRODUCTION

The Health of the Nation Summary Report provides data on some of the key issues related to Scotland's health. This year, Part A reviews recent mortality trends in Scotland and Part B provides examples of patterns of health in each of the six public health priority areas identified in the Public Health Reform programme (published 2018).

PART A - MORTALITY TRENDS

- Mortality in Scotland has hardly improved in the last 5 years – this is almost unprecedented since the Second World War.
- Northern Ireland, Iceland, England and Wales and the USA have worse trends in mortality than Scotland but many other countries have had continuing improvements over the same time period.
- For women in Scotland, life expectancy increased by a mean of 2.5 weeks/year between 2012 and 2016.¹ There were smaller increases in England and Wales (1.1 weeks/year) and in the USA (1.9 weeks/year). Other countries had much more stable and larger increases (Figure 1).
- For men in Scotland, life expectancy increased by a mean of 4.5 weeks/year between 2012 and 2016.¹ This is similar to the 4.0 weeks/year gain in England and Wales but substantially lower than before 2012, when life expectancy was increasing for men by over 17 weeks/year. In the USA, there was a decline of life expectancy of 0.4 weeks/year between 2012 and 2016. Several other countries continued to see substantial increases (Figure 2).
- Mortality inequalities in Scotland started to increase after 2011. Mortality rates have worsened in the most deprived fifth of Scottish areas, and overall inequalities by deprivation have widened.
- As yet we are not clear what is causing these trends but there is some evidence that austerity measures, influenza and pressures on health and social care services may be contributing.
- Further work is being undertaken urgently to improve our understanding^{1,2}.

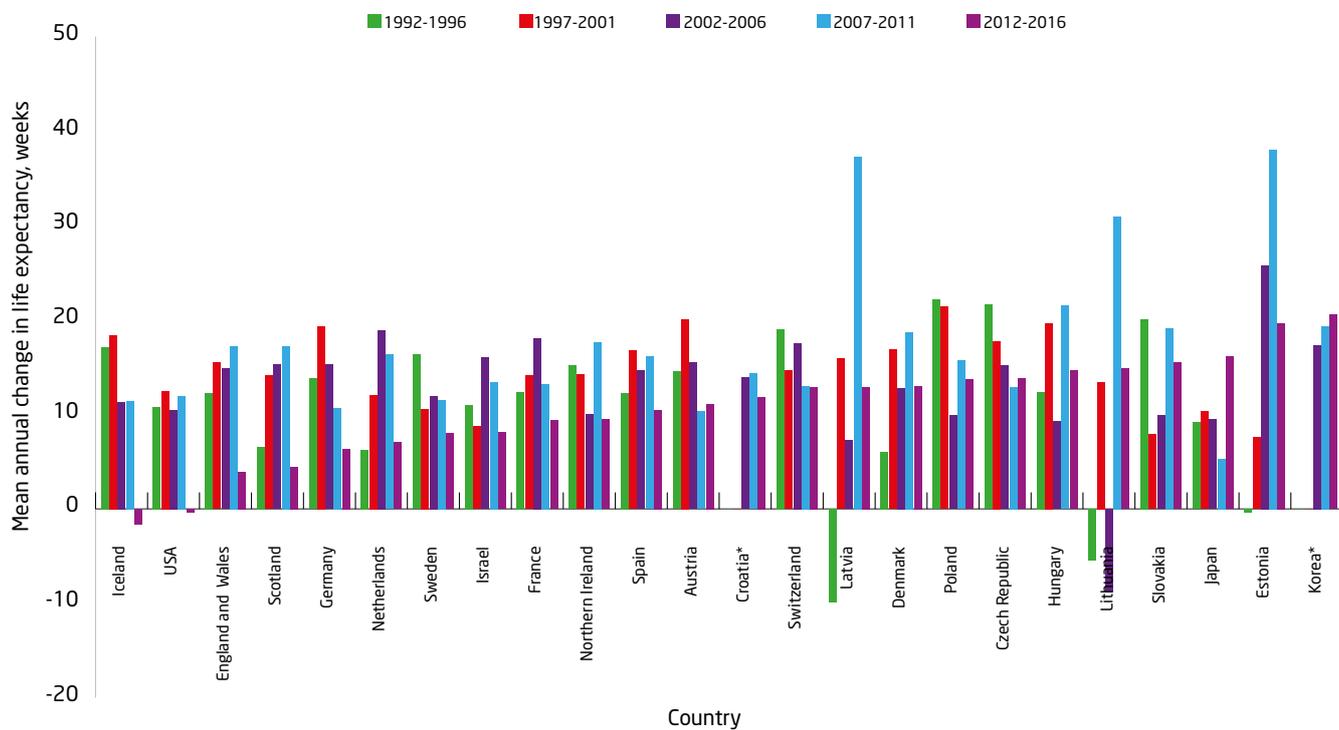
Figure 1: Mean annual change in female life expectancy at birth (weeks), for five year periods 1991-2016, by country



Source: Fenton et al.¹

*no data available for Croatia and Korea for periods prior to 2002

Figure 2: Mean annual change in male life expectancy at birth (weeks), for five year periods 1991-2016, by country



Source: Fenton et al.¹

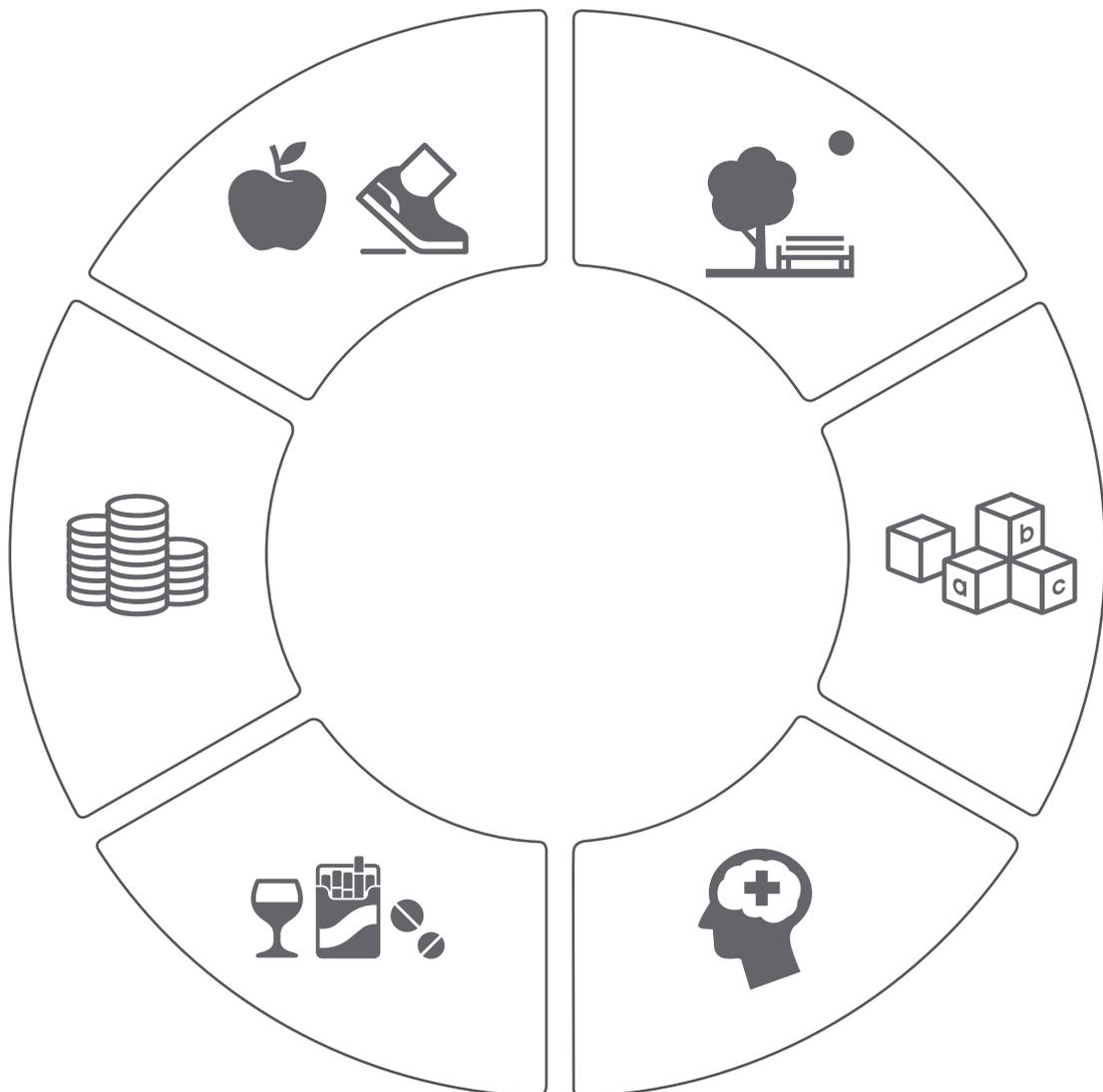
* no data available for Croatia and Korea for periods prior to 2002

PART B - 6 PUBLIC HEALTH PRIORITIES

The 6 Public Health Priorities for Scotland have been developed by the Scottish Government and by the Convention of Scottish Local Authorities (COSLA), and were published as part of the Public Health Reform Programme in 2018.³

The agreed priorities reflect the important public health challenges that we must focus on over the next decade to improve the health of the nation.

In this report, I consider each of these priorities in turn. As all of the priorities are complex and interdependent and as this is a summary report, I have not attempted to examine the priority areas in comprehensive detail. Rather, I have focused on a selection of patterns of health which relate to the priority areas and have provided an overview of these.



PRIORITY 1 – A SCOTLAND WHERE WE LIVE IN VIBRANT, HEALTHY AND SAFE PLACES AND COMMUNITIES

The places where we live, work and play, the connections we have with others and the extent to which we feel able to influence the decisions that affect us all have a significant impact on our health and wellbeing.

HEALTH AND HOMELESSNESS

Homelessness is an issue that is directly relevant to healthy communities and is a good illustration of the huge impact that social circumstances can have on health. While health inequalities across Scotland are well evidenced, the Health and Homelessness in Scotland project links homelessness and health datasets for the first time at a national level to explore the relationship between homelessness and health.⁴

The study shows the importance of considering homelessness and health together. One of the key findings is that at least 8% of the Scottish population (as at 30 June 2015) had experienced homelessness at some point in their lives.

The study considered 436,000 people who had been in households assessed as homeless or threatened with homelessness between June 2001 and November 2016. These households had been assessed by Scottish Local Authorities under section 28 of the Housing (Scotland) Act 1987. These people formed the Ever Homeless Cohort (EHC). Each person in the EHC was matched on age and sex to a non-homeless individual from the 20% least deprived areas of Scotland and to a non-homeless individual from the 20% most deprived areas of Scotland. This formed two control cohorts – the Least Deprived Cohort (LDC) and the Most Deprived Cohort (MDC). Each cohort had the same number of people and the same age-sex distribution. In total, the study contained over 1.3 million people.

Of those who had experienced homelessness at some point:

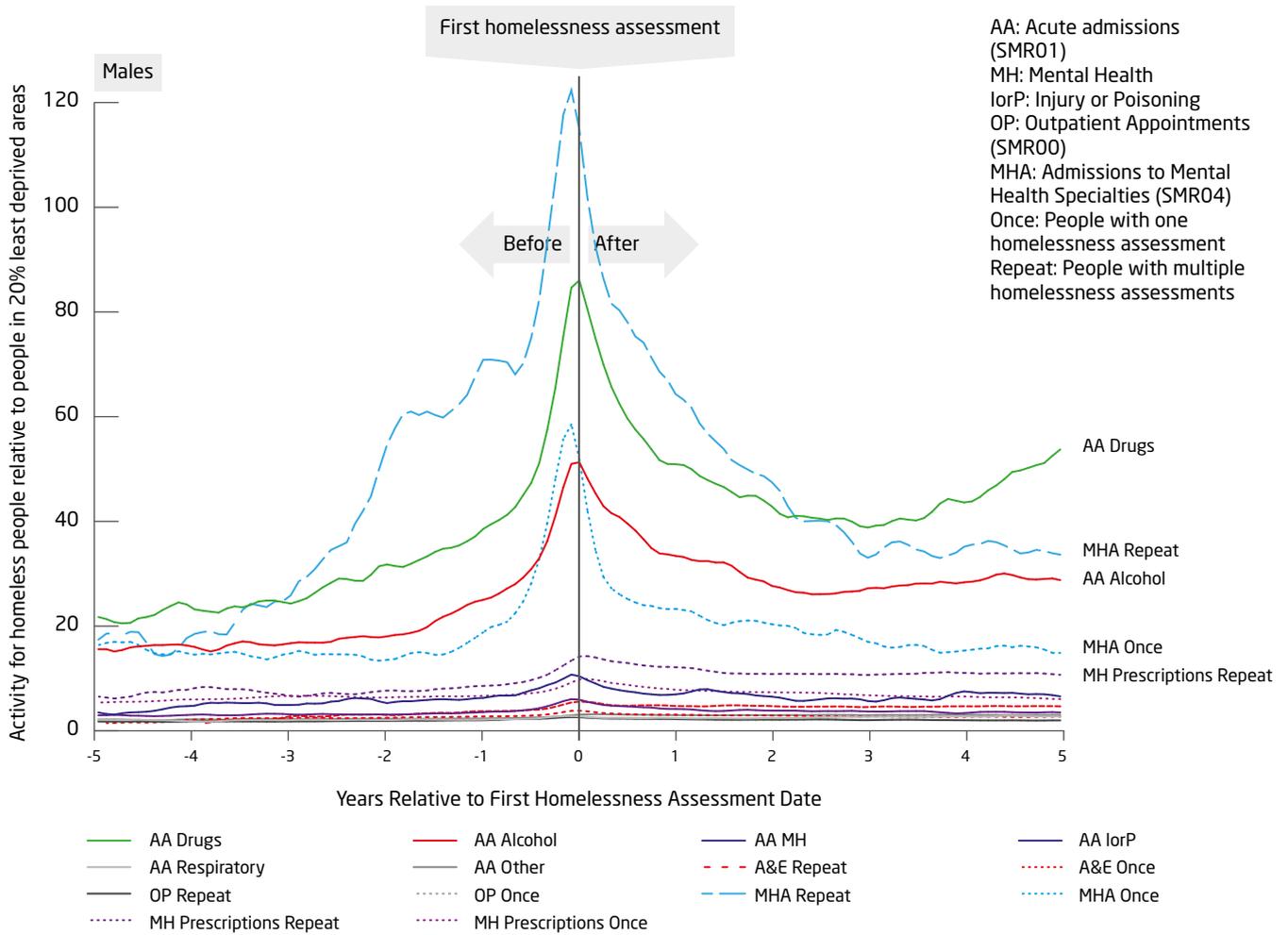
- Almost half (49%) had evidence of health conditions relating to drugs, alcohol or mental health. This was much higher than in the control groups (where there was evidence in 26% of the MDC and 14% of the LDC).
- Around 30% had evidence of a mental health problem at some point during the study period (with no evidence of drug or alcohol-related conditions at any point). This was higher than in the control groups (MDC 21%, LDC 13%).
- There was evidence of drug and/or alcohol-related interactions for the remaining fifth of people (19%), higher than in the control groups (MDC 5.1%, LDC 1.2%). Of these, the vast majority (94%) also had evidence of mental health issues.
- Around 6% of people experiencing homelessness had evidence of all three of the following conditions – a mental health condition, a drug-related condition and an alcohol-related condition – although not necessarily at the same time. This was much higher than in the control groups (MDC 1%, LDC 0.2%). The figure was markedly higher for those experiencing repeat homelessness (11.4%).

For a variety of health services, increased interactions with health services preceded people becoming homeless, compared to the control groups. A peak in interactions with health services was seen around the time of the first homelessness assessment.

For those who had been homeless on only one occasion, health activity eventually returned to the pre-homelessness levels. However, for people who were homeless on multiple occasions, levels of health activity remained high. It is not possible to say that health activity following homelessness is the direct consequence of homelessness itself. It could be due to further crises or health problems such as drug or alcohol related conditions, or a mental health condition.

Figure 3 shows the picture for males. The picture for females is detailed in the full report.⁴

Figure 3: Health activity before first homelessness assessment for males in Scotland



Source: Health and Homelessness in Scotland project⁴.

PRIORITY 2 - A SCOTLAND WHERE WE FLOURISH IN OUR EARLY YEARS

We want Scotland to be the best place for a child to grow up. This priority places particular emphasis on our early years, recognising the impact that early childhood poverty, disability and adverse childhood experiences can have on health outcomes throughout a person's life.

Children's early health and development is shaped by a wide range of factors and so all of the other five public health priorities are also important for child health. Children will have the best chance of flourishing when their families have a fair income (Priority 5), they live in a neighbourhood that promotes safe physical activity (Priorities 1 and 6), their parents have good mental wellbeing and are free from harmful substance misuse (Priorities 3 and 4), and they have access to nutritious food from breastfeeding onwards (Priority 6).

Creating the conditions which best support child health and development requires coordinated action across central and local government in sectors such as health and education, as well as strong partnership with families. There needs to be sustained focus on the fundamental determinants of health, children's rights, and equity.

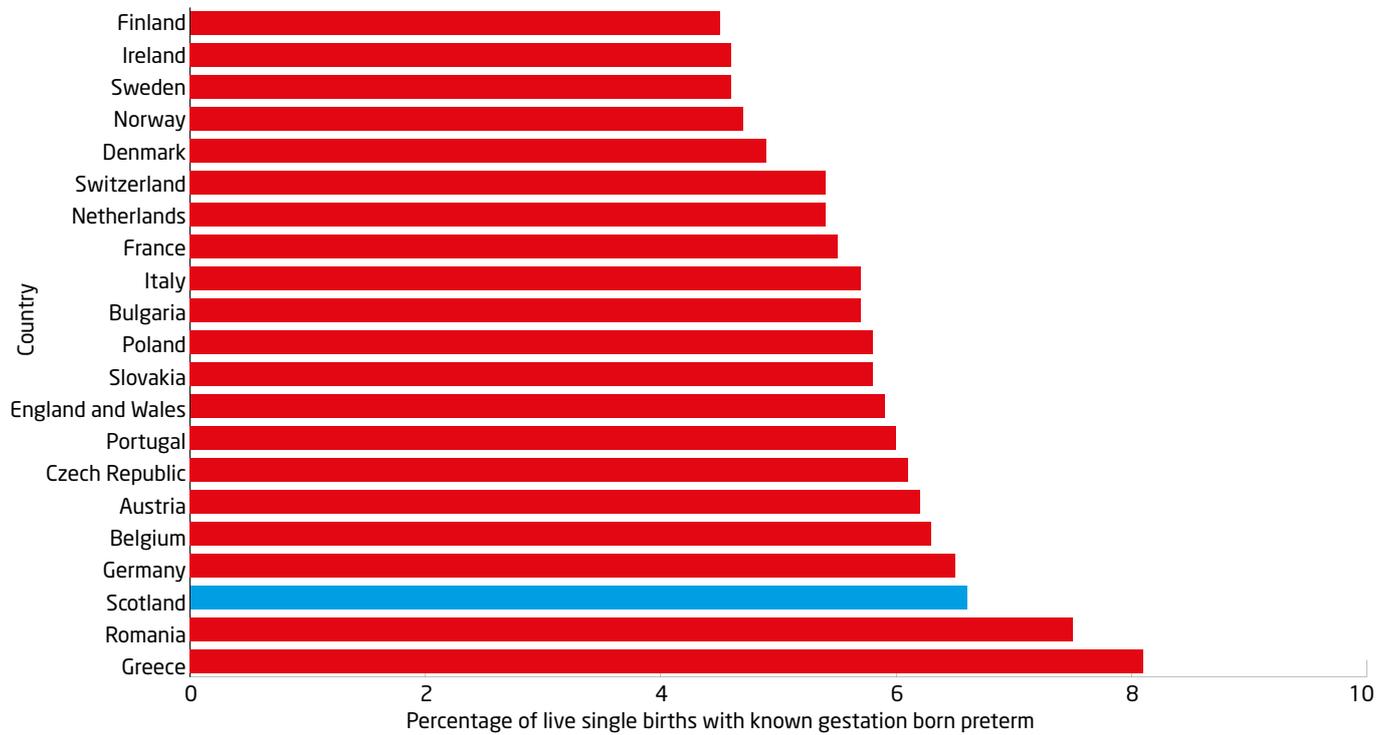
High quality data is available on many aspects of child health in Scotland. Here, because being born too early influences many aspects of children's subsequent health and development, we focus specifically on the proportion of babies born preterm or premature.

PRETERM BIRTH

The closer that babies are born to their 'due' date (at 40 weeks of pregnancy/gestation), the better their health and developmental outcomes. Babies born at less than 37 weeks of pregnancy are considered to be preterm. The earlier that babies are born, the higher the risk they will have serious problems immediately after birth. Complications associated with prematurity are the commonest cause of death in young babies in Scotland. Babies born preterm who survive are at risk of long-term health problems such as vision difficulties, ongoing breathing problems, and high blood pressure. They are also at risk of developmental and cognitive problems affecting their learning at school. Preterm birth can be spontaneous (following the mother going into labour or her waters breaking) or the result of medical intervention. Babies of multiple pregnancies (twins or more) are at much higher risk of being born prematurely than singletons.

The Euro-Peristat project publishes information on the health of mothers and babies across Europe. The latest report, published in 2018, provides information on babies born in 2015 in 34 countries (including the four nations of the UK).⁵ Figure 4 shows the percentage of live, singleton babies born in 2015 that were delivered prematurely. Results are displayed for the 22 countries that had at least 50,000 live births in 2015, had gestation at delivery known for at least 95% of births, and were able to show separate results for babies from singleton and multiple pregnancies.

Figure 4: Percentage of live singleton births that were born preterm (gestation below 37 weeks) in 2015



Source: Euro-Peristat project⁵

Of the 22 countries, Scotland had the third highest prematurity rate among singleton babies, with only Greece and Romania having higher rates. Scotland also had the second highest prematurity rate among babies from multiple pregnancies (twins or more).

The rate of prematurity in Scotland has also increased over time. The percentage of live singleton babies born prematurely has increased from around 5% in the mid-1970s (when reliable records began) to around 6.5% now. The percentage of live babies from a multiple pregnancy that are born prematurely has also increased: from around 33% in the mid-1970s to around 66% now. The ongoing increase in the prematurity rate seen in Scotland is not inevitable. The Euro-Peristat report compared trends in the proportion of babies born prematurely in different countries and found that some countries have seen a reduction in prematurity between 2010 and 2015.

The Euro-Peristat report shows that many of the risk factors for preterm birth, for example maternal smoking and maternal overweight and obesity (see Priority 6 on page 18) - are relatively common in Scotland compared

to other countries. Scotland also has persistently high social inequalities and high medical intervention rates in pregnancy, for example a high proportion of babies delivered by caesarean section.

Many risk factors for preterm birth, including the proportion of mothers aged 40 or over at delivery and the proportion who are overweight or obese, continue to increase in Scotland. By contrast, other risk factors, such as maternal smoking and the proportion of all pregnancies that involve twins or more, are starting to decline as a result of policy and practice developments.

As prematurity is such a key risk to children's short and long-term health and development, Scotland's high, and increasing, prematurity rate is a cause for concern. International comparisons suggest that more could be done to reduce our prematurity rate, and ensure that children have the best chance to flourish in their early years.

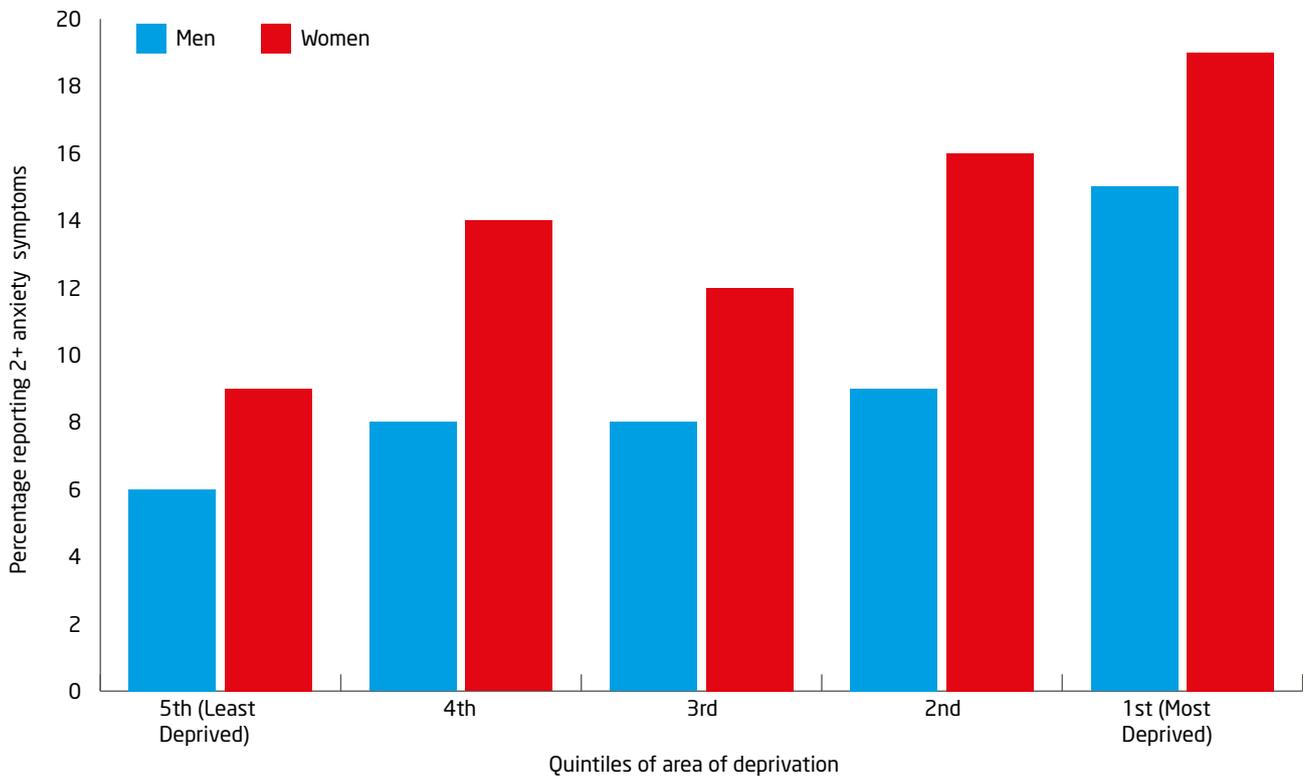
PRIORITY 3 - A SCOTLAND WHERE WE HAVE GOOD MENTAL WELLBEING

Mental wellbeing is about feeling good, maintaining positive relationships and living a life that has a sense of purpose. Good mental wellbeing arises where there is a supportive environment across all aspects of our lives, such as our workplaces, communities and education systems.

Burden of disease studies take account of both the length of life lost to premature death and the length of time lived with ill-health. Mental health problems represent a very substantial proportion of the overall burden of disease in Scotland. Although depression, anxiety and dementia are not responsible for a large percentage of early deaths in Scotland, we have

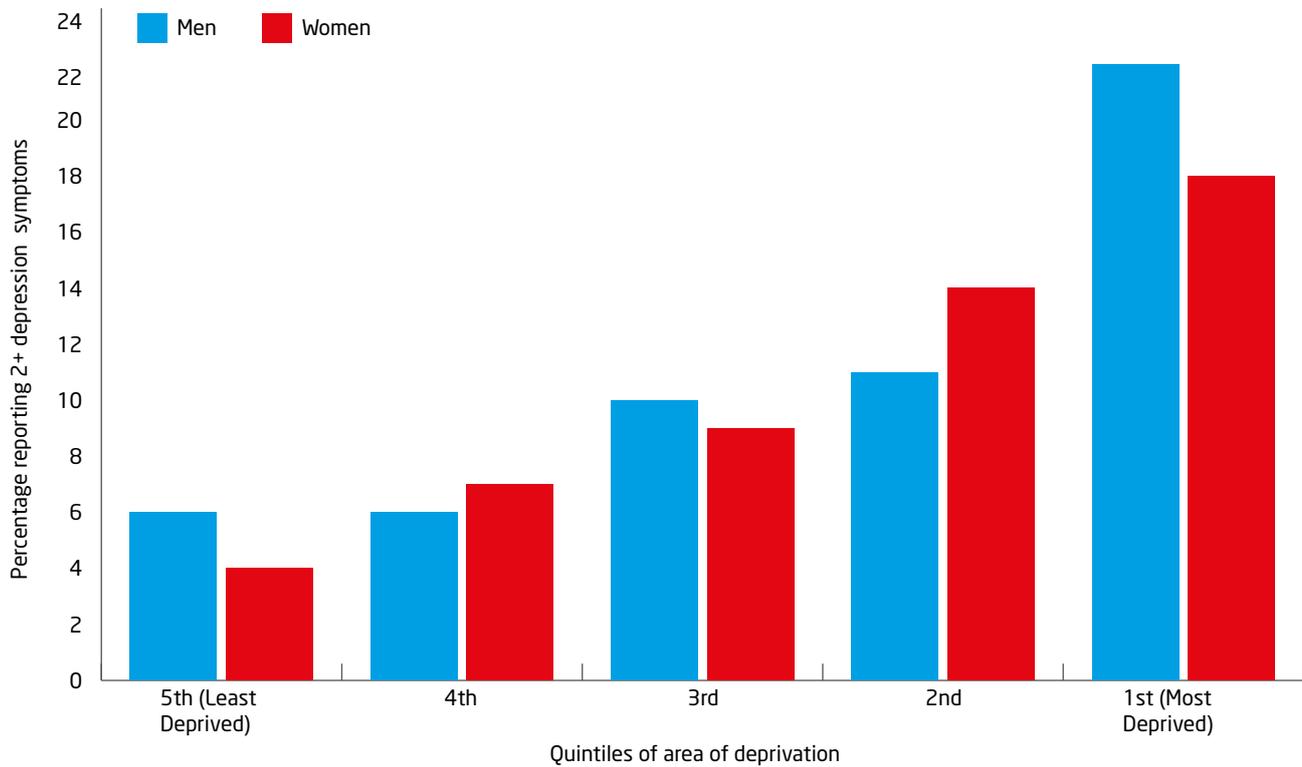
selected these two topics because they are chronic conditions which people have to cope with for long periods of time. Mental health problems can often be prevented at the population level, and their impact on people can be reduced if there are sufficient structures and supports in place across society.

Figure 5: Percentage of men and women aged 16+ years reporting anxiety symptoms on the Clinical Interview Schedule-Revised (CIS-R) score by quintiles of area deprivation score



Source: Scottish Health Survey [2014-17 combined]⁶

Figure 6: Percentage of men and women 16+ years reporting depression symptoms on the Clinical Interview Schedule-Revised (CIS-R) score by quintiles of area deprivation score



Source: Scottish Health Survey [2014-17 combined]⁶

- Positive mental health and mental health problems are two separate facets of health.
- Mental health problems are very common and, on many measures, are getting worse.⁷
- As the population has got older on average, the number of people living with dementia has increased.
- There are substantial inequalities across deprivation groups in the proportion of people reporting anxiety and depression symptoms (see Figures 5 and 6). Anxiety is more common among women than men in all groups but gender differences in the risk of depression are not consistent across deprivation groups.
- Many aspects of modern life have been suggested as contributors to mental health problems, including loneliness and economic insecurity.⁸
- A public mental health approach requires us to look at the factors that are changing the experiences of mental health across the whole population, focusing on the prevalence of cases rather than the causes of cases or the provision of services.

PRIORITY 4: A SCOTLAND WHERE WE REDUCE THE USE OF AND HARM FROM ALCOHOL, TOBACCO AND OTHER DRUGS

We need to reduce the harm caused by smoking, drinking and drugs in Scotland. The number of people using these substances and the harm caused to them and those around them can be minimised.

Substance use is an important contributor to Scotland's persisting health inequalities. Smoking, drinking and drug use continue to cause high levels of harm to individuals, families and communities across Scotland, with these harms experienced most by those living in disadvantaged circumstances. This section presents some key indicators that illustrate the impact of substance use on health.

SMOKING

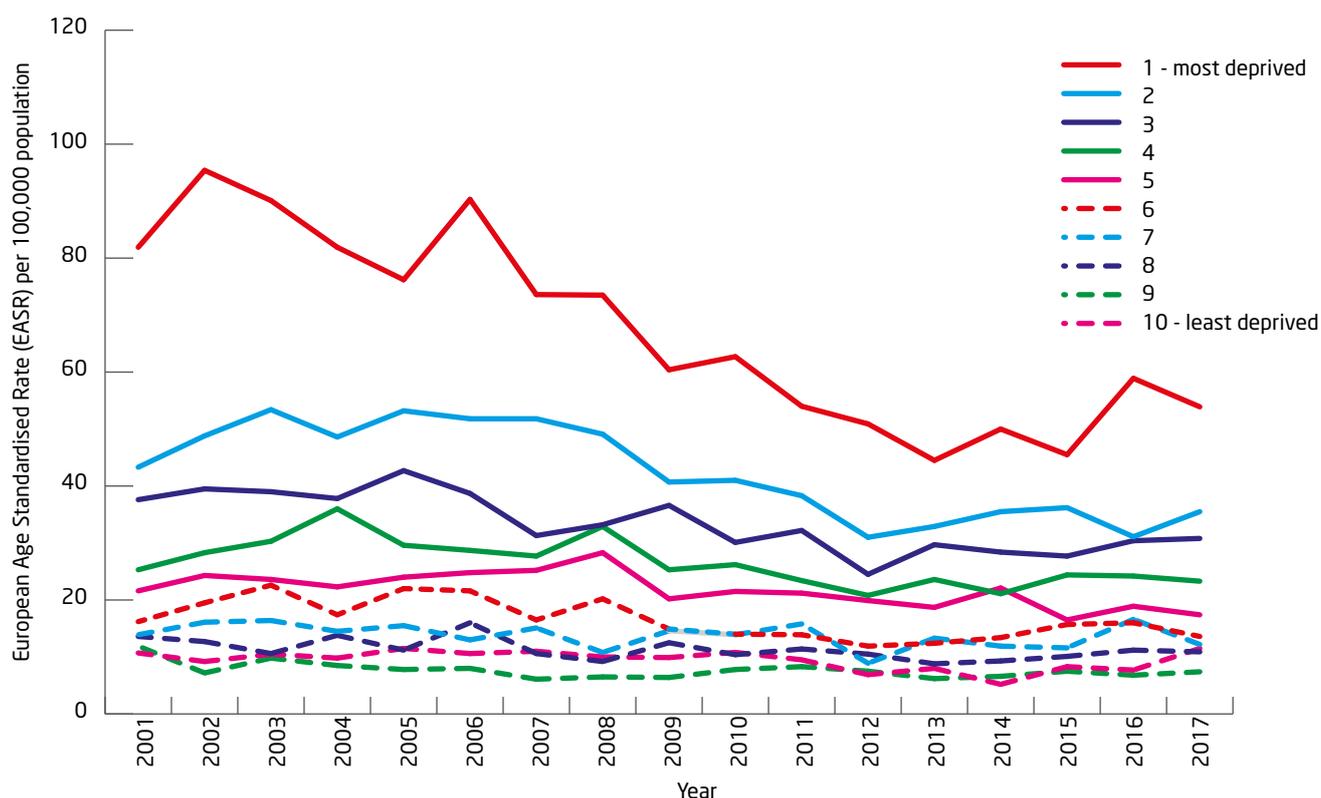
In 2017, approximately one in five (18%) adults smoked in Scotland, a fall from 28% in 2003. This coincides with an increase in the percentage of adults reporting that they had never smoked regularly or at all, from 50% in 2003 to 56% in 2017. Data from the Scottish Adolescent Lifestyle and Substance Use Survey (SALSUS) also shows a steady decline in the percentage of 13 and 15 year olds reporting as regular smokers.⁹

Despite these positive trends, smoking remains a leading cause of preventable disease and premature death. In 2017, 9,332 deaths among those aged 35 years and over in Scotland were estimated to be attributable to smoking¹⁰. There are also stark inequalities in deaths caused by smoking, with rates in the most deprived areas in Scotland being four times higher than in the least deprived areas. Despite the decline in smoking-attributable deaths occurring across all Scottish Index of Multiple Deprivation (SIMD) groups, relative inequalities have widened over time.

ALCOHOL

Between 2001 and 2013, the rates of death due to alcohol-specific causes (i.e. wholly attributable to alcohol) fell in Scotland, with the greatest absolute decline among those living in the most deprived areas. However, in recent years, this downward trend has not continued and the decline in inequalities in alcohol-specific death rates has now plateaued¹¹ (Figure 7).

Figure 7: Age standardised death rates from alcohol-specific causes by deciles of SIMD score for Scotland 2001-2017

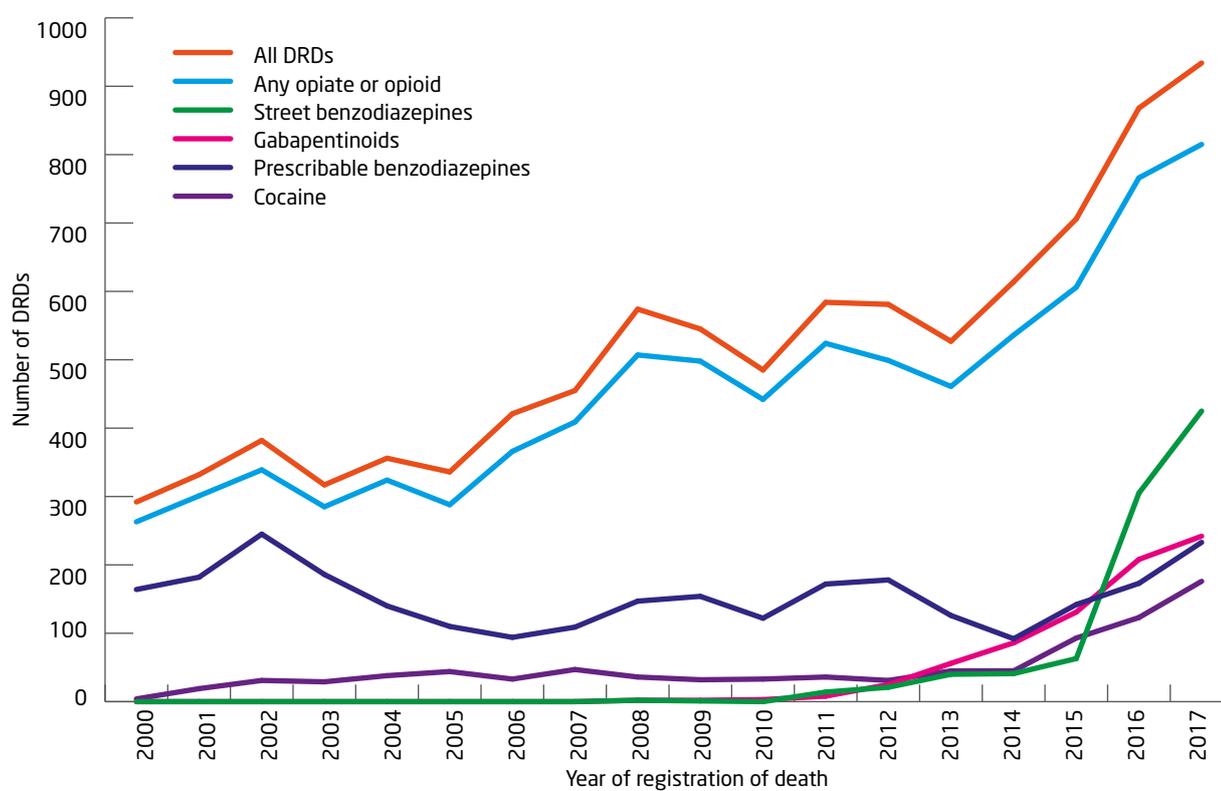


Source: National Records of Scotland¹¹

- In 2017, 1,120 people died in Scotland from alcohol-specific causes, an average of 22 people per week. The rate of deaths caused by alcohol was more than seven times higher in the 10% most deprived areas than in the 10% least deprived areas.
- In recent years, the general trend in alcohol-specific death rates has been upward for both men and women; this has been driven by increases in rates in the older age groups, particularly those aged 55 years and older.
- Rates of alcohol-specific death and alcohol-related hospital stays are around 2.5 times higher in men than in women.¹²
- Rates of alcohol-related hospital stays in general acute hospitals in Scotland were over four times higher in 2017/18 than in 1981/82. Since 2007/08, the general trend in alcohol-related hospital stays has been downward, but this has flattened over the last 5 years, remaining high at over 668 per 100,000 population in general acute hospitals in 2017/18.
- In 2017/18, alcohol-related hospital stay rates in general acute hospitals were more than eight times higher for those living in the most deprived areas of Scotland than those in the least deprived areas. Inequality by area deprivation is even more marked for alcohol-related admissions to psychiatric hospitals: stay rates were more than 12 times higher in the most deprived decile.
- The Scottish Public Health Observatory (ScotPHO) has estimated that alcohol consumption accounts for about 8% of the overall burden of disease in Scotland.
- Alcohol sales provide the best measure of population alcohol consumption levels in Scotland. In 2017, 10.2 litres of pure alcohol were sold per adult in Scotland. This is equivalent to 19.6 units per adult per week, which is 40% more than the low risk drinking guidelines of 14 units a week set by the UK Chief Medical Officers.¹³ Per adult sales in Scotland were 14% higher than in England and Wales. This was largely due to more alcohol being sold at lower prices in the off-trade (supermarkets and other off-licences) in Scotland.

DRUG USE

Figure 8: Numbers of drug-related deaths (DRDs) by type of drug implicated in Scotland for 2000-2017



Source: Information Request from National Records of Scotland with ISD definitions for benzodiazepine categories

Footnotes:

- 'Street benzodiazepines' are benzodiazepines (or metabolites thereof) which are a) not licensed for prescription in the UK or b) thought to have originated from an illicit source due to very low overall levels of prescribing in the UK.
- 'Prescribable benzodiazepines' are benzodiazepines (or metabolites thereof) which are licensed for prescription in the UK, but which may not have been prescribed to the individual who died.
- Gabapentinoids are the drugs gabapentin and pregabalin.
- Multiple drug types may be implicated in, or have potentially contributed to, each death.

■ In 2017, there were 934 drug-related deaths (DRDs) in Scotland. This was the highest number ever recorded and a more than threefold increase since 2000.

■ Scotland's crude DRD rate is more than twice as high as those of other UK countries and high compared to other European countries. This is in part due to the historically high numbers of individuals with problem drug use in Scotland (estimated at 57,300).¹⁴

■ Drug use disorders are the sixth leading cause of both early death and disability in Scotland and the leading cause of preventable death in 15-34 year olds.¹⁴

■ There is a marked deprivation effect with just over half of those who died having lived in the 20% most

deprived neighbourhoods in Scotland.

■ Figure 8 shows the number of DRDs in Scotland from 2000 to 2017 by selected drug types implicated in those deaths.

■ Opioids were consistently implicated in deaths (86% to 91%) across the time series. From 2014, the implication of three other drug types 'street' benzodiazepines, gabapentinoids and cocaine) began to increase.

'Street' benzodiazepines such as etizolam and alprazolam (Xanax) have been increasingly implicated in DRDs since emerging on UK drug markets in the early 2010s as New Psychoactive Substances (so-called 'Legal Highs'). Though the supply and sale of many of these drugs was banned by the Psychoactive

Substances Act 2016, they remain widely available via illicit drug markets. At high doses and when taken alongside opioids, benzodiazepines are a risk factor for DRD due to their respiratory depressant effects. Uncertainties regarding product type, purity and effect profile mean that the risks associated with consumption of unlicensed 'street' benzodiazepines may be higher than for prescribable benzodiazepines.

Gabapentinoids are prescription-only medications licensed for the treatment of neuropathic pain, epilepsy and (for pregabalin only) generalized anxiety disorder. There is growing evidence that, as a consequence of self-reported euphoric effects at high doses (particularly if taken with opioids), gabapentinoids are being used increasingly by people with a drug problem. However, potential side effects such as the reversal of methadone tolerance and respiratory depression mean these drugs are a risk factor for DRD. As a consequence of increasing evidence of diversion, misuse and harm, gabapentinoids became Class C controlled substances under the Misuse of Drugs Act (1971) on 1 April 2019.

There is evidence that cocaine use in the UK has increased in recent years due to a reduction in price and an increase in purity. Concurrently, cocaine-related harms (hospital admissions and deaths) have increased. The Needle Exchange Surveillance Initiative (NESI) reports an increase in injecting cocaine use among people who inject drugs (mainly opioid users), particularly in Glasgow. This has also led to an increased prevalence of HIV among the population of people who inject drugs in the city (with more than 100 new cases of HIV identified between 2015 and 2017). The health vulnerabilities of Scotland's ageing population of opioid users (a group often with multiple and complex comorbidities) alongside the risk of cardiac arrhythmia (and sudden death) from simultaneous cocaine and opioid use may help explain the increase in cocaine-implicated deaths.

PRIORITY 5: A SCOTLAND WHERE WE HAVE A SUSTAINABLE, INCLUSIVE ECONOMY WITH EQUALITY OF OUTCOMES FOR ALL

Inequalities in income, wealth and power are the root causes of inequalities in health. Addressing these inequalities is important if the right to good health for all social groups is to be realised.

CHILD POVERTY

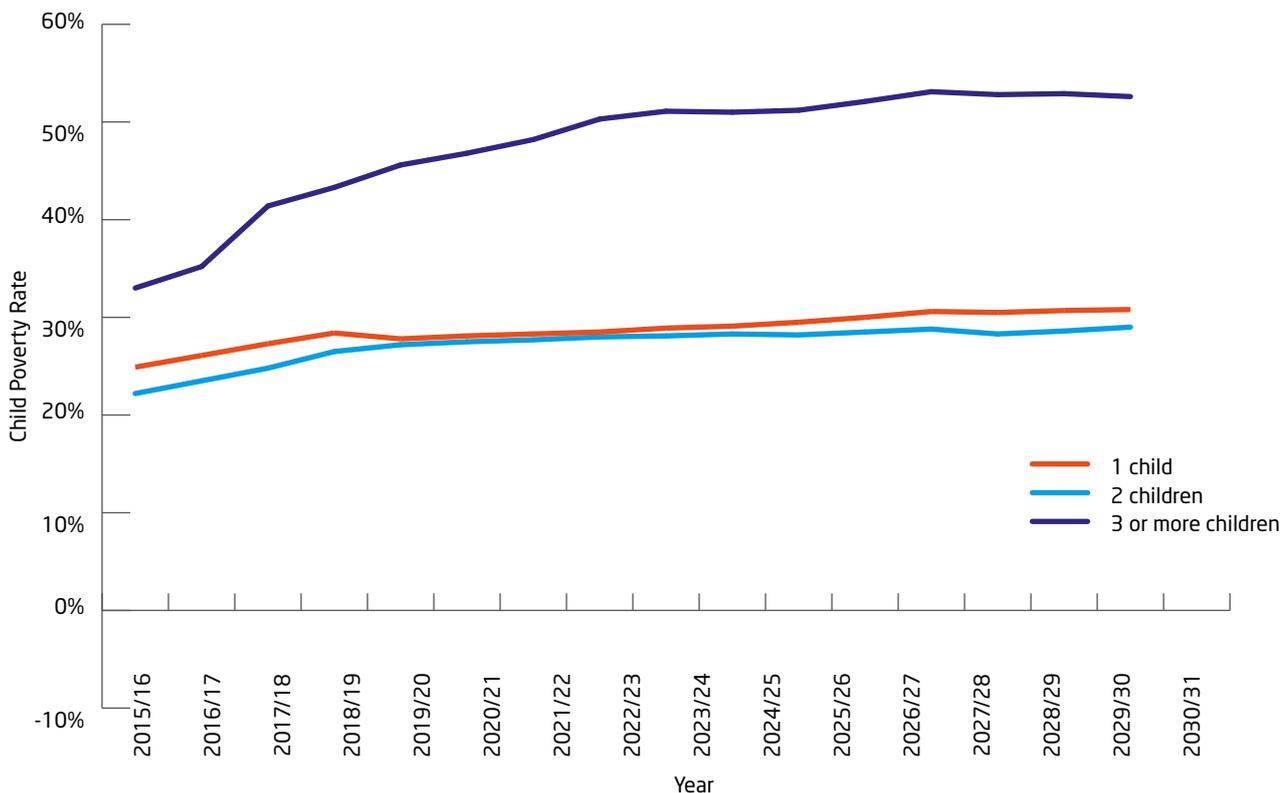
Although many measures of poverty have improved in Scotland over the last 20 years, income inequality has remained fairly static and at an historically high level. We have selected the topic of child poverty as an example of the importance of income for health and because of its potential lifelong impact on young people in Scotland. Child poverty is projected to increase markedly into the future. Much of that increase is due to changes in the social security system that will erode the value of benefits into the future. We therefore need an economy which is genuinely sustainable, both ecologically and economically, which creates high quality, fulfilling work and which generates sufficient wealth for us to flourish.

Statistical modelling by the Institute for Fiscal Studies (IFS) suggests planned changes to taxes and social security will increase child poverty rates substantially

until at least 2021. The increase in child poverty will occur in both relative terms (i.e. compared to contemporary median incomes) and absolute terms (the UK government measure of comparing to 60% of the 2010 median income level). The IFS has highlighted that there are significant uncertainties in the projected rates of economic and wage growth, but the projected impacts due to changes in taxes and benefits are based on policies that have already been announced. For child poverty, the introduction of the 'two child limit' would have been a major contributor to the projected increase¹⁶ but this will not now be implemented as originally announced.

The Scottish Government commissioned projections of child poverty based on the announced policies of relevant administrations and on a number of assumptions around demographic trends.¹⁷ It shows a large projected rise in the number of children in poverty in the future, especially in larger households (Figure 9).

Figure 9: Child poverty projection for Scotland by household size for period 2015/6 to 2030/1



Source: Scottish Government¹⁷

The ScotPHO Informing Interventions to reduce health Inequalities ('Triple I') project uses epidemiological modelling to estimate the potential impacts of various interventions on premature deaths, years of life lost, and hospitalisations, and on inequalities in these outcomes.¹⁸ The modelling suggests that income-based policies that redistribute income disproportionately to those with the lowest incomes are likely to be effective in improving health and reducing health inequalities in Scotland.

PRIORITY 6 - A SCOTLAND WHERE WE EAT WELL, HAVE A HEALTHY WEIGHT AND ARE PHYSICALLY ACTIVE

We want everyone in Scotland to eat well, have a healthy weight and enjoy being physically active. Reducing the future risk of overweight and obesity and increasing levels of physical activity in Scotland require substantial changes to our 'obesogenic' environment.

Diet, physical activity and weight are influenced strongly by wider environments. Sustained and coordinated action is required to promote easy access to affordable, nutritious food, to ensure communities are protected from the intrusive marketing of unhealthy food, and to provide safe and appealing opportunities for active travel and leisure.

A range of information sources on diet, physical activity, and weight are available for Scotland. Here, we focus on overweight and obesity trends among women in early pregnancy (maternal obesity) and on physical activity levels (in particular walking) in the wider population.

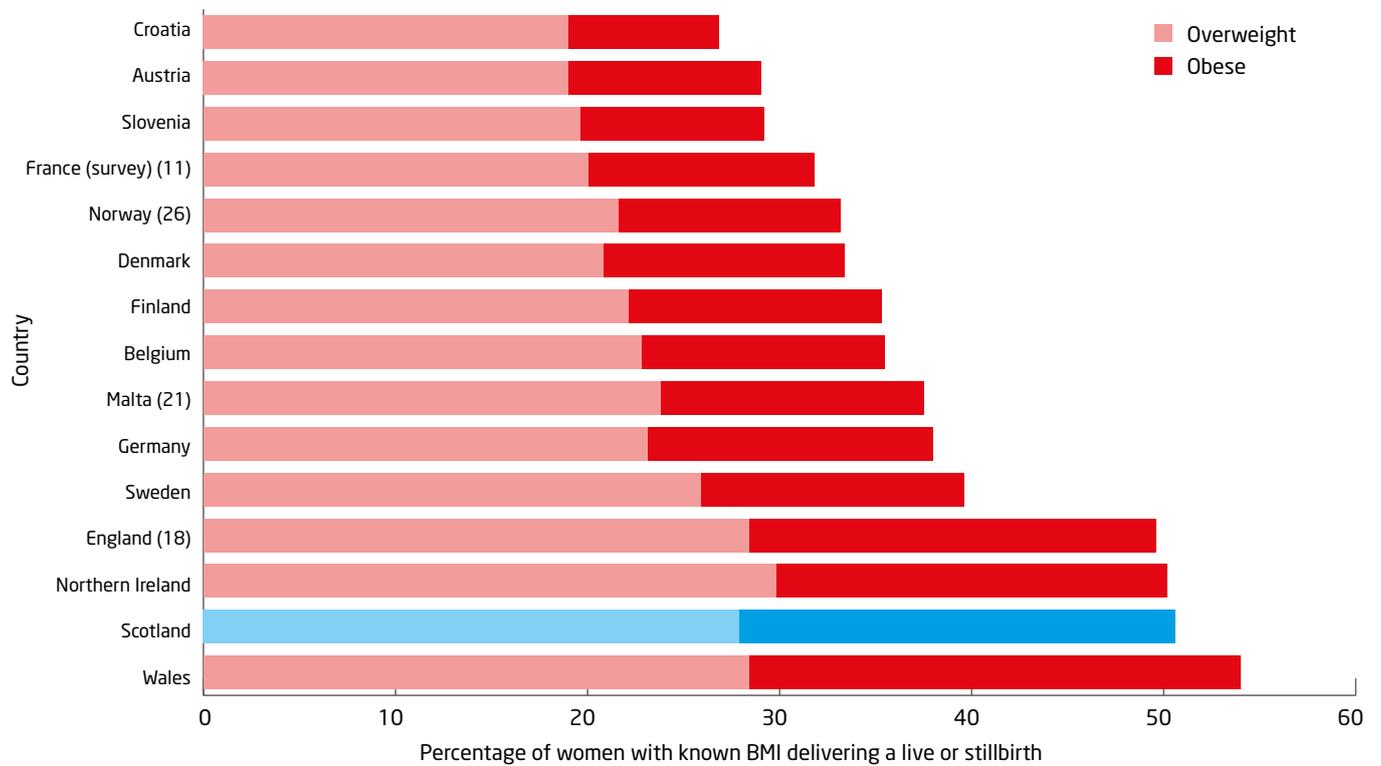
MATERNAL OBESITY

Maternal obesity is a marker of unhealthy weight levels in the general adult population. This topic has been selected to illustrate the problem of obesity because it carries particular short and long-term risks for women and their children.

Women who are overweight or obese are at higher risk of a range of complications during pregnancy, including pregnancy-related diabetes and high blood pressure, and are more likely than women of a healthy weight to require a caesarean section. Their babies are at increased risk of certain congenital anomalies, of having excessively low or high birth weight, and of being born prematurely. Maternal overweight and obesity increases the risk of the most severe adverse pregnancy outcomes for mother and baby, including severe maternal illness, death and stillbirth. Overweight and obesity beyond pregnancy is associated with long-term risks to women's health, for example type 2 diabetes, certain cancers, and joint problems.

Maternal overweight and obesity is also strongly associated with child overweight and obesity, which in turn poses short and long-term health risks for the child.

Figure 10: Percentage of women giving birth who were overweight (BMI 25-<30) or obese (BMI >=30) during early pregnancy in 2015.



Source: Euro-Peristat project⁵

Footnote:

Data shown for all countries that provided figures to Euro-Peristat. The % of women delivering in 2015 who had unknown/missing BMI data is shown in brackets after the country name for countries with ≥10% missing data

The Euro-Peristat project provides information on the proportion of women delivering a baby in 2015 who were overweight (body mass index [BMI] 25-<30) or obese (BMI ≥30) in early pregnancy, generally at the time of antenatal booking. All four UK nations but only 15 of the 34 countries submitting data to Euro-Peristat were able to provide information on maternal BMI. The proportion of mothers with overweight or obesity was noticeably higher in each of the four UK nations than in any other country. In 2015, over half (51%) of women giving birth in Scotland were overweight (28%) or obese (23%) at the time of antenatal booking.

Recording of maternal height and weight at antenatal booking has been mandatory on national maternity records since April 2011. The proportion of women with known BMI who were overweight or obese has increased steadily since then, from 49% of those delivering in 2011/12 to 52% in 2017/18. High levels of maternal overweight and obesity in Scotland reflect the situation in the general adult population.

For example, the Scottish Health Survey found that in 2017, 54% of women aged 25-34 years in the general population were overweight or obese.

Information from Euro-Peristat suggests that maternal obesity rates are increasing in most, but not all, countries with trend data available. Between 2010 and 2015, the maternal obesity rate remained the same in Denmark and decreased in Norway. This suggests that Scotland could look to international partners to explore what combination of policies and services could best counteract our high and increasing obesity levels.

Although maternal overweight and obesity is common throughout Scotland, it disproportionately affects women living in more deprived areas. Among women delivering in 2017/18, 56% of those from the 20% most deprived areas of Scotland were overweight or obese at booking compared to 44% of women from the 20% least deprived areas.

PHYSICAL ACTIVITY

There is strong evidence that increasing a person's amount of everyday activity can prevent and treat common and disabling health conditions, such as heart disease, type 2 diabetes and depression.

The recommended level of activity for gaining health benefits is 150 minutes of moderate intensity activity over the course of the week. This may be walking, running, swimming or other sports activities.

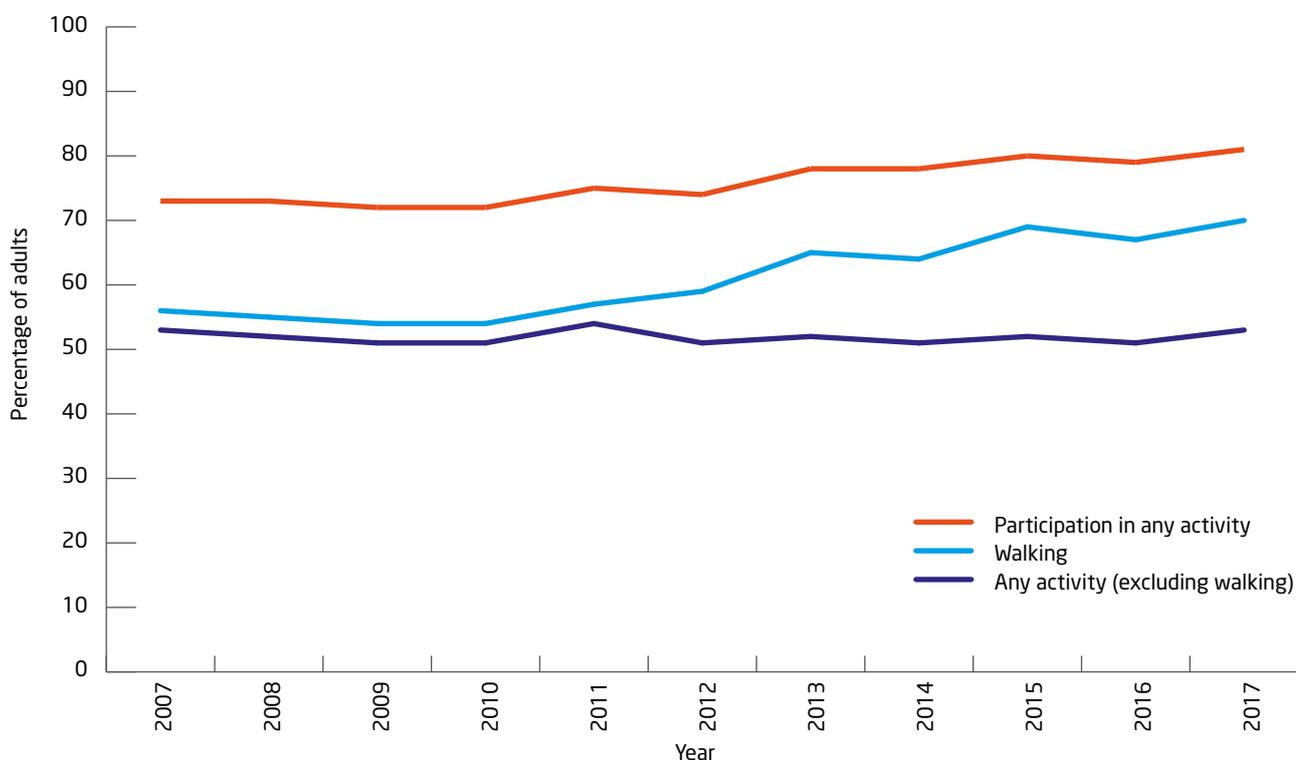
We focus here on walking as an indicator of physical activity because, for most people, walking is the easiest mode of physical activity to adopt. It requires no new skills or equipment and can be done as part of everyday life, making the 150 minute target feasible to achieve. Many sports and activities have greater rates of participation amongst men, younger people and those in the most advantaged social classes. For walking, the differences in participation by gender, age

and socio-economic status are smaller.

The percentage of people in Western European countries achieving the recommended 150 minutes of weekly activity is decreasing.¹⁹ This is not the case in Scotland. The Scottish Health Survey shows that two-thirds of adults achieve the 150 minute target and that, since 2012, there has been an increase in the percentage achieving this target. It is likely that much of this increase can be attributed to walking.²⁰ Scotland has a walking strategy which, along with efforts from Scottish Government and partners such as Paths for All, has contributed to increases in the proportion of people taking part in walking.^{21,22}

Figure 11 shows an increase in overall participation in any activity and in walking since 2007, based on results from the Scottish Household Survey. When walking is excluded, participation levels do not increase, showing the importance of the contribution of walking to the increasing overall levels of physical activity.

Figure 11: Trends in adult participation in physical activity and sport in Scotland from 2007 to 2017



Source: Scottish Household Survey²⁰

Footnote: Minimum base: 9,130

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Lee R Barnsdale, Principal Information Analyst (Drugs), Information Services Division, NHS National Services Scotland

Lucie Giles, Public Health Intelligence Adviser, NHS Health Scotland

Dr Lesley Graham, Associate Specialist in Public Health, Information Services Division, NHS National Services Scotland

Asif Ishaq, Public Health Priorities Lead, Scottish Government

Dr Gerry McCartney, Head of Public Health Observatory Division, NHS Health Scotland

Professor Nanette Mutrie, Director of Physical Activity for Health Research Centre, University of Edinburgh

Dr Andrew Riley, Senior Medical Officer, Health Protection, Public Health and Environmental Hazards, Chief Medical Officer's Directorate, Scottish Government

Dr Mark Robinson, Public Health Intelligence Principal, NHS Health Scotland

Dr Andrew Waugh, Statistician, Strategic Insights Unit, Scottish Government

Dr Rachael Wood, Consultant in Public Health Medicine, Information Services Division, NHS National Services Scotland

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Any enquiries regarding this publication should be sent to us at
The Scottish Government
St Andrew's House
Edinburgh
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