

*“We know what to do,  
we want to do it,  
but we find it difficult”*

**Community responses to  
Let Glasgow Flourish**

## INTRODUCTION

What do people living in Glasgow think about the public health issues that face the city? How closely do their concerns reflect those described in the epidemiological data? If the solutions to the city's health problems lie with the people living in the city, then it is important to know what Glaswegians perceive to be the causes of health inequalities in the city and what actions they think will turn around the city's health statistics.

*Let Glasgow Flourish*<sup>1</sup> was a comprehensive portrait of the health of the city and its determinants. Its publication signalled the beginning of a civic conversation about the city, describing the past and present and offering a glimpse of the future health concerns we will all have to respond to. The findings of *Let Glasgow Flourish* are well-known to those whose work involves tackling health inequalities locally and nationally. We wanted to know the extent to which the findings were familiar to people who lived in the city, those whose lives the health statistics are said to describe. If the statistics are recognised, how are they accounted for? From the perspective of Glaswegians, what are the main priorities we should collectively be addressing if we are to improve health?

## AIMS AND PURPOSE

The Scottish Poverty Information Unit at Glasgow Caledonian University took up the brief of finding out what Glaswegians thought about health in the city. Their report, *Glaswegians talk health: Community responses to Let Glasgow Flourish* provided some important insights that will enable us to understand how persistent health inequalities are perceived at the grassroots of the city and what actions will follow.

The aims of the study were:

- To establish how recognisable the city described in *Let Glasgow Flourish* is to the people who live there
- To identify issues that the public health perspective misses
- To recognise differences of opinion within the city about the causes of and solutions to health inequalities
- To canvass opinions from the grassroots of the city on actions for change

1 Hanlon P, Walsh D and Whyte B. *Let Glasgow Flourish*. Glasgow Centre for Population Health, 2006  
[www.gcph.co.uk/content/view/17/34](http://www.gcph.co.uk/content/view/17/34)

## APPROACH AND METHODS

The research was field-based and involved talking to city residents both on the street (during ‘roadshows’) and in more formal focus group sessions that facilitated deeper exploration of issues.

### Street-based data collection (‘roadshows’)

Community researchers were recruited to assist in the street-based data collection. Areas within the NHS Greater Glasgow and Clyde boundary were selected to represent areas seen to be ‘succeeding’, ‘getting-by’ and ‘struggling’: terms reflecting a workable, tripartite stratification of the city’s population along socio-economic lines.

One roadshow was held in Glasgow city centre and nine in localities in the wider Greater Glasgow and Clyde area. The nine areas were chosen to give a cross section of the socio-economic diversity that characterises the city. Central locations such as high streets and shopping centres were selected which meant we could not control the level of deprivation experienced by all respondents but it did increase the probability of getting a broad representation in socio-economic terms. The areas chosen were Hillhead and Shawlands (relatively higher on SIMD scores for surrounding area); Rutherglen, Partick and Dennistoun (mixed); and Easterhouse, Govan and Greenock (relatively lower). These produced data from 635 respondents.

Respondents were shown one of twenty headline findings from *Let Glasgow Flourish* (see Table 1) and asked whether this finding was characteristic of the Glasgow they knew. The headlines referred both to health outcomes and to social and environmental factors implicated in the creation or destruction of health. Reflections were sought on whether health implications arose from social and environmental factors and what the pathways of causality for health might be. In relation to health outcome statistics, the causes of the statistic and what could be done to address it and by whom, were explored.

### Focus groups

In the same areas, focus groups were conducted to ensure representation from key population interest groups that could ensure a diversity of perspectives were explored in more depth. These groups included Incapacity Benefit claimants, young parents, community volunteers, men and women from minority ethnic groups, retired professionals and working parents. Each focus group explored the health concerns of those within the group and the general health of the city. Sixty-three people took part in these focus groups.

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**FINDINGS**

### When it comes to the city's health, bad news is no news at all

The city's record of relative poor health and the inequalities that are evident both within Glasgow and in comparison with other areas of the UK are well recognised by those who live in the city. Glaswegians have come to expect bad news when it comes to health and inequality and there appears to be widespread familiarity with the picture painted by epidemiological trends. The researchers assessed this by measuring the degree of 'surprise' to the twenty headline findings from *Let Glasgow Flourish*. For example, when asked to consider the finding that 'the number of alcohol-related deaths in Greater Glasgow has almost quadrupled in the last 10-15 years', nine out of ten respondents were left unsurprised by this. Similarly, toward the finding 'on average men from Cambuslang live 10 years longer than men from Easterhouse', four fifths of those surveyed were unsurprised. Furthermore, the only finding that did appear to create surprise was the 'good news' story that mortality from heart attacks and strokes had decreased in recent years. It appears that when it comes to the health of the city, bad news is seen as the norm. Table 1 illustrates the recognition of health statistics used in the roadshows.

**Table 1: Community recognition of key health findings in Let Glasgow Flourish**

Let Glasgow Flourish Finding	%
The number of alcohol-related deaths in Greater Glasgow has almost quadrupled in the last 10-15 years	93
More than 6,000 children in Glasgow are living with a parent with a substance misuse problem	93
Despite improvements, significant numbers of properties still suffer from rising damp, poor heating efficiency, condensation and mould	91
Glasgow has the highest violent crime rate in Scotland and in some small, deprived parts of Glasgow, more than one in ten people have been a victim of a violent crime in the last three years	90
Well over half the adult population in Glasgow is thought to be overweight	88
Environmental issues (such as litter) and problematic behaviour (young people hanging around) concern many people in Greater Glasgow	86
Admissions to hospital for 'deliberate self harm' (includes attempted suicide, and other self harming behaviour) are around five times higher in poorer areas compared to affluent areas	85
Volume of traffic in Glasgow and the West of Scotland has increased year on year in recent times and is projected to grow by a further 25% in the next two decades	81
Compared to more affluent areas, in poorer parts of Greater Glasgow fewer residents think that people can be trusted or that neighbours 'look out for each other'	80

Rates of smoking among adults range from 36% in South Cambuslang to 63% in West Easterhouse	80
In less than ten years, almost one in two households with children in Glasgow will be lone parent households	79
Glasgow's middle class has doubled in numbers since 1981 – from 20% to 40%	79
Children born in the most deprived areas are more than twice as likely as those from the least deprived areas to be born with a low birth-weight	79
On average, men from South Cambuslang live 10 years longer than men from West Easterhouse	77
Two out of every five children in Glasgow are eligible for a free school meal – due to living on a low income	74
In Glasgow 2,500 children are currently looked after by the local authority ('in care') and more than double that are looked after by all West of Scotland councils	72
In 2001, more than 100,000 children were living in households where neither parent was in employment	71
Around a quarter of women in Glasgow and the West of Scotland smoke during their pregnancy – in some areas the figure exceeds one in two	70
Almost one fifth of the working age population of Greater Glasgow are classified as being unable to work due to illness or disability	67
Deaths from heart disease and stroke have more than halved in Greater Glasgow over the past 25 years	44

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## Understanding and explaining health

When exploration of the causes of the city's population health statistics was encouraged, both the focus group and 'roadshow' data revealed a reluctance among respondents to accept simple uni-dimensional explanations. A particular case in point was a resistance to accept behavioural choices of the city's residents as an isolated explanation. When respondents were offered 'social factors' to consider in relation to the city's health at population level, most would agree that social factors impact on individual health. When this is coupled with the recognition that social and environmental factors detrimental to health are widespread in the city, it portrays the city as somewhere where health is difficult to maintain for many of its residents. The social factors in Table 2 were offered to respondents as potential determinants of health.

**Table 2: Community recognition of 'social factors' as impacting upon health**

Let Glasgow Flourish Finding (social factors)	% believe it to be causal
Despite improvements, significant numbers of properties still suffer from rising damp, poor heating efficiency, condensation and mould	100
In Glasgow 2,500 children are currently looked after by the local authority ('in care') and more than double that are looked after by all West of Scotland councils	97
Two out of every five children in Glasgow are eligible for a free school meal – due to living on a low income	93
Volume of traffic in Glasgow and the West of Scotland has increased year on year in recent times and is projected to grow by a further 25% in the next two decades	91
Glasgow has the highest violent crime rate in Scotland and in some small, deprived parts of Glasgow, more than one in ten people have been a victim of a violent crime in the last three years	90
In 2001, more than 100,000 children were living in households where neither parent was in employment	90
Compared to more affluent areas, in poorer parts of Greater Glasgow fewer residents think that people can be trusted or that neighbours 'look out for each other'	89
Environmental issues (such as litter) and problematic behaviour (young people hanging around) concern many people in Greater Glasgow	87
Around a quarter of women in Glasgow and the West of Scotland smoke during their pregnancy – in some areas the figure exceeds one in two	86
Glasgow's middle class has doubled in numbers since 1981 – from 20% to 40%	79
In less than ten years, almost one in two households with children in Glasgow will be lone parent households	68

The percentage in the right-hand column again refers to the proportion of respondents who felt that the factor was causal in producing negative health outcomes. It should be noted that the 86% who recognised smoking in pregnancy as a cause of poor health were indicating a behavioural factor, but the general acceptance of social factors and their impact on health remains strong. Responses in general indicated a widespread understanding of the social determinants of health.

The open ended nature of the street-based data collection, and more so the focus groups, allowed exploration of how people understood the city’s health statistics to be created. A picture emerged of interrelated rather than singular causes. Elements within this complex picture included:

### Poverty and material prerequisites for health

A material understanding of health inequalities was revealed that also informed an understanding of economic development in the city particularly the numerical rise of the middle class. Four-fifths felt their experiences of living in the city accorded with the statistical picture of a growing middle class. However, the same proportion felt the health benefits of this were confined to the middle classes and a picture emerged of material wealth leading to a greater awareness of, and the ability to make, healthier choices. This had implications for the health of those not sharing in the city’s prosperity.

There was a sense that poverty was integral to poor health and an important pathway between the two was through the experience of poverty shaping behaviours. This was evident when the respondent below was asked to explore factors that might influence local variations in life expectancy in the city. We see that (s)he touches upon issues of material deprivation, social disintegration and the availability of negative behavioural options as explanations:

*‘Well it is poverty lifestyle issues, they drink more due to being unemployed and lonely. People in Govan don’t feed themselves properly and drink and smoke too much. People in Dumbreck have more money to spend.’*

### Mental health

Mental health was seen as both a correlate of physical health and arising from social conditions. There was acknowledgement that mental health and social conditions were intertwined and dealing with mental health issues through tailored health services was only part of the solution. And again, poverty was not the only factor in this. The context in which poverty was experienced, and particularly that of an increasing sense of fragmentation in the city, was a feature in this.

### Environment

Glasgow as a violent city was something recognised by 90% of the respondents and was seen to lead to a decline in the use of public space and a decrease in social contact. This could be amplified by the sense of an absence of trust and of ‘looking out’ for one another in Glasgow’s communities. These factors were seen to create a poor environment for living that had psychological consequences in isolation and depression.

## One city?

Social integration – or more specifically, its absence – between some parts of the city, was also seen as a problem leading to poor population health. A picture of two Glasgows emerged. The stark differences in life expectancy between geographic areas were believed to be absent from the face the city showed to others outside it. Although it was acknowledged that Glasgow had changed, it was also perceived that ‘old Glasgow’ still existed, albeit beyond the view of those visiting the city, and it was here that many of the public health issues were being lived out.

## Alcohol

As a behavioural factor, alcohol received special attention from focus group respondents. From their perspective, alcohol abuse is the greatest health problem in the Greater Glasgow area. Young people and underage drinkers were singled out for special attention, particularly for their visibility and for alcohol-related incivilities in communities and the city centre. Although a major behavioural choice influencing the health of the city, respondents also identified cultural, social and environmental factors underpinning problematic alcohol use that was further exacerbated by low-cost availability.

*Respondent 1: I would say in the West of Scotland alcoholism is the biggest problem*

*Respondent 2: I think you just need to walk around the city centre and see people at like 10 or 11 o'clock in the morning and they are a bit worse for wear and obviously it leads on to a lot of problems with liver problems and violence. There isn't anything that we can do but if you are looking at underage drinkers you are educating them but for the older folk it is how do you educate somebody in their 40s, 50s or 60s that has been drinking all their lives.*

*Respondent 1: I think there are too many places selling it now... vodka in the supermarket is cheaper than chicken*

Food was the other behavioural health concern that was raised by the focus groups. There was a view that strategies to tackle the issue of poor dietary choices needed to go to the heart of families if they were to succeed. As one retired professional put it “*there is no point in having a wonderful free school meal which is dead nutritious and then you go home and have two Big Macs for your tea.*” Again, it should be restated that behavioural choices were seen within the complexity of material, cultural and environmental factors and not a single point of intervention in and of themselves.



### Provision of services

Reflecting this view of multiple causes of poor health was a belief that services needed to become more person-centred in response. Although there was a recognition that population level interventions had produced improvements in people's ability to maintain a healthy lifestyle (such as the ban on smoking in public places) there was also an emergent view that counterbalancing trends and behaviours had worsened health. In particular, respondents drew attention to worsening habits with regard to exercise (more sedentary lifestyles), food (less nutritious diets) and alcohol (increased consumption). Although population level responses would play a part (as in attitudes around price control towards alcohol) the researchers noted a sense of reaching a point of diminishing returns in regard to health improvement. There were high levels of personal sentiment towards health improvement and high levels of knowledge and awareness of what needed to be done to improve health (as a consequence of health promotion), yet a sense of 'we know what needs to be done, we want to do it, but we find it difficult' prevailed. Person-centred interventions were seen as one way of overcoming this sense of diminishing returns in dealing with old health problems and the intertwined nature of material, cultural, environmental and social factors that characterise the new problems.

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CONCLUSION AND COMMENTS**Public Health responses in a city of similarity and difference**

In the perceptions around health and health inequalities identified, the dominant finding is of more similarity than difference in the views of those who took part. There were very few instances when opinions were not characterised by a strong majority position. This is of note given the diversity of respondents who took part. Glasgow's poor health is widely recognised and is part of the story the city tells about itself. This is reinforced by the issue that elicited most surprise: improvements in the city's heart disease rates. Expectations of poor health are so entrenched that good news stories are met with surprise.

The similarity in views is also surprising given the socio-economic inequalities evident in Glasgow. In one sense, accepting the tenacity of health problems in the city represents a collective element of the city's culture that crosses socio-economic strata. This could represent a positive resource if translated into momentum for change.

It was when statistics were contradicted by first hand experience that surprise at negative health statistics emerged. Notably, the young parents' focus group found it difficult to accept positive associations between the proportion of single parents living in an area and levels of smoking whilst pregnant in those areas. Given that many in the group were, had been or knew single parents, they had their own personal experiences as evidence. This indicates that beliefs can operate at multiple levels and that there is at the same time one Glasgow (with elements of a shared culture) and many Glasgows (distinguished by sub-group, local and individual differences). Consequently, a city resident can understand their city's population health as being broadly 'poor' whilst also holding a positive view of the health of their self and their peer group. It also reinforces the stigmatising potential of health inequalities statistics, no matter how well-intentioned the researcher.

In answer to the question '*what is to be done?*', suggested ways forward appealed both to common elements within the city's culture and recognition of the different ways the multi-dimensional influences on health play out at local and individual levels. Consequently, the idea of a person-centred approach emerged strongly (recognition of difference) as did action to tackle the city's culture around alcohol (recognition of common influences).

These findings can inform how we develop public health action and how we perceive the issues. The multi-dimensional nature of respondents' understanding of factors that make or break health should lead to a reframing of how individual level interventions are conceived. The concept of 'person-centeredness' differs markedly from that of 'individual responsibility for health'. The quote chosen to title this report illustrates this and the data collected and analysed tell of health trends affecting individuals not as lone actors armed with information about what is good or bad for their own health, but as experiential and interpreting agents at the hub of forces both within, and crucially, sometimes beyond their control. This accords with other findings produced from the Glasgow Centre for Population Health's community consultation work, particularly the work around cancer<sup>2</sup>. In helping people negotiate the opportunities and barriers to health within their experience of the city, understanding how these barriers manifest is the first step.

2 'Perceptions of Cancer in Three Deprived Communities in Glasgow', (2007), GCPH Findings Series Briefing Paper No. 2, Glasgow Centre for Population Health - [www.gcph.co.uk](http://www.gcph.co.uk)

From here, the development of strategies to deal with what is within individual control (such as health promotion approaches to informed decision making) is a key component, but so too is action aimed at the social, economic and environmental context that encourage or proscribe certain health-related behaviours. Further, person-centeredness should support opportunities for the fulfilment of individual aspirations and recognition of the healthful consequences of these. Thinking about the city as a place that facilitates the leading of fulfilled (and consequently healthy) lives should be a key public health project, whilst maintaining the idea of multiple paths to fulfilment. It will not be the same route for all.

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