



Accounting for Scotland's Excess Mortality: Towards a Synthesis

Commentaries and Responses

Edited by Chik Collins, Mhairi MacKenzie
and Gerry McCartney

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These commentaries contain the views of the authors and do not
necessarily represent the views of the GCPH.

Context

Accounting for Scotland's Excess Mortality: Towards a Synthesis was published by the Glasgow Centre for Population Health in May 2011. Slightly ahead of publication, a seminar was organised to discuss the report, at which John Foster, a historian specializing in the development of the West of Scotland in the 20th Century, provided an initial response to the contents of the report. Based on the further discussions at the seminar, a range of other contributors were asked to provide commentaries and responses of their own, with a view to wider dissemination. The contributions which were received, and which the authors were willing to see published, are collected in this document.

Each of the contributions provides a different perspective on the nature of the problem of excess mortality in Scotland and Glasgow, and suggestions as to the focus for future work. We are very grateful to the contributing authors.

Gerry McCartney, Chik Collins, David Walsh, David Batty
(*Synthesis* report authors) and Mhairi MacKenzie (Senior
Lecturer, Urban Studies/Institute of Health and Wellbeing,
University of Glasgow)

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The Scottish Effect: some comments from a historical perspective

Professor John Foster
Emeritus Professor of Social Sciences, University of the
West of Scotland

The question posed

Dates are important historically. So 1950, when Scottish mortality first deviated from that of the rest of western Europe and 1980, when this deviation became more marked, should both be kept at the forefront of any discussion. Yet there also needs to be a proviso. Deviations in life expectancy may not always be associated with events that happened at particular dates and are often the cumulative result of socio-economic developments over the previous period. Hence, we need to be concerned with both events and trends.

In mapping the territory for investigation, the comparative research conducted by Glasgow Centre for Population Health provides important pointers. To summarise: the 'Scottish effect' is most marked among those of working age, more among men than women and is more pronounced on Clydeside than across Scotland as a whole. Using comparisons across the UK and with other industrial areas in Europe, the effect cannot be associated with levels of poverty or the scale of loss of industrial employment in the 1980s and 1990s. Nor can it be explained by the migration of the more healthy – those moving away had similar mortality characteristics. On the other hand, it can be linked to an extent to unhealthy life styles, the level of alcohol consumption and smoking in Scotland – although the prevalence of these themselves needs to be explained.

This association with working age men in industrial Clydeside would seem, initially at least, to point the discussion towards experience in the workplace. The obvious starting point here is Scotland's health and safety statistics and what has been described as the Scottish Anomaly: the higher levels of workplace deaths and major accidents, as against the UK average, which cannot entirely be explained by the greater proportion of high-risk industries.

The 'Scottish Anomaly': higher levels of workplace injuries and death

Since the year 2000, the excess number of workplace deaths in Scotland has been less than a dozen annually and cannot in itself explain the lower levels of life expectancy – although the excess number of major accidents does run to over 200 a year and might have some impact on the longer-run likelihood of early death.¹ However, the main reason for considering the accident statistics is not for the impact on life expectancy itself but for the light it may shed on the character of work experience – particularly on levels of pressure and stress and the changing balance of authority between management and workers.²

Beck and Woolfson, who first identified the anomaly, date it to the 1980s and associate it with the decline in the proportion of unionised workplaces – with large unionised

workplaces closing (notably in engineering and mining), the fast expansion of the oil industry (where unions were generally not recognised) and the expansion of self-employment in construction.³ Johnston and McIvor trace the differential somewhat further back to the 1950s and find it particularly marked in Lanarkshire and on Clydeside.⁴ They associate it with the disproportionate scale of 'high risk' industrial employment together with the prevalence within it of pressured and authoritarian practices. Research sponsored by the Health and Safety Executive examined the higher levels of death and accident in the period up to 2000 and attributed the differential to the greater proportion of workers in high risk industries. Research undertaken by the National Audit Office of fatalities between 2005 and 2010 found that 83 per cent of the higher mortality could be explained in terms of the disproportionate size of construction and agriculture sectors. The other unexplained 17 per cent was ascribed to unidentified factors, which included 'different working practices and types of activity'.⁵ Research by the Health and Safety Executive in 2006 attributed the higher accident rate in construction to a 'higher proportion of manual workers employed by construction firms in Scotland compared to England and Wales'. No separate study appears to have been made so far of practices in Scottish manufacturing.⁶

This research therefore seems to offer some support to the proposal that there was something special about work practices that led to differences in mortality rates: 'many more manual workers' in construction would indicate an industry that was more labour intensive than that south of the border; the more general attribution of 17 per cent of the differential to unexplained 'workplace practices' would also seem to indicate a harsher environment – as would the oral testimony adduced by Johnston and McIvor.

The important research by Erik Sutherland on Fatal Accident Inquiries in the construction industry in the West of Scotland enables us to take this discussion somewhat further.⁷ It covered the period 1960 to the late 1990s and found that the 139 fatalities were overwhelmingly concentrated in the non-unionised sector (more than 97 per cent were in non-unionised workplaces while the actual proportion of non-unionised workers was on average across the period less than 75 per cent). The investigations of individual fatalities identified pressure for speedy completion, confused management responsibilities and employees who were isolated, individualised and lacked the scope and space to challenge unsafe procedures. Sutherland's more general and longer-term study of accident rates in the construction industry is also of interest here. It used Kuczynski's methodology to identify the periodic switches between intensive and extensive labour relations, their periodic combination and the impact of strong and weak collective bargaining.⁸ Applied to Scotland Sutherland identifies the 1970s as a period in which, for no more than seven or eight years, the balance shifted in favour of labour and collective bargaining and then from about 1979 again shifted strongly against – with the redevelopment of subcontract, the lump and the rapid rundown in public sector building employment.

A harsher workplace environment?

Workplace mortality, injury or illness will not by itself explain the Scottish or Glasgow Effect but it is a powerful indicator of the differential character of workplace relations in Scotland compared to England. As a hypothesis it might be advanced that these relations were more authoritarian, gave less room for collective solidarity and were hence more isolating and stressful than those elsewhere, that Scotland's employment has traditionally been, and continues to be, somewhat more labour intensive (with

higher proportions of unskilled and semi-skilled labour) and that this gave rise to behaviours, heavy smoking and drinking, that became 'cultural' – particularly for men.⁹ This difference also has deep roots. Scotland's separate legal system was far less tolerant of trade union organisation. For the latter part of the nineteenth century, when collective bargaining was generally accepted by English employers, it was usually refused by Scottish employers.¹⁰ This was in turn linked to attempts to maintain lower wages in Scotland, a differential seen by Scottish employers as an essential prerequisite for effective competition and compensating for lower levels of capital investment.¹¹ Though this differential was somewhat eroded by 1914, and even more during the 1914-18 war, it was re-established in the 1920s, again in the 1950s and continued in most areas of heavy industry and engineering into the 1960s.¹² Historically, before 1914, Scotland also had lower levels of trade union density and even in the twentieth century Scotland levels remained somewhat below the UK average.¹³ So, a harsher workplace environment, one that was more labour intensive and where workers were less able to challenge management authority appears to have been a recurring attribute of Scottish industrial life.

Yet, left at that level, as a hypothesis for explaining the Scottish Effect, it will not do. It fails to explain why Scotland's life expectancy only deviates after 1950 and, more markedly, from 1980.

There are, however, two other Scottish characteristics, both related to the workplace experience, which can be added. One is the periodic tendency for Clydeside trade union activity to move unpredictably beyond defensive resistance and become highly politicised – a tendency that may itself be associated with the authoritarian environment and the strength of worker militancy once labour market conditions improve. The other is the converse: interventions by employers and government to limit and reverse that politicisation – a process Collins and McCartney describe as 'political attack'. Twice in the twentieth century the West of Scotland saw levels of trade union based political mobilisation considerably stronger than those elsewhere in Britain that directly challenged governments and were seen by regional employers as threatening existing forms of workplace control. The first was during and immediately after the First World War culminating in the January-February 1919 Scottish General Strike.¹⁴ The second was the occupation of the Clydeside shipyards in 1971-72 and the concurrent and subsequent regional strikes on wages and trade union rights. The aftermath of 1919 saw the big employers adopting a policy of radical disinvestment: shipbuilding employment dropped from 50,000 to 18,000 between 1920 and 1921 and did not recover till the late 1930s.¹⁵ This 'sterilisation' of shipbuilding capacity, as it was described at the time, was accompanied by systematic attempts to erode collectivist attitudes.¹⁶ Throughout the interwar period unemployment ran at double the average for England and in parts of Glasgow reached 60 per cent.¹⁷ The aftermath of the radicalism of the early 70s saw a parallel assault on what were identified as the social bases of the class solidarity that had sustained the challenge of 1971-74. Collins and McCartney have examined this elsewhere.

'A drunk man looks at a thistle'

The social geographer David Harvey is particularly insightful on this front and takes the analysis of regional de-industrialisation beyond the physical closure of workplaces. Harvey conceives 'capital' as a social relationship, one that is both cooperative and conflictual, and which generates its own specific cultures. His analysis of

deindustrialisation is therefore posed in terms of the rupturing of these culturally embedded relationships and in some cases the deliberate attempt to eliminate cultures of class solidarity. He also stresses that this process inevitably involves not just the rupturing of these existing relationships but their replacement. Hugh MacDiarmid's aptly titled poem 'A Drunk Man Looks at a Thistle' is a reverie on the collapse of the hopes of revolutionary change in Scotland in the aftermath of the First World War. It reminds us, as does David Harvey, of the importance of the socio-cultural component of well-being and that the new cultures of disenchantment invoke divisive stereotypes of blame usually founded on internalised prejudices concerning ethnicity and gender.¹⁸ At the depth of interwar unemployment in 1933 the anti-Catholic Scottish Protestant League secured 23 per cent of the Glasgow vote concentrated in the very working class constituencies that only a few years before had sustained a series of unprecedentedly strong and community-supported industrial mobilisations.¹⁹

How, then, can all this be related to our keynote dates of 1950 and 1980? Was there, for instance, a similar 'political attack' after the radicalisation during the full employment of the Second World War?

It is quite difficult to argue that this was the case in any direct sense. During the brief return to high levels of unemployment in 1946-7, Clydeside employers did use it to purge the generally left-wing shop-stewards committees and restore old style management control after period in which the wartime Joint Production Committees had temporarily created a position of dual power.²⁰ Living standards did also fall temporarily during the imposition of a wage freeze in 1947-9 – at a time when unofficial strikes remained illegal.²¹ Yet this was also when the Labour Government established the National Health Service and nationalised rails, mines, road transport, iron and steel. Admittedly, the hopes for comprehensive industrial redevelopment as outlined in the Clyde Valley Plan were soon replaced by policies for the attraction of external investment and the beginnings of a 'dual economy'. However, it is difficult to see how the arrival of IBM at Greenock, in place of a state-owned steel plant at Linwood, would involve any immediate transformation of social attitudes.²²

The post 1950 Scottish deviation would seem more likely to be the result of a combination of longer-term factors – some carried forward from the earlier 'political attack' of the 1920s and 30s. It is important to remember its severity. Through the two interwar decades mass unemployment on Clydeside was both continuous and disproportionate to anything before 1914 or, with very few exceptions, elsewhere in Britain. So also were the resulting levels of poverty and overcrowding. Those entering work in Clydeside's heavy industry in the 1940s, within workplaces that were still very labour intensive as a result of the lack of new investment, carried with them the physical and mental legacy of that earlier environment. The Nuffield researchers studying young people entering the labour market in 1947-8 expected attitudes and experience matching the hopes of the post-war era. They were disappointed.²³ As previously noted, even in the 1950s and 60s Clydeside unemployment, though much lower than before the war, remained at double the British level. Average earnings were 10 per cent lower and housing conditions did not improve much until later in the 1950s. Hence, it may well be that in terms of any wider European level comparison what we are dealing with is a matter of differential improvement: a recovery elsewhere that was stronger, economically, politically and socially for working class communities, and one on Clydeside that did not fully overcome the social and cultural injuries of the interwar years.²⁴ Workplace stress, longer hours, anti-social shift arrangements and the accompanying cultures of heavy smoking and alcohol consumption would have had a

progressively adverse effect on a generation that had physically matured in conditions of serious deprivation.

Conclusion

These are tentative comments, the beginning of what needs to be a continuing discussion. The issues suggested as potentially important may be summed up as the character of the workplace experience and the balance of power and control within it and Clydeside's particularly authoritarian tradition of management and its probably associated phases of highly politicised workplace and community mobilisation. We noted Erik Sutherland's identification of 1973-1979 as the one brief period in the later twentieth century when the balance of power in construction, which was one of the least unionised industries, swung in the worker's favour – and then away again. Though this may be a particularly sharp and focused example, the same periodisation is likely to be observable elsewhere. The socio-cultural transformations of the 1970s, which temporarily saw the organisation of the working class movement securing something of a cultural and political hegemony in Scottish society, would in turn have made the impact of 'political attack' in the 1980s correspondingly more intense. David Harvey's perception of the 'devaluation of capital' as a social and cultural process is an important one.

In terms of further research it is also worth noting that the records of Fatal Accident Inquiries have only been very partially examined and those for shipbuilding and heavy engineering, it appears, not at all. These detailed testimonies are highly revealing windows on past workplace relations.

¹ National Audit Office, The Health and Safety Executive's Work in Scotland, Memorandum for the Scottish Affairs Committee, February 2011.

² The impact of long hours and workplace stress is examined by Mika Kivimaki et al. 'Using Additional Information on Working Hours to Predict Coronary Heart Disease – a cohort study', *Annals of Internal Medicine*, April 4, 2011 vol. 154 no. 7 457-463.

³ M. Beck and C. Woolfson, 'Accidents at Work: the Scottish Anomaly', *Occupational Safety and Health*, Vol. 29/12, 1999.

⁴ Ronald Johnston and Arthur Mclvor, 'The Scottish Anomaly: Occupational Health and Occupational Medicine since 1945', http://www.rcpsg.ac.uk/Triennial_Conference_November_2008/Presentations.

⁵ 'An analysis of Temporal and National Variations in Reported Workplace Injuries', Institute for Employment Research, 2000.

⁶ National Audit Office, op. cit., 2011.

⁷ Erik Sutherland, 'A Political-Economy of Safety and Health in the British Construction Industry with Special Reference to Fatal Injuries in the West of Scotland', PhD dissertation, University of Paisley, 1999.

⁸ Erik Sutherland, 'Modes of Exploitation and Safety in the British Construction Industry', *Radical Statistics*, Vol. 69, 1998; Kuczynski, J. A Short History of Labour Conditions Under Industrial Capitalism, Volumes I-IV. London: Muller, 1942-46.

⁹ Geoff Payne, 'Occupational Transition in Advanced Industrial Societies', *Sociological Review*, Vol. 25 (1), 1977.

¹⁰ Hamish Fraser, *Conflict and Class: Scottish Workers 1700-1838*, Donald, 1988. Alan Campbell, *The Lanarkshire Miners: a Social History of their Trade Unions 1775-1874*, Edinburgh, 1979 charts the success of the iron and coal employers of North Lanarkshire in eliminating trade union activity for almost half a century after 1856; J. Foster, M. Houston and C. Madigan, 'Irish Immigrants In Scotland's Shipyards and Coalfields: Employment Relations, Sectarianism and Class Formation', *Historical Research Online* August 2010, examine the ability of trade unionists to use labour market fluctuations on the Clyde to force reluctant recognition by the 1870s.

¹¹ R.H. Campbell, *Rise and Fall of Scottish Industry, 1750-1939*, Donald, 1980, chapters 4 and 6; D. J. Robertson, 'Wages' in A. Cairncross (ed.), *The Scottish Economy*, Cambridge, 1954.

¹² Scottish unemployment was running at over 200 per cent of the UK level through the 1950s and early 1960s and the differential was only reduced to 150 per cent in the late 60s and early 1970s (*Scottish Economic Bulletin* 1973, tables 72 and 73); Ministry of Labour, *Statistics on Incomes, Prices, Employment and Production*, HMSO, 1967, No.23 November 1967, pp. 30-41 for the lower wages in shipbuilding and engineering; Gavin McCrone, *Scotland's Economic Progress, 1951-1960*, Allen and Unwin, 1965, p. 44 gives the differentials for 1954 and 1958 ranging from 96 to 98 per cent in manufacturing, to 88 to 91 per cent in transport, 80 per cent in office work and 80 per cent in construction.

¹³ S. and B. Webb, *History of British Trade Unionism*, 1920, pp. 428-440 give the level of unionisation for Britain in 1892 as 4.6 per cent of workers in UK and 3.7 in Scotland; a 1926 survey put Scotland at 11 per cent against 12.6 for the UK and a further survey in 1947 gave Scotland 17.7 per cent against 18.2 for the UK: J. Bell, 'Trade Unions' in A. Cairncross (ed.), *The Scottish Economy*, Cambridge University Press, 1954.

¹⁴ J. Hinton, *The First Shop Stewards Movement*, Allen and Unwin, 1973 and J. Foster, 'Strike Action and Working Class Politics on Clydeside, 1914-19', *International Review of Social History*, XXXV, (1), 1990

¹⁵ Alan McKinlay, 'The Interwar Depression and the Effort Bargain: Shipyard Riveters and the Workman's Foreman', *Scottish Economic and Social History*, No. 9, 1989, examines the reassertion of management authority.

¹⁶ At the height of the 1919 General Strike Sir Harold Yarrow announced he was switching new investment to the construction of a new shipyard in Canada (*Glasgow Herald* 4, 6 and 10 February). In his economic survey of 1932 Professor W. R. Scott noted that there had been virtually no new investment on Clydeside since 1918 and attributed this to the region's reputation for political unrest (W.R. Scott, *Economic Survey of South West Scotland*, 1932, p.140). The papers of Lord Weir, one of the largest of the Clydeside engineering employers and Air Minister in 1918, also reveal his acute concern at the loss of management control by 1919 (Glasgow University Business Archives DC 96/3/5 Weir to Askwith 7 November 1919). Weir diverted investment to the Americas and, as Government Industrial Adviser in 1936, blocked plans for re-armament by insisting that they would have to be accompanied by peacetime 'direction of labour' (J. Barnes and K. Middlemas, Baldwin, 1995, pp.901-5). Weir was also a prime mover in the government initiative of September 1919 to spend £200,000 (half from government and half from private industry, equivalent to £250 million today) on anti-socialist propaganda in the form of 'independent' features syndicated through the national and regional press (Glasgow University Business Archives DC 96/3/4 Weir to Sir Robert Horne 14 August 1919; Edmund Talbot and Frederick Guest to Weir 16 August 1919; Talbot and Guest to Weir 23 September 1919). Sir William Lithgow, the biggest of the Clydeside shipbuilders and Industrial Adviser to the Bank of England, advocated parallel policies of disinvestment through the 1920s and 30s and implemented them as head of the National Shipbuilders Security Scheme (C. Woolfson, *Politics of the UCS Work-In: Class Alliances and the Right to Work*, Lawrence of Wishart, 1986, pp. 86-7).

¹⁷ Richard Saville, 'Industrial Background to the Post-War Economy', in R. Saville, ed., *The Economic Development of Modern Scotland*, Donald, 1985. The poverty of interwar Clydeside featured in the Beveridge Report with Beveridge contrasting the much lower levels of unemployment in London compared to Scotland (a reversal of the pre-1914 position): W. Beveridge, *Full Employment in a Free Society*, 1944, p.74.

¹⁸ David Harvey, *The Condition of Post-Modernity*, Blackwell 1990 and *The Limits to Capital*, Verso, 2006.

¹⁹ J.L. Smyth, *Labour In Glasgow 1896-1936*, Scottish Historical Review Monographs, No 11, Tuckwell, 2000, p.196.

²⁰ Woolfson, UCS., p. 155, sources cited.

²¹ Richard Hyman, 'Unions and Industrial Relations', in Jim Fyrrh, ed., *Labour's High Noon: the Government and the Economy 1945-1951*, Lawrence and Wishart, 1993, Table 2, p. 171.

²² Some of these issues are examined in J. Foster, 'The Economic Restructuring of the West of Scotland 1945-2000', in G. Blazyca (ed.), *Restructuring Regional and Local Economies*, Ashgate, Aldershot, 2003 pp. 57-72.

²³ T. Ferguson and J. Cunnison, *The Young Wage Earner*, Oxford University Press for the Nuffield Foundation, 1951: of the 1300 sample of 1947 Glasgow school leavers a fifth came from homes with one or both parents dead or absent, up to a third suffered some form of physical consequence of childhood poverty or slum housing and by 1951, after just three years in employment, 7 per cent had experienced physical injury at work.

²⁴ There is only scanty evidence on how far workers in Scotland sought to compensate for lower levels of pay by working more overtime. The Ministry of Labour, *Statistics on Incomes, Prices, Employment and Production*, November 1967, pp.30-41, gives hours including overtime for 'engineering and other metal using industries' as on average one hour longer for all grades of worker than the UK average; in shipbuilding, on the other hand, hours including overtime were at that point slightly less than the British average (which might be explained by the current lack of orders). *British Labour Statistics Year Book 1969*, Department of Employment, HMSO 1971, p. 82 gives average hours of work including overtime for iron and steel manufacture in 1969 as significantly higher in Scotland – for labourers almost four hours longer a week.

Why Scots die younger: a commentary

Alastair Leyland and Lyndal Bond
MRC/CSO Social and Public Health Sciences Unit, University
of Glasgow

The “Scottish effect” is that part of the excess mortality in Scotland compared to England that is not attributable to the higher levels of deprivation in Scotland.[1] Within Scotland, the high mortality rates in the Clydeside conurbation mean that the mortality of Scotland excluding this region compares favourably with many other developed European countries.[2] As such, explaining the “Scottish effect” may be simplified to explaining the “Glasgow effect” – the reason underlying the high mortality rate in Glasgow relative to comparable cities.[3]

In this commentary, we consider mortality in Glasgow relative to that seen in Liverpool and Manchester and reflect on the proposed hypotheses as potential explanations of the excess, with particular respect to the large excess seen for deaths due to suicide, alcohol and drug use, and violence. The list of proposed hypotheses identified in the paper by MacCartney et al certainly appears to be exhaustive; any other hypotheses that come to mind seem highly fanciful. We therefore ask two questions: which of these are most likely to explain such differences, and what kind of evidence might be used to prove or disprove the hypotheses?

The hypotheses that we believe most likely to cause the “Scottish effect” are those associated with deprivation, health behaviours and deindustrialisation. This is actually a simplification, since the single hypotheses listed above can all be combined with others on the list and themselves can appear hard to distinguish. But our rationale is as follows.

Deprivation is clearly of central importance since it is entangled in the definition of the “Scottish effect”. We might ask whether we could define deprivation in such a manner that there was no excess in mortality in Glasgow. However, given the extent to which the excess varies according to cause of death[3], a measure of deprivation which led to equal deprivation-adjusted mortality rates for suicide, alcohol and drug use and violence may well leave Glasgow with a lower deprivation-adjusted rate for causes such as cardiovascular diseases and cancers. Moreover, such a retrospective creation of a measure is scientifically unsatisfactory. The exact composition of an index of deprivation can be debated – particularly since the meaning of variables such as car ownership or overcrowding may change over time or may have differing predictive powers[4] – but such indices tend to be highly correlated with one another in as much as they are all good at identifying the most (and least) deprived areas and are not far apart when trying to order the areas in between.

So what makes us think that there is something artefactual about the way that previous analyses have adjusted for deprivation? It is really a question of scale. Geographers have long been aware of the Modifiable Area Unit Problem (MAUP)[5] which means that the results of an analysis may vary according to the way boundaries are drawn between areas and, in particular, the size of the areas used.[6] Analysis is typically

conducted at the level of postcode sector (average population 5000) or datazone (780). The comparison between Glasgow, Manchester and Liverpool used merged datazones (1650) to ensure comparability in terms of population size across countries[3] but what if the effects of deprivation “work” at a different spatial scale? The hypothesis on deprivation concentration investigates whether there are any effects on a larger spatial scale, but perhaps we should rather be looking at a smaller spatial scale. Within a deprived datazone it is possible that half of the population is living in a small area of extreme deprivation and half in moderate deprivation. If the degree to which this happens varies between countries – if there is greater polarisation in Glasgow than in the other cities – then we may approach an explanation. As the areas employed become smaller so we approach the characteristics of individuals as opposed to areas. This is not to say that area deprivation is unimportant; it is quite likely that we are talking about an interaction between the individual and the area. Moreover, whilst studies involving deprivation have tended to focus on the concentration of deprivation, it could be that measures of clustering or segregation also have a role to play.[7]

Health behaviours must play a role in the higher mortality rate seen in Glasgow. Alcohol and drug use are clearly implicated for two of the causes of death, and are recognised risk factors for suicide[8] and violence.[9] So either the risk factors differ between the cities within areas of equal deprivation or the relationship between the risk factors and subsequent mortality differs; in some sense this might relate to the hypothesis of different cultures of substance misuse. Although several studies have shown that risk factors do not appear to differ after taking deprivation or socio-economic status into account[10-13], these are based on survey data and the possibility remains that selective misrepresentation differs between countries or that the characteristics of the non-respondents differ.

The last hypothesis we think should be considered in more detail is deindustrialisation. Such an explanation takes both of us out of our comfort zones, being beyond our areas of expertise, but it is quite likely that health researchers generally are being overly simplistic if we consider that just because the three cities underwent deindustrialisation that this means that their experiences were identical. Indeed, what their industrial activities comprised may well have influenced their experiences of deindustrialisation. There are of course recognised similarities between the cities in terms of industrial activities but also differences: Manchester’s cotton industry along with engineering, mining and chemicals[14]; Liverpool more a commercial rather than manufacturing centre[15]; with Glasgow with a major focus on iron and steel production and heavy manufacturing (train and ship building) and mining.[14]

Where might we look for evidence to support or disprove these hypotheses? It would be possible to consider analyses similar to those that have currently been undertaken based on alternative (smaller) area sizes. The biggest single obstacle to such research is the difference in the geographies used in England and Scotland; the need to use areas of comparable size would necessitate the creation of a new geographical unit and associated deprivation index. Moreover, the MAUP means that whilst new evidence at a smaller spatial scale might disprove the existence of a “Glasgow effect”, a failure to explain Glasgow’s higher mortality rates with any chosen geography will not alter the fact that a different choice of area definitions might lead to a different answer.

The eventual linkage of the Health Survey for England to Hospital Episode Statistics will create a dataset comparable to the Scottish Health Survey-Scottish Morbidity

Records linked dataset.[16] This will permit the testing of the equality of the relationship between risk factor exposure and subsequent outcomes (hospitalisation and mortality). This is certainly the place to start before proceeding to test the idea that non-respondents may differ between cities.

To further the work on deindustrialisation we believe it will be necessary to broaden the field of researcher involvement, involving historians and social researchers among others to consider a more nuanced analysis of the experiences of deindustrialisation. This should fit within a life course approach to inequalities; that is to say, the period and stage of the life course (including inter-generational effects) at which one experiences adversity or insult will impact on the response and subsequent health outcomes. Such an approach would also fit with the call for greater consideration and theorising or hypothesising how different historical or social contexts might shape individuals' experiences and produce different health outcomes.[17,18] We would also suggest there is a role for qualitative research to investigate these questions and explore in depth the similarities and differences in experiences of living in these three cities.

In conclusion, it appears that we are necessarily talking about an interaction between the individual and their context, and all of the above approaches are dependent on being able to match individuals and contexts between cities. We also note that, given the plausibility of many of the listed hypotheses, any hypothesis should not be discounted if it is "only" found to explain 10% of the "Glasgow effect"; an accumulation of several such effects may amount to an explanation. And we return to the issue of timing and a life course approach; are we talking about a single effect that impacts on all of Glasgow's inhabitants with unusual even-handedness or can observed differences between subgroups defined by age, sex, socioeconomic status or ethnicity provide clues as to the action required to improve the health of the city's population? It seems unlikely that there is one single underlying explanation, and consequently we need to think not just of more complex analyses but also to gain a better understanding of the social history of Glasgow and its comparators. The paper by McCartney et al invites us to do that.

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The Scottish Effect: some comments

Annette Hastings

Professor of Urban Studies, School of Social and Political Sciences,
University of Glasgow

We need to understand why the Scots die younger. Not only because answering this question will mean that new, more appropriate forms of intervention can be devised to ensure that Glasgow's disadvantaged people only die at the rates 'enjoyed' by the more disadvantaged parts of Manchester or Liverpool's populations. But also because explaining Scotland's excess mortality is part of the quest to understand how social and economic vulnerabilities synergise into processes which lead to unequal health outcomes. Scotland's excess mortality is an anomaly – and therefore the subject of much scientific interest. However, the study of the Scottish Effect remains, at its core, the study of why such a strong association between class fraction or deprivation decile and mortality should pertain across the UK and beyond. From a research point of view – and it may seem strange to say this – the fact that the Scottish Effect exists is a good thing. It may mean that the scientific curiosity that the anomaly arouses has the capacity to drive research forward in the broader arena, with a potentially greater impact on health inequalities. For, as the *Towards a Synthesis* paper so vividly demonstrates – in trying to understand why the Scots die younger, both the complexity and social and economic embeddedness of health inequality is given the profile and scrutiny it deserves.

The *Towards a Synthesis* paper is very welcome. It presents a rich and complex web of inter-related hypotheses, any or all of which could be part of the explanation for Scotland's excess mortality. Indeed the very complexity of the mid-stream and upstream sets of hypothesis raises a preliminary question: if health inequalities and outcomes are as over-determined as is presented in this paper, then should we not expect local variation, anomaly, perhaps further unexplained 'Effects' elsewhere? Vulnerabilities are clearly contingent and the way they vary will matter for the cogency of an individual explanation, as well as for how a range of mechanisms will interact and synergise. The paper of course recognises this, but could perhaps make more of it. Should we expect to find more Scottish type effects in other places? Emerging over time? This would seem to be the logic of the argument.

It is intriguing, however, that the paper, despite its emphasis on complexity and on upstream vulnerabilities and triggers for explaining the Scottish Effect, nonetheless ends up presenting working class Scots in what could be read as a rather familiar culturally pathological vein, characterised by disempowerment and hopelessness, alienation and boundlessness. This representation is most evident in Figure 3 which presents a simplified picture of the synthesis of the cause of higher Scottish mortality from 1980 onwards (i.e. the later, more intense divergence) and is also evident in some of the related discussion. The story told here is of a population which was attacked when it was already down, whose members failed to fight back and rather collapsed in on itself in an acquiescent, viciously self-fulfilling set of pathological behaviours. By this means a whole set of destructive (largely alcohol and drugs related behaviours) was overlaid on already problematic levels of cardiovascular, respiratory and other disease.

It is important to problematise this deficit model of working class Scots, not least because cultural explanations for the causes of poverty and its associated effects have tended to pre-dominate outwith the academy (Hastings, 2004; Matthews, 2010.) Further, within academic scholarship, there is an ongoing dialogue between upstream structural explanations and those which emphasise the cultural and social characteristics of the poor as an explanation for their situation (see Small et al, 2010 for a useful review). As it stands, the Synthesis does not acknowledge this debate as much as it might. It is even conceivable that its message could be appropriated by those who do explain inequality and its effects by giving centrality to the deficiencies of the poor.

Two key concerns arise from my reading of this paper. These relate in particular to the framing of some of the hypotheses considered in the central part of Figure 3.

The first is that there is an alternative story to be told about how ordinary Glaswegians responded to what the paper argues was the “attack” made on the organised working class in the period post-1979; a working class made already vulnerable to such an attack by its political culture and industrial dependency. The Synthesis frames the Glasgow story as one in which there was substantial accommodation with a neoliberal, de-industrialisation and de-municipalisation agenda, although it does not make explicit accommodation by whom. In Collins and McCartney (2011), in which two of the authors explore the political attack hypothesis in more detail, the “connective routes between political attack health outcomes” are expanded upon. Crucially, the more expansive list makes it clear that there are further intermediary mechanisms between the attack and the response of working class Glaswegians, including the reaction of city governors, a harshening welfare regime, increased social and economic polarisation and so on. By omitting or backgrounding these key elements in the causal pathway between attack and health outcomes, the Synthesis paper appears to suggest that working class Glaswegians simply capitulated in the face of an inevitable, unstoppable force.

There are other elements in the alternative narrative of how Glasgow responded to the attack. There was, and still is, significant resistance to the imposition of agendas perceived as alien to the local socio-political culture. Some of this resistance has been highly politicised and high profile, such as the anti-poll tax campaign (Burns, 1996), the campaign against the transfer of Glasgow City Council housing stock to the Glasgow Housing Association (Defend Council Housing, undated) or, more recently, the support shown to the Jaconelli family as they were displaced to make way for development associated with the 2014 Commonwealth Games (Porter, 2009). Less high profile, but perhaps more ingrained in working class communities across the city, is the story of locally based community activism and self-provision in the city’s most disadvantaged neighbourhoods. Viewed as accommodation by some, but as resistance or appropriation by others (compare, for example, Clapham et al, 1989 and McKee 2010) these stories deserve at least to be recorded as part of the history of how Glasgow responded to political attack. Examples include the organised community in Castlemilk taking to the stage wearing T-shirts emblazoned with the slogan “Poverty is the issue!” in front of government officials there to announce an initiative designed to root out a perceived dependency culture (Hastings et al, 1996). Or the army of ordinary people who have shaped the Community-based Housing Association movement in the city to deliver not privatised housing, but locally negotiated solutions to historically severe levels of housing and social need, as well as a sense of individual and collective efficacy for those involved (Clapham et al, 1989). Crucially, whether we evaluate these

as acts of resistance, appropriation or accommodation, they remind us that the story of Glasgow is not of simple acquiesce but of an attempt to assert agency in the face of substantial wider forces. And clearly resistance as well as acquiescence can have health effects. Purely anecdotally, the history of community activism in Glasgow is partly a history of the 'burn out' and early death of a number of prominent individuals active in the organised community.

The second is that an important finding in the broader 'Scottish Effect' research programme is that excess mortality does not simply pertain amongst disadvantaged Glaswegians, but also among more affluent parts of the population, albeit it to a less substantial degree (Walsh et al 2010). Yet the Synthesis does not mention it. That there is also a 'Scottish Effect' in relation to the affluent is not only intriguing in itself (and deserving of its own Synthesis?) but also because of what it potentially has to say about the explanations offered in this paper about the mechanisms affecting the poor. Indeed, the narrative presented in Figure 3 is not plausible when the excess mortality of the middle classes is added into the mix. Instead, it becomes necessary to think of a different set of mechanisms to link 'attack' to deleterious health outcomes. Among these might be withdrawal into the home or privatism (See Watt, 2009). Related to this, and at a socio-spatial scale, is what Atkinson (2006: 829) has called the wider "disaffiliation" of the middle class, motivated by fear and a search for social affinity. This describes how, as real incomes have risen, large scale withdrawal into enclaves has become more pronounced. A typology is offered which sets out different forms and degrees of disaffiliation as they are practiced by different household groups, income levels and so on. These range from 'insulation', 'incubation' and (self-) 'incarceration' and are exemplified by residential choices from pioneer gentrification to gated communities. The first thing to note about these mechanisms is that they are agentive. They imply some attempt to take control or to shape a response. Arguably, they might also act as protective mechanisms, effectively sheltering the middle classes from the consequences of the massive social and economic change visited on working class populations. Finally, however, whereas these mechanisms might be protective of the middle classes, they might also further damage those in more disadvantaged settings by narrowing the social networks of those left behind, and undermining local institutions and capacities. (See Wilson, 1987 for discussion of the damaging effects of increasing socio-spatial segregation in US cities.)

To conclude: the Synthesis is an extremely valuable contribution to theorising the complex web of mechanisms leading to the severe social and economic conditions endured by too many Glaswegians. However, a fuller account in this paper of the potential intermediary mechanisms between political attack and the local response would have de-emphasised the deficiencies of ordinary Glaswegians. In further work, new hypotheses could be explored which place disadvantaged Glaswegians in an agentive role (such as resistance and appropriation). And finally, an additional synthesis focused on explaining how the Scottish Effect plays out for affluent Glaswegians could also have value. In particular, such an exercise could further elucidate how middle class disaffiliation may not only protect the health of the middle classes, but may also damage the health of the poor. Arguably, empirical research on such an intermediary mechanism would have an application beyond Glasgow and the Scottish Effect. There is the potential to add significantly to understanding of the health and other impacts of increased social polarisation and thus to drive forward even further the agenda on the determinants of health inequality.

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Towards a Critical Understanding of the Politics of Ill-Health in Contemporary Glasgow

Chris McWilliams

School of the Built Environment, Heriot Watt University

West-Central Scotland and Glasgow in particular has for decades experienced ill health and premature death rates higher than most parts of the UK (Walsh et al., 2010). The Clyde Valley Regional Plan (Abercrombie and Mathews, 1946) is a potential landmark document which recognised the so-called 'Glasgow Problem' at the end of the Second World War. This 'visionary plan' identified over-crowded slum housing conditions as a key contributor to poor health among local citizens. In 1945, Glasgow was the most over-crowded city in Western Europe, with three-quarters of the total population (1.2 million in 1941) living within less than half-a-mile of the city centre (Mooney, 1999). The task to sweep away the slums through comprehensive redevelopment was enormous. However, the dream of a brighter modernist utopian urban future was never fully realised. A messy political hybrid comprising of the Clyde Valley Regional Plan (Abercrombie and Mathews, 1946) and the Bruce Plan (Bruce, 1945), (which focused upon inner city slum clearance, building new towns, peripheral housing estates and high-rise housing), was for the most part largely unsuccessfully implemented (Boyle et al., 2008). To paraphrase Engels (1978) the solution to Glasgow's housing problem was to move it around, as new housing areas (e.g. Easterhouse) soon became problems in and of themselves. From 1945, an expanding Keynesian welfare state sought to actively change individual quality of life through the physical transformation of the urban environment and by implementing concerted public policy initiatives such as the introduction of a free national health service. By the 1980s, the long deindustrialisation of Glasgow and the West of Scotland left behind a legacy of unemployment, poor housing, a bleak industrial and polluted wasteland and increased morbidity and mortality rates among the poorest of its residents (Boyle et al., 2008). The post-war utopian dream had given way to a dystopian nightmare and the state had become an agent of 'compassionate wounding' (Sennett, 2003). The challenge to and rejection of Keynesian ideas resulted in the emergence of a neo-liberal agenda which sought to reduce the role of the state and public expenditure, dismantle inherited regulatory landscapes from previous eras and restructure welfare provision towards marketised and private provision. In short, the state was strongly implicated in generating many of the problems in need of addressing. In Glasgow, the local authority began to more openly court the private sector in its attempts to regenerate the city (Boyle et al., 2008). Thus, governance was to replace government as the motif behind regeneration approaches (McWilliams, 2002).

The first phase of neo-liberalism was characterised by 'roll-back' state policies (Peck and Tickell, 1995). Although its impact was uneven within the UK, this was exemplified by the massive reduction of council house building and the selling-off of existing stock (through the Right-to-Buy at discount prices). Privatisation of state assets such as gas and electricity came to dominate the public policy agenda (Murie and Malpass, 1999). Crucially, the reduction of key services and public goods and the erosion of working conditions and opportunities were very detrimental to those areas of Glasgow which

were experiencing the worst excesses of contemporary economic restructuring. This was most notable in the peripheral housing estates (e.g. Pollok) and many inner city neighbourhoods (e.g. Govan). Politicians and decision-makers looked towards trickle-down economics, where wealth and opportunities generated at the heart of the city were supposed to flow-down to other less fortunate areas. However, trickle-down 'solutions' far from helping to solve problems in Glasgow had in effect accentuated them (Mooney, 2009; Boyle et al., 2008). Neither the welfare state from 1945-75, nor Thatcher's neo-liberal policies in the period from 1979 has addressed 'social exclusion' (Boyle et al., 2008).

In spite of Glasgow's reputed post-industrial renaissance, socio-spatial poverty and deprivation has remained persistent and has in fact worsened among many communities (Dorling, 2010). By the late 1980 and early 1990s a second phase of neo-liberal welfare policy emerged and was designed to manage those disenfranchised by earlier waves of 'roll-back' neo-liberalism. This was more characterised by specific 'roll-out' state initiatives such as New Life for Urban Scotland (launched in 1988) and more recently Community Planning Partnerships (Boyle et al., 2008). Recent state approaches to 'include' communities reflect the deepening problems of a dual society, with its focus on encouraging city competitiveness and participation of the excluded (McWilliams, 2004; McWilliams et al., 2004). Thus, while Glasgow city centre is partly renewed where private capital flourishes, the peripheral housing estates and other locations of deprivation are more characterised by widespread poverty, poor housing, ill-health, premature death rates, and social alienation (Gray and Mooney, 2011; Boyle et al., 2009; 2008).

Harvey (1996) has argued that the city and the urban question have all but disappeared from political discourse. In Glasgow, for example, the lack of serious attention given to three (Pollok, Easterhouse and Drumchapel) of the four peripheral housing estates is evidence of this neglect. Thinking on urban issues has focused on how best to escape the consequences of the urban poor 'who are always with us', or how to protect and secure the rich's interests from the surrounding urban squalor. Urban policies in Glasgow have aimed to attract new wealth and capital within the city centre and have also enacted initiatives (e.g. social inclusion partnerships) to manage 'problem' areas and social alienation. More recently, the current coalition government's austerity measures (most notably public expenditure cutbacks) will undoubtedly accentuate Glasgow's inequality gap even further. The continual rolling back of welfare entitlement and rolling out of workfare and state surveillance of the poor, is having a very uneven spatial impact in areas such health and educational opportunities (Gray and Mooney, 2011).

While the 2007 financial crisis put into sharp focus the weaknesses and limitations of neoliberalism, there was a missed opportunity for progressive politics to change the terms of debate and escape the straightjacket of neoliberal policy reforms. Instead, cities like Glasgow have had to accept deeper cuts and measures and business-as-usual politics. In some sense, the recent economic depression can be viewed as a private crisis, where there are few visible or outward signs of the true underlying problems experienced by individuals and local communities. However, this clearly masks the daily reality that the crisis is being internalised by individuals and families, where recent coalition government claims that 'we are all in it together' rings hollow. As evidenced by Popham et al's (2010) research the health consequences of this across cities like Glasgow could potentially be very detrimental and largely negative.

Comparison with other former industrial cities like Liverpool and Manchester may be potentially fruitful in helping to shed some light on Glasgow's appalling health and premature mortality rates. However, it is important not to seek to simplify the complexity of reasons in pursuit of a deeper more nuanced understanding of 'actually existing health problems' in these three cities. While the three cities are clearly different in many respects, they do share some similarities such as their population size, their local economies were also once dominated by traditional industries (such as shipbuilding and port-related functions in the case of Liverpool and Glasgow, and industrial factories in Manchester) and they were politically controlled by the Labour Party throughout the 1980s. Thus, a key question worth exploring is to what extent do local political responses to the emergence and development of neoliberalism differentially impact upon individual health and mortality rates (see Collins and McCartney, 2011).

The approach of Liverpool (and to a lesser extent Manchester) to the emergence of a neoliberalist agenda from the early 1980s was to politically resist and continue to pursue urban managerialist policies, in the face of ever increasing centrally imposed budget reductions and fiscal constraints (Peck and Ward, 2002). This stands in contrast to Glasgow's more open acceptance and 'embracing' of neoliberal ideas (Boyle, et al, 2008). Liverpool and Manchester were viewed by the Thatcher government as 'problem' cities, not least because they sought to pursue policies which were opposed to centrally imposed cuts in welfare, jobs and local services (Quilley, 2002). The emergence of what became known as 'local or municipal socialism' (Boddy and Fudge, 1984) which focused upon attempting to pursue alternative strategies such as proactive local economic development strategies (Eisenschitz and Gough, 1993) in the face of a systematic economic crisis, placed an emphasis on addressing acute social and economic problems. Glasgow, unlike Manchester and Liverpool, could never be regarded as part of the progressive 'new urban left', and should be more appropriately viewed as embracing pragmatic neoliberal ideas (McWilliams, 2002). While the new urban left's strategies may have been derided as amounting to little more than attempting to 'drain an ocean with a tea spoon' (Cochrane, 1983), they did have a symbolic impact in that they suggested that (for a short while at least) in cities like Manchester and Liverpool there was an collectivist alternative to Thatcher's individualist agenda (Peck and Tickell, 1995). However, by the latter half of the 1980s 'urban entrepreneurialism' had all but replaced earlier managerialist approaches in addressing city problems as the neoliberal turn became embedded (Harvey, 1988). Increasing emphasis was now placed upon creating the optimum conditions in which capital would flourish, especially within city centre areas. The rise of public-private partnerships (which foregrounded the role of the private sector) symbolised a 'new' way for promoting and marketing de-industrialised cities such as Manchester, Liverpool and Glasgow. However, the 'bricks and mortar' property-led regeneration lacked not just a social dimension (Turok, 1992), it did little to alleviate poverty and high levels of unemployment in both cities. This can be witnessed by the failure of the Liverpool Docklands Regeneration Programme, which widened the inequalities between affluent and deprived neighbourhoods (Parkinson, 1989). For example, in Manchester the rise in ill health (especially mental illness) and mortality rates was most notable amongst the poor (Herd and Patterson, 2002; HMSO, 1998).

Liverpool's urban decline throughout the 1980s could be regarded as even more dramatic than Manchester's. Political leadership of the city throughout the early stages of the 1980s was in the hands of what became known as 'Militant Labour' (subsequently expelled by the National Executive Committee of the National Labour

Party in 1985). Liverpool City Council's strategy was to fight and fiercely resist swingeing cuts which the Thatcher administrations sought to impose (Taaffe and Mulhearn, 1988). The 1981 Toxteth riots in the city symbolised a deep-rooted urban malaise, social alienation, and institutional racism that was experienced by a large section of the working class (Parkinson, 1989). The city was largely united in rejecting emerging Thatcherite neoliberal policies. According to Taaffe and Mulhearn (1988) community solidarity and the sense of collectivism which was clearly evident in the city during much of the 1980s may have helped to mitigate the worst excesses on individual health and premature mortality rates. However, closer examination is required to ascertain its precise impact upon ill health and death rates amongst local populations. Partially, as a result of local political resistance and uncertainty of accumulation, capital took flight and left the city in collapse as the local docks and port-related employment went into terminal decline (Murden, 2006). While the public sector sought to fill the void through local-government led projects (most notably public sector house building programme) it was almost impossible to regenerate the city as public expenditure cuts hit severely and fell disproportionately on the most disadvantaged communities. The 1980s and much of the 1990s in Liverpool were characterised by high levels of unemployment and poverty (Murden, 2006). Liverpool's illegibility for European Union Objective 1 Structural Funds (notable as the only area in the UK to be bestowed such status) by the early 1990s highlighted the deep seated and seemingly intractable problems of the city. However, the main benefactor of the additional funds was city centre businesses rather than Liverpool's many disadvantaged communities (Kenyon and Rookwood, 2010).

To critically examine the overall effect that contemporary urban restructuring has had on the health and welfare of local communities is a very challenging task. For example, the impact of neoliberal policies is geographically very uneven. Neoliberalism promoted a growth-first approach to urban development, rendering social-welfarist approaches and arrangements, and redistribution and social investment as deeply antagonistic to the overriding objectives of economic development (Brenner and Theodore, 2002). This has created more fragmented and unstable urban environments (as witnessed in Glasgow, Liverpool and Manchester) in which the richest have benefited most and the poorest the least, a situation which has deteriorated even further with rising poor ill health and premature death rates (Walsh et al., 2010; Dorling, 2010).

Conclusions

There can be little doubt that politics and public policies, particularly the pursuit (or even resistance to) a neoliberal agenda, will continue to play an important part in influencing the health and death rates in the city of Glasgow. Glasgow has high premature death rates even when compared to similar former industrial cities in the UK (e.g. Liverpool and Manchester) (see Walsh et al., 2010). Thus, there is a need to conduct further research that explores cross-comparisons between Glasgow, Manchester and Liverpool in terms of how these former industrial cities have sought to manage urban change since the late 1970s under the influence of a neoliberal agenda and also an analysis of how the links with death rates have unfolded within these cities. Thus, it is now time for a more thoughtful and critical analysis of 'actually existing health' and overall personal well-being and how this is manifest differently in different locations throughout the contemporary city.

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Response to Accounting for Scotland's Excess Mortality: towards a synthesis

Sue Laughlin* and Jackie Erdman**

* Formerly Head of Inequalities and
Health Improvement, NHS Greater Glasgow
and Clyde

**Corporate Inequalities Manager, NHS Greater Glasgow and Clyde

Introduction

Glasgow has been characterised by poor health for many generations and the persistence of this situation is extremely troubling. As such, it has been the focus of a range of policy interventions, none of which have apparently affected Glasgow's pattern of poor health.

The study of the Scottish/Glasgow effect established by Hanlon et al and now presented in the synthesis paper by McCartney et al has usefully forged a link between sociology and public health, to better understand the causes of health inequality. In our view it is likely that a variety of factors have combined in the crucible of an urban environment to create a 'Glasgowiness', as opposed to a 'Liverpoolness' or 'Manchesteriness', which we might never fully explain. The Glasgow Effect is in many ways the tip of the iceberg in relation to the causes and consequences of the health gap in Glasgow. Any solution we can come up with needs to tackle the whole problem. The Glasgow effect may be a useful way to engage people in a renewed debate on health inequality and the structural causes.

This response is based on concerns about the manifestation of power and people's experience of 'otherness' based on either individual or combinations of different identities. It is intended to form the basis for future discussion by suggesting that any research into the Glasgow effect and subsequent interventions could be strengthened by-

- ⌚ Adequately explaining the impact and experience of social identity in Glasgow, particularly in relation to gender, class and the experience of otherness
- ⌚ Giving consideration to the ways in which local health, economic, social and cultural policies have addressed or entrenched structural gender and class inequality in the city
- ⌚ Illuminating people's lived experience in Glasgow by examining it through the lens of class, gender and otherness

Our view would be that no amount of quantitative measurement of deprivation will allow us to explain its actual impact on health and mortality. However, understanding the particular experiences of gender, class and otherness in Glasgow, or indeed any city, are essential in constructing better responses in the future.

Understanding the social make-up of Glasgow: The impact of gender and class

Gender

As in all cities, the majority of people's experience of living in Glasgow is affected by otherness, whether as a result of being working class, Black, the wrong gender (female), young, old, gay, or the wrong religion. Otherness is a manifestation of persistent structural inequalities and the relationship between different groups of people with and without power. This affects the development of city life, city space, city culture and other factors that impinge on health. Gender is a social construct that defines masculinity and femininity. Gender both shapes and is shaped by the urban environment (Jarvis, Cloke & Cantor, 2009).

The contribution of gender is rarely considered by policy makers as a major influence on the culture and decision making within a city although it has been suggested as one possible factor in the Glasgow effect.

There is a considerable body of evidence to suggest a strong and persistent West of Scotland male-oriented culture which has created Glasgow 'hard men' who "held traditional male ideals emphasising hard living, competitiveness and emotional detachment" (Gillon, 2010) and has meant 'women and children last' (Craig, 2010, p. 151). Gender socialisation and inequality affects the health of both women and men – women through their experiences of the caring burden and gender based violence and men through experiences of gender based violence in childhood and risk taking behaviour in adulthood.

Craig highlights that gender differences were magnified in Scotland partly by women's weak position in the labour market (Craig, 2010, p.147). Dundee was an exception to this with two women working for every man at the height of the jute trade between mid-nineteenth century to after World War I. A comparison between Dundee and Glasgow might be useful in uncovering the effects of this gender difference in relation to work and gender roles in the home.

Evidence suggests that women are going to be more affected in the current recession, which will again weaken their position in the labour market (The Guardian, 2011). There are few signs that Glasgow is doing anything differently to prepare for this impact on women and children.

Gender socialisation also has an impact on male attitudes to homosexuality. Ralph Glasser's autobiography of growing up in the Gorbals exemplifies past and possibly current attitudes;

"Homosexuals were thought of as less than manly – the demotic use of the word "pansy" conveying effeminacy, the opposite of aggressive, muscular masculinity, the only proper kind. For a 'normal' man to be approached – made a pass at – by a pansy was a terrible affront to which proper response must be violence, incontrovertible proof that he was not 'so'" (Craig, 2010, p.145)

Ben Campkin in his work on homophobia and cities discusses the dichotomy between increased tolerance of homosexuality on the one hand and rising hate crime on the other. He sees sexuality and gender as part of the continued spatial, minority identity and value struggles between communities in the urban environment (Campkin, 2010, p. 6).

In her essay on soccer and ethno-religious bigotry in the Scottish press, Irene Reid examines another aspect of 'otherness' linked to religion, racism and masculinity. Her critique is based on media characterisations of Neil Lennon of Celtic FC in 2005, which have been amplified in recent weeks with escalating violent attacks towards Lennon. She concludes that

"The discourses of 'outsider' and 'otherness' that surround Lennon, Celtic FC and the Irish Catholic community expose the myth of Scotland's collective self-image as an egalitarian and inclusive society." (Reid, 2008, p. 64)

The impact of gender on the lives of women and men in Glasgow merit a central role in understanding health outcomes and in formulating a way forward.

Class

Despite Glasgow's image as a working class city the experience of class is missing from most analysis of Glasgow's poor health. Analysing health outcomes by socio-economic status does not uncover the impact of class on health. People who grew up in Possil might end their days in Bearsden due to greater social mobility between the 50s and the 70s. However, their experience of class will still have an impact on their health.

The experience of class in Glasgow has been built into the fabric of the city, with areas of extreme deprivation and wealth side by side. These invisible boundaries are described as class 'apartheid' by Cathy McCormick, who has been a housing activist in Easterhouse since the 70s, in her autobiography (McCormick, 2009). In other words, class is about the experience of 'otherness' or lack of power, not just about the impact of material or relative poverty.

The experience of class power has been played out in the workplace through a combination of reduced working conditions, increased privatisation and reduced unionisation during the 1980s and 1990s. In his study of the construction industry and the enduring number of annual deaths Erik Sutherland points out that

"By 1989 trade union density had fallen to around 30 per cent, while strike activity fell massively from 281,000 days in 1980 to only 1,000 days in 1993. (Sutherland, E. p. 14)

Health behaviour approaches have consolidated class differences leaving the structures which created them untouched. This particular form of health divide is illustrated by Cathy McCormick

"It was a Saturday in May, 1988 and it was at the Postgraduate Medical Centre in Lancaster Crescent, a leafy Glasgow Street off Great Western Road. The conference was "The Health Divide-Distribution of Health Care".

Galbraith was talking about Glasgow's appalling health record and how we need to get 'these people' to change their lifestyle. I was raging" (McCormick & Pallister, 2009, p. 80).

The effect of gender and class on the city and the people living in it

If we accept that Glasgow is defined by its particular gender and class makeup and that this has a profound effect on health, then the political, economic and health related interventions over the past 50 years have to be examined. Policy problems like health inequality have been called wicked problems (Rittel and Weber, 1973). As Hunter states, "Wicked issues have complex causes and require complex solutions" (Hunter, 2009). However, people in Glasgow have felt excluded from defining the problems and creating the solutions to tackle health inequality. MacCormick's sense of otherness by dint of her social class, her gender and her location in an area of supposed regeneration is a common experience for those Glasgow residents that experience the poorest health.

Crawford et al in their 2007 report 'Will Glasgow Flourish' examine the relationship between city regeneration and health and highlight that, far from reducing health inequalities, decisions to support private sector projects over public sector investment risk widening them (Crawford et al, 2007, p. 66).

Boyle et al point out that the experiment in Glasgow in terms of slum clearance and the creation of peripheral estates was based on class delineation. Decisions made by Glasgow councilors which at first seemed to offer hope gave way to a

"dystopian nightmare and, in the words of Richard Sennett (2003), the state had unwittingly become an agent of 'compassionate wounding'" (Boyle, McWilliams & Rice, 2008, p. 315).

If local regeneration policies and employment practice can be shown to perpetuate or even extend the class divide, has there been more success in breaking down gender stereotypes and gender inequality? There are few studies on this but there are some markers that change is slow. Despite myriad women's committees and women's policies, only 25% of Glasgow councillors are women. Gender based violence remains a persistent problem – as evidenced by recent attacks in the city centre. Lack of equality over pay and the double role of home and work continues for women. Glasgow pioneered a Women's Health Policy that placed gender inequality at its heart but at best it remained of only marginal influence (Glasgow Women's Health Policy, 1992).

Doing something different

If, as we argue, the precise causes of the differences between Glasgow, Liverpool and Manchester may never be found but rather, the interplay between class, gender, history and local politics take subtly different forms, which then manifest themselves in poor health, what is the best way to proceed?

The work on the Glasgow Effect has renewed an interest in Glasgow's poor health and its causal complexity. Its emphasis on the centrality of political and economic decisions in the construction of health is extremely encouraging and can be used to engage people in a different form of debate about health inequality, with gender and class as

an underpinning dialogue. In order to make progress with this, it is vital that the plethora of research into the historical and current development of cities is also taken into account. This gives people in Glasgow an opportunity to re-examine what a city and its institutions should look like in order to promote health for all its citizens.

It is our fear however that the difficulties and unpopularity of addressing issues of power and otherness are so great that we will see a perpetuation of initiatives and developments which are designed to affect health behaviours rather than tackle the structural causes. If this occurs, we will still be engaged in the same discussions about Glasgow's poor health in another 30 years.

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