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HEALTH AND HEALTH-CARE IN WEST CENTRAL SCOTLAND

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Health and health care in west-central Scotland have a grim fascination about them — 'a marvellous opportunity for clinical observations' as Professor Checkland observed recently. The first conclusion (if anyone still doubted it) is that the quality of health care provided has no relationship to the health of the community. Thus, in Glasgow we have the biggest burden of ill-health born by any city in Europe, and yet health care by doctors and hospitals and the practice of medicine in the area is agreed to be of the highest standard and "free at the point of consumption". To take one particular irony, the Infant Mortality Rate (IMR) in Glasgow is unacceptably high, and has been for some time, yet the care of the infants in paediatric hospitals and in the community is as good as anywhere in the world, and the hospitals have a considerable reputation in research circles. Similar praise for Glasgow obstetric care and research is often heard, and the personal care and privacy offered by the new hospitals is so high that private obstetric practice in west-central Scotland has vanished.

These facts are not brought forward to question the usefulness of the doctor in the relief of pain and suffering, but to point out that conventional health care does not influence the incidence of disease. Most perceptive health professionals (a phrase used to include doctors, nurses, administrators etc.,) would agree with this and further agree that pouring extra scarce funds into health care will not make any impact on the dismal health statistics of west central Scotland.

Let us look first at these facts and figures. There is no lack of data and using these figures we can then look at the reasons for the health problems of west-central Scotland and the likely hope of amelioration. The impact of the recent reorganisation of the NHS on health care will also be studied.

Indices of ill-health like the I.M.R. have to be used in discussions on health, since "good health" defies any measurement. Indeed the more closely "health" is looked at, the greater the semantic and clinical difficulties become. Michael Cooper in "Rationing Health Care" has summarized the evidence.[1] For example, only 25% of people questioned in one survey had no "illness" in the preceding month and multiple screening programmes show up more and more abnormalities in 'normal' people. Indeed, it has been truly said the only healthy person is one who has not been questioned or examined by a doctor. Moreover, as living standards rise the incidence of persons reporting minor illness and mental ill health increases, though the objective indices of health, like I.M.R., fall.

We must also assume that improvement in health and living conditions is both desirable and desired by the people involved. And yet those who think this is self-evident should reflect on the failures of the new Glasgow housing schemes to recreate the spirit of the inner city communities which they replaced. We should also note that those Highlanders who eventually benefitted in a material sense by the more humane of the Highland clearances to new coastal villages, pined for the squalor of their earlier way of life in the black houses of the inland glens.

Facts and Figures

Hoping that social improvements can be humanely achieved and accepting that the I.M.R. is a sensitive index of the health of a community, let us look at the figures on health, or rather, the absence of health. Table I shows the I.M.R. for the European countries including Scotland and Glasgow and some areas within it, together with the differences in I.M.R. between the social classes in Scotland. Figure I shows the distribution of the areas of unsatisfactory I.M.R. rates within the U.K. Not only is west-central Scotland a bad area, but it also contains some of the rare rural areas of high I.M.R. Maps for other aspects of health and even individual diseases such as coronary thrombosis show a remarkably similar pattern.

In summarising these figures it can be seen that the I.M.R. is higher in Scotland than in the U.K. and that within Scotland, Glasgow is disadvantaged. Within Glasgow the I.M.R. can approach unacceptable levels. The variations in I.M.R. by social

Table I

INFANT MORTALITY RATES PER 1000 IN 1972

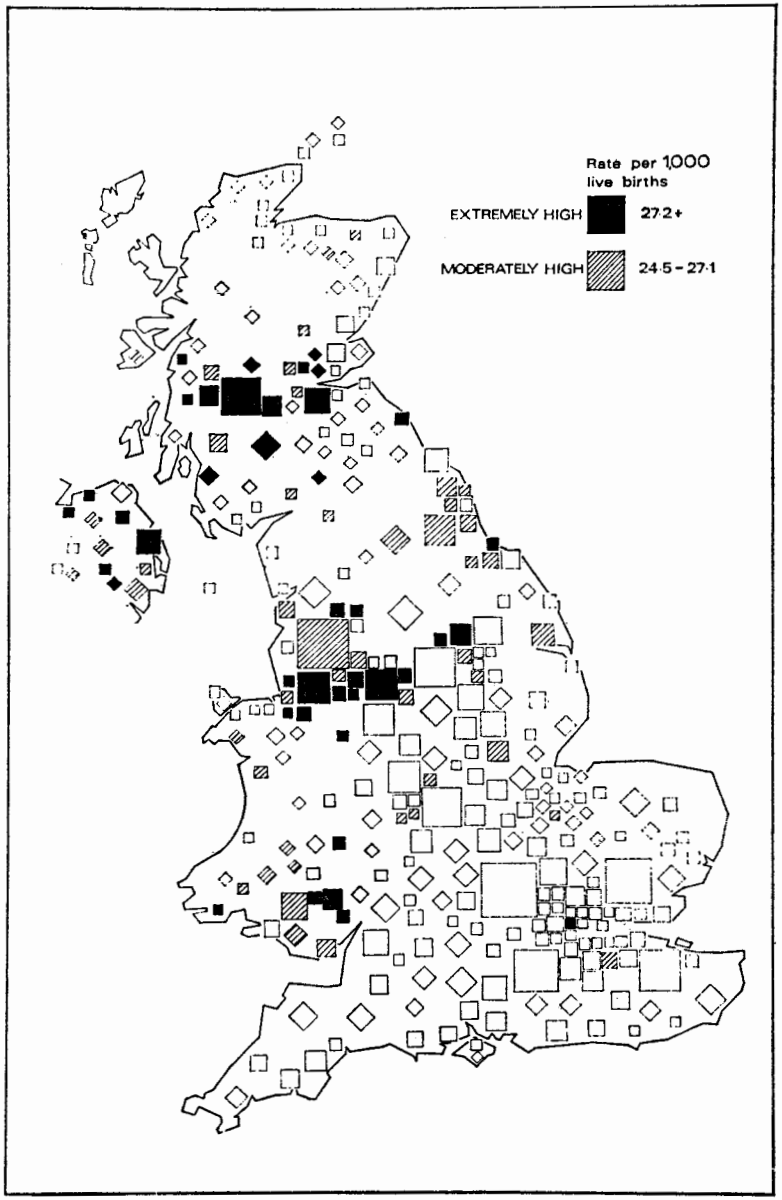
Portugal	50	Scotland All	19
		Social Class 1 10	
		Social Class 3 18	
		Social Class 5 24	
East-End Glasgow	50	England and Wales	17
Romania	42	France	16
Glasgow	23	Switzerland	14
Eire	20	Holland	11

Source: Annual Reports of the Scottish Home & Health Department and the Medical Officer of Health for Glasgow.

class are striking, and give statistical support to the impression that poverty and serious ill-health go together.

Analysis

Is the ill-health of the Glasgow area merely a reflection of the social class structure of the area? As the bourgeoisie fled to the suburbs (Bearsden, for instance, is not in the Glasgow area, for statistical purposes) or sought work in England, did they leave Glasgow as a preponderant working class area merely sharing the characteristic ill-health of working class areas elsewhere? This explanation would be a useful one for politicians since it would partly diminish the Glasgow 'problem'. On the contrary, it appears that it is not simply the class structure of west-central Scotland which gives the adverse figure. Figures from the Scottish Home and Health Department show that the social classes in Scotland have poorer health than their equivalent in England and Wales. For instance the health of Social Class 1 in Scotland is only equivalent to that of Social Class 3 in England and Wales and so on. Thus the poverty and deprivation of Social Class 5 is worse in west-central Scotland than elsewhere. The famous *'Census Indicators of Urban Deprivation: Working Note No. 6'* (originally a type-written document circulated in Whitehall, and courageously made public by some Glasgow socialists) gives statistics on social conditions in the Clydeside area.[2] It showed for instance that of the worst 1% areas of multiple social deprivation in the U.K. (housing a total of 400,000 people), 90% are in Glasgow. The report coldly analysed deprivation in different ways using single and multiple indices, and with different cut-off points, but Clydeside was the worst



area on every chosen measurement except one — the number of shared dwellings — for which Inner London was top.

Causes of Ill-health and Deprivation

If we accept that the ill-health of west-central Scotland has its roots in these uniquely adverse social circumstances, then the origins of this social decay are of interest, and are not hard to find. Though Glasgow was a prosperous city at the turn of the century and could boast of municipal services unequalled elsewhere, ill-health and over-crowding were already serious. In 1917, 11% of Glasgow houses had more than four persons per room, whereas in other cities in the U.K. this figure did not exceed 1%. Glasgow's poverty and over-crowding dated back to the time of the Highland Clearances and the migration of the people of the North to join the Industrial Revolution in the Clyde valley. As this heavy industry declined after World War II and as decay set in simultaneously in the vast areas of tenement buildings (all built rapidly at the time of Glasgow's greatest prosperity), deprivation settled on the Clyde valley.

In explaining contemporary health statistics, we can look at the industrial environment, over-crowding and sub-nutrition (malnutrition has now almost gone) and these can explain many of the problems, notably the amount of infectious disease in Glasgow, and the legacy of chronic bronchitis from air pollution. The excessive smoking and intake of alcohol in west-central Scotland is well known also and carries its own predictable toll of lung cancer, and alcoholism. The less obvious consequences of heavy drinking — road accidents, falls, brawls, self-poisoning, industrial accidents and absence from work — are also prominent in our area. That much of this burden of ill-health is borne by working class people is understandable, but some of the excessive afflictions of working class people which Table II shows are less easy to explain. The excess of coronary artery disease, duodenal ulcers and heart attacks in working class people is inexplicable (and dispel the popular myth that only executives are afflicted) and the greater incidence of stomach cancer is even more baffling. It is possible that malnutrition or pollution of some kind is a cause and that the types of food eaten may be a factor.

In explaining our figures on ill-health we have exonerated the health services as being in any way involved. Yet there is one way in which the health services can be blamed, or at

Table II

CAUSES OF MALE DEATHS FROM INDIVIDUAL DISEASES IN VARIOUS SOCIAL CLASSES, AS A PERCENTAGE OF AVERAGE MORTALITY

Cause of Death	*Social Class 5*	*4*	*3*	*2*	*1*
All Classes	+43	+3	Average	−19	−24
Tuberculosis	+85	+8	−4	−46	−60
Stomach Cancer	+63	+14	−1	−37	−51
Lung Cancer	+48	+4	+7	−28	−37
Coronary Disease	+12	−4	+6	−5	−2
Bronchitis	+94	+16	−3	−50	−72
Duodenal Ulcer	+73	+7	−4	−25	−52

Source: Scottish Home and Health Department Reports.

least involved in the record of ill-health. Table III shows the usage of the N.H.S. by social class and reveals that if we take dental care, eye care and immunisation rates as indices, working class people fail to use the therapeutic and preventive services

Table III

HEALTH OF SCOTTISH SCHOOLBOYS 1973

		% of schoolboys at age 5 suffering from: Refractive error in eyesight	Tooth decay	Height of schoolboys at age of 14 (in cm)
Social	1	3.7	6.7	158
Class	2	3.6	8.3	156
of	3	4.6	14.5	155
Parent	4	5.1	16.7	154
	5	8.6	21.2	152

Source: *Social Trends* No. 6 (HMSO, 1975).

HEALTH OF BRITISH SCHOOL CHILDREN 1965

		% of children never immunized against diptheria
Social	1	1
Class	2	3
of	3	3
Parent	4	6
	5	11

Source: Social Trends No. 6 (HMSO, 1975).

fully. Thus though the health service and preventive medicine are freely available, they are not equally used by all parts of the community.

The Way Ahead

The implications for attempts to improve the health of west-central Scotland are clear. Improvement in social conditions, notably housing, give the biggest hope for the improvement of health. With rising standards of living it would be hoped also that rising self-esteem and concern for family health might lead to less alcoholism, more concern for dental care, eye care, and higher immunisation rates. Increased spending on health education and government action on health hazards such as cigarettes, alcohol, fast and dangerous cars and food hazards will all contribute to better health.

We can return now to the role of the health services in the promotion of health. Having seen that extra expenditure on the conventional apparatus of health care (such as hospitals and doctors) is unlikely to reduce the burden of ill-health, is there a case for *cutting* health care expenditure in order to divert resources to promote these other expenditures which have an influence on health? The immediate answer is no, or at least, not yet.

This concept is not acceptable since the role of the health service in giving relief of pain and suffering is just coping with its own sharply defined problems at present. Nor could it be said that selective cuts, such as cutting out the expensive technology of modern health care (such as artificial kidney machines) is desired by voters since many members of the public are currently demonstrating clearly by their donations and charitable works that they wish treatment by kidney machines to continue. No political party could declare itself agaist kidney dialysis, nor could anyone calling himself a democrat advocate the reduction of the provision of kidney machines, since the people clearly approve of this form of treatment.

Help from the N.H.S. in dealing with ill-health may, however, come from another tactic. Attempts to improve the use of the N.H.S. by social class 4 + 5 of the services available might improve the health of the community. Since, as we saw above, these groups do not 'come and get it' then the N.H.S. may have to 'go out' into people's homes and place of work, as Sir John Brotherston has suggested. Interestingly enough,

this aggressive role was adopted by the early public health pioneers of Glasgow, who carried their zeal to the point of intrusion. With present day attitudes, this kind of health care might lead to discussion of the right to individual freedom, but the experence, say, of the aggressive unsought domiciliary visitation by family planning advisors in Glasgow is relevant, since their visits have been welcomed. It turns out that those visited (on the recommendation of social workers and others) had not sought contraceptive advice because of fear of the bureaucracy of clinics and health centres and fear and suspicion of doctors. It may not be flattering to regard west-central Scotland as an under-developed country, but it works.

The Organisation and Politics of Health Care

In the 1960s discontent arose over the managerial aspects of the National Health Service and there was concern that the three parts of the service (hospitals, general practice and public health) were separately administered. All observers agreed on these findings, and it led to the reorganisation of the N.H.S. In Scotland these changes occurred in 1974 under the N.H.S. (Scotland) Act 1972.

The changes brought about by reorganisation have now been widely criticised. Integration has been achieved at the administrative level, and at great cost, but little or no benefit at the clinical level has appeared. Worse still, the new administration has undoubtedly impeded clinical health care in many minor and irritating ways, and has led to petty bickering between the administrators and the administered. As for the effects on health care in west-central Scotland, public health (now renamed 'community medicine') was integrated into the Health Boards at the time of reorganisation and so it has lost touch with local government. Before reorganisation the Medical Officer of Health for Glasgow was a well-known figure, appointed by the corporation and his Annual Report was a major event in the life of the city. At times of epidemics or other threats to health, he was clearly the person in charge and success or failure was his responsibility. Not only was he seen to be responsible to the community, but he was appointed by, and responsible to, the Corporation of Glasgow. The reorganisation abolished the M.O.H. and diffused the responsibility to a series of "Designated Community Physicians." No annual report on health statistics in Glasgow or Strathclyde is now planned.

Not only did the reorganisation remove this small element of community control and accountability but it abolished the considerable lay representation on the old Hospitatl Boards. Before the reorganisation of the N.H.S., about 200 citizens of Glasgow sat on the various voluntary bodies and Boards of the hospital. These bodies were abolished by the reorganisation and each hospital and district has now only an administrative staff. Only at the level of the Greater Glasgow Health Board is there any lay help from the 15 or so people on the Board (all directly nominated). The effect of removing the N.H.S. from these minor grass roots democratic controls was realised during discussion of the Bill and a new watch-dog body, the Local Health Council (called a Community Health Council in England) was proposed late in the planning for reorganisation. These bodies (again directly nominated) have considerable powers, on paper, to question decisions of the Boards, but this comes at a late stage in planning, and they have no executive role. They have been in action in west-central Scotland for two years only and so far have made little impact and have not been much used by the public.

The steady reduction of lay influence (political and non-political) over direct care, planning and education within the N.H.S. is marked. The N.H.S. (Scotland) Bill leading to reorganisation was debated in 1972 in the Scottish Grand Committee and we can look back with interest to see if the many politicians who spoke correctly anticipated the changes it would bring. Disappointingly, almost all speakers took it for granted that great efficiency would result, though honourable exceptions were Bruce Millan (who argued for a single rather than double administrative structure) and Jack Dempsey who, in an aside, raised the fear of a growth in bureaucracy. The debate largely centred round municipal versus central control of health care and large numbers of Labour members spoke in favour of municipal control (e.g. west-central health care under control of Strathclyde Region or an elected body.) In the final vote on the Bill, however, only William Baxter voted against, a protest in which he now takes pride.

Overall, therefore, the N.H.S. in west-central Scotland, as elsewhere, has been progressively removed from public control and accountability.

This major organisation (budget in Scotland £400m/year) is now increasingly centralised and the remarkable fact in

Scotland is that, since the Secretary of State can have little day-to-day interest in the N.H.S., the central organisation in St. Andrew's House is run virtually without political control. The Health Boards beneath the Scottish Home and Health Department have a nominated membership and each chairman is appointed from the patronage list of the Government of the day. The Boards have no formal responsibility to or links with, local government.

This complete withdrawal of the Scottish N.H.S. from public accountability could be justified only if there were no contentious issues in health care today. On the contrary, the problems are steadily increasing and many are suitable for local democratic control. Thus to take two examples, the arrangements for out-of-hours medical help from general practitioners are rapidly deteriorating, and waiting lists for surgery can be long at one hospital and very short at a nearby one. The public are aware of these problems, yet cannot make their voice heard. At a national level the need for open debate is even more desirable, since the N.H.S. has agonising central decisions to make — kidney machines or convalescent homes, more doctors or more hospitals. At present these decisions are taken on behalf of the consumer by a small group of non-elected professionals. There may be advantages in this system, but it should be clearly labelled as undemocratic.[3]

Future Trends

The short term prospects for health in west-central Scotland are depressing. Unemployment and wage restraint are steadily lowering living standards and the sharp reductions in public spending will also contribute to increasing deprivation in the area.

The N.H.S. has been accustomed to annual increases of 10% or so in real terms but now has its budget frozen at 1976-77 levels. This budget restriction will be particularly severe in Glasgow, since the recent SHARE report announced new methods of allocation of N.H.S. money within Scotland and proposed a cut of 2% in the allocation to Glasgow. Ironically enough, the advisory mechanisms set up by the N.H.S. to advise on how to spend an increasing budget will now be called on to decide these priorities in reverse — i.e. where the cuts are to be made. The spending on hospitals and salaries will have to be maintained and hence the money spent on community health and

projects such as Health Education may suffer. The indices of health, such as infant mortality rate (I.M.R.) will be looked at anxiously in the next few years. If the I.M.R. were to rise, it would be a tragic indictment of this country's performance.

Looking further ahead prospects for health care are better, with the contribution to the economy to be made by North Sea oil. The uncertainty of Scottish politics raises further interesting prospects. Even the weak Scotland and Wales Bill would have given local political and professional talent the chance to try to do better with their budget.

Whatever the nature of Scottish Government in future, health and social conditions in west-central Scotland will present it with its greatest challenge.

REFERENCES

1. Rationing Health Care. Michael Cooper. Croom Helm 1975.
2. See "Areas of Urban Deprivation in Great Britain: an analysis of 1971 Census Data" in Social Trends No. 6 HMSO 1975.
3. For a contrasting view of the new structure see "The Reorganised Health Service: A Scottish Perspective," D. Hunter, in "Our Changing Scotland. A Yearbook of Scottish Government 1976-77."

Figure I: The Geographical distribution of high Infant Mortality Rate (I.M.R.) in the United Kingdom

Source: G. M. Howe, *Man, Environment and Disease in Britain,* David and Charles 1972.