Glasgows' Health
Old Problems - New Opportunities

A STATE OF COMPLETE PHYSICAL AND MENTAL WELL-BEING
THE ABSENCE OF DISEASE OR INFIRMITY

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FOREWORD

Glasgow the unhealthy city is a description that Glaswegians often hear. We have become used to finding that Glasgow tops the international league tables in illness and death. While many of the reasons for this are outwith the direct control of the city, over the past ten years there has been the development of many new alliances attempting to tackle Glasgows public health problems.

This publication has been developed from the annual reports of the Director of Public Health for Glasgow (1989 - 1992). The title ‘Glasgow’s Health: Old Problems - New Opportunities’ reflects the new developments in joint work on health issues that have been taking place in the city of Glasgow. Indeed this book is an outcome of some of those new ways of working.

Differences in health status within Glasgow are not a new phenomenon. Such differences and their relationship to socio-economic status were recorded, analysed and used to effect public health improvements many times during the 19th century.

John Strang in his annual reports (1855 - 1863) as City Chamberlain demonstrated marked differences in the levels of mortality between different quarters of the town, and concluded that:

‘there exists, within certain registration districts, causes more destructive to life than in other portions of the City’.

This type of analysis and advocacy for broad public health measures to deal with the problems identified were taken up strongly by the first two Medical Officers of Health for Glasgow, Sir William Gairdner and Sir James Russell.

Working within the city council they were able to use this information to support the development of a range of innovative approaches to public health, some of which we still have with us today, such as our water supply from Loch Katrine and the houses built by the City Improvement Trust.

The understanding that health in the city was the responsibility of all, and that it was shaped and developed by a wide range of environmental, social and personal factors, was understood by the early public health pioneers. Over time, as many of the gross inequalities in health outcomes were removed, as the quality of life for the population improved and as the health professions developed special expertise in many diseases, the broader focus of the public health pioneers tended to be put to one side.

Over the past ten years there has been a recognition that inequalities in health remain and are increasing. This has led to the development of what has been called the ‘New Public Health’ — a return to the concerns that were addressed by the Medical Officer of Health and the city council in the past: housing, environmental issues, the poor and disadvantaged. Here in Glasgow there are many projects that have developed to tackle these old but new problems.

As well as a describing the health of the city, this report highlights some of the innovative work that is going on both within the statutory services and in the community. Glasgow has been very successful in developing multi-agency approaches to health issues from within the cities own resources. If this work is to develop more support is needed from other sources. The report ends with a call to action for special status for the City to allow it to become a healthy as well as a cultured city.

G, D, Forwell
INTRODUCTION

The conventional attitude to health is that ill-health strikes at random and is dealt with, successfully or otherwise, by the health service. However, it is more instructive to regard health as a stock of capital with which we are all initially endowed, although in varying degrees; this stock depreciates through time and at an increasing rate in later life. Glasgow’s health problem, compared with Scotland as a whole, is that the years of life lost by premature death and disability are excessive. This effect is relatively more striking below the age of 65 than in later life.

The determinants of health include genetic endowment, standard of living, environment, lifestyle and health services. Of these, health services are by no means the most important. Greater Glasgow Health Board, as its name suggests, should be interested in all these determinants, although it has direct responsibility only for health services. Accordingly, it must find means of extending its influence on health in the city largely in association with a range of other agencies: community, voluntary and statutory.

The aim of this publication is to enlist even more support for the task of making Glasgow a healthier city. By showing that health is a concern for all organisations and individuals in Glasgow and giving a clear description of the range of factors that shape health in our city it is hoped that new healthy alliances will develop and that existing alliances will be invigorated.

700,000 of today’s Greater Glasgow population of 935,000 live in the City of Glasgow District and the health of this city population is poorer than that of the other four local government districts which together comprise Greater Glasgow. A one sentence summary of the health of Glasgow is that ‘we are born well and become ill’. This is a statistical fact, the explanation for which is likely to be multifactorial. However, adverse environmental factors are of paramount importance. It is striking that, within the boundary of the Greater Glasgow Health Board, there are Eastwood and Bearsden and Milngavie Local Government Districts which are among the most healthy district populations in Scotland and parts of Glasgow District which are the least healthy in Scotland. This differential impels the Board to seek to deliver its health services in such a way as to discriminate positively in favour of the deprived populations with poor health standards. In considering this discrimination it has to be kept in mind that apart from the large peripheral post-war housing estates there are many smaller geographical pockets of deprivation.

There is sometimes apparent a difference of perception whether Glasgow’s health problems primarily are due to ‘deprivation’ or ‘self-indulgence’. In practice, this difference is only of theoretical significance because both groups of factors apply and they interact with each other. For example, a higher proportion of the populations in socioeconomically deprived areas smoke than in less deprived areas. How independent are those two factors?

Smoking is the major public health hazard at present. People are beginning to give up smoking, and in Glasgow almost two thirds of adults who smoke are willing to try to do so. But we have little real understanding of the reasons why policies and health education activities that have reduced smoking in the better off in society have had little success in areas of deprivation. It is becoming recognised that even seemingly simple single issue health issues like smoking cannot be taken in isolation.
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"those who wish to promote better health for the whole population, not merely for the more fortunate, must radically rethink present policies and forge new working practices with those acting to combat poverty." [ASH 1993]

It is recognised that 'top down' or professional approaches will be relatively ineffective in addressing the health problems in deprived areas. No single organisation or agency can cover all of the work that needs to be tackled in creating healthy conditions. With real partnerships between the community and the service providers attempts are now being made to develop work tackling these issues.

The recognition of the need for collaborative working on health issues, and the support that this work has across the city is the "New Opportunity" referred to in the title. The development of collaborative approaches e.g. 'Womens' Health Policy for Glasgow' and the use of 'community development' ways of working e.g Drumchapel Health Project has increasingly strong support among local communities, voluntary and professional workers.

The Healthy City Project provides a vital stimulus for all agencies to collaborate in tackling the problems which underlie the poor health records of parts of Glasgow. It is also important in that it makes explicit the need to involve local people in the planning and management of services, and it has established the very important principle of equity — to strive to narrow the gap between the least healthy and healthiest communities — while promoting 'health for all'.

This report begins by describing what health is and what shapes it, it then goes on to explore how these factors operate in Glasgow. The next section outlines the state of health of Glasgow now. The ongoing practical work to improve the health of the city is described in the following chapter. The penultimate chapter provides an exploration of some of the wider changes that would support Glasgow's attempts to change health outcomes. The final chapter is a call for action for recognition of Glasgow's status as a special case and support for work on inequalities in health that could be replicated in other areas of the United Kingdom.
HEALTH AND ITS DETERMINANTS

Describing Health
A frequently used definition of health has been that of the World Health Organisation (1948)
' a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'.
This wide definition of health is difficult to define precisely but has the benefit of giving the notion of health a realistic shape. It is not, just about physical fitness or mental wellbeing but a complex mix of individual, social and political factors.

Health in these terms can be seen as an outcome of a range of activities: personal behaviour, service provision and environment all taken within their economic and social contexts. Health is created within our society and is amenable to change.

Blaxter (1990) investigated the many and diverse concepts of health held by the general public, and these include:
• Not being ill (never experiencing symptoms or using medical services).
• The absence of disease, or being able to cope with disease or misfortune.
• A robust constitution and temperament.
• Good lifestyle and habits.
• Physical fitness.
• Energy and vitality (being lively, alert and enthusiastic).
• Good social relationships.
• Satisfactory physical and mental functioning.
• Psychosocial wellbeing (being confident, proud, relaxed and in a happy state of mind).

Alwyn Smith (1992) proposed the definition
'that people are healthy to the extent that they are able to meet their obligations and to enjoy the rewards associated with membership of their community'.

He suggested that two strategies were required in the pursuit of public health:
• measures to protect and promote the capabilities of individuals to function in the widest diversity of social contexts (the traditional approach), and
• development of a society which permits the successful functioning of individuals of the widest diversity of capabilities.

Health may be assessed in subjective terms as well as by objective measures. A disabling impairment in an athlete might be no more than an inconvenience to most people; and the normal functional impairments of ageing are quite compatible with good health in older people. For this reason self-assessment of health status may be at least as reliable as clinical, biochemical and physiological indices of health. (Epstein, 1990).

We are undoubtedly much healthier as a population than we have been since statistical evidence began to be collected in the Bills of Mortality of the mid-18th century. While life span has increased relatively little since the three score years and ten of biblical times, more of us are living to reach this life span. It is clearly important to encourage this trend to continue; but in doing so we must strive to ensure that the quality of life experienced is of a high standard. A long life in misery is no life at all.

Good health should not be equated with a large volume of health service activity or with the number of hospitals. Rather, good health is associated with adequate income a safe, clean and warm home and working environment, adequate access to local services, freedom from the more harmful aspects of stress, avoidance of smoking and other addictive practices, and opportu-
nities to eat a healthy diet and take regular exercise. However we are under constant pressure to make unhealthy choices. Most people have little choice about the way they live: tobacco advertising, the food which is most readily available and affordable, vehicle exhaust fumes, unemployment and the frustration and stresses of daily living all predispose to ill health and premature mortality.

An assessment of the health of an individual or community should therefore include:

(a) Positive aspects of health such as physical and mental wellbeing, physiological functioning and quality of life.
(b) Measures of disability, morbidity and mortality.
(c) An analysis of the socioeconomic and environmental factors influencing health.

What Shapes Health?

"Analysis of the major advances in health... shows that these have been associated more often with improvements in social circumstances than with medical advances. Thus, where people are in a position to exercise greater choice in their housing, environment, employment, leisure activity and consumption generally this has tended to be beneficial to their health. By contrast those not able to exercise choice because of low income, lack of education or lack of capacity to take the initiative tend to suffer more ill-health." [Acheson 1991]

Investigations by the King’s Fund Institute (1992) show that the probability of having a good overall level of health is about 12 times less for men who live in the worst circumstances of material and social deprivation and take little exercise than for
HEALTH AND ITS DETERMINANTS

It would appear that material deprivation has a slightly greater impact on health than social deprivation, although both appear to be more important than lifestyle factors. Nonetheless, lifestyle does have an important influence on health, and it is likely that if just five factors (smoking, very high cholesterol, obesity, lack of exercise and heavy alcohol consumption) could be eliminated, then death rates would fall by 25%.

All these risk factors are potentially reversible, and the health service has a major part to play in reducing their prevalence. But behaviour does not occur in a social vacuum and research is now highlighting the ways in which behaviours are shaped by social and material deprivation. [Ash 1993, Blackburn 1992 p44-46]

The alleviation of material deprivation as expressed in poverty, unemployment, poor housing and adverse environmental influences is not a direct NHS responsibility; but unless this is accepted as a major political objective there will be no possibility of reducing health inequalities or of raising the overall health of the population to a satisfactory standard.

Determinants of Health

The traditional view that improvements in health over the past 200 years was largely the consequence of a more widely available and more scientifically based medical practice is now considered to be untenable (Alwyn Smith, 1992). Morris (1982) described the principal determinants of health as follows:

- Family history (genetic).
- Standard of living: eg poverty, unemployment.
- Lifestyle: eg smoking, lack of exercise.
- Environment: eg housing.
- Nutrition.
- Health Services.

These and other determinants of health interact, and a simplified model of the determinants of health status is illustrated in figure 1.

These determinants can be viewed in three groups -

- **Non reversible** (eg age, gender, family history).
- **Reversible Structurally** (eg deprivation, poor housing, unemployment, the environment, education).
- **Reversible Behaviourally** (eg cigarette smoking, raised blood pressure, raised serum cholesterol, lack of exercise, obesity, poor nutrition).

**Non Reversible**

**Age**

Data from the Health and Lifestyle Survey (Blaxter 1990) and the General Household Survey for 1988 shows that with the exception of measures of psychosocial
malaise, the prevalence of illness (both long-standing and acute) and disability increases dramatically with age. Health declines with age, being 'like a stock of capital with which we are initially endowed, and which naturally depreciates through time, and at an increasing rate in later life' (Williams, 1978).

**Gender**

Whilst women have a longer life expectancy than men, there is evidence to show that they suffer poorer health during their lifetimes. This is particularly so for mental health problems. Blaxter (1990) also found that at all ages women describe more illness than men. The poorer health of women has been attributed to the pressure of their role in society and in part, to their more complex reproductive system.

**Family History**

Some diseases such as haemophilia and cystic fibrosis are genetic in origin. The endowment of physical and mental health 'capital' at birth will also be considerably influenced by genetic factors.

**Reversible Structurally**

**Material Deprivation**

Material deprivation is positively associated with ill health (both subjectively and objectively measured), poor psychosocial health and decreased fitness. A variety of components of material deprivation may be described, each of which has an influence on health:

(a) **Poverty:**

Adequate accommodation, food and warmth are prerequisites of good health, but poor families are likely to live in unhealthy houses and to have to cut back on the amount of food and fuel which they purchase — or to use materials which are cheaper but less healthy or less efficient. ‘Poor people are denied access to many of the activities and services which are widely taken for granted. They experience poverty of restricted opportunities and inhibited life chances for themselves and their children. In addition, the living standards of poor people are often so low that they are forced to go without the most basic of essentials, such as adequate housing, clothing and nutrition.’ (Becker 1991).

Poverty is by far the most important cause of material deprivation, and material deprivation is associated with poor health in people of all ages.

(b) **Unemployment:**

The OPCS Longitudinal Survey shows that after standardisation for age and social class, mortality rates in men who are seeking work are almost 25% higher than for all men below retirement age. The wives of unemployed men have mortality rates about 20% above the average. For both sexes the highest standardised death rates are for accidental deaths, suicide and lung cancer. There is also a strong association between unemployment and poor psychological health. Unemployment also has links with poverty.
(c) Housing:
Both physical and mental wellbeing are influenced by housing — not only by the characteristics of individual houses, but also by the characteristics of the immediate environment.

Dampness and cold have been shown to be associated with respiratory disease in children. If mould is also present then illness is more likely, and more likely to be severe. There is a dose-response relationship between the amount of mould, and the severity of symptoms such as wheeze, sore throat, running nose, irritability, persistent headache, fever and temperature (Platt et al, 1989). Furthermore these childhood symptoms are associated with increased morbidity and mortality in later life.

There is also a significant dose-response relationship in adults between damp and mould and symptoms such as aching joints, nausea and vomiting, blocked nose, constipation, breathlessness and ‘bad nerves’, after controlling for differences in socio-economic status and smoking (Platt et al, 1989).

Overcrowding in houses is associated with infectious diseases, childhood accidents, gastroenteritis, skin disorders and respiratory infections. Lack of privacy and other stresses are also detrimental to mental health and reduce the ability of families to cope.

Children living in houses which are noisy, cold and overcrowded or in a poor state of repair are more likely to wet the bed, have temper tantrums or to be unhappy and unstable; and their parents are more likely to be tired, have ‘bad nerves’, headaches or to feel depressed (Hunt, 1990).

(d) The Environment:
The immediate environment appears to have an influence in addition to housing itself. Thus people from ‘bad’ housing areas report poorer health, more long-standing and recent illness and more symptoms of depression than those living in ‘good’ areas (Whitehead 1988). Living in blocks of flats — particularly high up — is also detrimental to health in some circumstances: respiratory disease in
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women and children and psychoneurotic disorders in women are associated with lack of facilities for children to play, lack of social contact, poor local facilities (including transport), vandalism and fear of criminal attack (King’s Fund Institute, 1992).

There are still many households with lead piping; in some of these houses lead concentrations in tap water are unacceptably high and in a much larger number the water lead content is near the current W.H.O limit. Exposure to such levels of lead has been shown to be associated with a small reduction in performance in intelligence and attention tests in school children.

There is increasing concern nationally about the potential effects on respiratory health of vehicle exhaust fumes. Such effects are difficult to measure. What is certain, however, is that any effects will increase substantially over the next two decades as a result of projected trends in car ownership. Air pollution is particularly dangerous for those at the extremes of life, pregnant women, those with heart or respiratory disorders and people such as parking wardens and traffic police and others who work in heavily polluted areas.

(e) Education:
Education is positively associated with good health. One reason for this is that it provides people with the skills required to control their health. It can give them the ability to assimilate information from books, magazines, the mass-media and health workers so that they can provide themselves with a better diet, find more economical ways of heating their homes, and minimise risks at home, in leisure pursuits and at work. Education also provides access to better jobs, and a higher income and therefore to a better and healthier standard of living. Better educated people are also more likely to spend their time in healthy pursuits and to be better equipped socially and psychologically.

Social Deprivation
(a) Lack of Support
Blaxter (1990) has described a close association between lack of social support and both physical illness and psychosocial health. The availability of a friend or other support is associated with a reduction in stress and depression, improved recovery from life-threatening illness, and greater efforts to seek help.

(b) Social Integration
Social integration in the form of employment, marriage and parenthood are associated with good physical health both in men and women. Relationships with other people provide emotional support and practical assistance in coping with difficulties of life. Conversely, the absence of social and community ties is related to premature mortality. People classified as having very low social integration in terms of social roles, social contact and community integration are over four times as likely to have poor health as those classified as having very high social integration (King’s Fund Institute, 1992).

Reversible Behaviourally
Lifestyle and behaviour
(a) Smoking is the largest single preventable cause of death (Health of the Nation, 1992) and contributes to 34% of all deaths in adults under the age of 65 years. There is a clear relationship between socioeconomic circumstances and the prevalence of smoking.
(b) Heavy alcohol consumption predisposes to cirrhosis of the liver, cancer,
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road traffic accidents and high blood pressure.
(c) Regular physical exercise increases life expectancy; reduces the risk of coronary heart disease; reduces blood pressure, obesity, diabetes, osteoporosis and the risk of bone fracture; and enhances psychological wellbeing by improving self esteem and self-confidence and by reducing anxiety and depression.
(d) Jacobsen et al (1992) estimate that 35% of cancer deaths may be due to diet, and the amount of saturated (mainly animal) fat in the diet is one determinant of cholesterol level and hence of the risk of heart disease.

Hahn et al (1990) estimated the reduction which would occur in age-adjusted mortality rates from the nine most prevalent chronic diseases if the main risk factor for each disease were eliminated. Analysed singly, cigarette smoking was estimated to account for 33% of deaths from these causes, obesity for 24%, lack of exercise and high cholesterol each 23%, hypertension 21% and diabetes 8%. The five principal risk factors (smoking, high cholesterol, obesity, lack of exercise and heavy alcohol consumption) were together estimated to be responsible for 47.5% of the deaths from these causes. It has been estimated that elimination of these risk factors would be expected to increase US life expectancy (both sexes) by 4 years - to 77.6 years, raising it to second place after Japan and the same as that for Switzerland.

Discussion
The chance of having a good overall level of health is about twelve times less in people who experience the worst material and social deprivation and take little exercise than in those with none of these three adverse factors. Health status in both sexes is clearly related to indicators of both material and social deprivation even after standardising for a wide range of lifestyle and demographic factors. The King’s Fund authors conclude that it is necessary to identify those aspects of material and social deprivation which are most damaging to health in different population sub groups, and then to determine what interventions are needed. They suggest the need for:

- Building a new political consensus which emphasises the relatively limited role of health care in health promotion and disease prevention.
- Addressing the central issue of health inequalities as the first step to improving health - requiring action on a broad range of public policy fronts.
- Health care resources being allocated to take account of the impact which material and social circumstances have on health.
- A concerted and imaginative approach to healthy public policy as a central strand for all government activity - including housing, transport, energy and agriculture - in order to make social and economic development more in tune with the promotion of health.
- Health advocacy initiatives to influence political and legislative reform; community development actions to promote social change; and intersectoral decision-making in the formulation of public policy.
FACTORS SHAPING HEALTH IN GLASGOW

The most striking feature of the health status of the Greater Glasgow Health Board population is the variation in health between different areas. The variation is attributable to two sets of factors. The first concerns differences in the prevalence of risk factors for disease (principally smoking and alcohol consumption, blood pressure and diet). The second concerns the susceptibility, or vulnerability, of the population to disease.

Vulnerability results in an increased likelihood of premature death from all causes, rather than an excess from specific diseases. It determines the age at which death occurs, rather than the precise cause of death. The tendency to premature death outweighs the effects on mortality of any specific environmental hazard, with the exception of cigarette smoking. About 2,600 deaths per annum out of the total 6,700 deaths under the age of 65 years are associated with the difference between the mortality rates of the healthiest section of the Greater Glasgow population and of the remainder.

Longitudinal analysis shows that differences in vulnerability are acquired and maintained from an early age. Different studies point to the importance of maternal nutrition, prenatal factors and the postnatal environment during infancy, childhood and youth. It follows that health promotion campaigns to encourage behavioural change in adults should be complemented by longer term strategies, targeted at the young and the very young, to give them the best start in life. It will take more than a generation to reap the full benefit of such policies.

Different generations will have been subject to different environmental experiences at the early stages of their lives. Many environmental factors which had a major impact on the early life of older generations, still influence current mortality rates. They include serious overcrowding, major infections, nutrition in infancy, air pollution, lack of sanitary facilities and exposure to asbestos and other dangerous chemicals at work.

Summary
Health in Glasgow is determined by three associated sets of conditions — socioeconomic disadvantage, lifestyle and possibly increased susceptibility to disease. In order to improve the overall health of Glasgow, effort must be targeted on those areas where disadvantage is greatest and health is poorest.
FACTORS SHAPING HEALTH IN GLASGOW

Apart from shortened life expectancy, vulnerability may result in short stature and impaired respiratory function, to an increased likelihood of having a stillbirth, low birthweight baby or infant death and to impaired resistance to infection and wound healing. These and other factors are likely to complicate health care and length of stay in hospital.

For example Burns (1992) has seen that people from areas of social and economic disadvantage tend to have longer lengths of stay in hospital due to a higher incidence of complications after certain surgical procedures. This means that health gain (a given improvement in health) will often cost more in deprived population groups.

These biological consequences of social and economic disadvantage however should be distinguished from the processes by which socioeconomic groups vary in their use of health service facilities, for example in different rates of attendance or referral for various services.

There is no single cause of increased vulnerability. Rather, there is a matrix of factors including poverty, housing and nutrition, which interact to impair the general health status of large sections of the population. Malnutrition is now more an aspect of the quality rather than the quantity of the food which people eat. The major deficiency is in the consumption of fruit and vegetables.

The major determinants of health in Glasgow are as follows:

Socioeconomic Factors
Good physical and mental health can be attained only in the presence of favourable social circumstances but Greater Glasgow has much higher levels of deprivation than any other health board in Scotland. 84% of the most deprived postcode sectors in Scotland are within the GGHB area, and so only about 16% of the most deprived people in Scotland live outside the area served by the Greater Glasgow Health Board. Since most diseases have marked social class gradients it is unlikely that it will be possible to improve health in Glasgow to the same extent as elsewhere in Scotland without increased input.

Poverty
Poverty causes ill health in a variety of ways. For example, income influences choice of diet, access to services, housing, local environment, heating, household safety, educational opportunities, empowerment and smoking behaviour. The relationship between poverty and health is clearly seen in mortality and other health statistics, but it is difficult to define in terms of biological mechanisms. The effect is non-specific, and is explained more plausibly as a determinant of general vulnerability to poor health, rather than as a risk factor for specific diseases.
Poverty has a pervasive effect on health, and operates through low birthweight, impaired growth, impaired resistance to infection and increased susceptibility to disease. The effect on morale compounds these effects on health and on healthy behaviour. Inner city slums have been cleared and replaced by peripheral council housing estates. Much of the council housing stock however is of inferior design, and predisposes to condensation and damp. Many households lack the resources to heat these properties adequately. As a result, large numbers of children are growing up in circumstances which are potentially hazardous to their health.

In addition to the poor nutrition which is associated with low incomes, poverty entails a general lack of resource and amenity, making life a struggle rather than a quest for self-fulfilment. Characteristic features of the associated lifestyle which militate against health and healthy behaviours are the continual need to cope with crises, and the lack of ‘futuristic perspective’. Excessive consumption of cigarettes and alcohol is seen by some as profligate behaviour, and by others as an understandable recourse to drugs of solace.

Defining poverty as the income support level Strathclyde Regional Council prepare a regular series of statistics, ‘Poverty in Strathclyde’. The most recent of these (March 92) shows that changes in the social security system have resulted in many people living at a level only marginally above the income support level. The figures given below (Table 1) give a constrained picture of the numbers living in poverty in our city.

Almost a third of all people in Glasgow are dependent on Income Support. There has also been a considerable increase in debt in Greater Glasgow over recent years. A higher proportion of low income households than higher income households are in debt. 90% social work clients seek advice about financial matters, and 92% of this group are dependent on income support. The main groups at risk from the effects of low income are elderly people, single parent families, unemployed people, people with disabilities, the low paid, ‘carers’, ethnic minorities, young homeless people and ex-offenders.

In some areas in Glasgow, over half of the child population is being brought up in households dependent on income support.

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<th>16-19 %</th>
<th>20-retired No</th>
<th>20-retired %</th>
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</table>
FACTORS SHAPING HEALTH IN GLASGOW

Employment
It has been estimated that between a quarter and one third of social class variation in health is due to occupation. This is mainly due to the lifestyles associated with certain occupations and the effects of low pay and unemployment rather than to direct occupational hazards. Since 1984 employment in Strathclyde as a whole is estimated to have fallen by 6.4%. This compares with an estimated increase for Scotland of 2.8% and an increase of 4.4% in Great Britain. Much of the decline in Greater Glasgow has taken place in traditional manufacturing industries and the great majority of jobs (70% of the total employed) are now in service industries. In Greater Glasgow, approximately 11% to 12% of the workforce is currently unemployed but the range for smaller communities is large (4.9% to 25.7%).

Gender
Despite the fact that gender monitoring does not routinely take place, it is possible to see that Glasgow women fare particularly badly when compared with international and national data. In the premature mortality league table of 35 countries that keep detailed statistics, Scottish women rank 32nd, exceeded only by Romania, Hungary and Russia.

The overall rate in Glasgow for women is 16% higher than for Scotland as a whole.

Women are affected by inequalities in health in the same way that men are. However, for women in the most disadvantaged areas the standardised mortality rate for heart disease (as compared with Scotland) is greater than for any other grouping.
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Environmental Factors
Most of the large improvement in health during the last 100 years has been due to improvements in the environment. The establishment of public water supplies from Loch Katrine and Loch Lomond, the clearance of slum housing from the inner city and the gradual enforcement of the Clean Air Act have all generally improved the circumstances under which Glaswegians are born and brought up. It is almost axiomatic that when one problem has been solved, another emerges to take its place. This review of environmental health problems discusses current day concerns about water quality, housing and air pollution, and shows that while huge progress has been made in population health, there is a need to remain vigilant and active in maintaining our living environment.

How the Environment Can Affect Health
There are two principal ways in which the environment is linked to the health of people living in an area.

1. Specific hazards can cause ill health. Thus, a wide variety of potential hazards have to be kept under control in the home, at work and in the wider community, in order to reduce exposure of the population to acceptable levels.

2. The structure of the living environment can also influence health and healthy behaviours. These physical, social and economic environmental determinants of health involve areas which are the responsibility of a wide range of agencies in local and national government, in addition to bodies which are concerned primarily with health.

In the GGHB area, these broader environmental determinants of health account for a larger number of ‘excess’ deaths than do specific environmental hazards, with the possible exception of cigarette smoking.

Housing
The relationship between poor housing and ill health has been appreciated and quantified since the early nineteenth century and more recent studies have demonstrated a more specific link between damp housing and respiratory disease. Glasgow’s current housing problems date to the period following the Second World War when a massive programme of new building was started. These houses were poorly insulated against both damp and noise and difficult to heat. For thirty years the inhabitants of housing schemes have been deprived of adequate physical shelter, warmth and even privacy. A survey of
housing conditions in Glasgow conducted in 1985 showed that 28% of the city's entire stock was affected by dampness and/or condensation. More than half of all council houses were affected and 9% of cases were so severe as to fall below tolerable standards. Half of all households with children have some problems with dampness or condensation. Only recently have major remedial works been undertaken to improve the environment and physical state of housing in Glasgow and with considerable success. However, a vast problem remains and it is estimated that some quarter of a million Glaswegians still live in accommodation affected by dampness or condensation.

**Overcrowding**

Population density was recognised by the pioneers of public health in the last century as a major factor in determining the health of the population. As a result, overcrowding in Glasgow has been reduced substantially from an average of 2.1 persons per room in 1811, to 1.9 in 1891 and 1911, 1.5 in 1931, 1.3 in 1951 and 0.81 in 1981.

Despite such dramatic improvements, it is important to note that in the 1981 census it was found that 40% of households in the peripheral housing estates such as Drumchapel, Easterhouse and Nitshill, have a population density of over 1.0 persons per room, compared with 4.2% of households in areas such as Eastwood and Bearsden and Milngavie.

**Winter Deaths**

Mortality rates in winter are about 15-20% higher than rates in summer. Several explanations are possible, including seasonal variations in diet, but the most likely explanation involves changes in the ambient temperature, and the extent to which internal temperatures can be maintained within households. Elderly people living alone on low incomes are at particular risk, in view of their impaired ability to regulate body temperature and sensitivity to sudden temperature changes.

**Lead in Water**

The lead problem was at its height in the 1970s when very many properties in the city had lead water levels which were above current safety limits for human health. Since then, a steady programme of lead pipe replacement, in conjunction with water treatment measures to decrease plumbosolvency, has resulted in a very much smaller proportion of properties with suspect water. The Environmental Health Department of Glasgow District has reported that while 84% of water samples in 1974 exceeded 50 ug/l, this had fallen
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by late 1989 to 7%. Although these were not random samples, they show a healthy trend. However about 160,000 households in Glasgow, divided equally between the private and public sectors, still have lead piping.

During the last ten years, our knowledge of the effects of lead on human health has been extended by scientific research, including a study carried out in Edinburgh on lead levels in school children. This showed that levels of exposure to lead which used to be considered safe are now associated with a small reduction in performance in intelligence and attention tests. As a consequence, the WHO is expected shortly to reduce its guideline level from 50 to 10 ug/l. EC and UK legislation is likely to fall into line. It is not known how many household tap water supplies exceed this limit, and there is uncertainty concerning the priority which should be now given to the lead pipe replacement programme.

Complete removal of lead piping from the 160,000 households in the city which are affected would entail substantial cost, and in the present economic climate could only be met by foregoing expenditure on other issues. In the case of council housing stock, a choice would have to be made between replacing lead piping, remedial work for dampness and condensation, installation of heating systems and rewiring. It is by no means clear which type of expenditure provides the ‘best buy for health’. It is also important to remember that over 90% of the variation in performance in intelligence tests in the Edinburgh study was due to factors other than lead.

Asbestos

Occupational exposure to asbestos was a feature of work in the shipbuilding industry, and accounts for the high incidence of asbestos-related cancers and disease in the Clydebank area. Although cases will continue to occur due to the long delay between exposure and development of the disease, awareness of the dangers and measures to reduce occupational exposure have resulted in this being largely an
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historical problem. Although great care is required in handling asbestos, particularly when it is discovered in old buildings, the risk to health is now very much reduced.

Radiation
The main sources of exposure of the general population to radiation are naturally occurring background radiation, exposure to X-rays in hospital and ultraviolet radiation from sunlight. In the large majority of cases the benefits to be gained as a result of the X-ray outweigh possible harm attributable to radiation exposure. Radiology departments are now encouraged to review their policies for taking X-rays so that unnecessary exposures are reduced to a minimum. The main potential risk of accidental radiation exposure comes from the remote possibility of a major nuclear accident at Hunterston power station, the nuclear submarine bases in the Clyde estuary or nuclear installations further afield. Increasing exposure to ultra-violet radiation is responsible for the increasing incidence of skin cancers.

Indoor Air Pollution
Passive smoking accounts not only for a doubling of the lung cancer risk in non-smokers, but also increased risks of coronary heart disease and respiratory impairment. In pregnant women, smoking reduces the birthweight of their babies.

As part of its health promotion strategy, Greater Glasgow Health Board has established a non-smoking policy within its premises for patients, visitors and staff. Other organisations within the city should follow this lead and review their policies.

Outdoor Air Pollution
Current monitoring data on ambient levels of sulphur dioxide, which are collected by the Environmental Health Department show that levels in central Glasgow are generally satisfactory, and low in comparison with those recorded routinely even in residential areas in the 1960s.

Projections of car ownership in the region, however, suggest that the number of private cars may double during the next 25 years. Measures such as conversion to lead free petrol and the installation of catalytic converters are likely to contain the problem of vehicle exhaust fumes in the short term, but over a longer period the increasing volume of traffic is likely to outstrip the gains made by such measures.

It seems unlikely that a single central site for monitoring nitrogen dioxide will continue to suffice as a means of monitoring the effect on the environment of vehicle exhaust fumes. Such information gives no indication of other exhaust gases such as hydrocarbons and carbon monoxide, nor of specific problems, such as the occupational exposure of policemen, traffic wardens, car park attendants and others to heavy traffic flows. A review of traffic flow through the city should provide a basis for identifying ‘black spots’ within the city, where there is likely to be advance warning of the air pollution problems which may lie ahead. Other sources of air pollution which require close monitoring in particular localities include industrial premises and various types of waste incinerator.

Waste Disposal
In 1990 the Public Health Department offered advice to the Glasgow District Planning Department on health issues raised by a private planning application to build a clinical waste incinerator at a disused industrial site in Scotstoun. This application attracted considerable public interest, both in terms of media attention and local reaction. The Department’s report, which was prepared in conjunction with the University
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Department of Public Health, advised rejection of the proposal on the grounds that insufficient information was provided in the application to support the claim that ‘the proposed development will pose no health impact to any residents in the vicinity of the plant’. Concern was also expressed in relation to the potential exposure of people with severe respiratory impairment to a combination of acid gases in low concentration. If such exposure is unavoidable, the main public health consideration in choosing between possible sites is the size and proximity of the local population. Only one site was under consideration in this case. The application was turned down. A subsequent appeal to the Secretary of State was withdrawn.

Clinical waste is one of several waste disposal issues which will have to be tackled during the next ten years in Glasgow. Glasgow’s waste is Glasgow’s problem, and there is little doubt that a greater level of public awareness and understanding of the issues and options involved will be necessary before these issues can be satisfactorily resolved.

Susceptibility to risk

Watt and E cob (1992) have compared all cause mortality rates for 10 year age groups of Glasgow and Edinburgh men and women born during the 5 year periods 1869-73, 1879-83, 1889-93, 1899-1903, 1909-13, 1919-23, 1929-33 and 1939-43. Mortality rates were 40% higher in Glasgow than in Edinburgh: these differences were established by the age of 25 years, and possibly much earlier. The same pattern is evident for the individual major causes of death — heart disease, stroke and all cancers. In 1979-83 the population of Glasgow reached an all-cause mortality rate 3.9 years earlier in men and 3.6 years earlier in women than did the population of Edinburgh. These differences have increased, and are predicted to increase further, especially in men. The excess in all-cause mortality was made up of an excess of all major diseases in Glasgow compared with Edinburgh, rather than by an excess of any single group.

The study clearly demonstrates that by the age of 25 years a general pattern has been established which has predisposed Glaswegians to an earlier death from a wide range of diseases. The link between health in early life and disease in middle age appears to operate on a larger scale than has been suggested previously.

Poverty, adverse environment and inadequate diet are likely to be important factors in determining susceptibility to disease risks. However there may be a genetic influence, in view of the large influx of population to Glasgow during the 19th century especially.

A key question is whether increased susceptibility (or ‘poor general health’) is amenable to change in later life. There is no doubt that health can be made worse by a variety of factors, but it is less clear whether and how health can be improved. In general, risk factor intervention studies in middle age have not been successful in making people live longer; they have been more successful in changing the cause of death.

Blood pressure, cholesterol, alcohol intake and exercise activity are broadly the same in both Glasgow and Edinburgh. The main differences are higher cigarette smoking and less consumption of fruit and vegetables in Glasgow. These differences give support to current health promotion measures to prevent deaths from coronary heart disease, stroke and lung cancer. However,
FACTORS SHAPING HEALTH IN GLASGOW

with the possible exception of diet, it is difficult to see how these risk factors can explain the substantial excess in Glasgow of deaths from other causes at all ages, and the deep-rooted nature of the inequality of health.

Watt and Ecobs findings have several important implications:

- Mortality rates have improved in both cities, but are improving more quickly in Edinburgh. In consequence, national health targets will be more difficult to achieve in Glasgow than in Edinburgh.

- Explanations of inequalities in health which are based on specific diseases provide a limited understanding of the problem and only a partial basis for health promotion measures.

- When populations vary in their tendency to premature death from all causes, it is likely that differences in mortality are due not only to differences in risk, but also to differences in susceptibility to risk.

- Campaigns to influence public behaviour in adult life should be complemented by longer term strategies, targeted at the young, not only to promote healthy lifestyles, but also to reduce susceptibility to risk.

- Maternal and child health require greater priority in public health policy, particularly in areas of socioeconomic disadvantage.

- The worsening economic and social conditions experienced by the least healthy and most disadvantaged populations are likely to result in increasing disparities in health - both between and within cities such as Glasgow and Edinburgh.

Lifestyle

In recent years a number of surveys within Greater Glasgow have provided a picture of lifestyles and key health related behaviours. Two clear patterns have emerged from these data. First 'unhealthy' behaviours are more common in Glasgow than in the rest of Scotland. Secondly, certain behaviours like smoking, poor diet and intravenous drug abuse are more common in areas of relative deprivation.

(a) Smoking

Smoking is the single most important preventable cause of ill health in Glasgow: it causes lung cancer, other cancers, coro-
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nary heart disease, chronic bronchitis and peripheral vascular disease. It has been estimated that 2000 deaths (mainly lung cancer and heart disease) per year in the GGHB area are attributable directly or indirectly to smoking. Smoking during pregnancy results in miscarriages, premature labour, higher perinatal mortality, low birthweight and subsequent reduced growth and educational attainment.

Passive smoking may claim the lives of a further 200 people each year, and predisposes to allergic diseases in infancy, to acute asthmatic attacks, and to middle ear effusion. However, the excess mortality due to smoking is only partly explained by smoking levels: there is also increased susceptibility among Glaswegians to a given level of smoking risk (Gillis, 1990).

During 1986 a survey was conducted of a random sample of 3,000 Glasgow residents. For social classes I and II the proportion of smokers was 26% daily smokers and 8% occasional; for social classes IV and V the corresponding values were 53% and 4%. Fifty nine per cent of unemployed people smoked daily, and 5% occasionally. Fifty six per cent of current smokers wanted to stop. These values did not vary very much with social class or area of residence. Thirty six per cent of residents have tried to give up smoking within the past 12 months, and an additional 28% had tried to give up at some time over a year ago.

In an ongoing telephone survey of the lifestyles of Glaswegians begun in 1989 it was found that 97% of respondents were aware of the health hazards of smoking, so strategies to decrease smoking have to be sophisticated enough to understand the pressure to smoke and also allow for the influence of social circumstances. Encour-

agingly, the prevalence of smokers has fallen during the past three years, particularly in men.

(b) Alcohol
Unlike smoking, alcohol, if used in moderation, has no adverse health affects. However, excessive intakes can lead to a variety of social, mental and physical health problems. Alcohol abuse in Greater Glasgow is common and 30% of men and 6% of women admit to drinking more than the safe limits.

(c) Drugs
It is clear that drug misuse in the Glasgow area is extremely widespread. Many drugs are abused but quantitative data are currently only available on the prevalence of drug injecting. It is estimated that in 1990 there were about 9,000 injectors in Glasgow, representing about 1.5% of the adult population aged between 15 and 50. During the first ten months of 1990 there were at least 53 deaths as a direct result of drug injecting. A large but unquantified proportion of the drugs misused have been prescribed by medical practitioners.

(d) Diet
An adequate and balanced diet is essential for health. Dietary patterns in Scotland are thought to contribute to our high levels of heart disease and may account for as much as one third of all cancers. Undernutrition remains a problem among some vulnerable groups (eg. the elderly), but the major dietary problems in Greater Glasgow are due to excessive intakes of saturated fat and low consumption of fresh fruit and vegetables.

One consequence of our poor diet is that over one third of the population is overweight and 6% severely obese. Remarkably, 36% of the adult population
FACTORS SHAPING HEALTH IN GLASGOW

of Greater Glasgow is on a ‘calorie reducing diet’ at any one time (42% of females, 29% of males). Clearly there is some very ineffective dieting taking place and at least some of those on diets have no reason to be. Much could be gained if the proportion of fat (especially saturated fat) in the diet were to decrease and the amount of fibre, fresh fruit and vegetables increased. There is, however, some evidence that the pattern of fat intake is improving, with fewer people using only butter (a fall from 22% to 18% between 1989 and 1992) and more using low fat spreads (increase from 30% to 38%).

There is a growing body of recent research into food and poverty which shows that; poorer people want to eat more healthily but cannot afford it; [National Childrens Homes 1992] and that food expenditure, being often the only flexible item in the household budget is squeezed, when times are hard [S Leather 1992].

(e) Exercise
Moderate exercise for 20 minutes three times per week has benefits for heart health but exercise also has important mental and social health benefits. It contributes to a healthy lifestyle and for this reason is frequently emphasised as part of positive health promotion. 48% of the population of Greater Glasgow take no regular exercise whereas 14% exercise more than four times per week.

(f) Sexual Health
Sexual health is an important and sensitive area. Education about relationships and sexual activity, family planning and awareness of sexually transmitted diseases are all important. In addition, promotion of ‘safe sex’, together with action directed towards intravenous drug users, are the main strands of AIDS prevention. Therefore, awareness of the risk of HIV and AIDS, use of condoms and the number of sexual partners are among the indices which are currently being measured in Greater Glasgow. However, the reliability of these data is open to question and much needs to be done to find effective ways of monitoring sexual health.

Education
The educational performance of a child is influenced by the home environment, the school and by the type of neighbourhood in which the child lives. The effects are large and extremely important. After controlling for differences in the home environment and the school, deprivation accounts for differences of up to four in the number of ‘O’ grades obtained (eg. between a pupil in Eastwood and another in Easterhouse). Because of the association between poor home and neighbourhood characteristics, young people living in deprived neighbourhoods are doubly disadvantaged in relation to educational attainment. The magnitude of this combined disadvantage is shown in the probability of entering higher education. Less than 1% of children from schools in peripheral housing areas achieve the minimum entry qualifications for higher education (at least three passes), compared with 44% of children from the most advantaged areas.

Strathclyde Regional Council has introduced several innovative schemes in an attempt to minimise the disadvantages suffered by the children of parents living in deprived areas. For example, schools in disadvantaged areas receive additional supplies and teacher staffing (at an annual cost of about £5 and £195 respectively per pupil). A supported self-study programme held after hours in some schools helps fourth-year pupils with their work and has
already had marked success. In 11 schools involved in this scheme, the proportion of pupils gaining three or more A grades at Standard Level increased from 5.4% to 11.9%. School timetables have been made more flexible so that where appropriate pupils can work for SCOTVEC qualifications on a modular basis at local colleges. Nursery provision is also targeted on deprived areas, one objective being to try to bring children from these areas to the level of development reached at the time of school entry by children from more advantaged areas.

**Safety**

Safety is a major public health issue in Greater Glasgow. Each year there are approximately 400 accidental deaths, 12,000 hospital admissions due to accidents and 100,000 casualty attendances. Road traffic accidents and accidents in the home are the areas of greatest concern and, in these locations, a combination of engineering for a safe environment and safety education could reduce accident rates significantly.

**Changes in the Size and Age Structure of the Population**

Between 1991 and the year 2001 the population of the GGHB area is expected to decline by 5% from 911,400 (current 1992) to 867,100. There will be a decline in the actual numbers of people in all age groups except in those aged 85 years and over, for whom there is an expected increase of 11% (from 12,000 to 13,000), and possibly in children.

**Discussion**

The wide variations in health which exist in Greater Glasgow are attributable mainly to interactions between material and social disadvantage, lifestyle differences and possibly susceptibility to disease of genetic and early environmental origin.

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"A credible strategy for improving the nation's health has to acknowledge the importance of health inequalities and put forward policies for improving the relative position of people lower down the social scale. This calls for co-ordinated health policies in areas such as housing, education, social security and the economy. Unless all citizens have secure employment, adequate housing and access to education, then the health divide will not only persist but it will widen."

Chris Ham (1992)
PHYSICAL HEALTH IN GLASGOW

Major Causes of Death
There are approximately 13,200 deaths each year among the GGHB population. Almost 80% of total mortality is attributed to four major causes: cancer, heart disease, stroke and respiratory disease (excluding lung cancer). See Fig 1.

![Graph showing major causes of death](image)

Fig 1 Major Causes of Death, GGHB.

It is important to pay particular attention to deaths in younger people (ie. up to the age of 65 years) since these lead to the greatest number of years lost and have the greatest potential for prevention. Fig 2 gives the standardised mortality ratio for the major causes of death for the age group 0 to 64 years. It shows that although the overall death rate for people in this younger age group in the GGHB area is 20% higher than for Scotland as a whole, for lung cancer and for other respiratory disease the death rate is 45% to 60% higher. For the other major causes of death (heart disease, cancers and stroke) the death rate for people under the age of 65 years is 14 - 18% above the average for Scotland.

The data in figs 1 and 2 relates to mortality at one particular time. It is clearly important to know also whether the situation is improving or becoming worse, and so it is necessary to examine trends. Two important trends are illustrated in figs 3 and 4.
Fig 3 shows that infant mortality declined by some 50% between 1974 and 1986 both for the GGHB area and for Scotland as a whole. The values for the GGHB area have also improved relative to Scotland: whereas in the 1970s infant mortality was consistently higher in the GGHB area, during the 1980s it was usually lower than for Scotland. In contrast, fig 4 shows that mortality for younger adults living in the GGHB area is increasing rather than decreasing relative to Scotland as a whole, particularly in men - for whom the SMR value for three year period 1988/90 is 23% above that for Scotland.

Fig 4 Standardised Mortality Ratios (SMRs) for GGHB 0-64 Year Age Group, by Sex, All Causes (Scotland = 1.0)
PHYSICAL HEALTH IN GLASGOW

Deaths Attributable to Lifestyle Factors
The relatively high rates for the major causes of death in the GGHB area can be attributed at least in part to unsatisfactory lifestyle factors — mainly smoking, but also diet, exercise and alcohol intake. Many deaths, and probably most deaths under the age of 65 years, are potentially preventable if remedial measures are taken sufficiently early. Table 1 gives the number of deaths attributed to smoking and other lifestyle factors in people of all ages who are resident in the GGHB area.

The potential of health promotion programmes in reducing the prevalence of these risk factors is clear. Many additional deaths are preventable through action directed at adverse social and economic determinants of health. The high death rates in Glasgow compared with Scotland as a whole are even more disturbing when one considers that of all the industrialised countries the death rate of people aged between 30 and 69 in Scotland is exceeded in women only in Hungary and Romania, and in men only by these and a few other Eastern European countries (see Annual Report for 1989).

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<th>% Deaths Attributable to Risk Factor</th>
<th>Number of Preventable Deaths</th>
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<td>Men</td>
<td>665</td>
<td>90</td>
<td>598</td>
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<td></td>
<td>Women</td>
<td>398</td>
<td>40</td>
<td>159</td>
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<tr>
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<td>1829</td>
<td>25</td>
<td>457</td>
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<tr>
<td></td>
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<td>20</td>
<td>318</td>
</tr>
<tr>
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<td>75</td>
<td>57</td>
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<tr>
<td></td>
<td>Women</td>
<td>68</td>
<td>60</td>
<td>41</td>
</tr>
<tr>
<td>Stroke and Hypertensive Disease</td>
<td>Men</td>
<td>541</td>
<td>18</td>
<td>97</td>
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<tr>
<td></td>
<td>Women</td>
<td>1069</td>
<td>9</td>
<td>96</td>
</tr>
<tr>
<td>Alcoholic Cirrhosis of Liver</td>
<td>Men</td>
<td>94</td>
<td>100</td>
<td>94</td>
</tr>
<tr>
<td></td>
<td>Women</td>
<td>52</td>
<td>100</td>
<td>52</td>
</tr>
<tr>
<td>Motor Vehicle Accidents</td>
<td>Men</td>
<td>60</td>
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<td>60</td>
</tr>
<tr>
<td></td>
<td>Women</td>
<td>26</td>
<td>100</td>
<td>26</td>
</tr>
</tbody>
</table>

Table 1 Deaths Attributable to Smoking and other Lifestyle Factors 1990
PHYSICAL HEALTH IN GLASGOW

Deaths Avoidable Through Effective Medical Services
There are also certain conditions which would normally not be expected to result in death if adequate medical intervention were to be effected at an early stage. The numbers of such deaths are small, but the death rates for the GGHB area from, for example, tuberculosis, rheumatic heart disease, appendicitis and cholelithiasis and cholecystitis are considerably above the Scottish average (table 2). Of greater concern however is the relatively high number of deaths from cervical cancer, respiratory disease in children and asthma in younger adults. Each of these deaths is a particular tragedy

<table>
<thead>
<tr>
<th>Condition</th>
<th>Age Group</th>
<th>GGHB</th>
<th>Scotland</th>
<th>% Above/Below Scottish Average</th>
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<tbody>
<tr>
<td>Tuberculosis</td>
<td>5-64</td>
<td>21</td>
<td>56</td>
<td>91</td>
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<td>Malignant Neoplasm - Cervix</td>
<td>15-64</td>
<td>77</td>
<td>401</td>
<td>0</td>
</tr>
<tr>
<td>Hodgkins Disease</td>
<td>5-64</td>
<td>15</td>
<td>107</td>
<td>-21</td>
</tr>
<tr>
<td>Chronic Rheumatic Heart Disease</td>
<td>5-44</td>
<td>7</td>
<td>16</td>
<td>174</td>
</tr>
<tr>
<td>All Respiratory Diseases</td>
<td>1-14</td>
<td>20</td>
<td>87</td>
<td>-30</td>
</tr>
<tr>
<td>Asthma</td>
<td>5-44</td>
<td>19</td>
<td>108</td>
<td>-8</td>
</tr>
<tr>
<td>Appendicitis</td>
<td>5-64</td>
<td>4</td>
<td>10</td>
<td>278</td>
</tr>
<tr>
<td>Abdominal Hernia</td>
<td>5-64</td>
<td>3</td>
<td>23</td>
<td>-7</td>
</tr>
<tr>
<td>Cholelithiasis &amp; Cholecystitis</td>
<td>5-64</td>
<td>8</td>
<td>23</td>
<td>82</td>
</tr>
<tr>
<td>Maternal Deaths</td>
<td>All Ages</td>
<td>5</td>
<td>18</td>
<td>212</td>
</tr>
</tbody>
</table>

Table 2 Deaths which are potentially avoidable through appropriate early treatment.
Morbidity
Morbidity is a measure of the amount of disease or ill health in a population. It comprises a spectrum of physical states from minor discomforts for which a remedy may be self-prescribed or not sought at all, through more serious but self-limiting conditions, to illnesses which require medical or surgical intervention, or which are so intractable and serious that only supportive treatment is available. The great majority of illnesses which reach any health professional, including many illnesses for which no medical treatment is necessary are dealt with by the general practitioner or other members of the primary care team. No details, either clinical or administrative, of general practice consultations are routinely collected either locally or nationally. In Scotland knowledge of morbidity is mainly confined to hospital morbidity (and usually only for in-patients rather than out-patients) supplemented to some extent by data from community health services. The 922,000 residents of the GGHB area, excluding geriatric (long stay), obstetric and mental health cases, undergo some 695,000 episodes of treatment in hospital each year - utilising some 1,750,000 bed days or the equivalent of some 4,800 beds. Fig 5 shows the main categories of use to which these beds are put.
Disability
The approximate numbers of moderately and severely disabled people living within the GGHB area are given in table 3, which has been derived from national survey data (OPCS 1988). Although many disabled people are under active health surveillance and possibly receiving treatment and care from general practitioners, community nurses and ‘paramedical’ services - no useful information about these individuals is collated in a retrievable form. The great majority of disabled people live at home, and are looked after mainly by informal carers, supported to a variable extent by health and social work services and by voluntary organisations. Health care services include district nursing, physiotherapy, speech therapy, chiropody and health visiting. Social work services include occupational therapy, home helps and home care.

Disabled Children
About 4% or so of children are born each year with some form of congenital malformations. It is not known what percentage of these have long-term disability or ongoing special needs.

<table>
<thead>
<tr>
<th>Age</th>
<th>Disability Level</th>
<th>6-7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>6-7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moderate - Severe</td>
<td>Very Severe</td>
<td>Extreme Incapacity</td>
<td>Almost Total Incapacity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>308</td>
<td>123</td>
<td>61</td>
<td>-</td>
</tr>
<tr>
<td>0-4</td>
<td>Home</td>
<td>340</td>
<td>60</td>
<td>60</td>
<td>45</td>
</tr>
<tr>
<td>0-4</td>
<td>Communal Establishment</td>
<td>461</td>
<td>230</td>
<td>173</td>
<td>230</td>
</tr>
<tr>
<td>5-9</td>
<td>Home</td>
<td>470</td>
<td>205</td>
<td>175</td>
<td>265</td>
</tr>
<tr>
<td>5-9</td>
<td>Communal Establishment</td>
<td>368</td>
<td>211</td>
<td>105</td>
<td>210</td>
</tr>
<tr>
<td>10-14</td>
<td>Home</td>
<td>30</td>
<td>28</td>
<td>26</td>
<td>21</td>
</tr>
<tr>
<td>10-14</td>
<td>Communal Establishment</td>
<td>5233</td>
<td>1667</td>
<td>1169</td>
<td>570</td>
</tr>
<tr>
<td>15-59</td>
<td>Home</td>
<td>286</td>
<td>200</td>
<td>202</td>
<td>201</td>
</tr>
<tr>
<td>15-59</td>
<td>Communal Establishment</td>
<td>2892</td>
<td>1097</td>
<td>997</td>
<td>299</td>
</tr>
<tr>
<td>60-69</td>
<td>Home</td>
<td>99</td>
<td>100</td>
<td>99</td>
<td>100</td>
</tr>
<tr>
<td>70-79</td>
<td>Home</td>
<td>4375</td>
<td>1548</td>
<td>1144</td>
<td>404</td>
</tr>
<tr>
<td>70-79</td>
<td>Communal Establishment</td>
<td>202</td>
<td>135</td>
<td>270</td>
<td>336</td>
</tr>
<tr>
<td>80+</td>
<td>Home</td>
<td>4561</td>
<td>1745</td>
<td>1837</td>
<td>765</td>
</tr>
<tr>
<td>80+</td>
<td>Communal Establishment</td>
<td>153</td>
<td>306</td>
<td>550</td>
<td>919</td>
</tr>
<tr>
<td>Total</td>
<td>Home</td>
<td>18198</td>
<td>6621</td>
<td>5486</td>
<td>2478</td>
</tr>
<tr>
<td>Total</td>
<td>Communal Establishment</td>
<td>770</td>
<td>769</td>
<td>1147</td>
<td>1577</td>
</tr>
</tbody>
</table>

Table 3 Estimated numbers of Disabled People within GGHB area by age group
PHYSICAL HEALTH IN GLASGOW

In addition to these congenital conditions which are evident at birth or early infancy, some 20 new cases of cerebral palsy and 30 cases of adolescent scoliosis are identified each year. Also there are in the GGHB area up to about 14,000 children with asthma, 220 with diabetes and 700 with epilepsy.

Disabled Adults
Table 4 gives estimates of the numbers of people aged 15 years and over with particular disabling conditions who live within the GGHB area.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Estimated Numbers</th>
<th>Number requiring special care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ischemic Heart Disease</td>
<td>60,000</td>
<td>n/k</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>50,000</td>
<td>n/k</td>
</tr>
<tr>
<td>Rheumatoid Arthritis</td>
<td>8,000 - 19,000</td>
<td>450</td>
</tr>
<tr>
<td>Chronic Respiratory Disease</td>
<td>14,000 - 60,000</td>
<td>n/k</td>
</tr>
<tr>
<td>Stroke</td>
<td>4,000 - 8,000</td>
<td>750</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>2,300 - 3,800</td>
<td>n/k</td>
</tr>
<tr>
<td>Parkinson's Disease</td>
<td>800 - 1,500</td>
<td>150</td>
</tr>
<tr>
<td>Alzheimer's Disease (Dementia)</td>
<td>9,000</td>
<td>n/k</td>
</tr>
<tr>
<td>Cerebral Palsy</td>
<td>1,500</td>
<td>100</td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td>600 - 800</td>
<td>150</td>
</tr>
<tr>
<td>Brain Injury</td>
<td>800</td>
<td>80</td>
</tr>
<tr>
<td>Spinal Injury</td>
<td>350</td>
<td>50</td>
</tr>
<tr>
<td>Stomas</td>
<td>500 - 1,200</td>
<td>n/k</td>
</tr>
<tr>
<td>Muscular Dystrophy</td>
<td>100 - 200</td>
<td>&lt; 50</td>
</tr>
<tr>
<td>Huntingtons Chorea</td>
<td>100</td>
<td>&lt; 50</td>
</tr>
<tr>
<td>Motoneurone Disease</td>
<td>&lt; 50</td>
<td>&lt; 50</td>
</tr>
</tbody>
</table>

Table 4. Estimated Nos of people with particular disabling conditions.

Disabled Elderly People
Table 5 gives estimates from the OPCS survey of disability of the numbers of moderately and severely disabled elderly people living within the GGHB area. The same survey shows that the main disability suffered in elderly people is locomotion, followed by problems with hearing and personal care. The other main disabilities relate to vision, dexterity, continence, communication, intellectual functioning and behaviour. In the more severe disability groups the great majority of sufferers will often have more than one and often several specific disabilities. In the milder disability groups there are of course a great many more sufferers. In people aged 65 years and over there are estimated to be 41% (60,000) people with some form of disability (OPCS categories 1 to 10) — representing 27% (23,000) of those aged 65-74 years and 60% of those aged 75 years and over.

Discussion
The differences in infant mortality which used to exist between the West and East of Scotland, and between Scotland and England, have disappeared. This is largely
because these inequalities were easy to measure and created sufficient public disquiet to bring about change (for example in obstetric and neonatal care and family planning). There is no reason why similar success should not be achieved in reducing death rates for adults, or for improving health in a variety of other ways. What is needed is to bring health differences more forcibly to public and political attention, and to encourage, and persist with, a lively debate about the changes necessary to make Glasgow at least as healthy as other towns and cities in the United Kingdom and elsewhere. Although such changes require intersectoral action, this need not become a party political or partisan issue.
MENTAL HEALTH IN GLASGOW

Information about mental health is much less complete than for physical health and is at present almost entirely limited to hospital discharge data. In most hospitals information is recorded for out-patient and other contacts, but as yet this is not available in a retrievable form. Hospital bed utilisation (table 1) is largely accounted for by patients with mental handicap and schizophrenia followed by senile dementia, because each of these conditions is category over the two year period 1988-1989). The average length of stay ranges from about 40 days for alcoholic psychosis to 700 days (men) and 900 days (women) for schizophrenia, with the affective psychoses and depressive illnesses having average values of 620 to 102 days. In older people by far the commonest diagnosis is dementia (2507 cases over the two year period) with much smaller numbers of cases of psychotic illness and depression.

<table>
<thead>
<tr>
<th>Disease Category</th>
<th>Bed days</th>
<th>Average Length of Stay</th>
<th>Discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Handicap</td>
<td>1,352,121</td>
<td>3.314</td>
<td>344</td>
</tr>
<tr>
<td>Schizophrenic Psychosis</td>
<td>1,315,182</td>
<td>764</td>
<td>1,491</td>
</tr>
<tr>
<td>Senile and Presenile</td>
<td>749,981</td>
<td>278</td>
<td>2,634</td>
</tr>
<tr>
<td>Psychosis</td>
<td>262,535</td>
<td>115</td>
<td>2,050</td>
</tr>
<tr>
<td>Affective Psychosis</td>
<td>194,167</td>
<td>206</td>
<td>882</td>
</tr>
<tr>
<td>Other Psychoses</td>
<td>178,116</td>
<td>88</td>
<td>1,934</td>
</tr>
<tr>
<td>Non Psychotic Depression</td>
<td>103,042</td>
<td>55</td>
<td>1,694</td>
</tr>
<tr>
<td>Alcoholic Psychosis</td>
<td>54,898</td>
<td>84</td>
<td>513</td>
</tr>
<tr>
<td>Other Conditions</td>
<td>50,264</td>
<td>127</td>
<td>356</td>
</tr>
<tr>
<td>Neuroses</td>
<td>42,426</td>
<td>120</td>
<td>316</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>14,530</td>
<td>20</td>
<td>710</td>
</tr>
<tr>
<td>Drug Abuse</td>
<td>1,201</td>
<td>75</td>
<td>14</td>
</tr>
<tr>
<td>Childhood Disorders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>4,318,463</td>
<td>306</td>
<td>12,938</td>
</tr>
</tbody>
</table>

Table 1 Bed utilisation in GGHG Mental Illness and Handicap Hospitals (Analysis for 1988 and 1989 by Diagnosis.)

Associated with prolonged lengths of stay. In terms of episodes of patient treatment however there are greater numbers (see 'discharges' in table 1) for psychoses (including alcoholic psychoses) and depression. There are also relatively large numbers of treatments for drug abuse.

In people under the age of 65 years (not shown in the table) most treatment episodes are attributable to psychotic illness, alcoholic psychosis, depression and schizophrenia (1400 to 1600 cases in each The average lengths of stay for older people in these categories were 278 days, 232 days and 121 days respectively. During 1988 and 1989 there were only 344 discharges from hospitals for the mentally handicapped, but their average length of stay was just over 9 years. Fig 1 (overleaf) shows that discharges from GGHG mental hospitals are higher than the Scottish average. Further analysis shows that this applies equally to short- medium- and long-stay residents, and that the same
difference is observed for both mental illness and severe learning difficulty. In the case of mental illness this may reflect either a change in the pattern of morbidity or in the treatment process. For adults with severe learning difficulties it reflects the policy of discharging patients as soon as adequate provision in the community is made available.

Information about in-patient hospital activity is clearly an insufficient base for the formulation of a policy relating to mental health. It is essential therefore to extend the information base to include general practice (both people attending with mental disorders and prescribing patterns), out-patient activity, and work in clinics and other locations — including self-help groups — where people suffering from conditions such as addiction may seek or be referred for treatment.

Of these the commonest and most important conditions are
(a) schizophrenia: there is a 0.8%–1.1% lifetime risk, which would suggest that 4,930-6,800 younger adults are affected long term, with 75% being aged between 15 and 30 years when illness begins;
(b) depression: 6% of men and between 12% and 17% of women (ie. between 49,690 and 71,290 persons) will be affected by depression at any one time, and 50% of these will be affected long term;
(c) anxiety states: between 2.8% and 12% of the younger adult population (17,300-73,900 patients) will be affected.

Extrapolation from the OPCS survey of disability suggests that in the GGHB population aged 16 to 64,12,000 persons will have some degree of intellectual impairment and that 900-2,500 persons will have severe intellectual impairment.

**Mental Health of Younger Adults (16-64 years)**
Various studies have shown that about 70% of women and 50% of men will at some time in their lives consult their general practitioner about a mental health

**Younger Adults (15-64 years) with Alcohol Related Problems**
In a study of Scottish 15 and 16 year olds 70% of boys and 61% of girls admitted to
MENTAL HEALTH IN GLASGOW

It is likely that in the GGHB population, some 21,800 people are at high risk of damaging their health from consuming too much alcohol and a further 96,500 are at moderate risk of damaging their health. Of these at least 2,500 are dependent on alcohol, 12,300 will have problems (health, social, psychological) related to alcohol, and 49,300 will have biochemical abnormalities related to alcohol.

Drug Abuse

The estimated total number of intravenous drug users in Greater Glasgow is in the range 7,000-12,000 representing 11-19 per 1,000 population aged 15 to 55 years. The estimated male:female ratio is 2.6:1, and the modal age group is 20-24 years. Some 1,300 intravenous drug users are in contact with the needle exchange scheme and a further 1,500 or so with other drug projects. About 150 patients each year receive detoxification.

122 of 208 (59%) street working prostitutes interviewed in Glasgow were intravenous drug users compared with 15% in similar studies in London and Birmingham.

Buprenorphine (Temgesic) is the most commonly injected drug. Benzodiazepines such as Temazepam and stimulants such as amphetamines are also commonly
MENTAL HEALTH IN GLASGOW

injected. There is evidence of a steady moderate decrease in the number of prescriptions being dispensed for these and other benzodiazepines. The number of prescriptions for Methadone, often used as an oral alternative to intravenous drugs, is increasing. During 1989 there were 510 suspected offences (possession and/or supply) in the GGHB area under the Misuse of Drugs Act. 43% related to opiates, 31% to stimulants, 20% to benzodiazepines, 6% to hallucinogens and 0.1% (2 cases) to barbiturates.

Mental Illness and Disability in People Aged 65 Years and Over

Functional Mental Illness

Extrapolations similar to those for mental illness in younger adults suggest that there are about 360 sufferers from schizophrenia and paranoid states (0.25% of people aged 65 years and over), 5,000 to 14,000 sufferers from major depression (4%-10% of this age group), and up to 7,000 (5%) with neurosis and personality disorders.

Organic Mental Illness (dementia or Alzheimer’s disease)

Population studies conducted elsewhere suggest that the prevalence rates and numbers of sufferers in the GGHB area will approximate to the following:

- 1% of 65-74 year olds, 830 people,
- 3% of 70-79 year olds, 1,970 people,
- 17% of 80-84 year olds, 3,180 people,
- 30% of 85+ year olds, 3,120 people;
9,100 people in total.

Severe Learning Disability

The numbers of older people with Severe Learning Disability are relatively small: prevalence decreases markedly with age since these people tend not to survive into old age. Strathclyde Region Social Work Department estimates suggest that there are about 300 mildly, 300 severely and 130 profoundly mentally disabled people aged 65 and over living in the GGHB area.
SOCIAL HEALTH OF GLASGOW

Social health is the most difficult to assess of the three health dimensions and the least influenced by health services. However in many ways good physical and mental health can be attained only in the presence of favourable social circumstances, and so it is important to identify and try to measure some of the social determinants of health. This is an essential prerequisite to the formulation of intersectoral policy for the improvement of health.

The GGHB population compares unfavourably with the Scottish average in terms of many key social and environmental variables. Fig 1 illustrates this for the proportion of children living in single parent households, economic inactivity due to ill health, social class, overcrowded households and car ownership. The population of the GGHB area however is perhaps uniquely variable in its socioeconomic and health characteristics. It comprises for example the healthiest and (apart from Monklands) the least healthy local government districts in Scotland.

Using a technique known as cluster analysis it is possible to group together small areas (postcode sectors) which have similar socioeconomic characteristics, as derived from the census. Thirty characteristics from the 1981 census have been used in this way to identify eight 'neighbourhood types' which differentiate the communities in Greater Glasgow in a way which accords well with people's own perceptions.

Socioeconomic Characteristics of Neighbourhood Types

Neighbourhood types 1 and 2 comprise the most socioeconomically advantaged areas, whereas type 7 comprises the peripheral housing estates and type 8 the inner city areas. Fig 2 (overleaf) illustrates the differences between the neighbourhood types in five key indicators. The differences between these areas in owner occupancy, overcrowded households, social class and unemployment are very considerable, as the histograms
ILLUSTRATE. HOWEVER, THE ONLY AREAS WHERE A SIGNIFICANT PROPORTION OF HOUSES LACK AMENITIES ARE THE INNER CITY AREAS (NEIGHBOURHOOD TYPE 8) AND THE AREAS WITH A RELATIVELY HIGH PROPORTION OF PRIVATELY RENTED ACCOMMODATION (NEIGHBOURHOOD TYPE 6).

A DESCRIPTION OF EACH OF THE DIFFERENT NEIGHBOURHOOD TYPES, TOGETHER WITH THE PERCENTAGE OF THE GGHB AREA LIVING IN EACH, IS AS FOLLOWS:

**Neighbourhood type 1**
Large owner-occupied housing, mainly professionals and non-manual workers eg. Eastwood, Bearsden and Milngavie (13% of population).

**Neighbourhood type 2**
Mainly owner-occupied housing, families with young children, professional and non-

MANUAL WORKERS E.G. SOUTH CAMBUSLANG, STEPPS AND MILTON OF CAMPsie (9% OF POPULATION).

**Neighbourhood type 3**
Mixed tenure accommodation, high proportion of families with no children, single persons and students. Mainly non-manual and professional workers eg. Shawlands, Broomhill, Kelvinside (10% of population).

**Neighbourhood type 4**
Mainly inter-war local authority housing with ageing and elderly population eg. Knightswood, Mosspark and Riddrie (17% of population).

**Neighbourhood type 5**
Mainly post-war local authority housing with young families and skilled workers eg. Pollok, West Castlemilk and Faifley (20% of population).
Neighbourhood type 6
Mixture of small rented furnished and owner-occupied households with shared amenities; single persons, students, immigrants and high unemployment eg. Woodlands, Strathbungo and Govanhill (5% of population).

Neighbourhood type 7
Post-war local authority housing with young families, high unemployment and mainly unskilled workers eg. Drumchapel, Easterhouse and Nitshill (10% of population).

Neighbourhood type 8
Mixed tenure-type but mainly local authority, vacant properties and small, overcrowded households sharing amenities. Ageing population with few children and high unemployment, mainly unskilled workers eg. Govan, Bridgeton, Ruchill (17% of population).

Further information about these neighbourhood types is provided in the Annual Report for 1989.

Some Health Characteristics for Neighbourhood Types
Fig 3 (a&b) provides, for a variety of health measures, a comparison between neighbourhood types 1 and 2 (aggregated) and 7 and 8 (also aggregated). Fig 3(a) shows that there is clearly a very close degree of association between these measures and socioeconomic circumstances. There is a greater than five-fold difference in the proportions of unimmunised children and of teenage mothers, an approximately three-fold difference in the proportion of mothers who smoke or who breast feed their babies, and a greater than 50% difference in the incidence of low birthweight and in perinatal mortality.
Fig 3(b & c) shows that for younger adults (below 64 years) there is a greater than two-fold difference in mortality and an approximately two-fold difference in hospital discharge rates.

Variation in Discharges from Hospital with Neighbourhood Type

In order to make meaningful comparisons it is possible to standardise rates of discharge of patients from hospital for differences in their ages and sex in the same way as mortality rates are standardised. The previous figure showed that there is an approximately two-fold difference in bed utilisation in the acute general (ie non-obstetric, non-mental) hospital specialities when younger people living in neighbourhood types 1 and 2 are compared with those living in neighbourhood types 7 and 8.

In the 1990 DPH report this analysis was extended to mental illness, and a selection of surgical procedures. It showed that for all patients treated in mental hospitals (all diagnoses) there is a four fold difference in discharge rates between the inner city and the most advantaged neighbourhood types. For the specific diagnoses alcoholic psychosis and drug abuse the differences are very much greater still (seven to ten fold), whereas for senile and presenile dementia and severe mental handicap there is no clear relationship between socioeconomic status and the proportion of people admitted to hospital.

The report also found that there appears to be no association between operation rates and socioeconomic circumstances in the case of cataract removals. For fracture of the neck of femur there is however a clear association - operation rates for residents of the
SOCIAL HEALTH OF GLASGOW

Peripheral housing estates being some three times greater than for people living in the most advantaged areas. Hip replacements however show the converse trend with people living in neighbourhood type 1 having a more than 50% greater chance of the operation than those living in neighbourhood types 7 and 8.

Discussion
The determinants of health which give rise to these inequalities cannot be attributed to lifestyle alone, but are the result of complex interactions between factors such as socioeconomic circumstances, education and the environment. Except for a very few indices, the health of the population of poorer areas can be improved only by carefully co-ordinated multisectoral action — involving the regional and district councils and the voluntary sector as well as the Health Board. Information about the health of these communities is available for several years past, and would provide a very suitable baseline for evaluating innovative health promotion measures. Another important factor in attempts to improve health in the least healthy neighbourhoods is the existence, in many of the most disadvantaged areas, of active self-help groups and other voluntary organisations.
LIFESTYLE AND HEALTH IN GLASGOW

Information is not routinely collected about the lifestyle of the population of the GGHUB area. A number of ‘ad hoc’ surveys however have been conducted, including a ‘Glasgow 2000’ survey on smoking, a baseline survey (1986) for the ‘Good Hearted Glasgow’ campaign, and the Scottish Heart Health Study (which included Eastwood and much of north and south Glasgow City).

Fig 1 provides, for a variety of lifestyle measures, a comparison between the populations (sexes combined) of the most and least ‘deprived’ areas of Greater Glasgow. 60% of people in the most deprived areas are current smokers, compared with 35% in the least deprived areas. Almost twice as high a proportion of the population of deprived areas drinks more than 15 units per week, although (not shown) more people in deprived areas claim that they do not drink at all. And about 12% more people are overweight in the most deprived areas.

Fig 2 shows consumption of low fat spreads is much higher in the least deprived parts of Glasgow, and that in these areas consumption of butter is also greatest. In the most deprived areas ordinary margarine — being the cheapest — is by far the most commonly used spread. At the time of the survey, almost 70% of people in the most deprived areas consumed
LIFESTYLE AND HEALTH IN GLASGOW

only white bread, compared with 25% in the least deprived area. Semi-skimmed milk accounted for almost 40% of milk consumed in both deprived and non-deprived areas. Since this type of milk is not very much cheaper than ordinary full-fat milk this suggests that people from all types of areas will reduce the fat content of their diet provided that a low fat option is available, acceptable and no more expensive.

Finally Fig 3 shows more than twice as high a proportion of people living in the most deprived areas say that they eat no fruit and green vegetables. The per capita intake of fresh fruit in Scotland is believed to be among the lowest in Europe.

Paradoxically nearly everybody understands what has to be done to have a healthy lifestyle, but there are many pressures which make it difficult to turn this knowledge into action. Since some unhealthy behaviours are strongly associated with deprivation, action to help reverse the effects of relative poverty must be the first priority. People with a reasonable income a good home and attractive environment are much more likely to adopt a healthy lifestyle. In the short term there is much that could be done to make the ‘healthy choices the easier choices’, healthy school meals, better and cheaper transport, banning cigarette advertising, improving the supply of affordable, quality food to low income households.

![Fig 3 Risk Factors for Cardiovascular Disease (1986) Comparison of Most and Least Deprived Areas](image-url)
IMPROVING HEALTH IN GLASGOW

Over the past ten years the city of Glasgow has undertaken a remarkable amount of work to address its social ills. The local authorities and development agencies have been working hard at economic regeneration and environmental improvement in a climate which has not always been supportive.

Running parallel to this has been a growing concern about health. Alliances have been forming at all levels, from small community groups up to senior officers and politicians. Work has been taking place on, and lessons learned about the ways in which health is produced in the city. For a complex issue like health which is shaped and developed in many ways there are many different approaches, this section outlines a range of them.

The Healthy City Project

The city of Glasgow became a member of the European Healthy Cities Project in 1988. Among the reasons for the World Health Organisation invitation to participate and Glasgow’s enthusiasm to join were:

- The relatively poor overall health of Glasgow, with some areas having levels of health as good as anywhere in Europe but with others being among the least healthy in the developed world.
- The realisation that the main cause of the poor health of Glasgow was its high levels of poverty and deprivation.
- The determination by Glasgow City Council, Strathclyde Regional Council and the Greater Glasgow Health Board to work together to improve the health of Glasgow by concentrating efforts on those areas with the poorest health.
- Work already done in urban renewal, economic regeneration, environmental improvements and in the involvement of voluntary and community sectors.

At the heart of the Project is the belief that with suitable social, economic and environmental improvements dramatic improvements in the health of the city will be possible. The partner agencies in the Project have made many advances in developing this work.

Glasgow City Council has developed a sub committee on Environment and Health to address these issues. It has also published a consultation document ‘Glasgow’s Environmental Action Plan’ on the links between the environment and health, and a working group on this subject has been established.

The council has also made major inroads into refurbishing houses in the peripheral estates, and in tackling the massive problem of damp housing. An initiative is also underway in Easthall, which will quantify the health benefits of providing warm, damp-free housing. A consultation document is also about to be published on the Council’s strategy for people with special needs — ‘Meeting Needs, Protecting Health’.

In 1988, the Greater Glasgow Health Board joined with Strathclyde Regional Council, Glasgow City Council and a variety of community-led organisations to establish the city of Glasgow as a member of the WHO Healthy Cities Project. This is the principal mechanism available to the Board for working with others to influence the determinants of health which are outwith the Board’s direct control. Two projects which have been established are the successful long-running ‘Glasgow 2000’ campaign against smoking, and the much more recent Women’s Health Policy for Glasgow. In 1989 the Health Promotion Department was extensively reinforced and re-structured and established ambitious programmes with clearly specified targets. These programmes are successful and are being developed continuously.
Strathclyde Regional Council has published a consultation document ‘Health for All, Whose Responsibility?’, and has also created a ‘Health for All’ working group. Health is also an integral part of the Regional Council Social Strategy document.

The Project funds three issue based working groups (environment and health; transport, traffic and health; women’s health) which report to the Project Steering Group. The Project is also actively developing work with Strathclyde Poverty Alliance which includes amongst other concerns the relationship between food, poverty and health.

The achievements of the Project so far fall into four main areas:

1. **Policy Development**
The development of a City Health Plan which will incorporate a community development and health strategy for the city. The Project through its Women’s Health Working Group has developed a Women’s Health Policy for Glasgow. The Project office lobbies for the inclusion of a health perspective in a variety of policy and strategy documents.

2. **Local Action Programme**
The Project is committed to innovative health promotion and has funded a local action programme which is now well established. The objective is to put ‘Health for All’ principles into practice in participation with local communities and to demonstrate practical benefits.

Through the work of its Community Health Support Unit the project has developed and supported a wide range of local action. Programmes have been established in Drumchapel, Haghill, Dalmarnock, Easterhouse and Gorbals.

3. **Information and Training**
Collaborative working on health issues is a rapidly developing area which the project supports. Activities to allow discussion of ongoing work in a broad health context and to explore collaborative ways of working on health issues are organised by the project, forums, conferences, lectures and seminars. It is also developed by its publications and advice. Publications include reviews of the annual community conference, ‘Community Development and Health Visiting’, ‘Your Patients’ Rights to Welfare Benefits’ and various Working Group publications.

4. **Networking**
The Project builds links between services, projects and communities by funding, information exchange, giving advice and by participating in conferences and working parties.
Women’s Health Policy for Glasgow

The Glasgow Women’s Health Policy was launched in June 1992 with the aim of improving the health and wellbeing of women in Glasgow. The policy document was prepared by the Healthy City Project- Women’s Health Working Group which is open to all women and has representation from a wide range of voluntary and statutory organisations.

The policy has been accepted by all the partners of the Project and they have set up mechanisms to put the policy into practice. It is intended that the policy should be followed wherever and whenever women’s health is of concern to agencies working within Glasgow. It covers women’s health in the workplace, in their private lives and in their contact with health and other services. Specifically, it makes recommendations to create a new awareness about women’s health and improvements in policies and practices which involve issues of women’s health.

The aim and objectives have universal application and it is recommended that all statutory and voluntary organisations should adopt them. In addition organisations should implement all the recommendations which relate to their activities.

The objectives are as follows:

1. Raising awareness about women’s health needs and an understanding of a women’s health perspective.
2. Introducing this awareness into policy and planning processes of statutory and voluntary agencies.
3. Ensuring women’s health needs and a woman’s health perspective is incorporated into the delivery of general health care.
4. Ensuring the provision of services and support specifically for women.

The five priorities of the Policy are: to improve emotional and mental health, to improve the health of women as carers, to improve reproductive health, to reduce the incidence of disease and to improve health and safety at home and in work.

Support for proposals for a Centre for Women’s Health in Glasgow has now been agreed by the main funding partners of the Project and the opening of the centre is scheduled for November 1993. It is hoped that the work put into both the Women’s Health Policy and the Centre for Women’s Health will form the basis for expanding and developing practices which will have a real effect in the health and wellbeing of women in Glasgow.
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Environment Group
In recognition of the increasing importance of environmental issues, the Public Health Department has established an Environment Group, whose tasks will include the development of environmental policies to protect and promote health in the GGHB area. The group is concerned not only with specific hazards to health, but also with more general environmental determinants of health and health behaviour, and aims to make full use of relevant expertise within the member departments and research units of the Institute of Public Health, based at Glasgow University.

A specific area of interest concerns the development of local profiles, comprising routine information on health and the environment, which may be used to inform local communities and to provide a basis for the development and monitoring of local plans to improve the environment.

Action to improve the environment can be taken by individuals, by local communities and by statutory organisations. As part of the Healthy City Project, it is intended that this group should provide recommendations and guidance on actions to be taken at all levels.

Community Health Projects
There are a growing number of community led health projects developing around the city. These are a response to specific health concerns in the community and harness the concern and abilities of local groups and workers. The Health Board through its Health Promotion Department has been active in these developments for a number of years, and continues to support local initiatives through its local teams and with the Healthy City Project.

One of the community projects that has developed recently has been in Drumchapel and it provides a good example of the scale and scope of this type of work.

"Drumming Up Health".
This project is the urban aided development of the Drumchapel Healthy City Pilot Project. Based in a community venue and developed from community health action in Drumchapel over a number of years this project is an excellent example of collaborative working in practice.

Funding for the pilot project came from the Glasgow Healthy City Project and the Drumchapel Initiative. The Health Board seconded two full time workers (Health Promotion Worker and a Health Visitor) and the department of Public Health at Glasgow University provided a researcher.

The lynchpin of the project is its development of a network of community health volunteers. These volunteers take an active part in the development and running of the project as well as in community health activities. Training is offered to local people in basic health awareness, counselling, first aid, desktop publishing, publicity and public speaking, video-making and environmental awareness.

The volunteers are then supported and
encouraged to participate in the various activities of the project. To date this has included membership of the working and executive groups and the community health forum, compiling and producing the quarterly newsletter and writing articles for the local paper. The volunteers have also designed and carried out health surveys, identified and highlighted local health needs and taken part in presentations and discussions.

The project has various initiatives. A community health library is based at the project which provides local residents and workers with a range of books leaflets and videos on health-related topics. The project also supports a number of community health forums.

Now with funding through the Urban Programme to supplement the continuing commitment of the Health Board the project continues to develop work that is based on the philosophy of ‘Health for All’ and reflects the needs of the local community.

The Health Promotion Department

The GGHB Health Promotion Department is one of the major agencies acting to fulfill the Board’s Health Promotion Strategy and it also makes a major contribution to the activities of the Health City Project described above.

The Board’s Health Promotion Strategy sets out three broad aims:

1. Prevention of illness.
2. Promoting healthy lifestyles.
3. Creating healthy environments.

The Health Promotion Department is committed to working through ‘Health for All’ principles to achieve these broad aims by influencing the following areas of activity:

1. Health services within Glasgow.
2. Health-related behaviours and lifestyles.
3. The local environment.
4. Education in all forms.
5. The media and popular culture.
6. Local policies which influence health.

These areas of activity are influenced by using the following approaches:

- The provision of resources for health education free of charge for all who need them.
- Training of individuals and groups involved in health promotion is given to support health promotion programmes.
- Media campaigns are conducted using newspapers, television, radio and outdoor advertising to raise awareness of health issues.
- Five key settings (local communities, the workplace, the primary care system, hospitals and schools/colleges) are the sites of major health promotion programmes.
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• The Department also runs a series of topic-based programmes dealing with smoking, nutrition, addictions, HIV/AIDS, child safety, exercise, child and adolescent health, dental health, women’s health and stress.

• The creation of healthier environments permeates much of the Department’s activity, although this function is fulfilled mainly through the workplace and community programmes and through collaboration with the Healthy City Project.

• Evaluation is carried out of large scale or innovative health promotion activities so that future plans can be soundly based.

• Information about health and its determinants is provided by the Department to a wide variety of interested parties.

Priority Areas

The Department of Health Promotion is working on five priority areas during 1992/93.

1. Implementation of the ‘Get Up and Glasgow’ media campaign which targets 15-25 year olds through TV, radio, outdoor media, press, local networks and business.

2. Establishment of a youth project and a GP support project aimed at addressing inequalities in health.

3. Health promotion in hospitals with particular emphasis on the GGHB Food Policy and Smoking Policy.

4. Developing links with the GGHB Community/Primary Care Unit to devise and implement locality based plans.

5. Development and implementation of a new health check programme.

Special Initiatives

In the past year the Health Promotion Department has developed a number of special initiatives:

1. Intensive health promotion in the Govan, Ibrox/Cessnock, Kinning Park area. Urban Aid funding has been secured for this project which will take an intensive and innovative approach to health promotion in a defined inner city area.

2. The Healthy Business Project. This research project is funded by the Glasgow Development Agency and supported by the Govan Initiative and Healthy City Project. The aim of the research is to find out whether health promotion at work produces measurable business/economic benefits to companies as well as health benefits to their employees.

3. East End Health Promotion Strategy. The East End Health Promotion Strategy has been approved by the East End
Management Group and will focus initially on three localities in the East End.

4. A comparison of different health check interventions. This research project in the Rolls Royce factory and a separate control site is designed to evaluate different components of a health check methodology. This information will be vital to the further development of this approach to health promotion.

5. Evaluation of the Healthy City Pilot Project in Drumchapel. Funded through a mini project grant awarded by the Chief Scientist Office this takes an action re-

search’ approach to evaluating the Healthy City Project in Drumchapel.

The above is a brief summary of the various programmes and activities being carried out by the Health Promotion Department. All of these are designed to further the strategic health promotion aims of GGHB but should be seen as a small part of the overall health promotion endeavour which is developing in a wide variety of ways throughout the city.

Glasgow 2000

Glasgow 2000 is a good example of an approach to health promotion which involves many sectors of the city’s life. It began as a project which was financially supported by the Greater Glasgow Health Board, the Scottish Health Education Group, Strathclyde Regional Council and Glasgow City Council. Funding and management have been taken over by the Health Promotion Department but the inter-sectoral links for operational activity remain.

Recognising the complex issues involved in tobacco control, ‘Glasgow’ 2000 is based on a comprehensive approach:

- to encourage children not to start smoking.
- to help those who wish to stop smoking.
- to promote the expansion of smoke-free environments.
- to raise issues about tobacco for public debate.
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The project’s activities have reflected the breadth of these aims, and particular successes include:

No Smoking Days:
A large network of local activists has been created, with the result that awareness and participation figures in Glasgow are consistently above the UK average.

Innovative children’s work
Glasgow has one of the first and now the largest Smokebusters Club, with 28,000 young members. The Club formed the focus of a European Conference on Young People Against Tobacco in 1990, and has been awarded a medal by the World Health Organisation.

Innovative materials:
‘Take Control In Your Home’ was a practical guide to reducing children’s exposure to tobacco smoke, designed for and distributed to areas of deprivation. Cessation materials for teenagers have been produced, including a pack for non-smoking children who want to help their families stop smoking.

Collaborative policy and strategy work
‘Glasgow 2000’ has worked with a wide range of local, national and international organisations both to advise on tobacco control policy and to plan strategy. The project now represents Glasgow on the Healthy Cities Multi-City Action Plan on Tobacco.

Future strategy for ‘Glasgow 2000’ will focus on collaborative work by Glasgow’s many partners in tobacco control. While education and cessation services are well established, progress is needed in the expansion of smoke-free public places and in the reduction of tobacco promotion to which children are exposed. Existing partners (statutory and voluntary agencies) will be encouraged to continue their activity, and new partners in the private sector will be approached to participate appropriately. Smokebusters will continue to develop by expanding members’ direct participation, and by addressing the needs of older teenagers including those who start to smoke.
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GGHB's Strategy to reduce Health Inequalities
Better health is 'everyone's business' and the key to success is co-operation between all relevant sectors and the Glasgow public. Participation by the community in decisions concerning their health is also vital and GGHB seeks to involve the public in decisions about health needs, priorities and service delivery.

GGHB’s strategy to improve health status is to:

1. Collaborate with other agencies which influence health.
2. Strengthen primary health care. This will be achieved by providing additional support and encouraging partnership with community services, particularly in areas of deprivation.
3. Further develop health promotion programmes.
4. Target health promotion initiatives and community services to areas of greatest need.
5. Use the hospital and primary care settings for prevention and health promotion as well as treatment.
6. Increase the priority given to the care of physically and mentally disabled people and others with special needs.
7. Purchase cost effective health care, to meet the needs of the population.
8. Work with providers, to ensure that resources are used in the most effective way to provide high quality and accessible health services.
9. Promote quality and the pursuit of excellence, by defining standards, promoting audit and valuing staff who are the most important resource.
10. Encourage a patient centred approach and participation by individuals and groups in decision making.

Actions to be taken
• Defining Target Groups
  Action directed towards reducing inequalities in health should be directed mainly towards younger people since the health of many people currently in middle age and later life has been determined by environmental and behavioural influences which began to have their effects several decades ago. If the health of Greater Glasgow is to change, the main potential for improvement lies with an enhancement in health status of those who live in the least healthy areas.

However, within these areas there are individuals and groups who have such profound social and economic difficulties that they are unlikely to respond to traditional preventive measures. These groups require initiatives directed at poverty, housing and associated factors in the first instance.

• Influencing Others
  The Health Board can do little to influence directly the city’s environment but it can analyse the health effects of wide range of environmental and social determinants of health and use this information to influence the activities of local government and other relevant bodies. For example, education is a major influence on behaviour and the Board has a role in advocating effec-
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tive health education in schools and the creation of a school environment which reinforces and supports health education (eg. healthy school meals and playground safety). The promotion and support of smoking, alcohol and food policies in many settings is another important example of advocacy for health. Other issues could also be addressed.

Specific actions agreed by the Health Board

The following specific proposals have now been agreed by the Board:

1. To support the principle that community services should be explicitly targeted to areas of greatest need and written plans for prevention and health promotion should become the norm among all community staff. It is intended that all community staff should devise and work to explicit locality based health promotion plans which have clear outcome indicators against which success can be judged.

Under this system of planning, natural communities or ‘localities’ have been identified and community staff are using a variety of techniques to assess local need. Plans will be drawn up to work with general practitioners, local government workers and others to improve local health outcomes. For example, if drug abuse, child safety and high levels of smoking are identified as problems in a given area, specific plans will be drawn up for accident prevention, drug prevention/harm reduction and smoking prevention/cessation. Locality plans of this nature do not currently exist so, in the first instance, the methodology will be piloted and refined in two communities (probably Easterhouse and Maryhill) during 1992/93.

Locality plans will be complemented by a Board-wide Community Strategy which ensures relatively high levels of staffing in areas of greatest need.

2. To introduce clauses in service specifications for acute hospitals to ensure that secondary prevention (in particular smoking cessation) is given high priority during admission.

People from the less advantaged parts of Greater Glasgow are admitted to hospital more frequently and stay longer than is the case for the population in general. However, the hospital setting is utilised in a very uneven way for prevention and health promotion. Disappointingly, the Board’s Smoking Policy has not been used as an opportunity to formalise advice and support for smokers.

Therefore, the Board as a purchaser of services will introduce the need for prevention as a quality clause in contracts with acute hospitals. Support for smokers who want to stop can be achieved fairly simply by introducing a clear protocol of advice and support which starts at the time of admission. Nurses and doctors already have detailed admission protocols, and a more proactive approach to smoking and related issues will be established for the period of admission.

3. To pilot two innovative approaches to prevention and health promotion in selected inner city areas and peripheral housing schemes at an estimated cost of £400,000 for two financial years (1992/94).

a. General Practitioner Project
The primary care team is the main focus for health care and health promotion within the community and therefore is a natural location for additional activity aimed at improving the health of people.
living in areas of multiple deprivation. The additional advantage of the primary care setting is that the general medical practitioner has a defined list of patients about whom information on smoking, blood pressure and screening status is increasingly being recorded in a systematic way. Seven practices in deprived areas were chosen, and these have been allocated usually one member of staff with specific skills and expertise, depending on the needs of the practice. Eight primary health care promoters have been appointed to manage the projects.

One project focuses on working with families, particularly single parent families and those with particular problems such as children with behavioural difficulties or facing social problems such as housing difficulties. Two projects explore what can be achieved by addressing a full range of general lifestyle issues in multi-practice settings. The health needs of young people within practice populations are the target of a further two projects and ethnic minority and mental health issues are being addressed in a project focusing predominantly on supporting, educating and promoting the health of women. The seventh project is promoting healthy eating.

b. Youth Health Promotion Project
The target group is defined as young people aged 11-18 years living in defined disadvantaged communities. Existing health services are very rarely used by young people, being poorly tailored to their needs. The proposal is to provide, in four pilot localities, a range of health
promotion programmes designed to address the health needs of young people. Teams of four staff, comprising a community nurse, a health promotion officer, a youth worker and a counsellor, will work intensively within the chosen pilot localities. Each pilot project will seek to increase youth involvement in healthful activities, improve health related behaviours and provide information and skills which will enable young people to stay healthy. The final choice of indicators for evaluation will depend on local circumstances but the success of the project will be measured in terms of reduced prevalence of harmful activities (smoking, drug use, alcohol abuse) and an increase in health enhancing activities (eg. exercise). Projects are now being established in St Leonards and Lochend Secondary Schools in Easterhouse; in a community flat in Cambuslang; in Gorbals Youth Project premises; and at the Claremont Terrace headquarters of the Family Planning Service.

4. To note the need for the Board to further influence other bodies which have responsibility for social and environmental determinants of health within Greater Glasgow. Collaborative work with agencies which have responsibility for social and environmental determinants of health (particularly housing, social work, education and central government) must be strengthened. Health promotion activities should continue to be targeted on areas of greatest need and preventive measures (eg. smoking cessation) are being included in contracts for hospital services.
IMPROVING HEALTH: WIDER PERSPECTIVES

New opportunities to develop health in the city through healthy alliances has been the central theme of this publication. The role of central government in providing support and a framework for action needs to be further explored.

With the welcome publication of the recent white paper "Scotland's Health: A Challenge to us All" the production of health rather than the provision of health services has become the focus of health board activity. This is a major and essential first step in the process of improving the health of the population of Scotland and particularly the West of Scotland to more acceptable levels. The provision of health targets is also extremely important in that it provides a focus for action and a basis for monitoring progress.

Poverty and deprivation
The White Paper (para 58) recognises that health promotion, health education and preventive services such as screening and immunisation which are now high on the agenda for all health boards must be focused 'on groups with particular problems eg. people in deprived areas'. It also indicates (Appendix B, para 17) that in Scotland's most disadvantaged communities 'poor health often co-exists with high unemployment, poor housing and poverty' and identifies four Scottish Office-led partnership initiatives (including one in Castlemilk, Glasgow), and regeneration initiatives led by other agencies in which a 'comprehensive multi-agency approach' to these problems is being taken. These initiatives aim to improve living standards by action on training, employment and housing and the White Paper recognises that this should lead to improvements in health.

Although it is acknowledged in the White Paper that poor health is associated with unemployment and poverty, and that preventive and other health services should be focused on deprived areas, poverty and deprivation are not specified as a priority; in fact the importance of increasing employment is mentioned only once and there is no discussion at all of the need to alleviate poverty.

The needs of the elderly, disabled and mentally ill
The targets in the White Paper are directed towards the more serious causes of mortality or disease for which there are preventive possibilities and where progress may be measured in quantitative terms. However if efforts are concentrated on attempting to achieve these targets, resources may be diverted from health problems which are perhaps of equal importance but more difficult to measure, for example the care of the physically disabled and elderly, and of people with mental illness and mental disability.

The Need for Legislative Measures
The White Paper emphasises the need for individuals to improve their own health but makes little reference to the need for Government intervention. The promotion of health is an activity for all levels of membership of society and has to permeate Government, Business and Social Sectors as well as the individual and community.

For example the possibility of dietary change for disadvantaged members of our society is governed more by the pricing and availability of foodstuffs, and the effects of marketing, than the exercise of free choice. This was admitted in the white paper and concern about retail provision of healthy foodstuffs was raised. The food industry has an important part to play in
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the health of the nation and it is necessary for government to balance the economic objectives of this industry with the health needs of the people.

The White Paper however does not discuss equity as a goal or even as a concept. This is at considerable variance with the report of the US Department of Health and Human Services (1990), which in specifying its targets for health by the year 2000 described the overall goals as being 'increasing the span of healthy life, reducing health disparities, and achieving equitable access to preventive services'. The provision of health care on the basis of health need is mentioned once in the White Paper, but it is not identified as a principle.

The importance of empowerment is acknowledged in the White Paper, for example in references to education and in efforts to enable consumers to be able to exercise real choice over the foods available for purchase rather than being restricted to what producers and distributors choose to make available. However there are many more aspects than these to enable people to realise their full physical and mental potential. This is a most important objective which requires much more extensive debate.

Participation by the community in decisions which affect health is not mentioned in the White Paper. This is a serious omission because participation by people themselves, particularly in the more deprived areas is a prerequisite for change. If the targets prescribed in the White Paper are to be achieved there must be genuine commitment by clinicians, managers and not least by people themselves; attempts to manage change from the centre will almost certainly be unsuccessful in those areas where change is needed most.

There is general agreement that inter-agency co-operation is essential if fundamental health needs are to be adequately addressed; there is also general agreement that primary care should be the focus for health service provision, and that it should be as responsive as possible to local needs.

Discussion
The UK has now caught up with much of the rest of Europe in setting targets and in giving clear directives for improving health. The White Paper places the promotion of good health and the prevention of disease rather than the provision of health services as the focus of responsibility for the NHS. In doing so it provides the first real opportunity to make the health services — with its recent reforms — effective in improving people's health. It is essential, particularly for those populations with the poorest health, that this opportunity is enthusiastically taken up.

Within the white paper there is support for collaborative working on health issues. What is needed now is a concerted effort by all of the partners, Central Government, Local Authorities, Business and local communities to focus on further developing the work that has taken place in Glasgow. The lessons that can be learned from the development of healthy alliances and collaborative working in Glasgow can usefully be transplanted to other areas of socioeconomic deprivation in Scotland.
CALL FOR ACTION

The principal message of this report is that the poor health record of Greater Glasgow, and of the city of Glasgow in particular, is attributable almost entirely to the predominance of material and social disadvantage. Disadvantage exerts an adverse influence on health from a very early age, and children who are brought up in an adverse environment are likely to suffer greater ill health and premature mortality throughout their adult life than their more fortunate counterparts.

Health Boards acting alone have limited ability to improve the health of the populations for which they are responsible: most health service activity is directed towards dealing with problems which public health has failed to prevent. Exceptions to this are preventive activities such as immunisation, the early detection of disease (eg. by screening or surveillance) and health promotion (eg. by discouraging smoking, or encouraging taking exercise and a healthy diet). The Greater Glasgow Health Board is making strenuous efforts on all these fronts and aims progressively to increase expenditure on such preventive activity. Also, it has embarked on innovative approaches to prevention and health promotion in deprived inner city areas and peripheral housing estates. Some of these are based on general practices while others are youth health promotion projects in specific settings.

The Health Board also must keep others informed about the ways in which their own activities influence health. It must work in partnership, in particular, with local and central government to try to address issues such as housing, tobacco consumption, safety, employment, and the availability of healthy foodstuffs — all of which are fundamental determinants of health.

The main focus for joint action with local government is the Healthy City Project. This is based on the conviction that health is the outcome of a wide range of activity for which many agencies as well as the individual have responsibility. This broad view of health is reflected in support from all three statutory agencies (the Health Board, Glasgow City Council and the Regional Council), the Universities and a wide range of bodies in the voluntary and community sector. More direct forms of collaboration with individual agencies also are needed. One example would be to explore to what extent cost effective interventions are available to combat the health damaging effects of poor housing. Another might be to determine whether an intervention targeted on a single issue such as housing can be successful outwith the context of a more comprehensive approach to urban renewal.

Enthusiastic joint commitment of the statutory agencies is essential if fundamental health determinants such as housing, safety and employment are to be addressed. Considerable financial support from central government is required if the necessary changes are to be put into effect. More specific actions from central government are also necessary if the targets for health set in the White Paper ‘Scotland’s Health - An Agenda for Action’ are to be achieved, and the health of Glasgow improved to nearer the average for the rest of Scotland. These include measures to reduce cigarette smoking, to reduce alcohol and drug misuse, to make healthy food more readily available and to improve road and other aspects of safety.

Most of the action necessary requires to be targeted specifically on people living in the more deprived parts of Greater Glasgow. Glasgow is important in a national
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context because it provides a ‘window’ on inequalities in health, which exist in all Boards, although to a lesser extent. Given that national health policy does not address this issue, it is up to Glasgow to take the lead.
In summary, the following actions are required:

Health Board
- Continue to strengthen programmes for the prevention of disease and promotion of good health.
- Continue to develop innovative methods of improving health in areas of material and social disadvantage, including measures targeted on adolescents and young adults.
- Increase commitment to effective joint working with local and central government agencies.
- Institute locality planning which fully involves local residents and locally based professionals in decision-making about the provision of health services.
- Develop and implement the concept of the health promoting hospital and health care.

Regional / City Council:
- Increase commitment to effective joint working with the Health Board in order to make much greater impact on issues which are the responsibilities of local government but are fundamental to good health (eg. housing, safety, employment opportunities).
- Make still further efforts to improve the quality of Glasgow’s housing stock and to improve living conditions particularly for families with young children.
- Make further effort to reduce accidents.
- Implement, with real resource commitment, the health promoting school/institution programme.

Intersectoral Action:
- Increase commitment to the Health Cities movement. All contributing organisations should agree a substantial increase of revenue to fund a programme of major joint initiatives. A Healthy Cities Working Group should draw up a suitable programme and report within six months.

Action Required by central government
1. Make Glasgow the subject of special targeting
   - Invest in Glasgow’s socioeconomic infrastructure — eg. by expanding the approach currently being taken in Castlemilk to other areas of deprivation.
   - Review health service revenue allocations.

2. Make healthy choices easier choices
   - Take further steps to reduce cigarette smoking (eg. by further restricting advertising and by increasing relative cost).
   - Review policy relating to the price and availability of healthy food.
   - Review policy relating to the price and availability of alcohol.

3. Confront the effect of deprivation on health
   - Unless the severe health problems associated with material and social disadvantage are addressed, Glasgow’s health relative to Scotland, the United Kingdom and elsewhere is unlikely to improve fundamentally. Action Required by Voluntary Organisations
   - Ensure that voluntary organisations which represent people with problems relating to physical or mental health contribute effectively to the Health Board’s assessment of health needs and planning processes. For its part the
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Health Board should do all it can to facilitate this process.
• Provide greater support in the community for people with disabling conditions.
REFERENCES


