Glasgows' Health
Old Problems - New Opportunities

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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.

INTRODUCTION

> *"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 Glasgows status as a special case and support for work on inequalities in health that could be replicated in other areas of the United Kingdom.

GREATER GLASGOW HEALTH BOARD

GLASGOW HEALTHY CITY PROJECT

HEALTH AND ITS DETERMINANTS

Summary

Health is a complex concept. Many interacting factors determine health status in Greater Glasgow. Assessment of Community Health should include; positive aspects of health; measures of sickness, disability and death; analysis of socioeconomic and environmental factors influencing health.

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 provison 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 relativly 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.

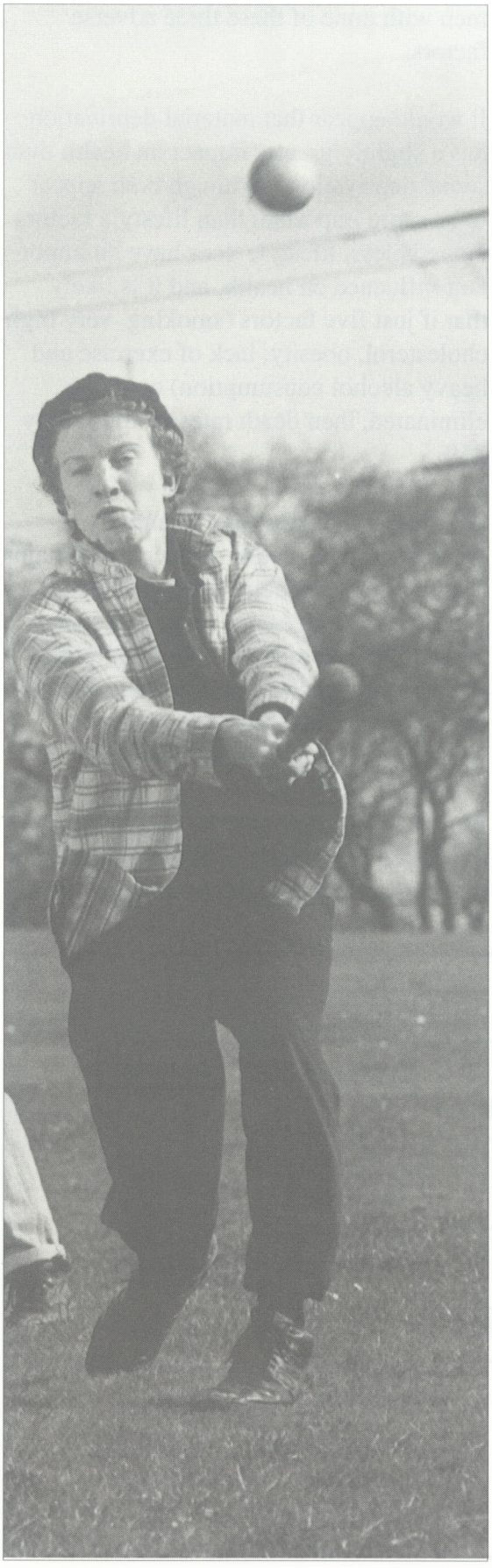
(b) Measures of disability, morbidity and mortality.

(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



The health of a population should be assessed in terms of positive physical and mental health and of the environmental and lifestyle factors which encourage good health. Numbers of hospitals and other institutions, or measures of activity such as numbers of people treated, are not appropriate for assessing health.