Poverty, Inequality and Social Inclusion in the New Scotland

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‘A problem is something you have hopes of changing. Anything else is a fact of life.’
C.R. Smith, Publishers Weekly, 8 September 1969

Introduction

Everyone who lives in Scotland, whether politician or member of the public, is well aware of the country’s high rate of premature mortality, heart disease, cancer and smoking, its ‘junk food’ diet, crippling poverty and inequalities. However, in the light of devolution and the progression to a relatively left wing politics, we think it is worth looking again at what has been happening to the health and wealth of Scots in recent years, what is happening now in terms of policy and what might happen as devolved Scotland matures. We see Scotland’s inequalities as a problem, not a fact of life.

In this chapter we present a selection of the latest evidence on progress in terms of health, poverty and social exclusion. We question how devolution might affect these issues and we look to possible futures for the health and wealth of the Scottish people.

We start with evidence focusing on health inequalities, poverty and social exclusion in Scotland today. We then consider briefly some historical aspects of Scotland’s situation and set devolution in this context. Next we present two sets of ‘reasons to be cheerful’ about inequalities in Scotland, looking first at the national or macro scale agenda and then the local or micro scale agenda. Within this section we try to show why there are reasons for optimism in Scotland, but also that there are challenges which have yet to be properly addressed. In conclusion will we consider the prospects for a healthier, wealthier more inclusive Scotland.

The Impacts of Devolution May Not Yet Be Visible

Poor public health, poverty and social exclusion are usually the products of long-term socio-economic, structural and political problems. A Scot approaching late middle age, who has spent his or her lifetime in adverse circumstances and raised in a family and/or a neighbourhood in adverse circumstances is more likely than others to be on a trajectory leading to an early grave. None of the contemporary initiatives, zones, schemes, campaigns, and recent radical change in parliamentary system has much chance of altering that trajectory very dramatically. It may be a cliché, but the image of the oil tanker which takes a long time to slow down or change direction is a good one when considering issues of health and social exclusion at a population level. The health and wealth of Scots is determined over their whole lifetime. Devolution took place three years ago and at a population level, in terms of health outcomes, socially excluded groups and poverty, almost nothing has changed. However, this does not mean that there are no prospects for change or that change is not beginning to happen. The tremendous efforts that have been going on in recent years have not been, and will not be, in vain but their impact cannot yet be seen in the statistics that we present here.
The Evidence for Poor Health

Death rates and life expectancy provide a stark and compelling indicator of health and life circumstances. Figure 1 shows clearly that Scotland does badly compared to other countries.

Figure 1: Scottish Life Expectancy in a Developed World Comparison


Rates and ages of death are influenced by levels of affluence, the quality of the physical and social environments in which people live and have lived in and, to a lesser extent, the quality of the health care they receive. People's health related behaviours are important too but it would be folly to suggest that these are chosen independently of the social and physical environment in which they live. Far too many Scots smoke and eat junk food. Nearly all of them know that this will damage their health. Knowledge does not often translate into behavioural change because the circumstances in which people live limits their capacity to alter their lifestyle.

Inevitably, a comparison with England and Wales is pertinent to Scotland and one of the most powerful means of making this comparison is with maps. Population level health data are best mapped using a cartogram in which the space on the page is proportional to the population of an area, rather than its physical size. This cartogram is presented in Figure 2. Each circle on the map represents a parliamentary constituency in Britain.
**Figure 2: Inequalities in Mortality Rate Within Britain**

Mortality Rates Of British Parliamentary Constituencies

- **Well Above Average**
- **About Average**
- **Well Below Average**

Constituencies shaded black are those in which, after accounting for the age and sex of the population, we found a higher number of deaths than we would expect. Constituencies shaded light grey are those in which we found a lower number after the same process.

Data are standardised to English and Welsh averages.
Source: Data from Mitchell et al. (2000).

The map shows rates of mortality at ages less than 65 for each of Britain’s parliamentary constituencies. Almost all of Scotland’s parliamentary constituencies have mortality rates well above the average for England and Wales; Scots die early at higher rates than their neighbours. This is an often-quoted fact, but it should interest us more than it does. Scotland has poverty, industrial decline, and all their associated social problems, but so do England and Wales. Researchers have struggled to establish what it is about life in Scotland that seems to send people to an early grave but no one yet has the whole answer. This poses an interesting challenge for the devolved nation — to try to ‘cure’ when the diagnosis is not entirely clear.

Inequalities also persist within Scotland. Death rates from coronary heart disease in the poorest parts of the country are more than twice that in the richest parts. The major inequalities in the health of different socio-economic groups within the Scottish population begin even before and just after birth. The perinatal mortality rate in social class V is 11.1 per 1000 compared with 7.1 in social class I, for example. Illness rates, both physical and mental, show vast differences within Scotland, within our regions and within our towns and cities.

The NHS is primarily reactive in its approach to public health. It does a fantastic job curing people and looking after them once they have become ill in some way, but very little by way of prevention. Most health researchers recognise that the key to improving public health is to lessen the rate at which people get ill or injured in the first place. This means that politics and the businesses that control so much of our society hold the key. There is also a paradox here since the general public tends to equate health issues with the NHS. If GPs are angry or waiting lists are growing more money to the NHS is often seen to be the answer. In fact many facets of the NHS have changed very little in recent years. The waiting list graph in Figure 3 provides some moments of hope, with a considerable fall in 1999, only to be followed by an apparent resurgence of tardy treatment in 2000. By and large however, the levels in 2000 are the same as they were in 1994.
Figure 3: NHS Waiting Lists in Scotland

![Graph of NHS Waiting Lists in Scotland]

Source: Information and Statistics Division (ISD), NHS Scotland [Form: SMR3]

Figure 4 provides an interesting look at the Scottish NHS workforce. The stability of the size and shape of the NHS workforce is the remarkable feature of this graph.

Figure 4: The Scottish NHS Workforce

![Graph of Scottish NHS Workforce]

Sources: ISD Scotland (Medical and Dental Census; National Manpower Statistics from payroll; General Medical Practitioner Database).

It is not all doom and gloom however. There has been limited success in the battle against cancer. The battle to detect and treat cancer in Scotland is being slowly won; more people are diagnosed, but fewer die. However, this is not a victory made by the changing administrative systems for Scotland. It has its roots in the early 1990s and in fact, owes its progress to a combination of medical and social advances (see Table 2 for more on cancer).

The Evidence for Poverty and Social Exclusion

One of the few successes for those monitoring health inequalities in Britain and adverse health in Scotland has been the communication of the basic equation that ‘poverty equals poor health’. So, whilst we will present some separate evidence for poverty and social exclusion in a devolved Scotland, it should be borne in mind that these are very strongly related issues.

Quantitative evidence for poverty and social exclusion is abundant within Scotland, but we are wary of its use. We think that the true meaning of social exclusion is hard
to articulate using graphs and charts and maps since it is about adversity in everyday life on a personal level. The despair and frustration of life on the bread line, experience of racism or sectarianism and the challenge of being illiterate in a complex world is better articulated by qualitative research and accounts of people’s day to day lives. In a limited way however, we can at least demonstrate the extent of the problem.

Poverty is not the only cause of social exclusion but it is usually the key component. About 22 per cent of the Scottish population is in a low-income household. This number includes about one million children. Figure 5 illustrates the growing disparity between incomes in Britain and within Scotland.

**Figure 5: Average Weekly Earnings in Scotland and Great Britain**

![Average Weekly Earnings Graph](image)

Source: Scottish Executive (2001a).

The New Labour Government in Westminster made much of its attempt to get people off benefit and into work. In Figure 6, a cartogram shows changes in income support claims for constituencies in Scotland. Again, the boundaries have been drawn to reflect the size of the population living within each area. The smaller map in the bottom left of the figure has thus been distorted to produce the larger, shaded map. The figures have been standardised for the whole of Britain. Note that Scotland contains no constituencies in the ‘best improvement’ category and several in the ‘worsening category’.

**Figure 6: The Changing Geography of Want Under New Labour**
Even those in work may have to contend with low pay. Although the minimum wage has lifted the earnings of low paid workers in a quite radical way, many part-time and minimum wage workers remain on or beneath the breadline. Whilst disposable incomes are rising in Scotland, they inevitably rise further and faster for the richest groups. Low pay results in poor families, childhood poverty and, eventually, pensioner poverty as people cannot afford to pay into pension schemes.  

Social exclusion is not just about poverty however. Education, socialisation and integration should be a life long process, but once an individual falls behind in any of these areas it can be incredibly difficult to get back into mainstream society. At the end of the 1990s, about 7 per cent of school leavers had no SCE qualifications.  

Although this number is falling, a sizeable group still move on into a society in which the basic school education is worthless in the labour market. Many employers now expect vocational or university level education as a minimum (though 36% of 16-21 year olds are not in full or part time education). The myth about increased access to a university education is that it promotes a more inclusive society. In fact, the degree simply becomes the common currency of social advance and the postgraduate or vocational qualification becomes the new marker of the elite. For those struggling to stay at school until 16, the much trumpeted ‘opportunity’ for university education is pretty meaningless. The net result is that many more people are better educated, but inequalities between the elite and the rest remain the same or become wider.

We can also think about less formal types of education – how young people and immigrants in Scotland learn to be part of its society and part of the nation. Scotland has become an increasingly segregated society over recent years. The housing market contrives to keep richer and poorer folk apart. Few Morningside residents have any idea what life is like in Craigmillar, few of Glasgow’s Kelvinside residents know what life is like in Easterhouse and few residents of Harris experience day-to-day life in the cities. The irony is that politicians are amongst the few Scots who encounter and face the divisions of wealth, health and society within the country, because they work in a world where their colleagues bring that geographical diversity alive for
them. In this sense, the devolved Scotland is at a tremendous advantage in dealing with its own diversity. It is run by a relatively small group of people dedicated to providing a voice to all those different needs within the country, and ultimately accountable to their constituents.

Many people are of the opinion that Scotland and its devolved government can and must spend its way to a more equal society. Figure 7 shows the patterns of spending in Scotland, and in the wider UK as we approached devolution and it is a pattern remarkable in its consistency. The key difference in Scotland today is that the power now exists to make a change to these patterns and to raise the overall budget available through taxation, albeit within the confines of devolution.

**Figure 7: Shares of Public Expenditure in Scotland and the UK**

Source: Scottish Executive (2001a)

**How did Scotland Become So Sick?**

As far back as records go, evidence abounds that areas within Scotland have had poverty and health problems, with the latter stemming from the former. Battles with cholera and tuberculosis characterised the era of infectious diseases. Scotland’s squalid cities provided the perfect breeding ground for wave after wave of epidemics. In more recent history, where degenerative disease has been dominant, Scotland has retained its poor health record. Between 11 per cent and 12 per cent more people died in Scotland between the 1950s and early 1980s than would have had Scots experienced the mortality rates of their English and Welsh counter-parts. This excess reflected the historical inequalities in material circumstances between these nations, most notably the legacy of the 1930s depression, the failure of the Special Areas Act of 1934 to mitigate ‘uneven development’ and the continued extreme poverty experienced in many parts of Scotland. Mortality rates were 25 per cent above average in Glasgow county in 1951. For men aged 15-44 rates were 52 per cent above average in the difficult conditions of work and life of Zetland county (now the Shetland Isles) at that time.
However, even these statistics are overshadowed by more recent events. Conditions were relatively good in Scotland in 1951 (following the 1945-50 Labour Government) and in 1969-73 (following the 1964/66 Labour Governments), when compared to the 1980s. Between 1986 and 1989 excess deaths in the whole of Scotland rose to 13 per cent. In 1990-92 they rose to 19 per cent and in 1993-95 they reached 23 per cent. They have continued to rise in relation to England and Wales ever since. By the late 1990s, men in Glasgow aged 45-64 had an excess mortality rate of roughly 100 per cent. This figure means that twice as many men of that age in Glasgow died when compared to the British average. Women of the same age had an excess of 90 per cent. The life expectancy for a man in Glasgow today is 68 years. This is the same as the UK average in 1966. Set against such a strong historical trajectory, changes following devolution pale into insignificance.

**Drawing The Evidence Together**

Arguments abound as to why Scotland has experienced such a dramatic worsening of its health position, relative to the rest of the UK since the early 1980s. Some evidence exists. Scotland has a poor health record, considerable poverty and social exclusion problems and precious little has changed in recent years, although the evidence for change post devolution is patchy at this time. The key questions then are what all this means for a newly devolved Scotland, and what condition a future Scotland might find itself in.

We have identified a number of ‘reasons to be cheerful’ within a devolved Scotland, based on the possible development of health related social policy within the country in the coming years. These are at two broad scales, macro (including national, international and global factors) and micro (including local authority, neighbourhood and individual factors). We have not felt it necessary to pen different scenarios for Scotland under different administrations since the main contenders for power are all further left on the political spectrum than the Labour/Liberal Democrat coalition and we do not envisage a more left-wing Government making reductions in the current attempts to tackle wealth, health and poverty in Scotland.

*Reasons to be cheerful part 1: the macro scale*

We believe that achieving real change at population level is a matter of ideology, an economic situation which permits delivery of that ideology and, perhaps, partly, the slow but steady advance of medicine (provided it has an equitable application).

The arguments over a ‘tax and spend’ or a ‘tax cut - trickle down’ approach to public services within Scotland (and Britain as a whole) have been won. The Conservative Party’s policy of ‘tax cut - trickle down’ was soundly rejected by the whole nation (and especially Scotland) in the 2001 election. We believe the Scottish electorate is unlikely to return to a very Conservative ideology in the near future. We think that fiscal policies which disproportionately favour those most in need, and which favour health, social and education services, will continue to attract electoral support. We believe the single biggest factor that would bring improvements in health enjoyed by rich Scots to poor Scots would be to address the inequality in wealth that exists between them. This includes wealth in people’s pockets, in their housing, in their
education and in their local environments. We will present some quantitative evidence to back up this claim in a moment.

It seems clear that things are not going to get very much better for those most in need, in worst health and most excluded without radical changes. At a recent policy meeting one of us met a health visitor who works in Glasgow’s east end. The conversation turned to wealth and the meaning of and attitudes to poverty amongst some of Glasgow’s poorest folk. The health visitor told a story about a young single parent with a child who required home based medical treatment with electrical equipment, on a daily basis. On making a visit and finding the home powerless due to an empty electric key meter, the health visitor moved heaven and earth to obtain an emergency payment from social services to get credit back on the electric meter. On returning to the property at the end of the day she discovered that the parent had spent £5 of the £15 emergency payment on electricity and £10 on treating the family to a special meal. The lesson here is not that this parent was stupid or reckless, it is that they live in an environment where £15 mattered so much and £10 was the most exciting and potentially up-lifting thing in that family’s life. Minor changes to benefits and tax systems which amount to a few pounds per week cannot be enough. The trick will be to take this family, and others like them, well away from the situation where £5 might be, literally, a life saving amount of money and where £10 marks a special day. Devolved Scotland has the power to raise taxes.

The bad news is that the radical policies required to achieve a dramatically more equitable distribution of resources and wealth are unlikely to bring their proponents to power. We do not think it unfair to say that the typical Scot believes that wealth, opportunities and resources should be distributed more evenly but we think it very unlikely that the typical Scot would elect a government dedicated to pursuing this policy on the dramatic scale needed to effect a very great narrowing of inequalities.

This is not to say that progressive social and economic policy has not and cannot make tremendous impacts on population health. In a report published in 2000, we demonstrated the implications for health in Britain of new Labour delivering the eradication of child poverty, full employment and a mild redistribution of wealth. For this chapter we have extracted and re-analysed the figures for Scotland’s 72 constituencies. The figures for each constituency can be found in the report. Here, Table 1 illustrates the figures for Scotland as a whole. Figure 8 shows this information mapped on a cartogram of parliamentary constituencies.

<table>
<thead>
<tr>
<th>Policy</th>
<th>Full employment</th>
<th>Redistribution of Wealth</th>
<th>Eradication of child poverty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lives Saved/year</td>
<td>&lt;65</td>
<td>369</td>
<td>672</td>
</tr>
</tbody>
</table>

Source: Mitchell et al. (2000).

Figure 8: Saving Lives in Scotland: The Potential Impact of Current Policies
Source: Data from Mitchell et al. (2000).
Figures are standardised to English and Welsh mortality rates per year.

These figures were established using a model of the Scottish population in which we knew every Scot’s age, sex, social class and employment status. These characteristics were used to estimate every individual’s risk of dying before the age of 65 and hence estimate population level mortality rates. The risk of dying can then be adjusted in accordance with the possible impact of each policy. The policies were defined as follows.

- Achieving Full Employment: the definition of full employment adheres to the Westminster Government’s preferred definition in which, whilst people may be temporarily between jobs, no one is in long-term receipt of unemployment benefit. To model the impact of this policy, everyone in the model who was unemployed is made employed, thus lowering their mortality rate.

- A Modest Redistribution Of Wealth: a steady widening of the wealth gap between rich and poor took place in the whole of Britain between the 1980s and the 1990s. The growing differences in wealth between the rich and poor were mirrored by differences in their health, measured by mortality rates (where social class is used a proxy for wealth). The modest redistribution of wealth referred to here is one that would return the inequalities in mortality to their 1983 levels.

- Eradicating Child Poverty: the UK government believes that one third of Britain’s children live in poverty and it is their stated aim to bring those children out of poverty. To estimate the effect of achieving that aim in Scotland, the life chances of the 20 per cent of children whose parents work in (had been working in, or were associated with) the most poorly paid occupations were raised to equal those of their peers not living in the poverty which results from low pay. This is a slightly more conservative definition of eradicating child poverty than the UK Government’s, but it is one that is more reliably tested.

If, as seems likely, any Scottish Government either supports or extends Westminster’s commitments to these kinds of policies, Scotland as a whole should reap a health
benefit and, of course, the accompanying effects on wealth and social exclusion. Although this research was only designed to measure the effects in terms of health, getting people into jobs and lifting families out of poverty will have benefits for all poor and excluded communities. These are not unreasonable or outlandish policies (they are, after all, already in existence). If the policies are sustained and shown to have a beneficial impact, we hope and believe they will prompt more radical large-scale policy interventions.

For a chapter principally about health in Scotland, there has been rather little talk about medicine. It was Thomas McKeown who famously demonstrated that early late nineteenth and early twentieth century falls in mortality rates were attributable more to rising standards of living than to advances in medicine, but in today’s Scotland the biggest killers are degenerative diseases such as cancer and heart disease rather than infectious diseases such as cholera and tuberculosis. Medicine may thus have more of a role to play in driving down death rates. The battle against cancer in Scotland is beginning to turn. A combination of reductions in smoking rates, healthier lifestyles, medical advances and service reorganisation means there is cause for optimism.

With the measures planned for Scotland over the next decade having the potential to reduce cancer deaths by around 1750 per annum (or 11 per cent of cancer deaths) by 2010-14, the Government’s target to reduce cancer deaths by one fifth from the 1995-97 baseline by 2010 just might be met. In terms of heart disease, rates are also falling. Capewell et al. demonstrate the contribution of medicine to falling mortality rates from heart disease. Of the reductions achieved between 1975 and 1994, risk factor reduction accounted for 51 per cent, (including 36 per cent for smoking) and medical treatments accounted for 41 per cent, including 10 per cent for initial treatment of acute myocardial infarction (heart attack) and 9 per cent for treating hypertension. Although this is potentially good news for the future as medicine advances further and further, the battle against smoking, poor diet and sedentary lifestyles is being lost amongst younger people (especially women). Those who persist with adverse behaviour tend to be especially resistant to health education programmes and thus changing their behaviour only gets more difficult. The 36 per cent reduction attributable to smoking cessation will have included more of the richest group of Scots, than the poorest.

Set against the increasing difficulties of changing adverse behaviour (almost always conditioned by adverse environment), lies the alchemy of ‘the new genomics’. It seems likely that this new medical knowledge will bring benefits to Scotland’s population. It will be a difficult task for the future governments to insure that those benefits are evenly distributed and that they do not eclipse the need for a more equitable environment in Scotland.

So, although devolution has not yet made any tremendous changes to the macro factors in control of Scotland’s public health, wealth and its inequalities, the potential is there to do so and the policies currently pursued will be having some limited effect.

Reasons to be cheerful part 2: the micro scale

Both pre and post-devolution, a large number of zones, schemes, demonstration projects and partnerships were established, each one focused on some aspect of
health, wealth and social exclusion. Many were highly experimental and had a local focus. There is an army of professional and volunteer labour working with and in communities to improve health, to tackle poverty, to connect people within communities and to enhance social and physical environments and in that sense, Scotland has established a grass roots culture of action to tackle these problems.

At all levels of government, health, wealth and social exclusion have been installed as cross-cutting concerns to be considered in projects, plans and programmes wherever possible, whether directly health related or not. This is an extraordinary change. The days in which inequality was hidden through terms such as ‘variation’, and the time when individuals were blamed for their own poor health outcomes, are over (for now). Whether devolution has enhanced these new freedoms or not, we cannot be certain but it is unlikely to have stifled it in any way.

It is our experience over the last couple of years that a consideration of inequality is being written into local activism and policy and that, encouragingly, the work is well informed and draws on the variety of models that are available for understanding and tackling these problems. As ever, Scotland’s greatest resource for working with communities are the communities themselves. They know what is possible and what is not better than any politicians. They also understand the nature of slow or minor progress and are not sidetracked into the desire to see huge-scale change in a short space of time. They often wish for dramatic fiscal change, but know it is unlikely. However, to present community-based action as an unproblematic means to tackle inequalities would be wrong. There is little formal evidence that local and micro-scale action can achieve population level improvements in health, wealth and social inclusion. Even we disagree as to the potential effectiveness of this kind of action. It is true that the richest neighbourhoods tend not to have strong community action forums, and that this suggests wealth, rather than neighbourhood activism, is the better way to achieve health and social inclusion. Nonetheless we will now present two short case studies of action ‘on the ground’ in which we have been involved and from which we draw some hope that inequalities and adversity are being tackled in a devolved Scotland.

As Scotland designs legislation that will open up access to the countryside, local councils and authorities are preparing by drawing up strategy documents. These documents are designed to guide ‘stakeholders’ towards mutually acceptable planning and implementation of new routes and better use of older routes. At one level, these documents are about paths; where they might go, and how they might be used. However, in the new Scotland that is well aware of its inequalities and health problems, the advent of access legislation is being set in a much wider context. In the preparation of almost all of these strategies, consideration is being given to the provision of access in relation to needs of communities, trying to make access opportunities available where they are most needed, realising the potential health benefits which recreational opportunities present, searching for economic opportunities which might arise from access, understanding that those who might benefit most from access opportunities might also be those least likely to take them up and setting up mechanisms to reach out to excluded communities and involve them in the process. Explicit consideration is given to making sure that access opportunities do not become yet another mechanism by which inequalities are reinforced in
Scotland - between rural and urban communities, between younger and older groups, between car owners and non-car owners, and between richer and poorer people.

We understand that these opportunities are a very small contribution to reduction of inequalities and promotion of well being, but it is significant because once these principles and ideals are built into the operation of policy at a strategic level, we can be more confident that benefits will be felt in the downstream processes and implementation. How does this tie in with the macro scale views taken earlier in the chapter? Well, in this instance it is the macro scale views, the terrifying statistics, which seem to provide the determination to act at every available level. Everyone involved understands that if all social and economic policy in a devolved Scotland questions its role with regard to tackling inequalities and promoting well-being, benefits will be felt. It is also a consequence of the directive in the *Towards A Healthier Scotland* White Paper that states;

The Scottish Office will ensure that its economic and social policies have positive health impact in the drive to tackle inequality, improve educational participation and attainment, boost housing and employment and promote social inclusion.

All Scotland’s local councils will be asked to follow the lead that some have already taken by making health improvement a corporate goal and, using community planning, to improve the circumstances in which people live.

The action we have seen on the ground is proof positive that motivation (and instruction) to implement a national agenda can work at a local level.

The second example is at an even smaller scale and is drawn from discussion with a small player in the *Have A Heart Paisley* scheme. This is a three year scheme running in Paisley and aimed at tackling the area’s high levels of heart disease. The project begins and ends in the community. It is primarily aimed at community based efforts to develop awareness of risk factors for heart disease, to promote healthy lifestyles, to promote community cohesion, develop self-esteem and raise expectations amongst younger people. A health worker in Paisley described a new scheme to us in which GPs have been able to ‘prescribe’ exercise classes to patients as a means of reducing their risk of heart disease. The exercise class is provided and paid for. According to the informant the scheme has been a success, principally because it has constructed a social grouping of patients. This group meet, take their class and then go out and socialise together. Sometimes, the class gets missed, but the socialising never does. They will, of course, be deriving some health benefit from the exercise but the significance of friendship and social contact where previously there had been none, is far greater.

There will be attempts to ‘evaluate’ the *Have A Heart Paisley* scheme. Those looking for significant changes in the statistics that describe poverty and ill health in Paisley may not get the results they hoped for after just three years, but we suspect the true value will be in strengthened community networks and better connections between medicine and community. For researchers and policy-makers who are used to dealing with population level statistics, it can be difficult not to dismiss these types of projects as useless. It seems unlikely that large numbers of Paisley residents will be richer or
that Paisley’s life expectancy will have perceptibly risen at the end of the project. However, weaving the fabric of society back together again by joining previously disparate groups through experience and education must be a good thing. It is important though not to lose sight of the reasons by which community and personal bonds were broken in the first place - poverty, unemployment and a neglected social, economic and physical environment. It will be futile to work so hard in the community in Paisley if the macro determinants of population level inequality are not tackled at the same time.

A key reason to be cheerful in devolved Scotland then concerns this last point. We hope for, and to some extent detect, a combination of the macro-level policy base designed to generate and redistribute wealth, opportunity and consequently good health, together with the community level activism which is being allowed to flourish in the new Scotland. Very few people suggest that a simple but radical redistribution of wealth is all that is required to stop Scots dying before they should, the community and the environment and support it supplies are part of that equation.

Good News and Bad News - Conclusions

In a research report based on interviews with a variety of agencies tackling poverty in the new Scotland, the Poverty Alliance states;

…it is felt that opportunities offered by devolution include more accessible Government and a more concentrated focus on Scottish issues. The Committee structure of the Parliament is a particular focus for optimism. However, the biggest worry expressed was about the limits to the Scottish Parliament’s powers to tackle poverty. Respondents are concerned about confusion and tension over the split in responsibilities for poverty-related issues, and their own feeling of distance from reserved issues.10

This is a neat summary of how we see devolution in relation to inequality in health and wealth in Scotland. There are advantages for a smaller, more focused and better informed governing body, in combination with committed local government and community players, struggling within the constraints of a UK and ultimately global economy. However, devolution is not insulation from the jaws of capitalism, which steers money away from the poorer folk and communities, towards the richer folk. The Barnett formula can be changed with positive or negative impact. Scotland might opt for independence and its financial circumstances alter for the worse or perhaps for the better. Trying to narrow the gaps between rich and poor is a long-term, expensive business. We see devolution as having been a significant, but not yet the significant, development in achieving the current state where by some redistributive policy is in place accompanied by a commitment to progress.

Although we have been invited to speculate on the future directions and potential successes or failures of health and poverty policy in Scotland under different political leadership, and to ponder how social democratic Scotland’s health and poverty status might evolve as the nation’s identity and character evolve, such speculation is fraught with difficulty. Halting, and then reversing the growth in inequalities in health and wealth are perhaps the most significant milestones Scotland needs to reach but these
seem unlikely to be passed in the very near future. A child born in Scotland today immediately begins to accumulate influences on their long term prospects for health and wealth. The family, neighbourhood and wider economy into which they are born controls much of their life’s trajectory. These are structures within society which dwarf the influence of politicians and politics. It would be an arrogant political machine which believed that a change of manifesto, or even party, at the head of Scotland for ten years or so will have much influence on that child’s health and wealth in their crucial (and often lethal) later middle age. That said, the emerging schemes, policies and general emphasis on early life circumstances (Sure Start Scotland, Starting Well etc.), numeracy, literacy and citizenship are amongst the most positive developments of this era. It is the politicians who will determine whether those schemes are given the time they need to take root and then whether the successful ones are allowed to graduate from being an ‘extra effort to help’ to being ‘a matter of course’ for those most in need. Ideally, the best schemes will eventually have no need for a special status or identity – they will become a part of everyday life.

To determine which schemes work best in the long term we would like to see party manifestos which promise to keep funding those started by preceding governments, rather than manifestos which promise new schemes but cut those already in place. How else will we ever learn what really helps in the longer term?

We argue then that the opportunity for a radical attack on inequality now exists within Scotland, but we also feel it is not yet really under way. It seems to have been easier to instigate and develop community action under devolution, but that action will have little effect if it is not backed by macro scale social and economic changes and by long term commitment to make the ‘special schemes’ of today, part of the more equitable society of tomorrow. New Scotland has the power to make these changes. The issue is, does new Scotland have the will?

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Information and Statistics Division, NHS Scotland, www.show.scot.nhs.uk/isd/


**Endnotes**

3. See, for example, Scottish Executive (2001b) and McCormick and Leicester (1998).
7. Further information is study available at www.social-medicine.com