SCOTLAND'S HEALTH – WHY IS IT SO POOR AND WHAT SHOULD BE DONE TO IMPROVE IT?

On 23 May this year the Edinburgh College of Physicians and the Public Health Institute of Scotland organised a major conference to explore the question that forms the title for this editorial. Data were presented that showed how Scotland has the worst health in the UK, worse even than comparable areas like the industrial northeast of England. Scotland's life expectancy also lags behind comparable Nordic countries like Norway, Sweden and Denmark. In fact, our nearest neighbours in the 'league table' of European nations are Slovenia and Portugal. Although life expectancy and many health indices are improving in Scotland, the rate of improvement is in the middle of the European spectrum, so we are unlikely to progress at a rate that will change our relative position compared with the rest of the UK or most of the European Union countries.[1]

Health emerges from an interaction of genetic inheritance, the physical circumstances in which people grow up and live (housing, air quality, working environment), the social environment (levels of support and trust), personal behaviour (smoking, diet, exercise) and, crucially, access to resources that give control over life. It is now well understood that these determinants operate over the whole course of life.

The importance of the distribution of wealth as a determinant of health has emerged in recent years. In countries that are already wealthy, the distribution of wealth is an important determinant of health. Nations that have a more even distribution of wealth enjoy longer life expectancies than those with similar gross domestic products (GDPs) but wider distributions of wealth.[2] The countries that have shown the fastest improvement in health in recent decades have been those with the fairest distribution of wealth. The mechanism that explains these observations is the subject of debate but the observation is not questioned. The gradient of health inequalities within Scotland is sharper than elsewhere in Great Britain.[1]

However, the situation is complex and Scotland's health problems cannot be fully explained by economics alone. For example, although the former Strathclyde region has the worst health in Scotland, the inequalities in levels of good health between Scotland and England affects nearly all the Scottish regions. Also, the proportion of the health gap between the two countries that can be explained by 'deprivation' (or at least the census variables that act as proxies for deprivation) has decreased in recent decades.[1] We need to understand these 'non economic' or cultural factors. Scottish culture and society has been changing rapidly. The structures that formerly played a key role in integrating individuals into larger social processes (unions, churches, professions, political parties) have all suffered a loss of support such that in a few decades they have all but vanished (e.g. maximum employment in manufacturing was in 1969, and maximum membership of the Church of Scotland was in 1957). Because self-confidence and individual identity are social products, they suffer when community features such as family solidarity, educational stability and social integration are eroded.

What should be the response to this challenge? Public health has been defined within the Acheson Report as the 'science and art of preventing disease and promoting health through the organized efforts of society'.[3] It is therefore relevant to ask into which specific directions the organised efforts of Scottish society should be directed. One approach is to take a historical perspective by describing three past waves of endeavour to improve health in Scotland.

The first wave of public health interventions arose in response to the disruptions to society that followed the Industrial Revolution. During that time alcohol consumption, crime and illegitimacy (to quote just three indices) were substantially higher in most UK and US cities than they are today. Victorian society deliberately sought to create institutions and instil values that would create order out of what seemed like chaos. Thus, in time, there emerged great public works like reservoirs and sewerage systems, and institutions like cooperative societies, modern police forces, health visitors, universal education, orphanages and much else. These were supported by grass roots efforts to create and sustain a series of informal norms and behaviours that in their time were important for social order. The philosophical tradition that informed that period was that of the empiricists (Locke, Hume and Berkeley) and the most influential economist was Adam Smith.

Much of the good work resulting from the first wave remains with us today. Clean water, effective sanitation and the rational planning of services are just three, from a multitude of examples of public health interventions, that have their intellectual roots in the Victorian era.

The second wave developed through the twentieth century and was informed by nineteenth century materialism. Hegel and Marx argued that it is material and structural changes that shape history and that the

superstructure of society is determined by the substructure of relationships between classes. This led to the establishment of communism as the all-embracing political dogma in many parts of the world but in Western Europe it developed into democratic socialism and a variety of experiments in social engineering (e.g. the programmes of Atlee's post-war government). At its most optimistic, the second wave was built on the premise that better housing, education, healthcare, jobs etc., provided equitably by a redistributing State, would cure society's ills.

Few would dissent from the proposition that the second wave has also profoundly influenced health in Scotland. In the decades following the War, rehousing, neighbourhood regeneration, comprehensive education and much else have been the main means by which concerns over health and wellbeing were addressed. Second wave thinking and the projects of the second wave are now central to Scotland's programme of government (Social Inclusion Partnerships, the New Deal, community planning, NHS redesign). As such, there is still a great deal of work to be done in this wave but the problem is that it, like the first wave, is beginning to suffer from diminishing returns.

The third wave is what we need to discover and develop if we are to respond to the new threats and opportunities in our society.

The period from the mid-60s till the present has witnessed profound social change. Crime and social disorder have risen while kinship as a social institution has accelerated its long decline. Fertility rates have fallen, divorce has increased and out-of-marriage childbearing has risen. Within local communities, mutual ties between people have tended to become weaker and less permanent. Perhaps most important of all, trust and confidence in institutions have declined. In this new world, large rigid bureaucracies find it impossible to control everything in their domain through rules, regulations and coercion. In short, the state and its bureaucracies (the main tools of the second wave) are less able to respond to modern pressures.

Consequently, this is a need to create a new public health (building on and including the first two waves) that can serve a mobile society in which the nuclear family is in the minority, jobs are rarely for life, most people work flexible hours in the service sector, firms compete in global markets, life expectancy is increasing, education and learning last far longer, consumers are better informed, values are more diverse and people expect a say in what is going on.

Self-confidence and individual identity are social products: they depend on group and community features such as family solidarity, educational stability and social integration. Many people today feel 'in over their heads'; they lack confidence in their ability to 'keep afloat', to control their own lives and destiny. This expresses itself in a variety of behaviours (smoking, drinking, substance abuse, working patterns, eating patterns, relationships etc.) and creates a challenge for healthcare which needs to take account of the impact of personal factors, such as stress, emotional trauma, grief and loneliness on organic disease. The problems are that current approaches too often miss out a mind/body perspective, delivery can be rushed and treatment is overly dependent on medication. Patients and staff complain that fragmentation is occurring, with too many specialists seeing the one patient and not enough 'glue' in the centre of care management to keep things together.

Current evidence suggests that Scotland requires a 'step-change' in the trajectory of its health improvement if its relative standing within Europe and the UK is to improve. How is such a step-change to be achieved? If the health of Scotland is going to change the determinants of health will have to change. The physical environment of our most deprived areas has to change, problems of social isolation, stress and fear of crime have to be confronted. Key behaviours like smoking and the rising problem of obesity have to be tackled. Scotland will have to examine its approach to alcohol as never before. We need to respond to the pressures that lead to widening differentials in wealth that in turn lead to greater inequalities in health.

Some of our responses to these challenges will draw on our experience of the first two waves of public health. More innovative thinking will also be required. The third wave, now facing us, and which we are struggling to articulate in the changed world of the twenty-first century, may be about the need for 'authorship' and a new kind of 'community'. It needs to move beyond a simplistic consumerist model, which still largely governs the relationship between the public and professionals, towards a participative model which empowers the individual and the community – an infectious process that makes professionals feel good, gives authorship to people and fosters new forms of community beyond historical neighbourhoods. The key questions, therefore, might be: 'What would it take to give a much larger proportion of people in Scotland a sense of "authorship" over their own lives?'; and 'How do we foster networks of mutual support that fit with the realities of modern lives?'.

REFERENCES

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