Representations and Lay Perceptions of Inequalities in Health: An Analysis of Policy Documents, Press Coverage and Public Understandings

Rosemary J. C. Davidson

Thesis submitted for the degree of Doctor of Philosophy at the University of Glasgow

MRC Social and Public Health Sciences Unit
March 2003

Four goals for healthier Britain could save 15,0
War on root causes of ill hea
Glasgow
takes five
years off
your l
Gap betwe
rich a
Wealthy
ealthy bu
he poor ge
nore poorly

Abstract

This thesis examines the presentation of UK public health policy in the late 1990s and the associated media coverage of health inequalities. It also examines lay perceptions of these inequalities and of government initiatives to reduce them. Such a project is timely for a number of reasons. Inequalities in health were once again on the political agenda with the election of a Labour government in 1997. Subsequent media coverage of the government's consultative and policy documents, as well as an independent inquiry, put health inequalities in the public domain. In addition, research into health inequalities had been accumulating. One line of enquiry focused on the role psycho-social mechanisms might play in the causation of ill health, yet little empirical work had been carried out on lay perceptions.

Two distinct yet interlinking methodologies were employed in the study. Content analysis was carried out on government public health documents, an independent inquiry, their press releases, and of the subsequent press coverage, in order to examine the profile given to inequalities and the manner in which they were presented. Images and headlines from the press coverage were then used to facilitate discussion, in a focus group setting, on inequality, poverty, and relative deprivation.

The government's intention to reduce health inequalities was communicated mainly in broadsheet publications. An absence of coverage in the tabloid media suggests that a large section of the population may have been unaware of the government's intentions. The transition from Green Paper to White led to a dilution of the initial fervour of the government to tackle inequalities, and this lack of emphasis was followed through in media coverage of health policy. What had started out as a strong issue faltered in the journey from consultation to policy. Political affiliation of newspapers greatly affected the way in which the inequalities debate was presented. Striking differences emerged in the reporting of health inequalities by right and left-of-centre newspapers. Right-of-centre newspapers focused on proposals to improve and promote healthy behaviours, whereas left-wing publications focused their reporting on initiatives targeted at the deprived.

Researching lay views on health inequalities, and inequality in society at a broader level, elicited often compelling and emotive responses. The government's intention to reduce health inequalities did not appear to register with participants. Inequalities were not discussed in the manner of a public debate churned out by the media. Rather, inequalities were a sensitive issue, affecting people in a very personal and far reaching manner. Those of lower socio-economic status were often painfully aware of their status in relation to others, and a large proportion expressed frustration, anger and helplessness, and linked such feelings to their health and well-being. Views from higher income groups tended to be more disparate and distanced, yet this only reinforced how polarised certain sections of society have become. The social snapshot presented in this thesis conveys a picture of a fundamentally fractured and divided modern Britain with very direct consequences for the future quality of social life.

Declaration

I declare that, except where acknowledged, all the work has been undertaken by myself.

Rosemary J. C. Davidson B. Sc.

Acknowledgements

Special thanks go to the following:

Kate Hunt and Jenny Kitzinger, for their expertise, guidance, support, and belief in me throughout this project.

Those who took part, for without their kind participation this project would not have been possible.

Margaret and Duncan Davidson, for never being pushy parents, but for knowing the value of learning and of a good opportunity. For their diplomacy in not asking too many questions, as well as their love, kindness and support.

Gordon Taylor, for day-to-day encouragement, making me laugh, brown bread, golden syrup and cups of proper tea.

Steve Cummins, Pete Seaman and Ros O'Brian, my fellow Ph.D. inmates.

And my friends, who distracted me when I needed it most. Especially Claire Marriot, Paddy MacQueen, Lucie Giles, Del Shields, Frederique Villain, Severine Tochon, Stephanie Church, Dave Ralph, Helen Eastcroft, Ruchi Gulati, Maryam Parisaei, Tracy Randall, Barbara Stepansky, Mags Attwood, Clare Forest, Lesley Grey, and last but certainly not least, Deeside Divas Mhairi Morrison (Steenbock) and Emma Bannerman.

This thesis is dedicated to William Kenneth Baines (1909-2002), a grand old man who knew the real reason why girls leave home.

CONTENTS

List of tables

Chapter Two

Chapter Three

Chapter Four

Chapter Five

Chapter Six

List of figures (focus group materials numbered according to running order)

Chapter one

1.1 Introduction

Two decades of work confirming the existence of inequalities in health was recognised with the Labour government's establishment of the Acheson Inquiry in 1997. This thesis looks at the re-entering of inequalities as an issue into the public domain by examining the press coverage of the Acheson Report, and the government's consultative and policy documents on public health. Lay perceptions of health inequalities are analysed in an attempt to contribute to explaining research that suggests that the marked socio-economic gradients in health prevalent in developed societies are due to psycho-social processes based on people's detailed awareness of social hierarchies, which influence population health and well-being. This study makes a start by looking at how people themselves see inequalities. Therefore this thesis will explore people's sense of relative deprivation and how they compare their experiences, and themselves, to others. It will document how people experience inequality on an emotional rather than just material level. People's understandings of health inequalities will be examined and the public profile of this debate will be scrutinised both as it is presented in the media and how it is perceived in communities. The following introduction details the inequalities debate from the Black Report to the postulation of psycho-social mechanisms by Richard Wilkinson, the current work on lay perceptions, and health inequalities as a policy issue.

1.2 Overview of the inequalities debate: from Black to Wilkinson

1.2.1 The Black working group: a background

The latter half of the 1970s saw a steadily increasing concern over inequalities. In his 1976 Galton lecture, Sir John Brotherston, the former CMO for Scotland, asked the question, 'Inequality: is it inevitable?'. It has been speculated that this event led David Ennals, then Secretary of State for Social Services, to set up the Working Group on Inequalities in Health (Black 1999). The Labour government's 1976 White Paper,

Prevention and Health: Everybody's Business, expressed concern with 'Britain's failure to match the improvement in health observed in some other countries and acknowledged the relationship of this to persistent internal inequalities in health' (Townsend, Davidson *et al.* 1988, p. 1). In 1977, David Ennals stated that 'it is a major challenge for the next ten or more years to try to narrow the gap in health standards between different social classes' (Townsend, Davidson *et al.* 1988, p. 1).

However, it should be noted that *Prevention and Health*, despite its concerns about widening inequality, based its ethos on the notion that people were responsible for their own health as a result of their lifestyle choices. Macintyre (1997) reminds us that 'The notion of the importance of lifestyles and personal responsibility for health was fashionable in the mid-1970s, rather than being particular to the 'radical right' Conservative Government elected in 1979'. Furthermore, it was a Conservative government of the early 1970s who identified the issue of 'transmitted deprivation' and subsequently set up a seven-year government funded research initiative (Macintyre 1997, p. 726).

Sir John Brotherstone's question could reasonably have been expected to place health inequalities further up the public agenda. However, Richard Wilkinson, a public health researcher with a particular interest in the effects of income distribution on health, claims that it was his open letter to David Ennals, 'Pointing out that, as a Labour minister, he presided over the largest social class differences in mortality then on record', which prompted the Black Report. The 'urgent inquiry' Wilkinson had called for, was set up three months later (Wilkinson 1996, p. ix). Blaxter (1990), on the other hand, takes a broader view when describing how inequalities in health became again a matter of public discussion in the 1970s. She describes how the 'rediscovery' of inequality could be seen to be based on two concerns: 'one was the growing realization of a failure in Britain to match the absolute improvements achieved in other developed countries, and the other the suggestion that relative differences between groups of the population might not, as anticipated, be decreasing' (Blaxter 1990, p. 6). The precise order and weighting of these

events can be contested, but what can be concluded is that inequalities in health became enough of an issue to merit an independent inquiry.

Under the instruction of David Ennals, the Department of Health's former chief scientist, Sir Douglas Black appointed a small group. The four members included Black as Chair, Professor Jerry Morris, Dr Cyril Smith and Professor Peter Townsend. All had been concerned for some time that inequalities in health had not diminished. Worryingly, Britain's standing on a world table of infant mortality rates had actually deteriorated. It was at a workshop early in 1978 at the King's Fund Centre that Professor Morris stated a good case could be made for focusing on the under fives (Blume 2003, p. 111-112). Relatively early on the focus was placed on child health.

Professor Stuart Blume, Scientific Secretary to the group, observed that it was often difficult for the committee to arrive at a consensus, prolonging the length of the inquiry (Blume 2003, p.116). Townsend describes the set-up of the Black Committee as an 'interesting democracy' where the four members sat with twenty-five Department of Health officials, present at every meeting[1]. Whilst the DHSS were pressing for an early report by the summer of 1978, members of the Black committee were unable to agree on the focus of the report. Townsend argued that international comparisons were necessary. Morris argued that separate attention should be paid to spatial indicators of deprivation (Blume 2003, p. 113). Between the summers of 1978 and 1979, finance became a big issue. It was suggested that hospital expenditure could be cut in order to expand and extend access to community services. The value of free school milk and school meals was debated. Discussions continued into December 1979 with no prospect of agreement (Blume 2003, p. 116). By the final meeting in February 1980, concern was expressed by committee members at the public response to proposals for substantial public expenditure. A change in government, from Labour to Conservative in 1979, reflected a change in public opinion since the group's formation (Blume 2003, p. 116). The members of the committee were united in the problem they were addressing, but for a long time

[1] Taken from a presentation by Professor Peter Townsend, *'Inequalities in Health – The Current Debate'*, London School of Hygiene and Tropical Medicine, 18th July 2000.

they could not agree on the details of the Report's recommendations. Given that the Black Committee had such problems arriving at a consensus, it seems less surprising that debates spanning the following two decades were at times so polarised.

1.2.2 The Black Report

The Black Committee was convened to review information about differences in health status between different social classes. The inquiry relied on analyses of mortality by social class from the 1970-2 decennial supplement on occupational mortality. Four explanatory models or categories for inequalities in health were put forward: artefact, selection, behavioural and materialist. The Black working group itself concluded that material conditions were most important in the generation of health inequalities. However, the central conclusion of the Black Report was that there were 'large differentials in mortality and morbidity that favoured the higher social classes, and that these were not being adequately addressed by health or social services' (Shaw, Dorling *et al.* 1999, p. 2). Given that this was 1980, more than thirty years after the NHS had been created, this finding was seen as a 'grievous disappointment' (Morris 1990, p. 491).

The Black committee believed that inequalities in health had been widening since the 1950s, and that this trend was principally related to inequities in material resources. This favouring of the material model of explanation was reflected in the Report's recommendations and assertions of where future policy should be focused. In broad terms, the working group recommended: higher social security benefits; a more equal distribution of income; improved housing conditions and services; the abolition of child poverty; a focus on the health and welfare of mothers, and of pre-school and school children; and extra help for people with disabilities and for the elderly

Although the committee believed that much of the evidence on social inequalities in health could be 'adequately understood in terms of specific features of the socio-economic environment', this view was intended to be taken in context. Above all else, the committee asserted that they did not believe 'there to be any single and *simple*

explanation of the complex data ... assembled' (Townsend, Davidson *et al.* 1988, p. 199)[2]. Despite this qualification, much of the subsequent debate on health inequalities often viewed Black's four explanatory models as mutually exclusive and competing, leading to acrimonious disputes. In the Black Report's thirty-seven recommendations, particular attention was given to the young: 'We have concluded that early childhood is the period of life at which intervention could most hopefully weaken the continuing association between health and class' (Townsend, Davidson *et al.* 1988, p. 199). Stronger still, the committee stated that the '*abolition of child poverty* should be adopted as a national goal for the 1980s' (Townsend, Davidson *et al.* 1988, p. 169)[3].

1.2.3 Reaction to the Black Report

Growing concern about inequalities in health had led the Labour government to commission the Black Report. Thatcher's Conservative government of 1979 heralded a new era, anticipated by the Black Committee's concern about a shift in public opinion. The new government favoured the cult of the individual, leading to a glorification of individual effort and responsibility. Whilst it has been argued that the mood of the 1970s was individualistic across the political spectrum (Macintyre 1997), the Labour government had addressed inequalities as a growing and widening phenomenon, whereas the incoming administration attempted to sideline the issue. Part of the new administration's efforts at image management included attempts to divert attention from health inequalities. Patrick Jenkin, the new Secretary of State, received the report in April 1980 with little enthusiasm. In the Foreword to the Black Report, Jenkin rejected the working group's recommendations on cost alone, 'quite apart from any judgement that may be formed of the effectiveness of such expenditure in dealing with the problems identified' (Townsend, Davidson *et al.* 1988, p. 4).

As part of the government's efforts to downplay the findings of the Black Report, only 260 'unappealing' cyclostyled copies were printed by the DHSS (Black 1999, p. 149). No

[2] Emphasis in Penguin edition of Black Report, Townsend, P., Davidson, N., Whitehead, M. (1988) Inequalities in health: the Black Report and the Health Divide. Harmondsworth, Penguin.
[3] Emphasis in Penguin edition of Black Report, Ibid.

press release or press conference was organised, and the Report was released on an August bank holiday. It was at this point that the backlash began. Both the *BMJ* and *Lancet* criticised the government's indifference to such an in-depth and considered investigation[4]. A journalist, Jill Turner, covering the Black Report recounts that at the time, she was 'amazed' at the lack of support from the DHSS[5]. She subsequently went on to organise an alternative press conference for Black and his colleagues at the Royal College of Physicians. One of Turner's colleagues, a correspondent for the BBC World Service, recounted how the Black Report quickly became a leading news story around the world that day.

Marmot argues that *despite* the government's refusal 'to take seriously Black's recommendations or even properly to publish the Report, it had enormous influence' (Marmot 2001, p. 1166). However, I would argue along with many other commentators that it was *because* the government attempted to cover up the Report that the issue was fuelled to such an extent. It was this process of image management that added greatly to the Black Report's symbolic significance.

1.2.4 From Black to the late 1990s: a review of the reviews

A huge number of empirical studies on health inequalities were published during the 1980s and 1990s. In fact the literature on health inequalities is so vast that it is not possible or appropriate to review all the empirical evidence in the context of this thesis. With this in mind, a brief outline will be given of the reviews emerging from the period between Black and the late 1990s. Vagero and Illsley (1995, p. 219) assert that 'Most academic writing on health inequalities has...tended to adopt [the Black Report's] agenda, questions, concepts and definitions, and to debate its conclusions'. Indeed, reviews of developments in the health inequalities field during the 1980s tended to

[4] For a detailed description of events following the publication of the Black Report, refer to the Penguin edition introduction Ibid.

[5] Comments made by Jill Turner, '*Inequalities in Health: The Historical Dimension*', London School of Hygiene and Tropical Medicine, 19th April 1999. See also the 'Witness Seminar' chapter 'The Black Report and *The Health Divide*' (Berridge, V. (eds) pp. 154-155 in *Poor Health: Social Inequality before and after the Black Report.* London: Frank Cass).

confine themselves to the debates surrounding Black's four explanations (for example Blane 1985, Carr-Hill 1987). Just as the members of the Black Committee had difficulty in arriving at a consensus, subsequent debate surrounding the 'Black paradigm' has often been passionate. In fact, it was the (often) rigid adherence to Black's four explanations as mutually exclusive and opposing that led to debates on inequalities in health in the UK being heated, vehement affairs to the puzzlement of international observers (Macintyre 1997, 2002).

From the 1980s onwards, evidence began to accumulate that those in disadvantaged circumstances bore the brunt of premature mortality and excess morbidity. Over 400 empirical studies were published in the UK documenting the extent of social inequalities between 1985 and 1993 alone (Mackenbach and Kunst 1994). The mid to late 1980s brought further evidence that inequalities were in fact widening with the publication of the Decennial Supplement on Occupational Mortality (Office of Population Censuses and Surveys 1986). The subsequent publication of Margaret Whitehead's *The Health Divide* (Townsend, Davidson *et al.* 1988) in March 1986 generated intense media coverage and public comment. The image management engineered by the new government in 1980 with the suppressed publication of the Black Report was duplicated. Some commentators feared that the disbanding of the Health Education Council (HEC) on 31st March 1987 'was another attempt to subdue independent criticism of official policies voiced by bodies like the HEC in the 1980s' (Townsend, Davidson *et al.* 1988, p. 7). With an hour to go, the Chairman of the HEC decided to cancel a press conference at HEC offices, leading to a relocated, impromptu briefing of the *Health Divide* (which the HEC chairman had instructed the Director General and HEC staff not to attend). It was this situation which led '...some journalists who had also been present at the Black Report's alternative conference nearly seven years earlier... to experienc[e] a distinct feeling of déjà vu – in the event, both reports had been similarly treated' (Townsend, Davidson *et al.* 1988, p. 8).

The *Health Divide* surveyed the evidence on inequalities in health which had accumulated since 1980, as well as assessing progress made on the 37 recommendations set out by the Black Committee. Its conclusions did not make encouraging reading. According to Whitehead, not only was there 'convincing evidence of widening health inequalities between social groups' but also 'Disappointingly, in the intervening eight years there seems to have been little progress on the basic problems underlying inequality in health' (Townsend, Davidson *et al.* 1988, p. 350). On a methodological level, the Black committee highlighted 'major deficiencies' in data collection, yet in the intervening years between Black and Whitehead, these deficiencies had 'still not been remedied' (Townsend, Davidson *et al.* 1988, p. 314).

Nineteen-ninety marked the tenth anniversary of the publication of the Black Report, with the *BMJ* (Davey Smith, Bartley *et al.* 1990), *Lancet* (Morris 1990) and *Journal of Public Health Medicine* (Strong 1990) all publishing articles to mark the occasion. The *BMJ* and *Lancet* articles were broadly in agreement in their view that socio-economic differences in mortality were still widening. The intervening years since the Black Report had culminated in a 'disheartening decade' (Morris 1990, p. 492). Confirmation of a widening gap was provided by new information on socio-economic position, morbidity data, comparisons with other developed countries, as well as a greater understanding of the causes of these differentials (including psycho-social mechanisms and the legacy of deprived circumstances in early life). Both Davey Smith *et al* (1990) and Morris (1990) noted that despite the Black Report's emphasis on a materialist model of explanation, research had tended to focus on behavioural or lifestyle factors. In fact, Davey Smith *et al* stated that it was 'remarkable' that materialist types of explanation were the subject of 'relatively little' research during the 1980s (Davey Smith, Bartley *et al.* 1990, p. 376).

Speculating about emerging trends in the 1990s, both Morris and Davey Smith *et al* critically reflected on an even greater inequality in the distribution of income throughout the 1980s. An improvement in the situation seemed unlikely: a 'further widening of mortality differentials may be expected' (Davey Smith, Bartley *et al.* 1990, p. 373).

Moreover, the Thatcherite belief in market forces 'has not provided a solution; too little has trickled down' (Morris 1990, p. 492).

A very different thesis is developed as part of Strong's 1990 review in the *Journal of Public Health Medicine*. He asserted that it is 'far from obvious that the mortality gap has remained constant or even become worse' (Strong 1990, p. 168) and focused on methodological problems such as: a reliance on relative mortality despite substantial changes in class size during the last century; lack of quantification of the extent of social mobility and selection; organisational and interpretative problems associated with the compilation of official statistics; the reliance on occupational class when a large proportion of the population are not assigned to one; and finally, flaws in the Black Report's conceptualisation of social class. So, a decade on, the perception in some quarters was that inequalities in health were steadily increasing and very much a problem still to be addressed. On the other hand, a debate continued concerning the existence of inequalities in the population, a situation that was questioned from a number of methodological and philosophical standpoints.

From the 1990s onwards, the inequalities field moved beyond the research questions generated by Black's four initial explanatory models. Macintyre (2002) defines some of the new issues as: early life/critical stages versus cumulative life course/adult life generation of health and inequalities in health; material versus psycho-social explanations; and aggregate income inequalities versus individual income (Macintyre 2002). Whilst it was true that research was now moving in different directions, the legacy of Black remained. For example, Vagero and Illsley (1995) juxtaposed theories of poverty-driven 'biological programming' in the foetus or early infancy with the typology of Black's explanations which according to them, revealed 'a number of unspoken sociological assumptions' (Vagero and Illsley 1995, p. 219).

The late nineties brought a more reflective mood to proceedings as researchers in the field began to take stock of nearly two decades of work. In 1997 both *Social Science and Medicine* and the *Journal of Health Psychology* published special issues on health

inequalities. The *Social Science and Medicine* special issue, 'Health Inequalities in Modern Societies and Beyond', featured a comprehensive review by Macintyre (1997). In it, she pointed out that concern about health inequalities could be traced back well before the Black Report, dating to the mid-nineteenth century (an observation also made by Strong (1990)). She also introduced a distinction between 'hard' and 'soft' versions of the Black Report's four explanatory models in an attempt to explain the 'polarisation and politicisation not only of the policy response...but also of the academic response' (Macintyre 1997, p. 732).

In the *Journal of Health Psychology* special issue 'Health Variations', Carroll and Davey Smith introduced various 'broad intervention strategies' in an attempt to understand the 'factors that generate socio-economic health variations' (Carroll and Davey Smith 1997, p. 279). This search for a strategy to reduce health inequalities was consistent with much of the literature at the time (and subsequently). A mass of evidence had accumulated over the previous two decades yet little attention had been paid to the policy implications of widening inequalities[6]. Carroll and Davey Smith's four interventions were as follows: behavioural, psychological, health services, and structural. They concluded that structural interventions would be most effective as 'more equitable income distribution might not only reduce health inequalities, it might do so without adversely affecting overall population health' (Carroll and Davey Smith 1997, p. 281).

A sense of progress and optimism was generated in the inequalities field with the election of a Labour government in 1997 and the subsequent commissioning of an Independent Inquiry into health inequalities, to be called the Acheson Report (Acheson 1998). However, this was tempered in some quarters with the observation that bad feeling and hostility continued to exist between some researchers (primarily because of the belief that there was one universally applicable explanation for health inequalities) (Macintyre 2002). Yet the Black Report itself seemed to be increasingly appreciated for its contribution to the debate, as it 'summarised the evidence, gave it focus, reached

[6] The policy-oriented literature is discussed in section 1.4, *The advent of critiques converting evidence into policy.*

conclusions and hence brought [health inequalities] to public attention' (Marmot 2001, p. 1165).

Perhaps most revealing are Professor Black's (1999) observations, nineteen years after the inquiry he chaired, and not long after the publication of the Acheson Report. He draws parallels between the two reports, particularly because of their shared conclusion that a strategy to improve health would have to extend beyond the boundaries of the health service to inequalities in disposable income, housing, education and lifestyle. Both reports singled out the health of children, expectant mothers and women of childbearing age. Whilst the Black committee's recommendation was based on 'clinical pragmatism', research in the intervening years had shown that adverse conditions in pregnancy and early life were related specifically to increased mortality and morbidity in later life (Black 1999, p. 148). Black describes a 'vast expansion of knowledge' in the field allowing each subsection of the Acheson Report to be backed up with a summary of the relevant evidence not available at the time of the Black inquiry (Black 1999, p. 149). Moreover, official international bodies had recognised health inequalities as a serious problem, particularly the World Health Organisation. By the advent of the Acheson inquiry, the influence of poverty on health had been accepted. Whilst the Black committee had found it necessary to 'marshal substantial statistical evidence' concerning the links between poverty and health, the Acheson committee was able to call on a 'virtual consensus of opinion, rather than attempt to create one' (Black 1999, p. 149).

Many of the reviews throughout the nineties referred to the possible influence of psycho-social factors on population health (for example Davey Smith, Bartley *et al.* 1990, Carroll and Davey Smith 1997, Macintyre 1997, Bartley, Blane *et al.* 1998, Marmot 2001). Wilkinson (for example, 1992a) had repeatedly emphasised that life expectancy was not related to average income but to income distribution, and asserted that the more polarised income distribution becomes, the more a population can expect to experience increased levels of stress, low self esteem and a deterioration in social relations. By the late nineties, research on psycho-social mechanisms and income distribution became a staple in special issues of journals devoted to health inequalities. For example, a 1998 issue of

Sociology of Health and Illness contained a number of articles in this area (Bartley, Blane *et al.* 1998, Wilkinson, Kawachi *et al.* 1998, Elstad 1998, Popay, Williams *et al.* 1998). Interest in psycho-social mechanisms had increased exponentially and much of the momentum can be attributed to the work of Richard Wilkinson.

1.3 The rise of the concept of relative versus absolute inequalities

1.3.1 Richard Wilkinson and Unhealthy Societies

Richard Wilkinson's landmark book '*Unhealthy Societies: The Afflictions of Inequality*' (Wilkinson 1996) draws together a vast array of evidence from various disciplines in support of his thesis on the causes of ill health in developed societies. He argues cogently throughout the volume that life expectancy in developed countries is greater where income differences between rich and poor are smaller. His argument can be summarised as follows. Developed countries have passed through the epidemiological transition whereby the diseases associated with absolute poverty are no longer prevalent and degenerative diseases take over. Within such an environment, where the vast majority of the population experience a standard of living sufficient to buy basic necessities, it is relative, not absolute, deprivation which matters. In countries where income differences are small, such as Sweden and Japan, community life is strong and levels of social cohesion are high. In countries where large income differences exist, such as in Britain and the United States, social cohesion suffers, community life breaks down which in turn impacts on population health.

The central question that Wilkinson poses is, why, when the majority of a population experiences more than a basic standard of living, do health differences 'run right across society with every level in the social hierarchy having worse health than the one above it' (Wilkinson 1996, p. 53), rather than there being a boundary between the 'poor' and the rest of society in the experience of compromised health. The effects of social mobility, the influence of genetics, behavioural factors and medical care are discounted as ways of explaining such a marked social gradient. After this 'process of elimination', Wilkinson

concludes that the differences in health 'associated with differences in socio-economic status have to be explained very largely in terms of those socio-economic differences' (Wilkinson 1996, p. 70). When examining income distribution and health Wilkinson comes across the apparent paradox that income is closely associated to health *within* countries and not between countries. That international comparisons seem to be incommensurate suggests that there is something about the processes happening within countries – within societies – that might provide an answer. Within this context social position is particularly salient. Wilkinson suggests that 'what matters would not be whether you have a larger or smaller house or car in itself, but what these and similar differences mean socially and what they make you feel about yourself and the world around you' (Wilkinson 1996, p. 75).

Wilkinson provides examples of countries, regions and towns which at certain points in time have experienced high levels of social cohesion and a strong sense of community life. Britain during wartime, a small town in Pennsylvania, and the social and economic structure of Japan are described as communities and/or societies in which egalitarian income distribution, a common sense of purpose and a robust social fabric increased life expectancy to impressive levels. Although Wilkinson admits that it is not clear in which direction causality goes, in societies where social cohesion is strong public life 'remains dominated by people's involvement in the social, ethical and human life of the society, rather than being abandoned to market values and transactions' (Wilkinson 1996, p. 136). In fact, it is impressed upon the reader that the monetary economy has only become the 'dominant force' throughout most of the world during the last half of the twentieth century. Before then, societies employed systems of gift exchange and food sharing to maintain good relations and avoid animosity. Contrasting primitive societies described in anthropological literature with the economies of modern countries, Wilkinson laments the individualism that the latter institutionalises:

'Dependent on individual incomes, my income is for my needs and any acknowledgement of your needs endangers the sufficiency of my income and so of my security.' (Wilkinson 1996, p. 144)

Going on to compare different countries with wide income differences, Wilkinson describes the effects of what he terms the 'symptoms of disintegration'. He argues that differences in income distribution have widespread psycho-social effects, citing associations between income distribution and homicide, violent crime, alcohol-related deaths, traffic accidents and deaths from 'other injuries'. Turning to trends over time within a single country (partly due to the lack of internationally comparable data), Wilkinson uses 1980s Britain as an example of income differences widening faster than at any time recorded before. Here, widening income differences are shown to have accompanied a slowing down in the rate of improvement of national mortality rates in age groups below 45 years of age. As children's reading ability declined throughout the period, rates of violent crime, suicide and drug dealing offences increased. Wilkinson argues that:

'...the extent to which we have an integrated and harmonious society with high levels of social involvement, or at the other extreme a society that is divided, dominated by status, prejudice and social exclusion, which gives rise to aggressive subgroups antagonistic to the rest of society, and the stigmatisation of the most disadvantaged, will be closely related to the extent of income inequality. As people in early forms of society recognised only too well, you cannot achieve social integration without economic integration.' (Wilkinson 1996, pp. 171-172)

Rather than seeing psycho-social influences on health as weak, Wilkinson marshals a range of evidence to warrant the opposite view. He perceives the health effects of unemployment and house repossession to be the tip of the iceberg. He claims that the deterioration in health associated with job loss begins a long time before, when redundancies are first announced. Job insecurity is claimed to be far more widespread than unemployment, and the people who lose their homes mask even greater numbers living with large debts. Those with little autonomy at work can expect to experience poorer health than those with greater professional control. Social support and social contact are shown to have beneficial effects on health whilst the negative effects of stress on the immune system are documented. In a population where the social safety net weakens and the majority of redistribution is directed from poor to rich further polarising

distribution of income, psycho-social pathways become increasingly salient through various forms of worry, stress and insecurity.

In terms of stress and health-related behaviour, Wilkinson speculates that health educators view the higher levels of behavioural risks amongst those on lower incomes to be a 'reflection of ignorance'. Yet Wilkinson focuses, from a psycho-social perspective, on the 'very high' overall levels of consumption of unhealthy products in the UK despite the coaxings of health promoters:

'Seen as a group, alcohol, cigarettes, the 32 million prescriptions for psychoactive drugs, caffeine-laden drinks and the comforting – probably antidepressant – sweet and fatty foods, present a picture of a remarkably neurotic society.' (Wilkinson 1996, p. 189)

By the conclusion of *Unhealthy Societies*, Wilkinson is really making an impassioned plea to the leaders of the developed world to rethink the way in which economies are run and resources are distributed. Wilkinson argues that societies are judged by how they treat their deprived members. Societies that treat those most disadvantaged with compassion are in turn most civilised. A missing 'social economy of well-being' can only be captured when policies on education, employment, business and industry are all assessed in terms of their 'impact on social justice and social divisions' (Wilkinson 1996, p. 223). Using the rapidly growing (at that time) Asian economies as examples, Wilkinson argues that countries do not have to choose between equity and growth, and that in fact the two appear to be mutually beneficial. Inequality, on the other hand, 'turns a large proportion of the population from net contributors to a society's economic welfare into net burdens on it' (Wilkinson 1996, p. 225). The vision of what society could be is contrasted with what Wilkinson terms our current 'cash and keys' climate. Although everyone is dependent on each other for survival, 'this interdependence is turned from being a social process into a process by which we fend for ourselves in an attempt to wrest a living from an asocial environment'. As a consequence, 'others become rivals, competitors for jobs, for houses, space, seats on the bus, [and] parking places' (Wilkinson 1996, p. 226). Central to this thesis is the aftermath, the psycho-social

processes postulated to play an instrumental role in contributing to ill-health in developed societies:

'...processes of social comparison – favourable or unfavourable – mean everything is constantly monitored. We feel hurt, angry, belittled, annoyed and sometimes superior as the processes of social distinction and social exclusion thread their way between us.' (Wilkinson 1996, p. 226)

1.3.2 Origins of a thesis: Income distribution, health, and discord

Unhealthy Societies was the culmination of almost a decade's work on income inequality (Wilkinson 1986a, 1990, 1992a, 1993a, 1993b, 1994a, 1994b). However, Wilkinson's work was by no means the first, as evidence suggesting a relationship between income distribution and health began to accumulate from 1969 onwards (Lynch and Kaplan 1997)[7]. Yet as a catalyst within the field throughout the 1980s and 1990s, Wilkinson's research has not been without its detractors. Illsley took issue with the comparison of class death rates over time as such comparisons involved 'a number of implicit conceptual and methodological assumptions', as social classes change in size and composition over time making it impossible to compare 'like with like'. In any case, for Illsley, the assignation of the population to a specified 'social class' is fraught with methodological problems (Illsley 1986, p. 151-152). Having unpicked the tools with which to measure mortality rates within the population, Illsley concludes that the concept of inequalities in health ceases to exist 'because empirically the hypothesis rests solely upon that evidence'. Wilkinson rebuffs these methodological problems by citing research that he claims overcome such difficulties (Wilkinson 1986a)[8].

Other debates centred on the data used. After re-analysing two sources of data employed by Wilkinson, Judge claimed that the relation between income inequality and average life expectancy had been exaggerated. Describing Wilkinson's hypotheses as predominantly a

[7] For a comprehensive review of the literature on income distribution and health, see Lynch, J. W. and G. A. Kaplan (1997). "Understanding how inequality in the distribution of income affects health." Journal of Health Psychology 2 (3): 297-314.

'monocausal explanation', Judge called for any future research in the area to adopt 'more sophisticated multivariate methods' (Judge 1995, p. 1284). In response, Wilkinson focused on Judge's use of only two out of five sources of data shown to substantiate the link between income distribution and life expectancy. As a consequence, Wilkinson claims that Judge leaves the 'bulk of the evidence unscathed' (Wilkinson 1995a, p. 1285). Judge's failure to replicate other researchers' findings is seen as a reflection of 'faulty methods and poor quality data' (Wilkinson 1995a, p. 1287). Citing the work (forthcoming in 1995) of two groups of American researchers (Kaplan, Pamuk *et al.* 1996, Kennedy, Kawachi *et al.* 1996) Wilkinson concludes that they provide the 'strongest confirmation that population mortality is associated with income distribution' (Wilkinson 1995a, p. 1287). Furthermore, Wilkinson asserts that future research is likely to rely on the 'superior quality and quantity' of data from the American states.

Richard Wilkinson has been outspoken about the implications of his research and has singled out certain areas of the UK for special attention, as well as being critical of government policy. Citing the Whitehall Study (Davey Smith, Bartley *et al.* 1990) as evidence of the burden of ill-health shouldered by those in lower grades in the civil service, Wilkinson asserts that 'the more deprived sections of the population have paid a heavy price for the official failure to take the social causes of disease seriously' (Wilkinson 1994c, p. 1113). Wilkinson attributes the decline in Britain's rank position in average life expectancy (signifying a drop from 12th to 17th position amongst the 24 nations belonging to the Organisation to Economic Co-operation and Development between 1970 and 1990) to 'growing socio-economic divisions' (Wilkinson 1994c, p. 1113). Elaborating further, he opines that 'The deep divisions in our society are both a reflection and a cause of financial and human waste on a scale we cannot afford' (Wilkinson 1994c, p. 1114). Glasgow, as the most deprived area in Scotland (and the location of this Ph.D. project), is singled out as a city where mortality differentials widened as income differentials increased throughout Britain (Wilkinson 1994c). In another paper Wilkinson focuses on Glasgow's longstanding mortality disadvantage in

[8] Wilkinson cites three indexes of inequality: 1. Gini coefficients. 2. An 'index of dissimilarity'. 3. The slope of the regression of class death rates on the cumulative percentile distribution of total population ordered by class.

comparison with Edinburgh (Wilkinson 1992b). In 1995, Wilkinson criticised the British government for its usage of the term 'variations' rather than 'inequalities' in their investigation into ways of reducing the health divide (Wilkinson 1995b, p. 1177). 'Political safety' is cited as the reason why discussion would be limited to what the NHS and the Department of Health could do, while 'Poverty, housing, job insecurity, the inner cities, the rationing of health services, and other embarrassing problems' were outwith the scope of the inquiry (Wilkinson 1995b, p. 1177).

1.3.3 Strong praise... and a number of criticisms: The reviews of Unhealthy Societies

Unhealthy Societies is perceived as a book drawing together an 'extraordinary diversity of evidence' (West 1997, p. 669) making it's impact 'profound for years to come' (Albee 1998, p. 165). It has been asserted that 'the importance of [*Unhealthy Societies*] cannot be overstated' (Sinfield 1998, p. 178). However, perhaps the best way to summarise reactions is the observation that Wilkinson's work has 'aroused considerable controversy in public health circles' (Epstein 1998, p. 28).

On an empirical level, *Unhealthy Societies* is perceived to be less than watertight for a number of reasons. West is not convinced that the data on income used by Wilkinson is of good enough quality to arrive at 'such far-reaching conclusions' (West 1997, p. 669). West is also unconvinced by Wilkinson's dismissal of reverse causation in the generation of relative poverty. That the two central elements of Wilkinson's thesis appear to be lacking direct evidence is also cause for concern. First, the impact on mental health remains unquantified due to Wilkinson's preference for mortality over morbidity data. Second, the impact of social cohesion is 'inferred' when 'Quality of Life' surveys, if they had been used, would have been able more directly to test the relationship between income distribution and social cohesion (West 1997, p. 670, Webley 1998) . Platt backs this viewpoint by suggesting that what is missing 'is any attempt to undertake a direct empirical test of the hypothesis by specifying quantitative indicators of social cohesion' (Platt 1998, p. 171). Platt also observes that Wilkinson 'tends to rely on death rates' despite the assertion that death is a 'highly socially constructed event, with cause-specific

death rates subject to considerable inaccuracy and unreliability' (Platt 1998, p. 171). However, on the issue of mortality vs. morbidity at least, it should be pointed out that Wilkinson's earlier work (Wilkinson 1992a, Wilkinson 1995a) does employ studies of morbidity including the Health and Lifestyles survey (Blaxter 1990) in order to demonstrate the link between health and income distribution.

For Catalano, Wilkinson's book is a 'failure as epidemiology' (Catalano 1998, p. 168). *Unhealthy Societies* 'strips the [social] reformer's argument of its subtlety by asserting that income disparity is not like a pathogen but, indeed, *is* a pathogen' (Catalano 1998, p. 166). Wilkinson is described by Catalano as 'allud[ing]' repeatedly to empirical work in a 'blatantly uncritical manner' (Catalano 1998, p. 166). Yet Catalano does concede that *Unhealthy Societies* makes an important contribution as the book 'extends market logic to argue rationally for more humane policies' (Catalano 1998, p. 168). To understand the human costs, however, Catalano argues that we should focus on job loss as the pathogen as the 'epidemiologic work reporting health effects of the fear or experience of job loss and of occupational exploitation is much more theoretically and empirically compelling than that concerned with income distribution' (Catalano 1998, p. 168).

In contrast with Catalano, Platt writes of Wilkinson's 'elegant marshalling of the empirical evidence' (Platt 1998, p. 170). However, like Catalano, Platt refers to Judge's research, observing that Wilkinson fails to cite a major critique of his own work. Similarly, Sinfield observes that 'important methodological issues' raised in the debate between Judge and Wilkinson remain untouched. In particular, he observes 'how little discussion I found of the nature and duration of time-lags which might be expected in relating changes in income distribution to, for example, changes in life expectancy' (Sinfield 1998, p. 177). Another perceived omission is the work of Barker (Barker 1992, Wight 1998). Wight views Wilkinson's rejection of any significant role for genetics, health selection or health behaviours as 'shaky' (Wight 1998). Wight argues that the work of Barker *et al* on pregnant women's malnutrition and the subsequent health of their children 'provides an important explanation for the distribution of heart disease' (Wight 1998, p. 174).

The examples Wilkinson employs to demonstrate the advantageous health effects of socially cohesive populations are criticised on various grounds. Catalano is critical of Wilkinson's citing of the perceived psycho-social benefits experienced by the British population during the First and Second World Wars. Catalano finds the citing of war as a mechanism that induces cohesion and improves health to be 'distressingly parochial and insensitive' (Catalano 1998, p. 167). The fact that Wilkinson attributes the beneficial effects of high levels of social cohesion on the vast numbers of the population left at home, not the brutal fatalities of direct conflict, seems to be overlooked by Catalano. Catalano further dismisses Wilkinson's historical 'anecdotes' by suggesting an alternate explanation as to why the industrial societies of the former Soviet bloc have relatively short life expectancy despite increases in living standards. Colleagues in Prague, Catalano recounts:

> '...attributed the gap between life expectancy in their society and Western Europe not to illness among socially isolated adults, but to neonatal mortality. Their data were very convincing. The refusal of the regime to emulate the Western investment in capital-intensive neonatal care clearly led to a widening difference in death rates in neonates. This, in turn, dramatically affected life expectancy at birth.' (Catalano 1998, p. 167)

Japan and Sweden are also doubted as examples of egalitarian countries enjoying higher life expectancies. Catalano ventures that 'migrant, culturally different' populations in both nations do not seem to enjoy the same high health standards (Catalano 1998, p. 167). Perhaps more damaging is Webley's (1998) observations of the 'highly selective' nature of the evidence Wilkinson uses. Webley claims the 'idealised' picture of Japanese society Wilkinson paints is based 'essentially' on three sources: two books published over twenty years ago and a newspaper article in the *Guardian*. As a consequence Wilkinson misses the less palatable aspects of Japanese culture, for example, a management style which favours a passive workforce disciplined 'through surveillance and peer pressure' (Webley 1998, p. 172).

Criticisms of a similar nature are voiced by Wight who comments on Wilkinson's 'selective reading' and 'idealised interpretation' of the anthropological literature (Wight

1998, p. 175). According to Wight, Wilkinson overlooks the long history of capitalist agriculture in Britain and ultimately simplifies human experience into 'non-hierarchical hunter-gatherer societies and those dominated by the market' (Wight 1998, p. 175). Similarly, Wilkinson's overwhelmingly positive interpretation of gift exchange strips the custom of its many forms, particularly its pivotal role in actually sustaining hierarchical societies. Wight argues that gift exchange may actually perpetuate unhealthy behaviours as peer groups use alcohol and cigarettes as a medium of exchange. Besides, *Unhealthy Societies'* 'puritanical critique' of drinking 'entirely overlooks its role in many cultures as a medium for social interaction and, presumably, social cohesion' (Wight 1998, p. 175). Wilkinson's treatment of other disciplines outwith medical sociology is also frowned upon, specifically economics, which is perceived to be presented in *Unhealthy Societies* as 'caricature' (Webley 1998). Webley takes particular issue with Wilkinson's description of economics as a 'mental illness' and cites Duesenberry's work as an example of the importance of the concept of relative income within the discipline for over half a century (Duesenberry 1949).

Another major problem according to observers of Wilkinson's work is his usage of the term 'social cohesion'. A couple of commentators feel that the term remains ill-defined (Platt 1998, Sinfield 1998). Platt comments that:

'Wilkinson does not provide nominal or operational definitions of the concept, tending to refer instead to a range of apparently related or analogous concepts, such as social capital, sense of coherence, civilisation, social affiliations and social support.' (Platt 1998, p. 171)

Others perceive an 'uncomfortable opposition' between the 'material' and the 'psycho-social'. Smail writes that 'Over and over again Wilkinson refers to the psychological *sense of* deprivation, as though it is some kind of disembodied phenomenon split off from the material world' (Smail 1998, p. 169). Yet surely there is a distinction between material deprivation *per se* and perceptions of that deprivation depending on an individual's circumstances and how they compare their experience with others. However, Smail's argument that power is 'through-and-through *material*' (Smail 1998, p. 170) is one dimensional, completely missing the psychological core of Wilkinson's thesis. A

more salient point is made by Wight who asserts that '[s]ocial cohesion can come about in several different ways other than through egalitarian income distribution'(Wight 1998, p. 175). He cites examples such as English rural society or the Indian caste system.

Another consideration with *Unhealthy Societies* is its focus on developed countries. Albee wonders where developing countries fit in the equation, particularly as a great deal of manufacturing takes place in 'Third World' nations for the benefit of developed countries (Albee 1998, p. 163). Similarly, the book is described as too 'afflu-centric' with its exclusive focus on affluent countries (Fryer 1998, p. 179). However, *Unhealthy Societies* does set its parameters clearly: Wilkinson is looking at the relationship between income distribution and health in developed countries as a defined pattern has emerged. It could be argued that the very high mortality rates of developing nations demand more attention, but it is a situation with a different set of problems demanding different solutions. No book can suggest an answer for every challenge faced in a particular field[9].

1.3.4 Refinement and expansion: the climate post Unhealthy Societies

Post *Unhealthy Societies*, Wilkinson and others continued to expand on research looking at the relationship between income distribution and health. In a 1997 British Medical Journal article, Wilkinson (Wilkinson 1997) outlines his thesis by looking at the role of absolute and relative standards in the generation of inequalities in health. The article is the first in a series examining different aspects of the relationship between deprivation and health. Included in the series is an article on income inequality authored by Kawachi and Kennedy who conclude that income inequality 'induces 'spillover' on quality of life, even for people not normally affected by material wants. Wide income disparities result in frustration, stress, and family disruption, which then increase the rates of crime, violence, and homicide' (Kawachi and Kennedy 1997, p. 1040). Another article in the series examines the effects of inequality on children: 'the statistical links between

[9] Wilkinson replies to the criticisms of reviewers of *Unhealthy Societies* in the Journal of Community and Applied Social Psychology Wilkinson, R. G. (1998). "Unhealthy Societies: Richard Wilkinson replies to reviewers." Journal of Community and Applied Social Psychology **8** (3): 233-237.

increasing relative deprivation and growing psycho-social problems among young people are compelling' (Roberts 1997, p. 1123). Bartley *et al* look at the employment of 'safety nets' throughout the life course: 'Even for those enjoying periods of employment and material sufficiency, redistributive policies create a more stable psycho-social environment' (Bartley, Blane *et al.* 1997, p. 1196). Brunner assesses the physiological effects of living in hierarchical societies: 'There is incomplete evidence, but biological plausibility, for the view that psycho-social factors may be important determinants of population health' (Brunner 1997, p. 1475). Elsewhere, the psycho-social 'perspective' has been unpacked by examining the roles of social stress, self-efficacy, the sociology of emotions, and social cohesion in understanding health inequalities (Elstad 1998). Although seen as a 'striking attempt' to explain inequalities in health, Elstad concludes cautiously that it is 'perhaps too much to claim that it signifies a paradigm shift' (Elstad 1998, p. 598).

Arising from a number of the reviews of *Unhealthy Societies* (for example, Sinfield 1998) was the criticism that, despite its central role in the book, the term 'social cohesion' remained ill-defined. Perhaps due to such criticisms, Kawachi, Kennedy and Wilkinson's 1999 article 'Crime: social disorganization and relative deprivation' attempts at least to make a distinction between 'social capital' and 'social cohesion':

> '...it is important to note that social capital and social cohesion are not the same thing. In a well-known example, criminal gangs may provide social capital to its members at the same time as disrupting the extent of social cohesion within a community.' (Kawachi, Kennedy *et al.* 1999, p. 722)

Wilkinson concedes elsewhere that his view 'of what might lie behind the relation with income inequality has changed substantially over the years' (Wilkinson 1999b, p. 956). Here, Wilkinson writes how the assumption cannot be made that individual and societal pathways 'map neatly on to the distinction between material and psycho-social processes' (Wilkinson 1999b, p. 956). He also appears to favour a more multi-causal, multi-layered explanation than ventured previously: 'On top of the individual effects of relative deprivation and social status, there are probably also cultural processes by which less egalitarian societies develop more aggressive and less supportive environments'

(Wilkinson 1999b, p. 956). On the balance between individual and societal pathways Wilkinson writes that it is: '...likely to vary from one country to another, and with the size of the areas over which inequality in measured' (Wilkinson 1999b, p. 957).

A recent debate has called into question the very existence of psycho-social mechanisms. Lynch *et al* (2000) discount psycho-social factors and instead favour 'neo-material' explanations. For them, a focus on perceptions of inequality ignores the material conditions that structure everyday experience. This then leads to an unhelpful political agenda of victim blaming (Lynch, Davey Smith *et al.* 2000). Rather than focusing on any alternate theory, Marmot and Wilkinson respond by reinforcing the importance of psycho-social explanations (Marmot and Wilkinson 2001). In excluding psycho-social effects, it is claimed that the effects of 'relative deprivation involving control over life, insecurity, anxiety, social isolation, socially hazardous environments, bullying and depression' on health remain untouched (Marmot and Wilkinson 2001, p. 1234). Marmot and Wilkinson emphasise the psycho-social importance of consumption, again moving away from the absolute standards favoured by Lynch *et al*:

'...over and above satisfying basic needs, consumption serves social, psycho-social, and symbolic purposes. It expresses identity. Self image is enhanced by possessions. Shopping provides 'retail therapy'. Wealth is a marker for social status, success, and respectability, just as poverty is stigmatising.' (Marmot and Wilkinson 2001, p. 1234)

Finally, Marmot and Wilkinson argue that a focus on psycho-social factors does not detract from the structural determinants of health in need of attention. However, there is 'added urgency' with psycho-social factors as they exacerbate other social problems, including violent behaviour and educational performance (Marmot and Wilkinson 2001, p. 1235). Nevertheless, the emotive and powerful words of 'insecurity', 'anxiety' and 'isolation' – the emotional states people in hierarchical, income polarised societies are supposed to experience – are backed up with very little direct evidence. The closest Wilkinson has come to testing this aspect of his hypothesis appeared in his 1998 paper utilising the views of prisoners (Wilkinson, Kawachi *et al.* 1998). Wilkinson's later work has often focused on the links between income inequality, crime, social trust and

mortality rates (Wilkinson, Kawachi *et al.* 1998, Kawachi *et al* 1999). His co-authored 1998 article 'Mortality, the social environment, crime and violence' (Wilkinson, Kawachi *et al.* 1998) is particularly salient to this Ph.D. project as it appears to be the first time Wilkinson utilises lay accounts (as well as professional views) in the form of ex-prison inmates. Yet it appears that Wilkinson *et al* have to justify this approach rather than view it as a logical progression in research focusing on social inequalities. The argument is as follows:

'We conjecture that one of the salient characteristics of social environments marked by wide income disparities is that they generate invidious social comparisons, which in turn engender a sense of exclusion and alienation among vulnerable individuals. Under such conditions, violent behaviour may be seen as an expression of the quest for respect from others. To shore up these arguments, we turn to evidence of a different nature, viz. narrative histories of violent individuals describing their quest for respect from others... The reason for making this macro-to-micro transition is to attempt to link the social environment (income inequality) to individual health outcomes, via intervening psychological variables, including the lack of self-esteem and the sense of not being respected.' (Wilkinson, Kawachi *et al.* 1998, p. 588)

The following section goes on to examine the development and formulation of policy within the health inequalities field.

1.4 The advent of critiques converting evidence into policy

'I believe in greater equality. If the Labour Government has not raised the living standards of the poorest by the end of its time in office it will have failed.'
[Rt Hon Tony Blair MP, *Independent on Sunday*, 28 July 1996]

Prior to the Labour government's electoral victory in 1997, there had been growing frustration in the inequalities field. It had been seventeen years since the publication of the Black Report, but in this period of Conservative rule, the recommendations to increase benefits, redistribute income, improve housing and abolish child poverty had been ignored. A mass of evidence had accumulated during the previous two decades, yet little attention had been paid to what should be done to reduce inequalities in health. Tony Blair and the Labour Party seemed committed to reducing inequality as a party in

opposition, and so their victory in the late nineties was greeted with high expectation as onlookers awaited the action the new government would take to reduce inequalities in health.

1.4.1 The King's Fund

Throughout the 1990s a gradual transformation occurred as a lifestyle-focused approach towards policy formulation made way for increasingly strong calls for some form of wealth redistribution to improve the population's health. In 1991, a King's Fund publication considered the 'economic approach' of increasing wealth and redistributing resources as a way of reducing deprivation (Jacobson, Smith *et al.* 1991). However, such a suggestion seemed to be overshadowed by policies aimed at improving lifestyles and promoting individual responsibility. The report declared:

- '...Risk factor reduction aims to sever the link between deprivation and ill health by promoting behaviour change.
- The educational approach aims to promote a better educated community – especially among the most disadvantaged.
- The community development approach aims to support and promote self-esteem and autonomous action among the most deprived groups in the community.' (Jacobson, Smith *et al.* 1991, p. 122)

By 1995, the emphasis had changed slightly. A report from the King's Fund looking at possible ways to reduce health inequalities identified four main policy levels after taking into consideration reviews undertaken by the Dutch government (Gepkens and Gunning-Schepers 1993), the Northern Regional Health Authority (Bunton, Burrows *et al.* 1994), and the World Health Organization (WHO) (Whitehead and Dahlgren 1991; Dahlgren and Whitehead 1992; Dahlgren 1993). This report addressed four areas: strengthening individuals, strengthening communities, improving access to essential facilities and services, and encouraging macroeconomic and cultural change (Whitehead 1995, p. 24).

The 'Tackling inequalities' report (Whitehead 1995) examined these four policy areas, providing examples of action already taken. For example, under 'strengthening communities', a number of initiatives had been implemented in Scotland, such as a campaign for better housing in Glasgow and an Edinburgh-based withdrawal group,

providing support for those wishing to lessen their dependence on tranquillisers and anti-depressants (Whitehead 1995, p. 35). The report goes on to look at policy options for reducing inequalities in the areas of housing, family poverty, smoking, and the role of the NHS. Subsequent King's Fund publications fine-tuned this approach. A report published in 1998, with a focus on local inequalities targets, recommended establishing teams of experts at national or regional level to help develop and implement inequalities strategies, the need for effective co-ordination at regional level, working with the private sector, the establishment of a research and development strategy, and a 'what works' approach, disseminating best practice (King's Fund 1998).

1.4.2 Why reduce health inequalities? The justification of a policy framework

Despite the accumulation of research documenting inequalities in health and the growing realisation of a mounting toll of preventable deaths, there still appeared to be a need in some quarters to justify policies aimed at narrowing the gap. Vagero (1995) argued that the reduction of health inequalities could potentially improve the health of the population as a whole. However, even if implementing such policies did not contribute to improved health overall, there is still a moral justification for pursuing them. Going against the approach of the King's Fund, Vagero goes on to state that:

> 'It is tempting for those producing health inequalities research to be drawn into policy-making themselves, but apart from their research knowledge they have no more credentials as policy-makers than have nurses or bricklayers.' (Vagero 1995, p. 13)

Yet that is exactly how a growing body of policy-focused research aimed at narrowing inequalities in health began. Five years later, Woodward and Kawachi (2000) attempt to justify the reasoning for reducing health inequalities, concluding that fairness is the most compelling and influential argument. They also suggest that inequalities affect everyone, they are avoidable, and that interventions to reduce health inequalities are cost effective. Yet against a backdrop of arguments justifying a policy response, the UK government

had already taken action, commissioning an independent inquiry into inequalities in health shortly after their victory in 1997 (Acheson 1998)[10].

1.4.3 'Frustrating generality'? Reactions to the Acheson Report

The Acheson Report was viewed as another milestone in the inequalities field. It was a milestone which, unlike the Black Report, was openly endorsed and supported by the Labour government. The results of the Independent Inquiry were greeted with both excitement and anticipation of progress and change, yet as the results of the Acheson Report were assimilated amongst the research community, a number of dissenting voices began to emerge. Some commentators felt that the recommendations put forward by the Inquiry were too vague:

> 'We recommend the development of policies to...' What policies? Developed by whom? Nor do the authors of the Report set priorities among their recommendations, or deal with issues of affordability and cost-effectiveness.' (Evans 2002, p. 63)

Similarly, Maynard (1999, p. 282) observes that while the Acheson Report lists over 130 policies to reduce inequalities, 'None...are costed and there is no attempt to prioritize them.' Williams (1999, p. 292) suggests that it was because the Inquiry ignored cost effectiveness and affordability that the 'central problem' of priority setting was overlooked. Furthermore, because the majority of evidence cited was cross-sectional rather than longitudinal, the Inquiry had '...no framework within which to judge its overall significance within a lifetime perspective'. Williams also suggests that good health may vary in importance depending on stage of life, giving the example that 'inequalities when bringing up young children may be more important from a policy viewpoint than inequalities at other stages of life, such as old age' (Williams 1999, p. 298). Yet Williams argues that with the Acheson Report, 'we are left with the impression that all inequalities are equally inequitable...' (Williams 1999, p. 297), compounded by

[10] In July 1997, Tessa Jowell, the then Minister for Public Health, commissioned Sir Donald Acheson to chair an independent inquiry into health inequalities in England. The content and press coverage of the Acheson Report is considered in chapter four.

the fact that the words 'inequality' and 'inequity' are used interchangeably throughout the report (Williams 1999, p. 298).

The conceptual framework used as a foundation for the recommendations of the Acheson Inquiry is also called in to question as it 'appears linked to the authors' recognition of a lack of evidence for interventions associated with reductions in inequalities in health' (Birch 1999, p. 301). Of the many recommendations listed, there is no evidence to suggest that they will be particularly beneficial to the most disadvantaged. This scarcity of evidence has led, in the eyes of some commentators, to 'a shift in attention from inequalities in the distribution of health towards improving the health of the poorest groups in society' (Birch 1999, p. 301). In fact, the conceptual framework Birch refers to is the model developed by Dahlgren and Whitehead (1991), which reappears in the 1995 King's Fund report detailed earlier in the section, with its four main policy layers (Whitehead 1995, p. 24). As a result, Birch suggests that the work of the Acheson inquiry does not reflect current research 'in the determinants and population distribution of health' (Birch 1999, p. 303), with the socio-economic gradient unmentioned in the Report's recommendations (Evans 2002, p. 65). Instead, the Inquiry's focus on material conditions 'implies that the authors see health inequalities as a result of income *inadequacy* in the poorest groups, and not with income *inequality* in the population' (Birch 1999, p. 304), so that any policies developed to alleviate poverty may lift some out of poverty yet have little impact on the overall distribution of health. Summing up the situation, Evans writes:

'Whatever the understanding of its authors, the Report's recommendations seem rooted in the view, still quite widespread despite the counter-evidence, that there is some sort of poverty threshold above which the relation between income inequality and health inequality either does not exist, or does not matter. This is a long way from the Whitehall studies, as well as from Wilkinson.' (Evans 2002, p. 65-66)

1.4.4 Redistribution as a viable policy option

'It is an interesting speculation as to why populations in the English-speaking world have become so much more generous toward their richest members, and so much less so toward the poorest... How many people actually know what is going on?' (Evans 2002, p. 77-78)

Commenting on Whitehead's four policy levels, Scambler and Higgs (1999) argue that the fourth level, policy interventions involving macro-economic and cultural change, would be most effective at reducing health inequalities. Whitehead's first three levels have entailed 'operational' change, that is 'health promotion or service initiatives overseen by health workers and allied experts, 'encouraged' or otherwise by government, which neither challenge nor threaten powerful or other interests' (Scambler and Higgs 1999, p. 291). Whereas the fourth level requires 'political' change, which refers to:

'... initiatives which bear on health but are beyond the conventional spheres of authority and influence of health workers alone to accomplish; such change, typically requiring government sponsorship or action, may increase awareness of powerful class or other interests, and may indeed indirectly pose a challenge or threat to them (e.g. fiscal measures).' (Scambler and Higgs 1999, p. 291)

Policy initiatives fitting in the remit of the first three levels have not been 'uncommon', typically requiring only operational change, while initiatives at the fourth level, requiring political change, have been 'far rarer' (Scambler and Higgs 1999, p. 291). The Acheson Report, although summarising the problem, offers 'only vague, sometimes poorly evidenced, proposals for efficient policy implementation' (Maynard 1999, p. 282). Such a situation is viewed by some as highly regrettable as 'it permits the Blair Government to use the rhetoric of concern for these issues, whilst doing little both to confront the opportunity cost of equality policy and to identify cost-effective means of reducing health inequalities' (Maynard 1999, p. 282).

Subsequent government reports have addressed inequalities in health (Department of Health 1999, 2001a, 2001b), yet nothing proposed could be viewed as the kind of action many commentators favour, which is essentially to instigate change at Whitehead's fourth policy level. In 1997, the year Labour came to power, Benzeval (1997, p. 167) called for the next government to 'put equity at the centre' of its health policy. At that

time it was observed that 'Radical changes to economic and social policies are required to promote social justice for all in Britain (Benzeval 1997, p. 167). Yet three years later, at a time when the Chancellor was no longer tied (by his own restrictions) to the previous Conservative limits on expenditure, and after such initial high expectations, questions of the same nature were still being asked. Mitchell *et al* (2000) predict the health consequences of full employment for all, a modest redistribution of wealth, and an end to childhood poverty respectively. They conclude that a mild redistribution of income would save 7597 lives or 7% of all premature deaths in Britain, by far the greatest number of lives saved when considering the impact of each scenario. More fundamentally, the scenarios detailed suggest to the authors that macroeconomic policy would have the greatest impact on health outcomes rather than the government's preoccupation of targeting resources through various 'zones'.

Scambler and Higgs (1999), quoting the work of Bauman (1998), suggest that 'as a consequence of globalisation, governments of nation-states, including that in Britain, have now lost (most of) their power to intervene politically to regulate 'their' economies' (Scambler and Higgs 1999, p. 291). This would imply that there is only so much any modern government can do in terms of macroeconomic change, leaving any notion of redistribution out in the cold. Yet others argue that governments do indeed have power in the distribution of economic rewards. It is simply that we have come to accept 'conventional economic wisdom ... that there is a 'natural rate' of unemployment, that aid programmes are ineffective, and that governments are largely powerless to offset a global trend towards increasing inequality' (Atkinson 1999, p. 287). Contrasting the current political climate with that of forty-odd years ago, Atkinson writes:

'A person who had gone to sleep the day that Harold Wilson was first elected Prime Minister in 1964 and who woke today would be struck by many changes... In the heady days of the 1960s, it was believed that governments could choose from a menu of inflation and unemployment, that overseas aid programmes would speed the development of poor countries, and that governments could redistribute domestically through taxes and transfers.' (Atkinson 1999, p. 286-287)

In addition, it is also claimed that there is widespread support for policies to reduce poverty and inequality due to the rapid growth of both in Britain throughout the 1980s. Shaw *et al* (1999) quote a number of surveys which reveal a willingness from the British public to pay extra taxes to eradicate what is perceived to be a very real and serious problem. Rather than searching for a quick fix, Shaw *et al* argue that poverty 'really is a problem of the lack of enough money – if you give poor people enough money they stop being poor – it is as simple as that' (Shaw, Dorling *et al.* 1999, p. 184). A possible option, costed by economists, is a Basic Income scheme, which in its various guises is perceived as a way of effectively ending poverty in the UK (Shaw, Dorling *et al.* 1999, p. 192). Basic Income schemes (Desai 1998, Brittan and Webb 1990) are perceived as a way of plugging the gaps and loopholes in social security and reducing the numbers of people in poverty. On an ideological level, these schemes are seen as fair as 'people should have a means of subsistence independent of needs and not dependent on complicated contribution records or intrusive scrutiny of personal means' (Shaw, Dorling *et al.* 1999, p. 192). Others describe a 'universal citizen's income' which is unaffected by employment status, and has the potential to facilitate re-structuring of the economy. Such a far-reaching claim is based on the premise that people 'may be more willing to take risks, to retrain, and to change jobs, in a society in which there is adequate social protection' (Atkinson 1999, p. 287). From a lifecourse perspective, where critical periods in human development have been identified[11], 'safety nets' are deemed to be particularly important. Echoing Wilkinson, such a system benefits 'Even... those enjoying periods of employment and material sufficiency, [as] redistributive policies create a more stable psycho-social environment' (Bartley, Blane *et al.* 1997, p. 1196).

A call for macro-economic policies to reduce health inequalities has occurred alongside increasing scepticism over the value of targeting. Policies which address those most in need are perceived as positive, but they 'essentially provide micro solutions for a macro problem' (Watt 2001, p. 175, Deaton 2002). Targeting, as the term suggests, concentrates on the few at the expense of the many, missing 'large numbers just above the arbitrary

[11] Such as entry to labour market, establishing own residence, transition to parenthood, and job insecurity, change or loss.

threshold. Sinking the iceberg, rather than attacking its tip, is a better basis for public policy' (Watt 2001, p. 175). Perhaps most worrying is the continuing view that, crucially, there is very little evidence on which to formulate meaningful policy on reducing inequalities. As Macintyre succinctly puts it, 'there is much more evidence about the magnitude and nature of inequalities in health than there is about the effectiveness of interventions to reduce them' (Scottish Executive 2001, p. 119). This view unfortunately applies to the Acheson Report as Macintyre *et al* reflects that the evaluation group assisting the inquiry were:

'...struck by the lack of empirical evidence available for a government to base policies or decide on priorities, despite the large amount of research undertaken and published on the subject in the United Kingdom.' (Macintyre, Chalmers *et al.* 2001, p. 224)

Echoing Vagero's comments on researchers lacking credentials as policy makers (Vagero 1995, p. 13), Macintyre observes the 'readiness of researchers to recommend policies the effectiveness of which they know little about' (Macintyre, Chalmers *et al.* 2001, p. 224). Such comments form a larger debate on evidence-based medicine, on which public policy is supposed to be increasingly based (Macintyre and Petticrew 2000, Davey Smith, Ebrahim *et al.* 2001). It appears that policy formulation to reduce health inequalities has reached a crossroads until clear evidence is gathered on which programmes are particularly beneficial to the most disadvantaged groups (Birch 1999, p. 305). This leaves the government in a situation where as much as they have placed inequalities higher on the political agenda, 'without new research into interventions, much of this effort will flounder in a quagmire of unevaluated projects and programmes' (Horton 2002, p. 186).

The lessons learned however, are a step in the right direction. There have been calls for a new research agenda to evaluate the effects of policies put in place to redress health inequalities (Marmot 2001). Similarly, Health *inequalities* Impact Assessments of all policies likely to have an impact on inequalities in health have been suggested (Whitehead, Diderichsen *et al.* 2001). Different countries need to cooperate and learn with each other in their implementation of policies to reduce health inequalities (Whitehead 1998), with the proviso that the pathways leading to poor or good health may

be different depending on existing policy frameworks and cultural factors (Whitehead, Burstrom *et al.* 1999). Perhaps most critical for the application of any policies to reduce health inequalities is the desire to see them through as any change is likely to take decades to bear fruit (Leon, Walt *et al.* 2001). As any action will take place in a social climate where the proportion of children born and brought up in households with less than half of average income tripled during the 1980s, any positive results will indeed be a long time coming. As a way of warning, Watt speculates:

'We have still to learn the consequences of living in a society in which nearly a third of adults have been brought up in conditions of relative poverty, though the US may be a guide.' (Watt 2001, p. 175)

The challenge becomes ever more daunting as researchers report that health inequalities have been increasing to the end of the twentieth century (Davey Smith, Dorling *et al.* 2002). Increases in inequalities in mortality have been particularly apparent among young adults, suggesting that 'continuing increases in mortality differentials at older ages are currently being set in train' (Davey Smith, Dorling *et al.* 2002, p. 435). Furthermore, income inequality increases have hit families with children most severely, feeding into the 'reproduction across generations of inequalities in both material circumstances and health outcomes' (Davey Smith, Dorling *et al.* 2002, p. 435).

1.5 A 'flourishing area'? Evidence on lay perceptions of societal and health inequalities

Richard Wilkinson and other psycho-social theorists are responsible for a body of research which opened up the inequalities field in new directions, leading to potentially intriguing and fascinating paths of enquiry. Yet although it is reasonable to suggest that mechanisms linking inequalities to ill health may stem from relative deprivation rather than absolute poverty, where is the evidence on lay perceptions? With regard to health inequalities, Mildred Blaxter writes that there is 'no evidence that inequality in health is an issue of great concern among the lay public in Western industrialised societies' (Blaxter 1997, p. 747). Although Britain has a long tradition of recording the variations in

death and illness between different social classes, inequalities in health are habitually rediscovered by the media 'as though it were something newly uncovered' (Blaxter 1997, p. 747). On the basis of this pattern, Blaxter suggests that it is not an issue 'at the front of the public's consciousness, though there is very little research on what the general population actually thinks about it' (Blaxter 1997, p. 747). Blaxter explores the literature on general ideas about health and the causes of illness as a route into the topic and notes that the study of lay concepts is a 'flourishing area' (Blaxter 1997, p. 747). Blaxter goes on to give an extensive review of this literature, including classic texts such as *Hard-earned lives* (Cornwell 1984), *Mothers and Daughters* (Blaxter and Paterson 1982) and *Health and Illness: The Lay Perspective* (Calnan 1987). Such work has provided an in-depth insight into lay concepts and theories of health and illness. In addition to the literature Blaxter reviews, a number of studies emerged throughout the late eighties and nineties looking at lay perceptions/experiences on a number of health-related subjects (for example Blane 1987, Backett 1992, Walters 1993, Furnham 1994, Elstad 1996). Pierret (1994) has researched lay views of health and illness with a particular interest in differing discourses constructed by working and middle class respondents in France. Notably, a study published in the late nineties attempted to link health behaviours with psycho-social characteristics (Lynch, Kaplan *et al.* 1997).

Others have theorised the role of lay views/perceptions in the context of the medical profession (Williams and Calnan 1996) and public health research (Popay and Williams 1994, 1996). An observation to bear in mind in the context of this study is Williams and Calnan's assertion that 'in late modernity, a far more 'critical distance' is beginning to open up between modern medicine and the lay populace' (Williams and Calnan 1996, p. 1617). In what could almost be seen as a response to this observation, Popay and Williams assert that 'If research in the field of public health is to develop more robust and holistic explanations for patterns of health and illness in contemporary society, then it must utilize and build on lay knowledge – the meanings health, illness, disability and risk have for people' (Popay and Williams 1996, p. 760). Later Popay *et al.* (1998) refine this argument for the study of inequalities in health, stating that 'lay knowledge...offers a vitally important but neglected perspective on the relationship between social context and

the experience of health and illness' (Popay, Williams *et al.* 1998, p. 620). Wight captures the complexities of understanding lay views in all their forms and contexts in his review of Richard Wilkinson's *Unhealthy Societies*:

'...the extent to which the various causes of stress affect all levels of society (to differing degrees) depends very much on individuals' reference groups and expectations. These subjective views are likely to be complex and context-specific, and need to be researched rather than assumed.' (Wight 1998, p. 174)

Another challenge, according to Forbes and Wainwright, is to assess the contribution of cultural and sub-cultural factors when exploring lay perceptions of inequalities. They venture that psycho-social theorists have 'largely overlooked' this aspect, but perhaps it is too much to take such factors into account without any substantial data on lay perceptions in the first instance (Forbes and Wainwright 2001, p. 804).

Much has been written on the role of social capital and social networks in generating good health (Health Education Authority 1999), with studies going on to focus on specific aspects such as gender (Sixsmith & Boneham 2002) and stage in the lifecourse (Morrow 2002). Within such debates the role of place appears crucial (Macintyre, MacIver *et al.* 1993). Cattell, who has carried out research in East London neighbourhoods (Cattell 1995, 1999, 2001), identifies three factors influencing social networks and social capital: neighbourhood characteristics and perceptions; poverty and social exclusion; and social consciousness. Interestingly, she concludes from her interview-based study that perceptions of inequality 'could be a source of social capital as well as demoralisation' (Cattell 2001, p. 1501).

Two recent studies add further empirical data to the debate. Popay, Thomas *et al.* (2003) used in-depth interviews to explore the links between lay knowledge, place and health related action. They discuss the ability of respondents to '(re)construct a positive identity despite living in what they and others perceive to be an 'improper' place' (Popay, Thomas *et al.* 2003, p. 55). In a related paper (Popay, Bennett *et al.* 2003), exploring lay understandings of social inequalities in health using both quantitative (postal questionnaire) and qualitative (in-depth interviews) methodologies, it is reported that

people had 'no problem' offering explanations for health inequalities. However, the in-depth interviews revealed that people living in disadvantaged areas were 'reluctant to accept the existence of health inequalities highlighting the moral dilemmas such questions pose for people living in poor material circumstances' (Popay, Bennett et al. 2003, p. 1). When considering these studies it is important to appreciate that as social trends shift, so do lay views (as well as 'professional' and institutional views etc.) and that this may be most salient in terms of the generational differences of respondents within any given study.

In summary, researchers have moved forward in theorising the place of lay perceptions in health inequalities research but the actual collection of lay views and experiences on this subject remain limited. In addition to Popay's studies, two UK-based projects (located in Bristol and York respectively) starting out with the aim of exploring lay perceptions of health inequalities have yet to publish their results. However, at the time of writing it appears that the projects have either moved away from a lay perceptions approach (Bristol) or have subsequently become more economics-based (York). Blaxter and Popay's papers on lay perceptions of health inequalities stand out as landmarks in this area (Blaxter 1997, Popay, Bennet *et al* 2003, Popay, Thomas *et al* 2003). However, it is also important to have a distinction between lay views of societal inequalities and health inequalities. A few key points from Blaxter's paper are highlighted below. These observations will be vital in considering the results of this Ph.D. project and will be evaluated further in the concluding chapter.

Utilising survey data (Cox *et al.* 1987, Cox, Huppert *et al.* 1993), Blaxter observes that individuals in more favourable circumstances were more likely to think in economic or environmental terms when discussing the causes of health and illness. Those who did cite poverty as a cause of ill health were more likely to be in higher income groups (Blaxter 1997). Incidences of individuals attributing illness explicitly to poverty are viewed as 'unusual' in the qualitative literature (Blaxter 1997, p. 750). When the findings of the Black Report (Black, Morris *et al.* 1988) were described to respondents of one study 'a large group simply declined to believe it' (Blaxter 1997, p. 751). This fits in with the

observation that 'lay people have rarely talked about inequalities in health' and that existing evidence suggests that the notion 'does genuinely represent a feeling of disbelief or unease... especially among those most at risk' (Blaxter 1997, p. 753). At a superficial level, the importance of a healthy lifestyle is expressed by all social classes, an account which is acceptable to a stranger, or 'lay interpretations of 'expert' opinion' (Blaxter 1997, p. 755). Perhaps most relevant to this study is the consideration that 'To acknowledge 'inequality' would be to admit an inferior moral status for oneself or one's peers...' (Blaxter 1997, p. 754). Research in this area is potentially full of sensitivities because essentially the researcher is asking respondents to 'engage actively in the construction of their ideas and the presentation of their own social identity' (Blaxter 1997, p. 755), a concern to be taken seriously considering Popay, Bennet *et al's* conclusions (2003). Consequently, it is understandable that those 'most exposed to 'unequal' health... will be least likely to talk readily about their risk status' (Blaxter 1997, p. 756). Is it really possible to expect people to divulge in this manner, to talk about inequalities, in relation to health or otherwise?

1.5.5 Summary, questions raised by the literature, and how this thesis will address them

This chapter began by reviewing some of the key literature in the inequalities area. Evidence had been accumulating steadily since the publication of the Black Report on the existence of inequalities in health. The debate between absolute and relative inequalities has been detailed with particular attention given to Richard Wilkinson's theory of psycho-social processes mediating health outcomes in developed societies. With regard to policy, although the Acheson Report was perceived as a landmark, equivalent in importance to Black, it seems that the evidence needed to back up interventions to reduce inequalities in health is still lacking, despite the wealth of research conducted in the area. Finally, it has been shown that evidence on lay perceptions has been limited despite the rising interest in social status and social cohesion.

Aims:

- To examine the relationship between lay perceptions of societal and health inequalities and societal (media) representations of health inequalities (as represented by newspaper coverage)
- To ascertain the extent to which people perceive societal inequalities, and if so, whether this extends to perceptions of inequality in health?
- To identify whether people are aware of fine gradations of material inequality and if such an awareness is perceived to impact on their health (physical and/or psychological). Is there a discordance or concordance between Wilkinson's overarching theory of the determinants of population health and lay accounts?
- To identify the extent to which psycho-social mechanisms are represented in lay views as well as the significance of material factors within this framework.

This will be achieved by:

- Examining the presentation of health inequalities in government consultative and policy documents and in an independent inquiry
- Analysing the subsequent media coverage of these documents
- Conducting focus groups in order to access lay views

In 1997, before the Acheson Inquiry was in existence, and as the Labour Party had secured victory, expectations were high as to what the government could achieve in terms of reducing inequalities. At this particularly fascinating juncture in British political history, how was the inequalities debate presented by the government and in the media? The first half of this thesis presents an analysis of government public health policy, with its stated intention to reduce inequalities, along with an analysis of the ensuing media coverage. The literature reviewed in this chapter charts the growing interest and lively debate surrounding the existence of psycho-social mechanisms and their suggested role in the generation of health inequalities. It has been suggested that people are aware of fine gradations of material inequality, and that this awareness is sufficient enough to impact on their health, yet little research has been conducted on lay perceptions. This thesis attempts to contribute to the literature with a detailed examination of lay perceptions of

inequalities, the findings of which are presented in the second half of this thesis. These chapters will explore people's sense of relative deprivation and how they compare themselves, and their experiences with others. Do people experience inequality on an emotional as well as material level, and what are their understandings of inequalities in health? Has the media coverage of health inequalities, as a result of their prominent profile in government policy, heightened public awareness of the issue?

The following chapter (two) details the methods employed in this study. Chapter three presents an analysis of the English and Scottish Green Papers and their coverage in the press. In similar fashion, chapter four examines the Acheson Report, chapter five looks at the Scottish White Paper and chapter six details the English White Paper[12]. The second half of the thesis presents the data collected on lay perceptions of health inequalities. Chapter seven examines lay perceptions and awareness of inequalities, chapter eight analyses the language employed in discussion of inequalities, before going on to look at image management and self presentation. Chapter nine addresses the perceived health effects of living in an unequal society and the solutions put forward by participants before the discussion, limitations and conclusions drawn from this study are set out in chapter ten.

[12] An analysis of the coverage of the Green and White Papers has been accepted for publication (Davidson, R., Hunt, K., Kitzinger, J. (2003) "'Radical blueprint for social change'? Media representations of New Labour's policies on public health" Sociology of Health and Illness (forthcoming)).

Chapter two

Methodology

2.1 Introduction

This study comprises two areas of investigation involving first, the analysis of public policy documents and subsequent press coverage, and second, lay views of health inequalities. Content analysis of UK press coverage of five major public health documents over specified time frames was undertaken in order to establish the extent to which the inequalities debate had entered the public domain. Focus groups were conducted with a cross-section of the population to explore how they understood health inequalities and related to media coverage and government policy. This chapter will first describe how content analysis was used in this project, and then goes on to detail the design and execution of the focus groups.

2.2 Content analysis of UK press coverage of five major public health documents

As this project began in 1997, a new Labour government was beginning its first term after an eighteen year period of Conservative rule. This was considered an exciting time in politics by many, and the Labour government itself was keen to make its distinct mark on the policy agenda. As a result, this research was a 'live' project, *responding* to changes and developments in the political arena as they occurred. It was not known in advance when the government's anticipated statements on public health policy would be released. Given the uncertainty involved in awaiting the publication of government documents, and the publication of five key consultative or policy documents during the study period, it is not surprising that the media section of this thesis (chapters 3-7) turned out to be substantial.

Although the timing of publications could not be controlled, the method chosen to examine the media coverage could be. From the outset, the central question was *'to what extent has the new Labour administration factored inequalities in health into their public health agenda, and to what extent has this emphasis been conveyed by UK newspapers?'* This would involve analysis of both government consultative and policy documents (as well as an independent inquiry), as well as analysing the reporting of these documents by the UK press.

2.2.1 Government documents sampled

The decision to analyse media coverage of the new government's public health policy was prompted by the publication on 5th February 1998 of the English and Scottish Green Papers *Our Healthier Nation: A Contract for Health* (Department of Health 1998) and *Working together for a Healthier Scotland* (Scottish Office Department of Health 1998). The names and dates of publication of the Green Papers, and the other three documents which became the focus of this part of the study are detailed below. The table also shows the dates of the period for which the press was scrutinised for each document:

Table 2.1 Five key government documents

Document title	**Publication date**	**Time period of media review**
Our Healthier Nation: A Contract for Health	5th February 1998	5/2/98 to 4/3/98
Working Together for a Healthier Scotland	5th February 1998	5/2/98 to 4/3/98
The Acheson Report: An Independent Inquiry into Inequalities in Health	26th November 1998	26/11/98 to 23/12/98
Towards a Healthier Scotland	17th February 1999	17/2/99 to 16/3/99
Saving Lives: Our Healthier Nation	6th July 1999	6/7/99 to 2/8/99

As the Green Papers, or consultative documents, heralded a new era in which inequalities in health appeared at the forefront of the policy agenda, they seemed an obvious choice to analyse as a barometer of the extent to which the issue was being aired in the media. It then made sense to include the media coverage of the government's ensuing White

Papers, or policy documents. In the intervening period, an independent inquiry on health inequalities (the Acheson Report) published its results. Given the study's focus on inequalities, it seemed vital to undertake analysis of the media coverage of this document too.

2.2.2 Newspapers sampled

The sample consisted of all national UK and Scottish newspapers. Television news coverage was also collected, but due to time constraints, it was decided not to include this data in the content analysis for this study. This study focuses exclusively on the presentation of health inequalities in five key documents and the subsequent newspaper coverage of these documents alone. As well as the omission of other forms of media (such as television and radio), this study does not take in the wider context (and therefore does not include in the coding scheme) of newspaper reports featuring 'human interest' stories conveying situations of poverty, deprivation, inequality, injustice and ill-health. Therefore, people's impressions of an 'inequalities debate' via the five key news events is limited and does not take into account public awareness of a wider media discourse on inequality. This is highlighted in chapter nine where focus group participants do make reference to media stories whilst referring to a range of sources, including television and radio, as well as newspapers, spanning a considerable length of time.

Given the research was based in Scotland, and the specific issues that arise in Scotland's place in the UK political system and health ranking, it was also considered essential to include both Scottish and English publications. I also included one Glasgow-based tabloid (the *Evening Times*) in order to include a local perspective (see table 2.2). The *Financial Times* was excluded from the sample as it was considered too specialised. The UK press can be divided into two basic categories: tabloids and broadsheets. Tabloids are perceived as 'downmarket' in the UK, yet have a readership of millions. Broadsheets are perceived as more 'high-brow' than tabloids. They are literally 'broad' – bigger – in comparison to tabloids, have a far greater proportion of text to images, and the standard of reporting is perceived to be far higher. It is also worth noting that UK newspapers

often have strong, but also shifting, political leanings. For example, the *Guardian* newspaper is traditionally perceived as left-of-centre, whereas the *Daily Telegraph* has traditionally lent to the right.

To maintain clarity, the process of collecting and analysing the data will be mainly described in relation to the English and Scottish Green Papers. However, a broadly similar procedure was employed when collecting and analysing data in the subsequent sampling periods.

Table 2.2 Newspapers included in sample

Classification	*Newspaper*	Circulation figures[13] (Sep 2000)
National UK daily broadsheets	*Guardian*	391, 162
	The Times	674, 957
	Independent	197, 683*t*
	Daily Telegraph	969, 976
National UK daily tabloids	*Sun*	3, 528, 128
	Mirror	2, 161, 506
	Daily Star	640, 703
	Daily Mail	2, 343, 166
	Daily Express	962, 501
Scottish broadsheets	*Herald*	90, 217
	Scotsman	74, 243
Scottish Tabloids	*Daily Record*	598, 159
National UK Sunday broadsheets	*Observer*	414, 289
	Sunday Times	1, 359, 544
	Sunday Telegraph	770, 936
	Independent on Sunday	215, 247
National UK Sunday tabloids	*Sunday Mirror*	1, 844, 325
	Sunday Express	884, 924
	Mail on Sunday	2, 254, 976
Scottish Sunday broadsheets	*Sunday Herald*	58, 708
	Scotland on Sunday	None available
Regional tabloids	*Evening Times*	95, 562

Newspapers were collected for a twenty-eight-day period from the date of a document's publication. This was to some extent an arbitrary time period to set. However, this time frame proved more than adequate as the majority of coverage in all sample periods fell on

[13] In terms of readership, 84% of all British adults (40 million people) read a regional newspaper, and 67% read a national newspaper (http://www.newspapersoc.org.uk/facts-figures/ataglance.html).

the day following the publication of a report. Subsequent coverage continued for a week at most. (The exception to this was coverage of the Acheson Inquiry; however this will be dealt with after an initial description of collection and analysis has been outlined.)

2.2.3 Data collection

2.2.3.1 Government reports

The government reports were obtained as soon as possible after their publication. The publication of each document in each sample period was accompanied by a launch in which government ministers held a press conference. A press release was also issued summarising the main points of the document in question. The most straightforward means of accessing the relevant press releases was by downloading them off the government's official website. It was also possible to access the Green and White Papers, and Acheson Report via the government's website. However, bound copies of each publication were also obtained as clarity was lost in printing out versions of online documents, particularly with diagrams and tables.

2.2.3.2 Newspapers

Newspapers were purchased on a daily basis from a local newsagent. This meant hard copies of all newspapers within each sample period were obtained, enabling inspection of the actual text, images, editing and layout. This was particularly useful when coming to analyse the data, as will be explained in the following section. Much of the context in which the news stories were being reported would have been lost if, for example, all news reports had been collected from the internet. Newspaper layout and running order in particular would have been missed. As the study was conducted in Glasgow, Scottish editions (where relevant) were purchased. Whenever possible, English editions of newspapers were also obtained to ascertain if there was any difference in reporting between versions.

2.2.4 Selection criteria

Each of the 1496 newspapers purchased over the four sample periods was scanned for relevant items. A news item was included in the sample for analysis if it explicitly referred to one or more of the five documents, or made any reference to inequalities. Table 2.3 details the number of items (news reports, editorials, features, letters, columns etc.) found reporting on each government document, or referring to inequalities.

Table 2.3 Number of items found in each sample period

Document	**Sample period**	**Number of items**
English Green Paper: *Our Healthier Nation: A Contract for Health*	5/2/98 – 4/3/98	11
Scottish Green Paper: *Working Together for a Healthier Scotland*	5/2/98 – 4/3/98	10
The Acheson Report: An Independent Inquiry into Inequalities in Health	26/11/98 – 23/12/98	10
Scottish White Paper: *Towards a Healthier Scotland*	17/2/99 – 16/3/99	14
English White Paper: *Saving Lives: Our Healthier Nation*	6/7/99 – 2/8/99	27
TOTAL		**72**

2.2.5 Analysis

2.2.5.1 Why content analysis?

Content analysis is a 'systematic way of exploring the meanings of documents' (Deacon 1999, p. 17). Content analysis was used to gauge the extent to which inequalities featured both in government documents and the subsequent newspaper reports. The method allows a way of ascertaining exactly what information is left out, just as much as what is included:

> 'By counting how often particular topics, themes or actors are mentioned, how much space and prominence they command, and in what contexts they are presented, content analysis provides an overview of patterns of attention. It tells us what is highlighted and what is ignored.' (Deacon 1999, p. 17)

However, a perceived limitation of content analysis is that although the method might tell us something about the document 'it does not delve below the surface to explore implicit meanings, nor does it ask *how* various levels of meaning are organised or conveyed' (Deacon 1999, p. 17). In addition, therefore, the content analysis was combined with elements of textual analysis with attention to words and images. The way in which analysis was carried out for different texts is outlined below.

2.2.6 Government reports and press releases

As each report was published, it was read through in great detail[14]. It was important to note the 'main goals' the government was presenting as the overriding aims in each document. The ways in which inequalities in health were presented, and the weighting given to the subject, was assessed in a number of different ways. Thus word usage was examined carefully. For example, in the English Green Paper the word 'blame' was used frequently as a means of distancing the new Labour government from the previous Conservative administration, who favoured a lifestyle-centred public health strategy. The number of times the term 'inequality' or 'inequalities' was used throughout a document was counted as a crude measure of the emphasis placed on health inequalities as an issue. The language within which discussion of inequalities was couched was also noted.

The extent to which inequalities in health were related to government policy was assessed, as well as which proposals were specifically designed to reduce inequalities. Government documents often contain a number of tables or graphs, and if any of these depicted inequalities, they were given special attention. Lastly, putting each publication in context, I examined how the document fitted in with previous public health policy. For example, how did the Scottish and English Green Papers position themselves in relation to the previous Conservative White Papers on public health, published in 1992?

The press releases accompanying the publication of each document were perceived as an attempt to condense the government's message into two or three pages of A4-size paper,

in a form designed to attract and promote a particular type of media response. Press releases allow journalists to assimilate very quickly the main points of a document, and often they refer solely to a press release rather than reading the document itself. Inevitably with such a level of abbreviation, certain proposals or policies are emphasised or downplayed. I therefore systematically compared the press releases to the main policy documents. These considerations reveal not only the extent to which a document can differ from its press release, but also the initial (and sometimes only) impression given to journalists. The presentation (e.g. language, use of metaphor, etc.) of the press release was also examined in relation to the document it was attempting to convey, as well its subsequent usage by journalists in press coverage. Often the language used in a press release was less formal and drew on popular cultural references. Finally, the number of times the term 'inequalities' appeared in each press release was counted. It was also noted if a press release included examples illustrating inequality, or if inequalities were alluded to (rather than being explicitly referred to). The manner and context in which inequalities were related to government policy, or to specific initiatives, was also analysed.

2.2.7 Content analysis of newspapers

As described in the data collection section (2.2.3), and following a standard content analysis for any press sample, hard copies of all newspapers in the sample were bought and were scanned from cover-to-cover in order to ascertain if they contained coverage of the chosen documents. By reading newspapers in their entirety, it was possible not only to locate articles focused on health inequalities but also to gauge the wider news context. However, although the coding scheme excluded reference to stories with a more general discourse of inequality, any items found during the sample periods were noted. Interestingly, there were few general stories making reference to societal or health inequalities. Other competing news stories in the media during a given sample period were taken into account as factors potentially affecting the level and depth of reporting of the chosen documents.

[14] The content of the two Green Papers and two White Papers are summarised in Appendices B, C, D and E.

A total of 72 items were collected. Each item was given a number, and I recorded its date, newspaper, headline, page number, page type, journalist, journalist's specialism (to ascertain, for example, if a specialised health or medical correspondent focused on a particular aspect). In the text of the thesis, items are referred to in brackets by their assigned number and document featured (i.e. EWP2)[15]. A specifically developed coding sheet, determined by the research objectives, is shown for the Green Papers in Appendix A.1. This allowed detailed coding of the format of the items; page description, images used, story type, content, tone, documentation of inaccuracies, sources quoted, and the use of specific phrases from the original documents or their press releases. Headlines appear in the thesis in single quotation marks and are underlined. With respect to format, it was noted if coverage took the form of a news report, editorial, feature, column, letter or 'other', to get a sense of the style of reporting. An important consideration was the type of sources and images used in the construction of a news story. Spokespersons, organisations, and/or government ministers quoted or referred to as sources were listed for each item. Images, if any, used as part of coverage were described, along with any captions. In addition I recorded roughly how much space an item occupied on the newspaper page i.e. 4/10 of a page, ¾ of a page, and so on. Lastly I coded which government initiatives were covered in each item.

This allowed the following questions to be considered. What was the pattern of reporting? When did most coverage occur? On what day was the launch, and did this affect coverage? (e.g. Was it later in the week, and therefore closer to the weekend?) Which newspapers reported most extensively on each document? Which newspapers contained no coverage whatsoever? Were there any distinct patterns formed in terms of tabloid and broadsheet coverage? Which newspapers focused on which initiatives, and were there any patterns (e.g. in relation to a newspaper's political leanings or broadsheet/tabloid differences). Was the tone of the items positive or negative? Were quotes, phrases or statistics taken from a document itself, the accompanying press release, both, or neither? Were quotes included from government ministers, opposition

[15] For pre-publication coverage of the Acheson Report, items are referred to in brackets by newspaper (in italics), date (if more than one item appeared on a given day of the same format, they were labeled 'a', 'b', and so on), and format i.e. [*The Times*, 7th July 1999c, news report].

parties, doctors, academics/researchers, charities, or the public sector? Were lay views reported in items? Were the sources used positive or negative about government proposals/policy, and how did this fit in with an item's tone as a whole? How was the inequalities debate presented by journalists, and in what context? Was a specific angle taken? If criticisms were made of government strategy, what form did they take? Which newspapers endorsed the government's approach, and how did this relate to their political leanings?

2.2.8 A special note on the analysis of the Acheson Report

Analysis of the Acheson Report (Acheson 1998) and its media coverage differed in certain respects to the Green and White Papers. As an independent inquiry (commissioned sixteen months previously by the government) looking specifically at the reduction of inequalities in health, it was not salient to assess the extent to which the document referred to health inequalities (as with the Green and White Papers). However, the Report's treatment of different aspects of inequality were focused upon, for example, absolute and relative inequalities. It was also important to assess how the Acheson Report's recommendations fitted in with stated government policy (particularly as the Inquiry's findings were published in the consultation process between publication of the Green and White Papers).

Media coverage of the Acheson Inquiry differed markedly from the government reports in that its impending publication was leaked to the press. It could also be argued that such a report would arouse heightened media interest than the launch of government proposals/policy, given its status as an independent inquiry concerned with a potentially contentious subject. Consequently, media coverage did follow a different pattern with substantial pre-publication coverage. To keep the method consistent throughout, the pre-publication coverage was analysed separately, although the items were taken into account when assessing the media coverage of the Acheson Report.

2.3 Focus groups: an introduction

The second part of this inter-linked methodology involved the use of focus groups to examine lay views of inequalities. Content analysis enabled an assessment of the extent to which the Labour government had presented inequalities on their agenda, and how this emphasis was interpreted and conveyed by UK newspapers. Focus groups were conducted to access lay views on the subject. A selection of images and headlines from the coverage of the key public health documents were used in the focus groups as a means of facilitating discussion on inequalities without forcing an agenda. It was also a potential way of exploring how people related to the media representation of the debate (Kitzinger 1993).

2.3.1 Why focus groups?

Focus groups are 'group discussions exploring a specific set of issues'. The group is 'focused' in that it involves some kind of collective activity', in this case viewing newspaper images and headlines (Kitzinger and Barbour 1999, p. 4). Focus groups rely on group interaction, so instead of asking questions sequentially to each participant, 'focus group researchers encourage participants to talk to one another: asking questions, exchanging anecdotes, and commenting on each others' experiences and points of view' (Kitzinger and Barbour 1999, p. 4). As this study was concerned with observing how individuals and groups relate to each other, their perceptions of inequality (if any), and the extent to which they place themselves in a social hierarchy, focus groups were a particularly valuable research tool. Focus groups are a contextual method, enabling:

> '...researchers to examine people's different perspectives as they operate within a social network. Crucially, group work explores how accounts are articulated, censured, opposed and changed through social interaction and how this relates to peer communication and group norms.' (Kitzinger and Barbour 1999, p. 5)

Pre-existing groups were recruited for this study rather than groups of 'strangers' brought together by the researcher. Precisely because the research was concerned with looking at

social hierarchies, the study aimed to access '...the networks in which people might normally discuss (or evade) the sorts of issues likely to be raised in the research session'. The naturally occurring group is 'one of the most important contexts in which ideas are formed and decisions made' (Kitzinger and Barbour 1999, p. 8-9). Of course, pre-existing groups are likely to have 'established their own norms as to what can and cannot be said and hierarchies within groups and in broader society may inhibit the contributions of members in particular structural positions' (Kitzinger and Barbour 1999, p. 9). Yet it is observing the way in which such norms operate and how awkward moments are managed within groups that can afford the most enlightening insights.

2.3.2 Sample selection

Normally, focus group researchers are not aiming for statistical 'representativeness' with their sampling strategies. Instead, researchers aim to 'encompass diversity and compose a structured rather than random sample, guided by the particular research questions which they are addressing' (Kitzinger and Barbour 1999, p. 7). Although a defined sampling strategy was attempted, the experience of recruiting groups in this study is echoed by other researchers:

> 'As with many other aspects of focus group design...the guidelines overemphasize the extent to which the researchers can control for all characteristics of participants which are likely to be relevant. Some details are likely to emerge only once discussion has been initiated and the precise composition of groups will often be the product of circumstance rather than planning.' (Kitzinger and Barbour 1999, p. 8)

Similarly, Deacon *et al* state that 'qualitative sampling strategies are rarely straightforward matters involving well-established sampling protocols' (Deacon 1999, p. 55). The sampling criteria employed for this study demanded that groups were selected to encompass as wide a range of socio-economic circumstances as possible. As extensive research has suggested that inequalities in health have worsened as a result of a widening income gap in the UK over the past twenty years (Shaw, Dorling *et al.* 1999, Walker and Walker 1997), socio-economic status was deemed to be the most crucial variable. Participants should also, if possible, represent a broad range of political backgrounds or

beliefs due to the political focus of the study. An additional aim was also to attempt to represent men and women as equally as possible and to include people from ethnic minorities, as well as encompassing a broad age range.

In order to achieve the primary aim of sampling groups from as broad a socio-economic range as possible, recruitment was facilitated with the aid of DEPCATS[16]. These are derived from the Carstairs scores, which are 'derived by combining variables taken from small area Census data'[17] (McCloone 1994, p. 1). The Census data used reflects access to goods and services, resources and amenities, as well as the physical environment expected in a developed society (Carstairs and Morris 1991). The scores have been calculated from the combination of four variables:

- Overcrowding: *the proportion of all persons living in private households with a density of more than one person per room*
- Male unemployment: *the proportion of economically active males seeking or waiting to start work*
- Low social class: *the proportion of all persons in private households with an economically active head of a household in social class four or five*
- No car: *the proportion of all persons in private households which do not own a car* (McCloone 1994).

It is emphasised by McLoone that such a method does not tell us the 'extent of material well-being or relative disadvantage experienced by *individuals*' (McCloone 1994, p. 1). Rather, the scores provide a method of 'quantifying levels of *relative* deprivation or affluence in different localities' (McCloone 1994, p. 1). DEPCATS range from DEPCAT 1, the most affluent postcode sectors, to DEPCAT 7, the most deprived. The DEPCAT system is most successful in categorising small area populations where areas are predominantly affluent or deprived, a 'homogenous' situation. However, where an area is 'not affluent' and 'not deprived' as occurs in 'heterogeneous' populations, distortions may occur. As McLoone points out, these 'heterogeneous' areas will contain deprived households and, 'because the population of postcode sectors varies considerably, it could

[16] Categories of deprivation (DEPCATS) based on areas of residence.
[17] See the Medical Research Council's Social and Public Health Sciences Unit website at http://www.msoc-mrc.gla.ac.uk and click on the 'Unit Reports' icon for McCloone, P. 'Carstairs Scores for Scottish Postcode Sectors from the 1991 Census'. First published May 1994, Republished November 2000.

be that these 'middle' areas contain more deprived households than some of the sectors identified at the deprived [homogeneous] extreme' (McCloone 1994).

DEPCATS were used as a crude, yet extremely useful criteria in the recruitment of focus groups for this study. DEPCATS are available for all Scottish postcodes, and as this study recruited predominantly from Scotland (and mainly from the Glasgow area), it was possible to get a good idea of the level of deprivation or affluence in a given area. The use of DEPCATS could also be problematic in other ways, not only because of the problem of classifying 'heterogeneous' populations. One such problem in this study is that DEPCATS were based on the location of the group, not the area of residence of participants which was not known in advance of the focus groups. Often this proved to be reasonable, as participants lived in the area in which the group was held. However, on one or two occasions, this was not the case. For example, group fourteen, a higher income professional group, worked in an inner-city area classified as experiencing 'mixed' deprivation according to the DEPCAT scores (see table 2.4). Participants in each group were asked to complete a one-page questionnaire asking about some key characteristics. Table 2.4 lists the groups recruited for the study, with level of deprivation according to DEPCAT scores, the expressed political allegiance, age and gender of group participants, as well as the location of the groups.

Table 2.4 Focus group sample

No.	Date conducted	Level of deprivation of area	Politics	Age range	Gender	Location
1	9/3/99	HIGH (76777)	SNP	20-40	6W	Greater Glasgow
2	23/3/99	MIXED (4541)	SNP	25-45	3W 1M	Greater Glasgow
3	25/3/99	HIGH (666)	LABOUR	50-85	5W 1M	Greater Glasgow
4	12/4/99	HIGH (77)	LABOUR	65-85	3W 3M	Greater Glasgow
5	15/4/99	MIXED (74)	LABOUR	25-50	4W 3M	Greater Glasgow
6	18/5/99	HIGH (77)	SNP	20-60	1W 4M	Greater Glasgow
7	28/6/99	LOW (2)	LAB/CONS	20-40	4W	Aberdeenshire
8	29/6/99	LOW (22)	CONSERVATIVE	20-25	4W	Lothian Region
9	3/9/99	HIGH (N/A)	LABOUR	20-70	3W 4M	Greater Manchester
10	15/9/99	HIGH (7776)	LABOUR	30-50	6W	Greater Glasgow
11	6/10/99	LOW (N/A)	LAB/CONS	30-70	5W 2M	Greater Manchester
12	1/12/99	MIXED (262)	LAB/SNP/LIB	20-39	4W 2M	Greater Glasgow
13	30/12/99	LOW (21)	LAB/LIB DEMS	40-70	3W 1M	Aberdeenshire
14	23/2/00	MIXED (3737)	LABOUR	20-49	2W 2M	Greater Glasgow

Total Participants = 76	**53W 23M**	**Av. no. per group 5-6**

It must be emphasised at this point that the use of DEPCATS was the basis of the *initial recruitment* of groups. Consequently, when analysing and writing up the focus group data, groups were described as 'affluent' or 'deprived', or 'high(er)' or 'low(er)' income, as when going to interview groups it became clear that the term 'mixed' was an arbitrary distinction that was difficult to enforce and therefore could not be applied. This was particularly so as 'pre-existing' groups were recruited, where the likelihood of participants coming from starkly contrasting socio-economic backgrounds would be slim. It was largely possible to estimate the level of affluence or deprivation experienced by participants from their accounts, information they gave in the questionnaires, and by my own perceptions of an area. A couple of the groups were conducted in the north of England where DEPCATS were not available. In these cases initial recruitment decisions were made with the help of local knowledge, in addition to my perceptions on visiting an area.

After deciding which areas to target by means of the DEPCAT classifications, different postcodes could be focused upon in more detail. Then, it was a case of looking through local phone books, the Yellow Pages, informal contacts, and 'snowballing' to find community groups, clubs and organisations in the chosen areas. Informal contacts in this instance involved speaking to other researchers conducting groups at the time, as well as friends, acquaintances and colleagues. Where possible, participants from groups were also asked if they knew of anyone who would be interested in being interviewed. Deacon *et al* describe the process with direct analogy, 'Like a snowball rolling down a hill, a snowball sample grows through momentum: initial contacts suggest further people for the researcher to approach, who in turn may provide further contacts' (Deacon 1999, p. 53). They also state that snowball sampling is 'mainly used where no list or institution exists that could be used as the basis of sampling' (Deacon 1999, p. 53). However, in this study, 'snowballing' was used in conjunction with looking through various directories and lists[18].

[18] Snowball sampling was also used with caution, as the aim was to avoid groups which had been recently or repeatedly interviewed by other researchers.

2.3.3 Access and recruitment

Once groups or individuals were selected, a covering letter was sent asking if they might be interested in participating in a group. Inequalities were not specifically referred to at this stage. Instead, the wording of the letter was kept very general: 'We are conducting research into what health issues are important to the public'. The fact that the group discussions would concern media coverage of health issues, and that payment for participating would be made (individually, to general funds, or in the form of a discretionary charitable donation) was also stated. Letters were printed on white A4 paper with the 'MRC' logo located on the top left-hand corner of the page. The basic letter lay-out is a standard template used by researchers in the Social and Public Health Sciences Unit, Glasgow. Details of how the Unit is supported are printed at the bottom of the page: 'A Research Unit supported by the Medical Research Council and the Chief Scientist Office of the Scottish Office Department of Health at the University of Glasgow'.

Six copies of an 'invitation sheet' (see Appendix A.2) containing further information about the nature of the group discussion were enclosed with each covering letter. The invitation sheets were designed to be distributed to potential participants and were printed on A4 sized, bright yellow paper. The colour choice was intended to be eye-catching, with the view that sheets may be pinned to notice boards or left lying in public/communal areas. The design was intended to be accessible, with the title containing the word 'invitation'. Underneath, the sub-headline states 'Can you help?' Engagement of the reader was attempted with questions such as 'What do **you** think are important health issues?' asked in the opening paragraph. As well as arousing interest, the invitation sheet was designed to complement the covering letter by providing more information about the groups. It was emphasised that the group discussion would take place 'at a time and place that's convenient for you', and that the discussion would involve being shown 'some pictures from newspapers and headlines from news stories'. A final paragraph highlights that 'All views are equally important', and that 'your opinion is valuable'.

Information on the number of people required (4-6 per group), the approximate length of time needed (one and a half hours), the fact that the discussion is tape recorded, and the amount paid (ten pounds per participant) was included on the sheet. Lastly, it is stated that the named researcher, Rosemary Davidson, would telephone 'in the next few days', and that I could be contacted by telephone or in writing. My email address was also printed. The source of funding for the project (Medical Research Council) was stated at the bottom of the page.

A follow-up telephone call was made to the individuals or groups who had been sent letters approximately a week after posting. One telephone call often developed into a series of telephone conversations if interest was established. The outcome of all contact was logged on a separate (secure) computer file, along with the names and addresses of individual/groups contacted. Once negotiations to set-up a group were in progress, an ongoing diary was established, with all conversations and their contents logged. This served as an efficient organisational tool when setting-up groups as it was possible to maintain consistency with gate-keepers over (often considerable) lengths of time. On occasion, a meeting would be arranged with a gatekeeper in order to discuss the proposed focus group further. For some, it was reassuring to meet the researcher in person.

Recruiting groups was a long, ongoing and dynamic process. Recruitment started in January 1999, with the first group held on the 9th March that year and the final group held on 23rd February 2000; thereby the process spanned a fourteen-month period. As emphasised at the beginning of section 2.3.3, sampling is rarely straightforward. In order to recruit groups from diverse socio-economic backgrounds and with differing political beliefs in particular, it was necessary to constantly monitor the recruitment process. If it was becoming apparent that a certain social group was becoming over-represented, efforts were made to redress the balance. However, as table 2.4 illustrates, despite these efforts, the final sample was slightly biased toward individuals of lower socio-economic status, and more left-wing beliefs. The problems encountered with access and recruitment are discussed in section 2.3.4 below.

Contact with each group ended with a letter of thanks, posted after each group discussion had been conducted. Although this was, in a way, a conclusion to the participation process, the letter emphasised that the researcher could be contacted at any time.

2.3.4 Access and recruitment: Problems encountered

In the process of recruitment, it soon became clear that certain individuals/groups were more willing to participate than others. It appeared, by definition, that enthusiastic, proactive people were more likely to volunteer their time. The worry that those most enthusiastic and motivated would constitute the majority of groups was of major concern in this study. However, it was a problem that would have been very difficult to rectify. As it turned out, such a worry was allayed by the range of responses and the nature of discussion in groups (see chapters seven to nine). Nevertheless, the concern remained that the most socially excluded as well as the most affluent, were not represented in a study focused so heavily on inequality and social hierarchies. Therefore, when considering the findings of this study and their validity, it is worthwhile noting that the 'extremes' of the social spectrum may be underrepresented.

A considerable barrier to access and recruitment was distrust. On one occasion, the researcher went to meet a community group leader at a community centre. Despite attempts to explain how the study was being funded, and that it was based at a reputable research institution, the group leader had clearly been discouraged by approaches from television researchers. She remained unconvinced and consequently no further contact was pursued. More generally, because of multiple interventions or approaches from various external institutions, many individuals or groups contacted in deprived areas were wary of being 'studied'. The reaction could be described aptly as 'goldfish in a bowl' syndrome, and that feeling could only be respected.

A final factor which was difficult to govern was the actions of gatekeepers. As Kitzinger and Barbour point out, focus group work 'often involves increased dependency on gatekeepers' who may 'screen potential participants' (Kitzinger and Barbour 1999, p.

10). As this activity goes unseen by the researcher, it is difficult to ascertain the extent to which 'screening' occurred. In the context of this study, the observation was made that in one group (five) in particular, the gatekeeper dominated discussion, suggesting that he was keen to take part in order to put his own views across, and was less concerned about his peers' views being aired.

2.3.5 Focus group running order and content

A questionnaire was given to participants at the beginning of each group. A sheet of bright yellow A3-sized paper, folded in half into a booklet, was used to collect basic demographic details. The first page asks participants for the following details: first name, age, gender, number and age of children (if any), and any newspapers read regularly. The middle pages provide space for participants to write their answers to the warm-up exercise (discussed below), using the headlines **War on root causes of ill health** [Fig. 1] and **Four goals for a healthier Britain could save 15,000 lives** [Fig. 2]. The first half of the back page is for any comments participants wanted to add, and anything they felt they were unable to ask or say in the group. The second half asks participants to briefly outline their employment history, their voting patterns, and if they see themselves belonging to any particular national or ethnic group. The questions on the front and back pages of the booklet were designed to add further context to participants' accounts. As the study was built around media coverage of health and of the government, it was necessary to gather basic information about participants' media consumption patterns and political beliefs. Similarly, questions about employment history were a further indicator of socio-economic status. The questionnaire was collected at the conclusion of each group.

The process of deciding the conduct and running order of the focus groups (questions to ask, materials included) was directly informed by the results of four pilot groups conducted in the summer of 1998. In addition, the pilots enabled me to gain experience and confidence in conducting focus groups, particularly as my past interviewing had consisted solely of one-on-one encounters. These early groups also allowed the opportunity to test the initial running order. The initial questions and materials included

did not adequately access lay views of inequalities. The subsequent publication of the Acheson report, after the pilots had been conducted, with its resultant newspaper coverage, provided a number of strong images depicting inequality and deprivation to incorporate into the main fieldwork. Consequently, the focus group design changed between the pilot and the final version used for the main sample.

The use of some of the images and headlines from the press coverage which directly highlighted inequality seemed an ideal way in which to get groups talking about issues surrounding inequality and deprivation. The images and headlines had already been in the public domain, as part of the inequalities debate constructed by the media and instigated by government. Given this excellent foundation on which to have a discussion on inequalities, it was a matter of arranging the materials in an order that would lead such a discussion without forcing the issue. In deciding the materials to be included, and the order in which they were to come, it was useful to think of the discussion as a 'funnel', filtering down from a general discussion about health and the media to directly addressing inequalities in health, thus seeing what people raised spontaneously before directing their attention to specific issues. Table 2.5 lists the exercises executed in the focus groups, and the materials used in each exercise. Table 2.5 also details (in italics) the way in which questions were actually asked, and the purpose of each exercise. Appendix A.3 contains the running order used in the groups, which gives a further sense of how each discussion progressed schematically.

Participants were asked to fill out a receipt at the end of each group discussion once they had received payment. This procedure was partly for administrative purposes as a receipt for money from petty cash from the Social and Public Health Sciences Unit. It was also a systematic way of ensuring that all participants received payment, as well as giving the researcher an opportunity to speak to each person individually before leaving. The receipts took the form of the same standard Unit letter format, with logo, address and funding details. It was printed on grey A4 paper. Marked clearly as 'Receipt of payment' under the title, 'Media coverage of health study', the receipt listed the researchers involved in the study. Participants were required to sign and date a statement which reads

that they have been paid 'for the purposes of being interviewed as part of the above study. S/He has been given ten pounds for his/her time and reimbursement of travel expenses.' Both the researcher and participant then signed the receipt.

2.3.6 Ethical considerations

Ethical approval for the focus groups was granted by the University of Glasgow's Ethics Committee.

2.3.6.1 Informed consent

The reliance on gatekeepers to set-up focus groups raises the issue of informed consent because 'an enthusiastic group contact may facilitate access without passing on all relevant information' (Kitzinger and Barbour 1999, p. 10). If it became clear in any of the groups that a participant was not adequately informed, efforts were made to provide a detailed explanation of what the group discussion involved. The focus group running order was designed to allow participants to explore certain topics – such as inequality or deprivation – if they chose, as well as not assuming the existence of 'inequality' per se.

2.3.6.2 Confidentiality

I have protected individual confidentiality by changing individual names (i.e. using pseudonyms), and omitting any local place and street names which could have in any way led to the identification of participants. Data and documentation were kept secure and separate in locked filing cabinets[19]. However, the very nature of focus group discussion had the potential to leave participants in a vulnerable position. Unlike individual one-to-one interviews, Kitzinger and Barbour warn that 'focus group participants cannot be given an absolute guarantee that confidences shared in the group

[19] In accordance with MRC good research conduct (see MRC Unit User Manual http://www.msoc.mrc.gla.ac.uk p. 9-10, 'Research Issues').

Table 2.5 Focus group exercises and materials used

	Exercise	Materials used	Introduction of exercise/ Questions asked/prompts used	Purpose
	Info sheet	short questionnaire		To get basic information i.e. age, gender, occupation, voting preference, newspapers habitually read
	Warm-up	Headlines: **War on root causes of ill health** [Fig. 1] and **Four goals for healthier Britain could save 15,000 lives** [Fig. 2]	*These are recent headlines about health stories.* First show participants **War on root causes of ill health.** *What do you think are the 'root causes' of ill-health (pick four things you think are responsible)?* Then show **Four goals for healthier Britain could save 15,000 lives.** *If you could set four goals for a healthier Britain, what would they be?*	Warm-up for the group. Establish rapport, insight into what factors participants believe promote good health and causal factors responsible for ill health. Ask informally about what participants come up with to see what they spontaneously mention rather than systematically going round the whole group. Will focus increasingly on health later in the discussion.
1	Images I	photos from Green Paper coverage (Feb '98): 'beer & chips' [Fig. 3] 'nanny' [Fig. 4] 'man riding bike' [Fig. 5]	*These are three images taken from newspapers in February 1998. They all appear alongside news articles covering the same story.* *What do you think the articles were about? What do you think these pictures are trying to convey? Are there other pictures you would associate with this sort of story?*	These images are conveying lifestyle messages, apart from the 'nanny', which is supposed to symbolise the approach of the previous government. Do participants pick up on these messages? Do they add anything more to them? Do they recall words or ideas from coverage? Are they aware of the Green Paper? Is there any spontaneous mention of inequality at this early stage?

Table 2.5 (cont) Focus group exercises and materials used

	Exercise	Materials used	Introduction of exercise/ questions asked/prompts used	Purpose
2	Images II	2 sets of 4 images: 'infant' [Fig. 6] 'estate' [Fig. 7] 'child with plate' [Fig. 8] 'woman with pushchair' [Fig. 9]	Ask participants to split into two groups. *These images were taken from another story that appeared in Oct/Nov of last year.* Ask groups to construct news bulletin, bringing the two groups together to discuss what they came up with. Then focus on personal experience - *What do you think of these images?*	Investigate perceptions of poverty and inequality. Also used so participants can reflect on own perceptions. Do the images have any bearing on their own lives? If inequality is perceived, what sort of inequality? Do participants make reference to themselves or compare themselves to others?
3	Images III	2 images depicting inequality: 'workers drinking/estate' [Fig. 10] 'supermarkets' [Fig. 11]	*These two sets of photos were also used in Oct/Nov of last year to illustrate the same news story as the last photos I showed you.* *What do you think the journalist or editor is trying to convey with these pictures?*	Do people pick up on these depictions of inequality? Do participants talk about inequality, either directly or indirectly? If participants perceive inequality, can they speculate on possible causes? What action would they take to redress the inequalities they perceive?

Table 2.5 (cont) Focus group exercises and materials used

	Exercise	Materials used	Introduction of exercise/ questions asked/prompts used	Purpose
4	headlines I	**Labour 'ends the Nanny State' with new health targets** [Fig. 12] **Revealed: the three nations of Scotland** [Fig. 13] **Living in Glasgow takes 5 years off your life** [Fig. 14]	*These headlines are taken from the Jan/Feb of '98, around the same time as the first photos that I showed you, although the headlines don't necessarily accompany those images.* *What do you think the headlines are about? What exactly do you think is meant by the 'three nations' of Scotland? What do you think is meant by the 'nanny state'?* *What do you think is meant with the headline* **Living in Glasgow takes 5 years off your life?** *Do you think there is any truth in these headlines?*	To bring out themes/awareness of exclusion, political debate and introducing inequality implicitly. Following on from previous exercises in a more direct manner. An opportunity to pursue questions which previously may not have been appropriate to ask if inequality has not been discussed implicitly or explicitly.

Table 2.5 (cont) Focus group exercises and materials used

	Exercise	Materials used	Introduction of exercise/ Questions asked/prompts used	Purpose
5	Headlines II	**Gap between rich and poor widens again** [Fig. 15] **Wealthy stay healthy but the poor get more poorly** [Fig. 16] **Children at risk as health inequality between rich and poor increases** [Fig. 17]	*These headlines are taken from Oct/Nov of '98, around the same time as the second set of photos I showed you. Have you seen any of these headlines in the press?* *What do you think about these headlines* **(Gap between rich and poor widens again, Wealthy stay healthy but the poor get more poorly)***? Do you think the affluent are healthier than the less well-off? If so, why is this the case? How would the 'poor' be more likely to experience ill-health? Is there anything that could be done to reduce the gap?* *This headline describes health inequalities as widening* **(Children at risk as health inequality between rich and poor increases)** *- what exactly do you think they mean by 'health inequalities'? Do you think there is any truth to these headlines?* *In the last exercise, I showed you the headline,* **Living in Glasgow takes 5 years off our life** *- but what about health differences within Glasgow? Do you think that people living in deprived areas, such as Drumchapel, will die at an earlier age than those in more affluent areas, such as Bearsden? How much earlier - is it a matter of weeks? months? years? Why do you think there are such differences in life expectancy? What would you do to try to change the situation?*	Understanding of inequalities in health debate as an 'issue'. Do participants think it is an issue? If so, how did they become aware of it. Are participants aware of inequalities in this country? What does inequality mean to participants? How are inequalities generated? Allows me to ask direct questions and present some facts about inequalities as well as encouraging estimates from participants concerning the extent of inequalities.

Table 2.5 (cont) Focus group exercises and materials used

	Exercise	Materials used	Introduction of exercise/ questions asked/prompts used	Purpose
6	images IV	Picture of Frank Dobson with quote: **'This government recognises that poverty, poor housing, low wages, unemployment, air pollution, crime and disorder can make people ill in both body and mind'** [Fig. 18]	*This is a picture of Frank Dobson, Secretary of State for Health.* *What do you think about what he has to say? Are you aware that the government has highlighted this area (health inequalities) in its health plans?*	Inequality and inequalities in health have now been brought up in different forms in the discussion. The introduction of a politician allows participants to contextualise the subject as a very real issue discussed by public figures. Explores participants' views of the government and awareness of government policy.
		question sheet	*Before you go, could you complete the back of the questionnaire. There is space provided to add anything else you think is important.*	To bring out any issues that participants had difficulty discussing amongst their peer group.

will be respected'. Participants may slip into a form of 'vicarious disclosure' about others belonging to the same social network, and the 'temptation to 'gossip' may be strong (Kitzinger and Barbour 1999, p. 17). Of course, the actions of others cannot be controlled.

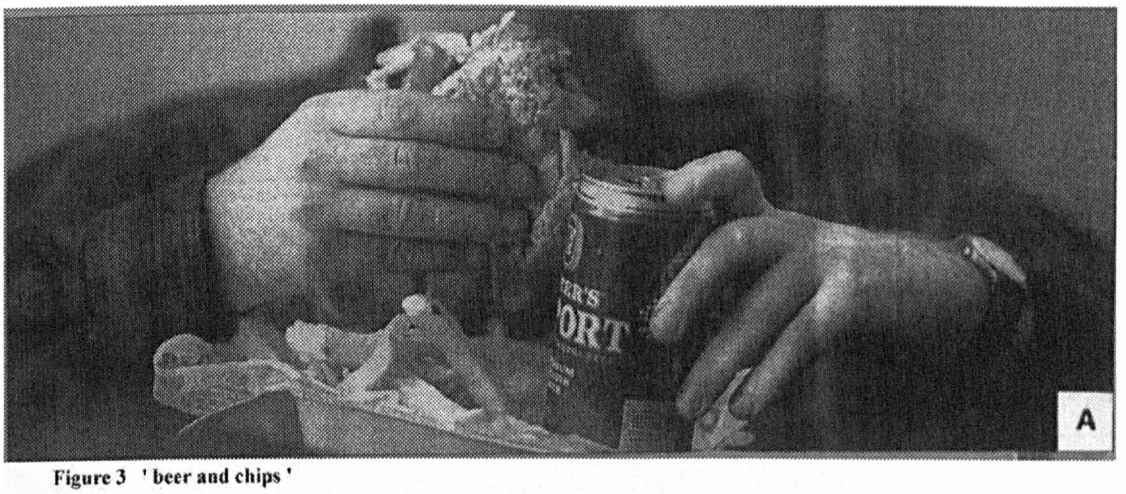


Figure 3 ' beer and chips '

2.3.6.3 Debriefing and writing-up

The design of the focus group running order in this study gave an opportunity for participants to 'debrief' in the event that sensitive topics of conversation arose. The questionnaire included sections in which participants could add further comments, as well as explicitly asking if there was anything they felt unable to say or ask in the group discussion (none of the participants used this to disclose anything more). Also, the researchers involved in the study were all named, and it was made clear that I, as the researcher conducting the groups, was contactable via telephone, letter and email. An effort was made to promote an atmosphere of approachability at the end of groups, where participants could talk about any issues raised in the discussion. One participant approached me at the end of a group for further discussion, but I had no instances where contact was instigated by a participant at a later date. When it came to writing-up, I tried to respect the integrity of the data by being reflective about how I wrote about research participants and the kind of language I used. I endeavoured to use quotes honestly by placing them in context.

2.3.6.4 Power of the focus group

Focus groups may be ideal for observing the norms and hierarchies present in an existing peer group, however the method itself, it has been argued, is 'relatively *non-hierarchical*' (Wilkinson S 1999, p. 64). Whilst it was deemed crucial to observe the

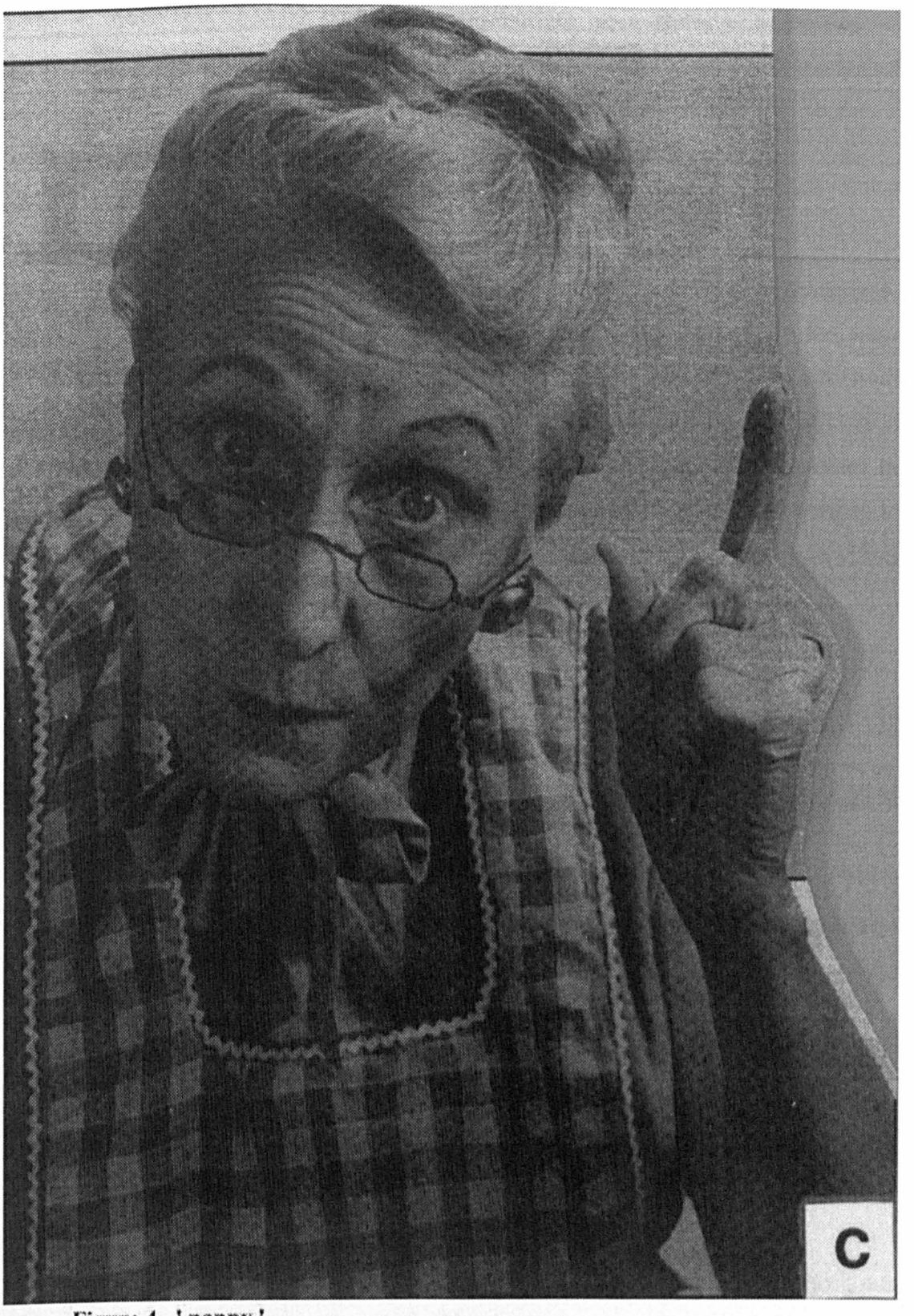


Figure 4 ' nanny '

interactions between participants, as well as how they viewed society at large, the non-hierarchical nature of the focus group helped to encourage a shift in the balance of power 'away from the researcher towards the research participants' (Wilkinson S

1999, p. 64). This seemed particularly appropriate as a sizeable proportion of participants taking part in this study were from deprived areas, whereas the researcher was in a different position (see section 2.3.8). In contrast to one-to-one interviews, focus groups reduce the researcher's power and enable 'research participants better to assert their own agendas and points of view' (Wilkinson S 1999, p. 64).

Focus groups have the potential to 'facilitate, rather than inhibit' discussion. Moreover, it is claimed that people can feel 'empowered and supported' (Farquhar and Das 1999, p. 47). For the research aims of this study, the focus group method seemed most appropriate. However, rather than consistently gaining the impression that participants felt 'empowered', there were, on occasion, individuals present in groups who said very little despite the efforts of the researcher to include them in discussion. Given this impression, in retrospect the inclusion of individual interviews in combination with focus groups may have allowed certain participants more of a voice. Lynn Michell argues in the context of her research based in schools that:

'...although focus groups were a highly productive method of charting the 'pecking order' and examining how it was maintained, it was the interviews which allowed in-depth exploration of the experience of victimization and the identification of some underlying contributory factors.' (Michell 1999, p. 36)

Michell concludes by cautioning against a 'headlong rush into adopting focus groups in an unreflective way if this means further disenfranchising those at the bottom of the social hierarchy'. The individual interviews conducted in Michell's study were a valuable outlet, as it was only here that pupils, particularly 'low' status girls (who were mute and withdrawn in the focus groups), 'revealed certain feelings and experiences which would have remained untold if they had taken part only in focus groups' (Michell 1999, p. 45).

It appears then that individual interviews are more likely to elicit private accounts from participants while focus groups would tend to encourage more public accounts. Such concerns cannot be ignored in the context of this study, as individual interviewing may well be a valid avenue for exploring the role of psycho-social mechanisms in the generation of inequalities in health. However, the status of

different types of data is probably more complex: there may be individual interviews where the respondent offers a public account due to a reluctance to divulge anything more and focus groups consisting of close friends comfortable with exchanging private accounts. However, in the present study, the dynamic nature of focus groups may be more likely to elicit discussion on debates reported in the media, and media representations of specific issues, as people exchange and elaborate a range of media stories and public issues.

The decision to offer payment to participants for their involvement was made on the basis that an exchange should take place rather than a one-way process from interviewee to researcher. For giving up to two hours of their time, participants were given a one-off payment of ten pounds towards travel expenses and any time lost from work. Such a set-up ensured that both parties benefited, not just the researchers and consequently the study.

2.3.7 Location

Groups were always conducted at a venue most convenient for the participants involved (normally a community centre, a workplace, or a participant's house). Therefore a model was observed where the researcher travelled *to* participants rather than holding the expectation that groups should be held in a venue most convenient to the researcher. This approach was meant to encourage participants to feel comfortable, and to be on their own territory as much as possible. A risk assessment had to be completed, a requirement of the Social and Public Health Sciences Unit's fieldwork regulations. The risk assessment determines the level of risk involved in a particular piece of fieldwork, as well as encouraging researchers to adopt a strategy which maximises confidence, and minimises potential hazards to them. For this study, it was agreed that I had to inform two individuals of the whereabouts of the focus groups, and inform them of my safe return (taxis were taken to and from the location of each group). A mobile phone was carried whenever fieldwork was conducted; and I telephoned my contacts once I had left each group, and again on returning home or to the unit.

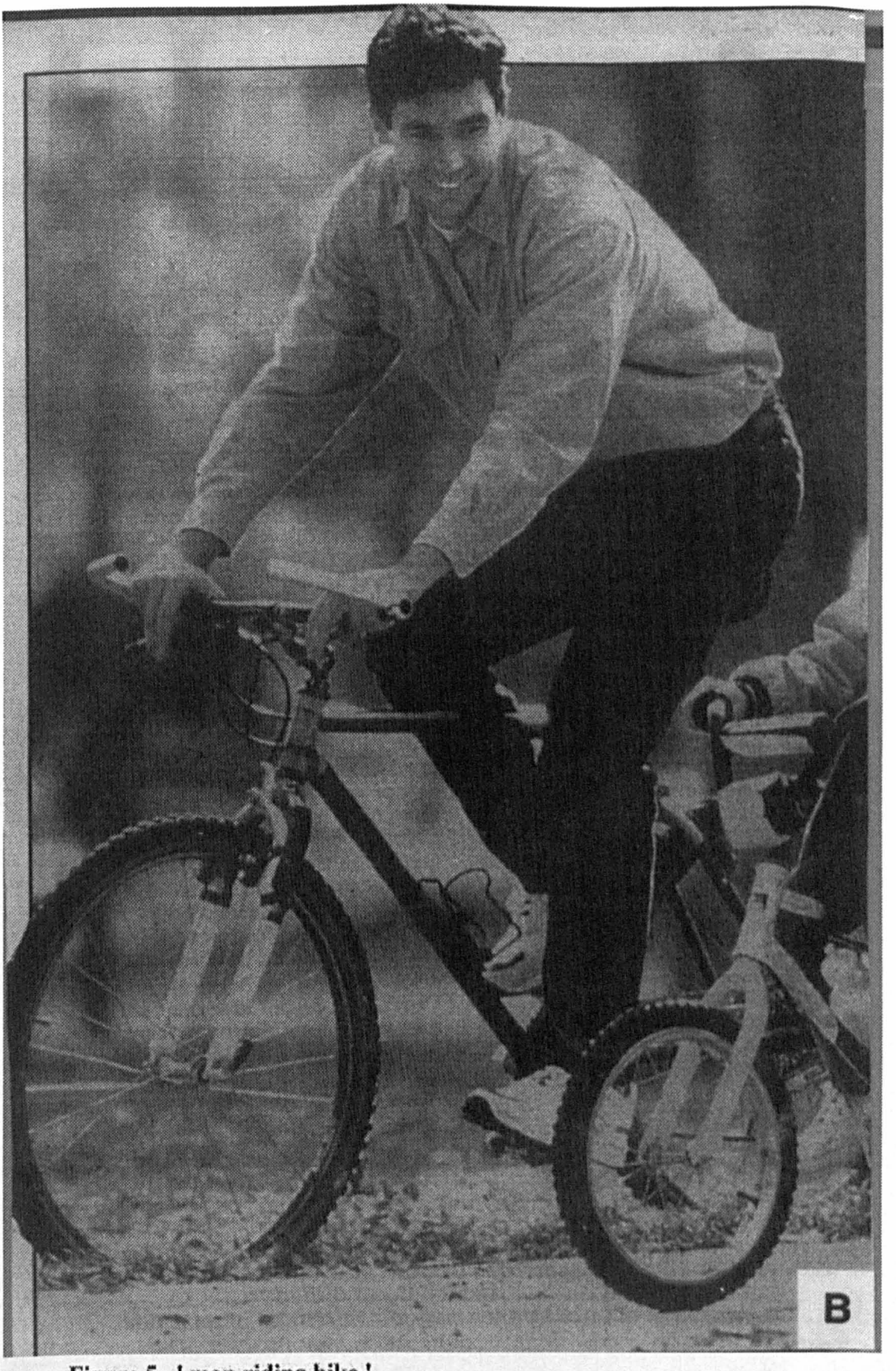


Figure 5 ' man riding bike '

2.3.8 Persona, self-presentation and reflexivity

In order to aid recruitment and to be perceived as credible, the study was presented in the context of the MRC and the University of Glasgow's Social and Public Health Sciences Unit. The backing of such institutions was a means of presenting a professional, yet trustworthy image. However, it was often difficult to maintain the right balance. As discussed previously in section 2.3.4, distrust was sometimes a barrier to recruitment, and the association with 'big' institutions may have been a source of unease for prospective participants. However, as a Ph.D. student in her early

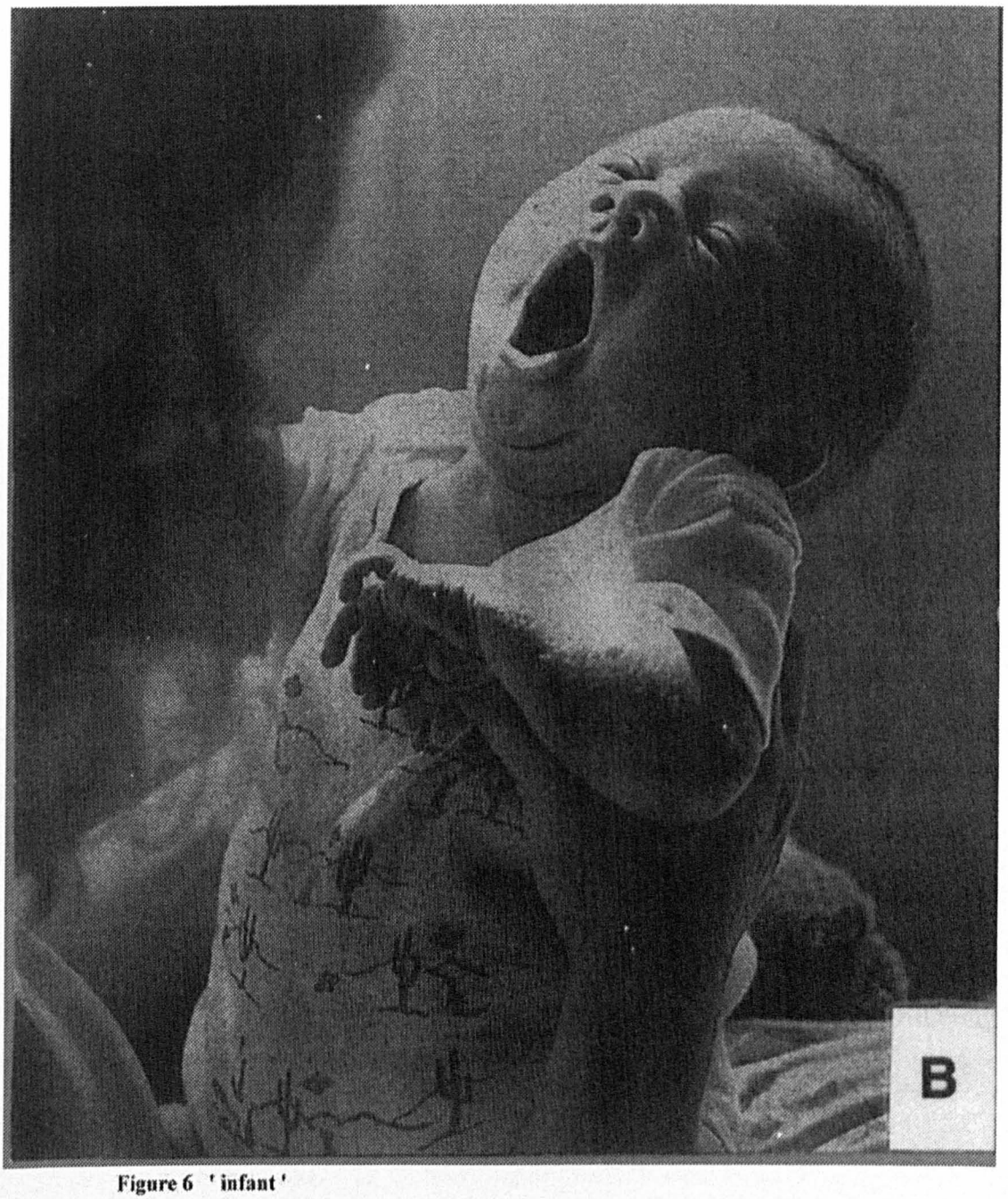


Figure 6 ' infant '

twenties (at the time of recruitment), it was important for me, as the researcher facilitating the groups, to appear professional. As a result, I placed myself as 'related to 'authority'', as a part of a big institution in the presentation of this study (Kitzinger and Barbour 1999, p. 14).

From the outset, this could be perceived as intimidating, particularly to those already feeling excluded from mainstream society. However, this attempt at officialdom was offset by my appearance. As observed by the participants of one group, 'we were expecting some big doctor person', yet they got a 'young-looking girl' instead (Richards and Emslie 2000). Such a perception could often be used to the advantage of the research, as will be discussed in the following section (2.3.9). In terms of self-

Figure 7 'estate'

presentation, I dressed in a smart but casual manner. Having a Scottish accent seemed to be an advantage when conducting groups in Scotland, particularly when facilitating low-income groups.

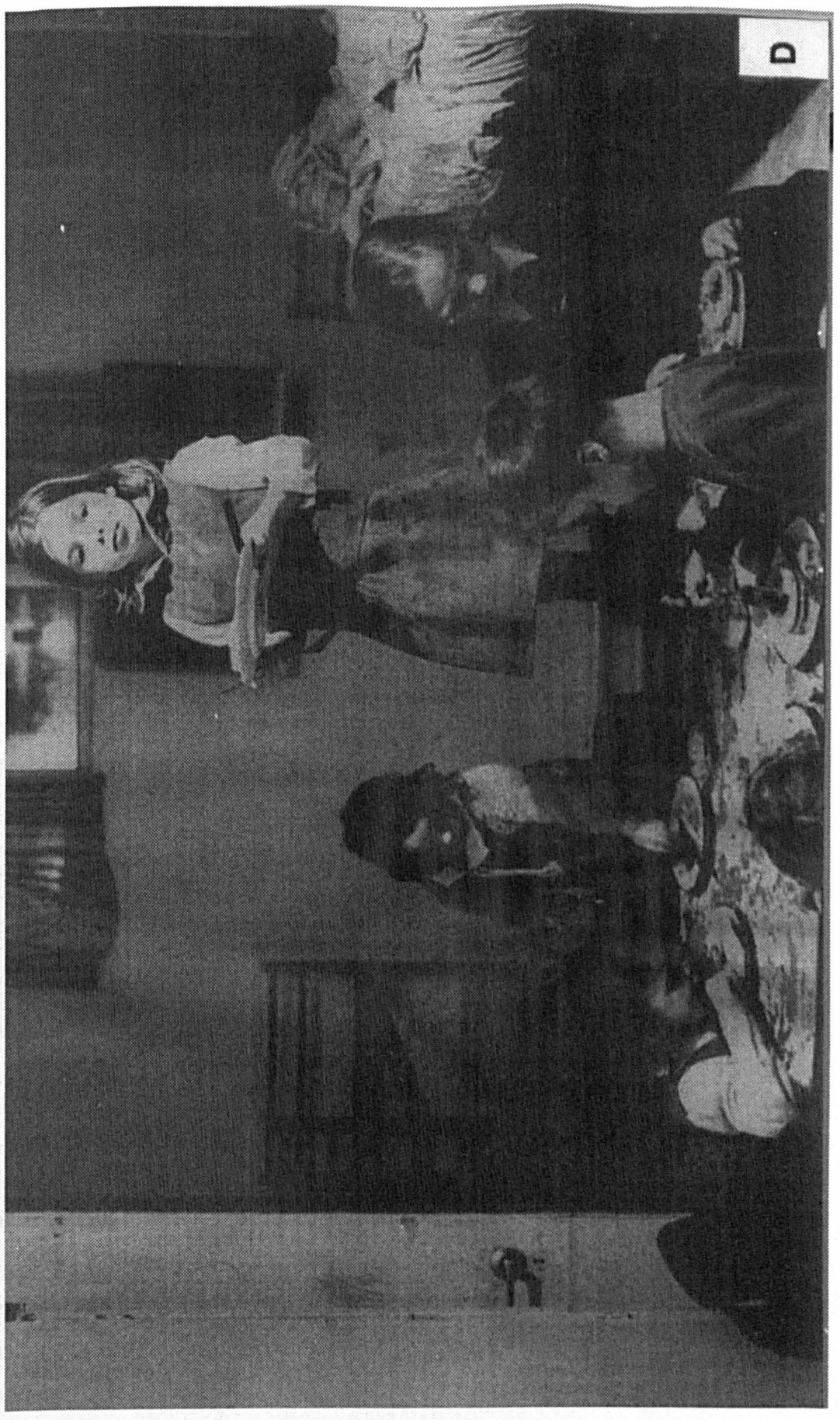


Figure 8 ' child with plate '

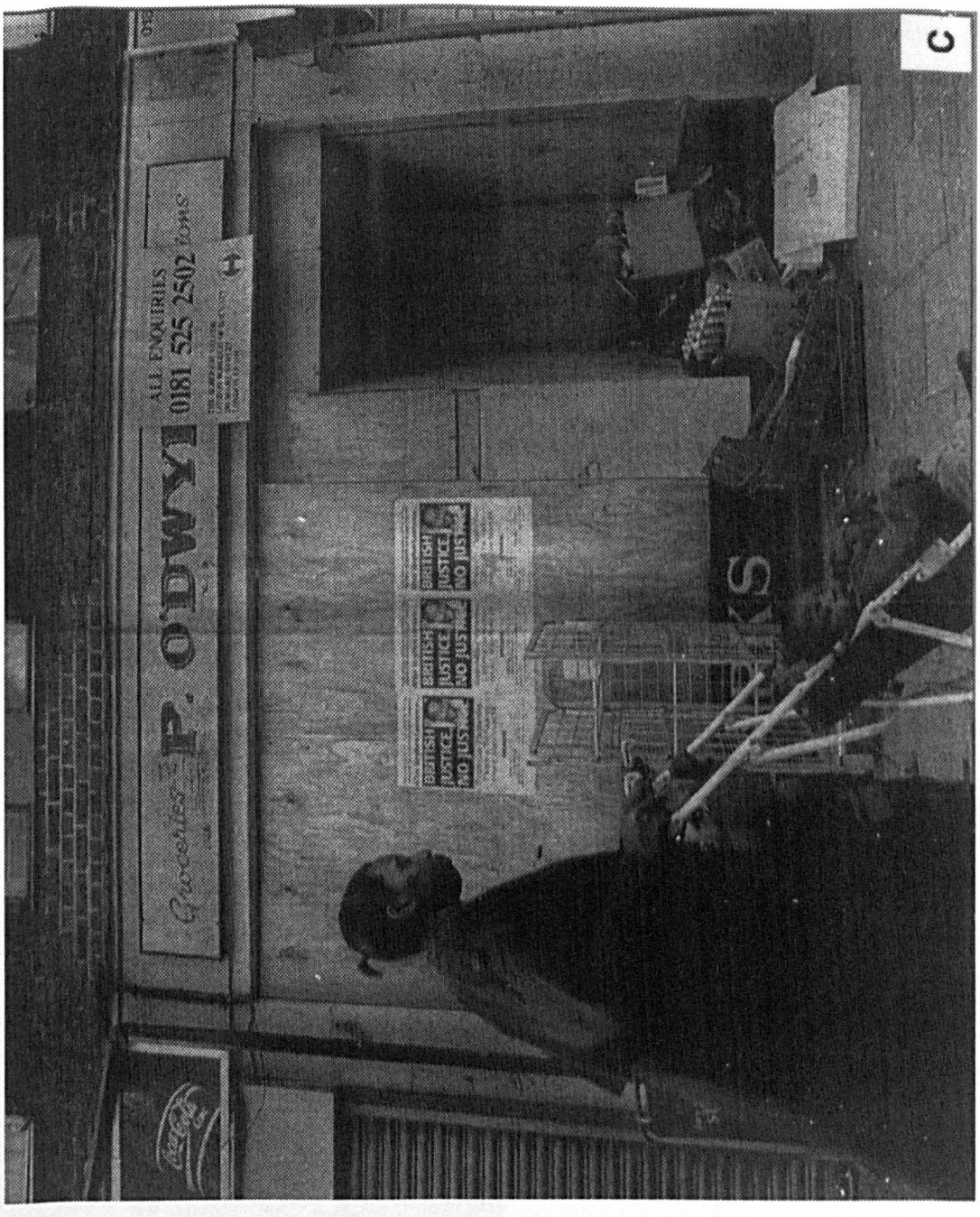


Figure 9 ' woman with pushchair '

2.3.9 My skills as a facilitator

The pilot groups, involving friends and colleagues, were a first opportunity to develop group facilitation skills. Certain skills could be transferred from prior experience of conducting individual interviews. For example, I already recognised the importance of researchers avoiding 'being judgemental, presenting themselves as experts or making assumptions which close off exploration' (Kitzinger and Barbour 1999, p. 13). Also important for facilitators in a group context is the skill in 'balancing keeping quiet with knowing when to intervene...to be able to think on their feet to clarify

ambiguous statements, enable incomplete sentences to be finished, encourage everyone to participate and ensure that interesting and unexpected avenues are pursued' (Kitzinger and Barbour 1999, p. 13). Kitzinger and Barbour believe that one of the 'key skills' is ensuring that 'interaction between research participants is of the encouraged' (Kitzinger and Barbour 1999, p. 13). It was often the case in this study that participants would initially address their comments to me rather than to other group members. In order to minimise this, I explicitly encouraged participants at the beginning of each group to address their comments to each other.

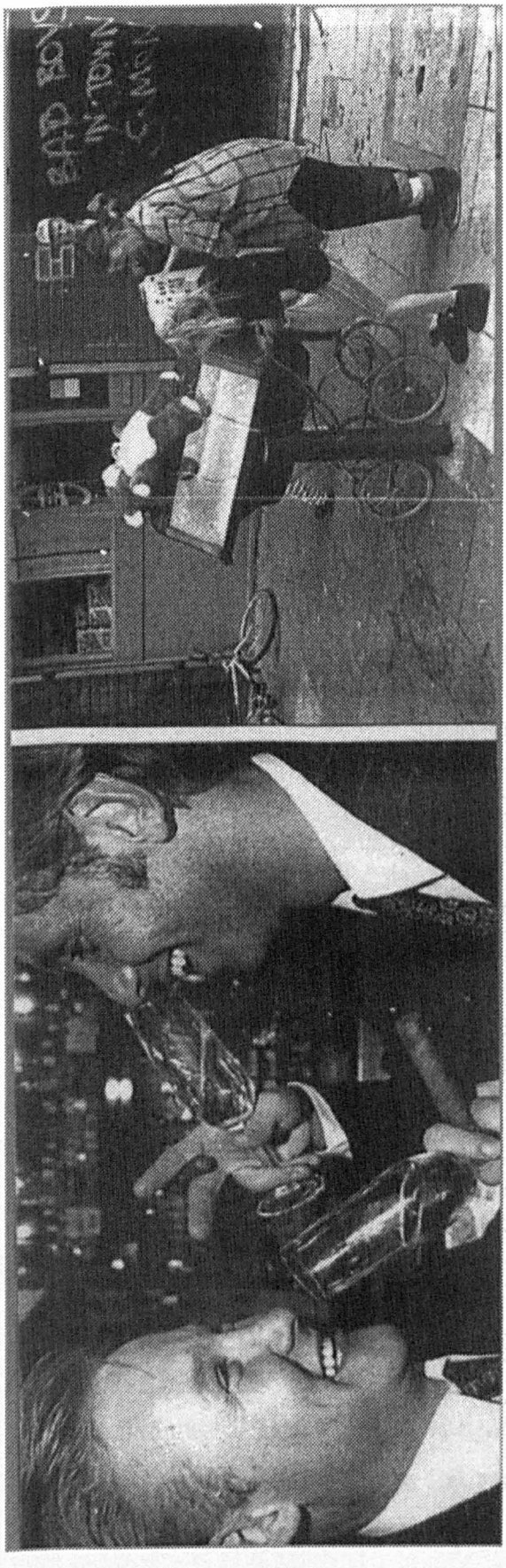


Figure 10

As a 'young looking' junior researcher, it seemed that participants relaxed more, were less guarded, and less on their 'best behaviour'. A contested issue in focus group research is one of maintaining 'control' of discussion, and on occasion in this study, I (as facilitator) felt it difficult to do so. This was perhaps because I was not perceived as an 'authority' or a 'threatening' presence. In any case, it seemed to be advantageous as 'the 'freer' and more dynamic situation of a focus group may actually access 'better data' than a more subdued and formal encounter'

(Kitzinger and Barbour 1999, p. 13). This was certainly the impression I formed when facilitating groups as part of this study.

2.3.10 Recording and transcribing

All groups were audio-taped on a high-quality Marantz tape recorder in conjunction with a multidirectional 'flat mike' microphone. I transcribed in full the first two groups. Subsequent groups were initially transcribed by an audio-typist. As the transcriber had no knowledge of the project as well as the context of each group, often much of the meaning was lost or misinterpreted. I viewed each of these transcripts as a 'skeleton' from which to build. Whilst listening to the corresponding audio tape, each draft transcript was checked for missed dialogue, context, tone and expression. This process allowed each transcript to be as accurate a reflection of group discussion as possible. Each transcript became a detailed record of group discussion word-for-

Figure 11 'supermarkets'

word, with notes for participants' reactions (laughter, sarcasm, anger, and so on). In addition, a journal was kept recording my perceptions of the areas in which groups were held. Efforts were made to record events in the journal which would be missed if relying on transcripts alone. This included comments made before or after discussion, relationships between participants, dynamics within groups, and so on.

At the beginning of each group, participants were asked to give their first names in order to aid transcription. Once the different voices in a group had been identified, the

names of all participants were changed in all transcripts. The process of checking each transcript in so much detail was incredibly time-consuming. However, it enabled

Figure 12


Labour 'ends the Nanny State' with new health targets

A

Figure 13

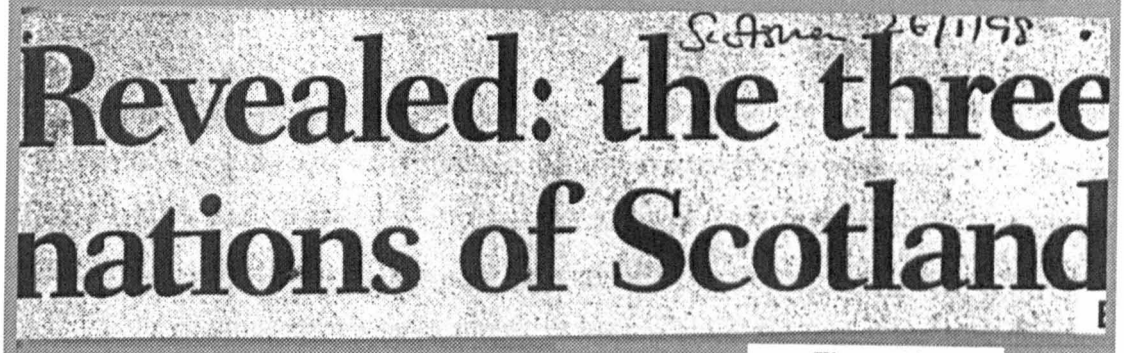
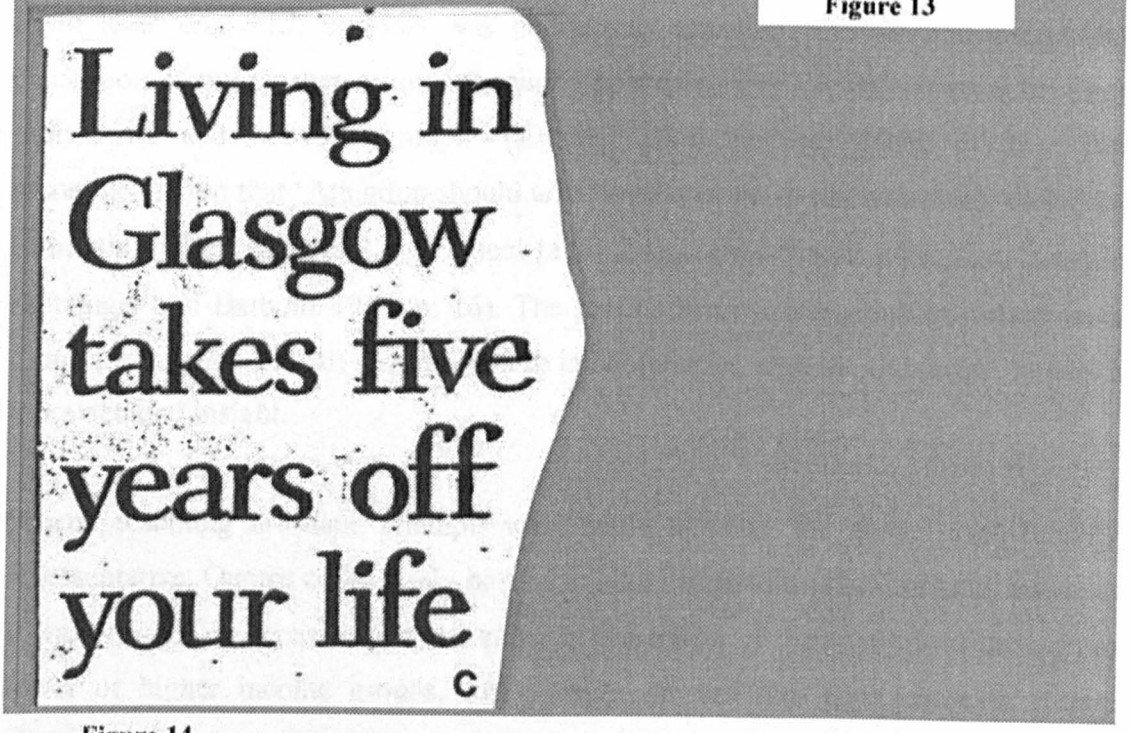

Revealed: the three nations of Scotland

Figure 14


Living in Glasgow takes five years off your life

C

me to build-up a detailed, intense familiarity with each group discussion, which aided analysis enormously.

2.3.11 Analysis of focus groups

All transcripts were imported into QSR NUD*IST Vivo (NVivo). Broad codes were created around the study's principal questions. For example, initial codes spanned from 'SH1' to 'SH6' ('SH' standing for 'sub-heading'), and are listed below:

- SH1 – Are people aware of inequality?
- SH2 – How do participants conceptualise inequality?
- SH3 – What kinds of language do participants employ when talking about inequalities?
- SH4 – Management of talk
- SH5 – Relating inequality to participants' own health
- SH6 – Resolution, solution and responsibility for addressing inequalities in health

NVivo was used, for the purposes of this project, as a tool for broad coding. Utilising this qualitative data analysis package was only one avenue of analysis. The majority of fine coding and organising of data was enabled with hard copies of transcripts which could be freely written on and highlighted. The broad codes were intended to be thematic, picking up the main trends emerging from the data. This was the most basic level on which analysis was conducted, 'drawing together and comparing discussion of similar themes and examining how these relate to the variation between individuals and between groups' (Kitzinger and Barbour 1999, p. 16). The recommendation that 'Attention should also be paid to the group dynamics, including examining jokes, anecdotes, agreement [and] disagreement' was adhered to strongly (Kitzinger and Barbour 1999, p. 16). The journal recording my perceptions of each group (see section 2.3.10) was referred to in conjunction with the transcripts to gain a more detailed insight.

When presenting the data, attempts were made to make the quotes used broadly representative. Quotes could rarely be said to apply across the whole sample; however it was possible on occasion to use a quote as illustrative of the opinions of those from lower or higher income groups, for example. It was also appropriate in certain circumstances to use a 'juicy' quote, which may not have been representative, but was particularly enlightening or poignant within the context of a specific group. Effort was made to present reasonable 'chunks' of data, demonstrating the interaction occurring

Figure 16

Figure 17

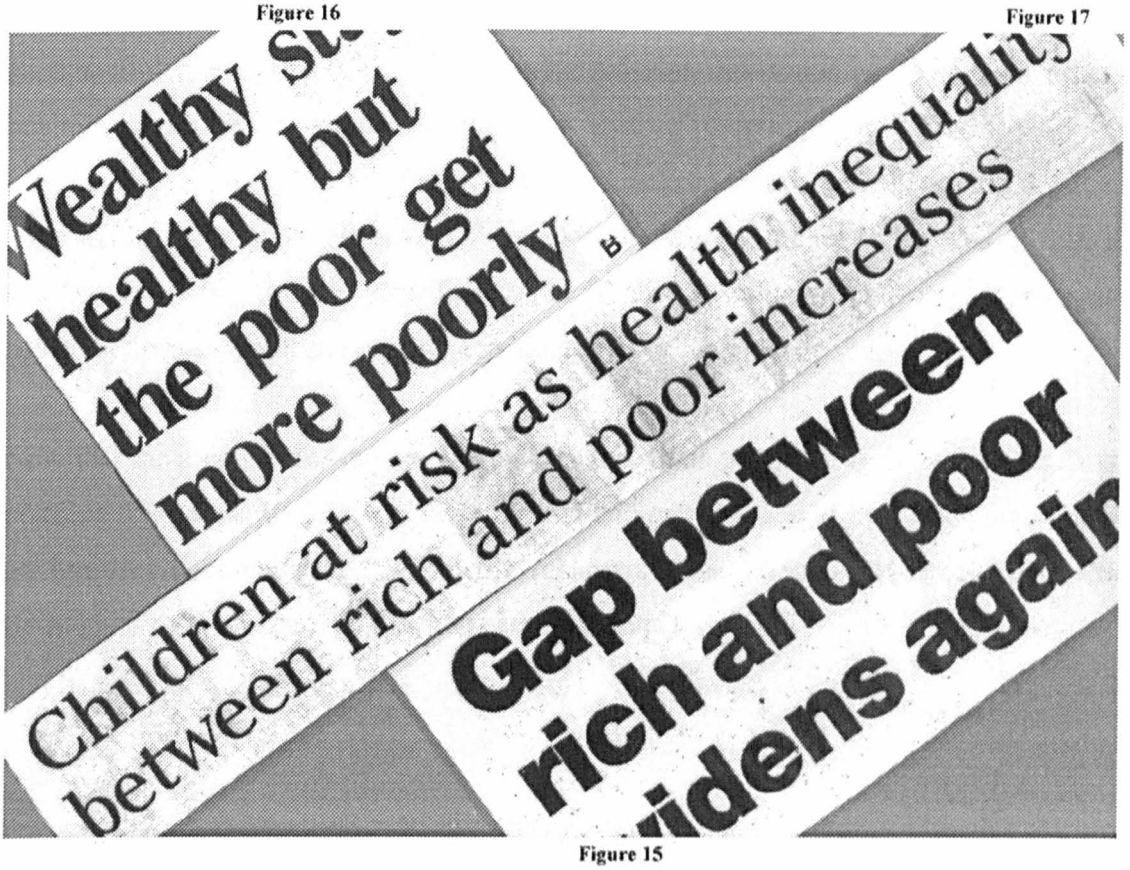
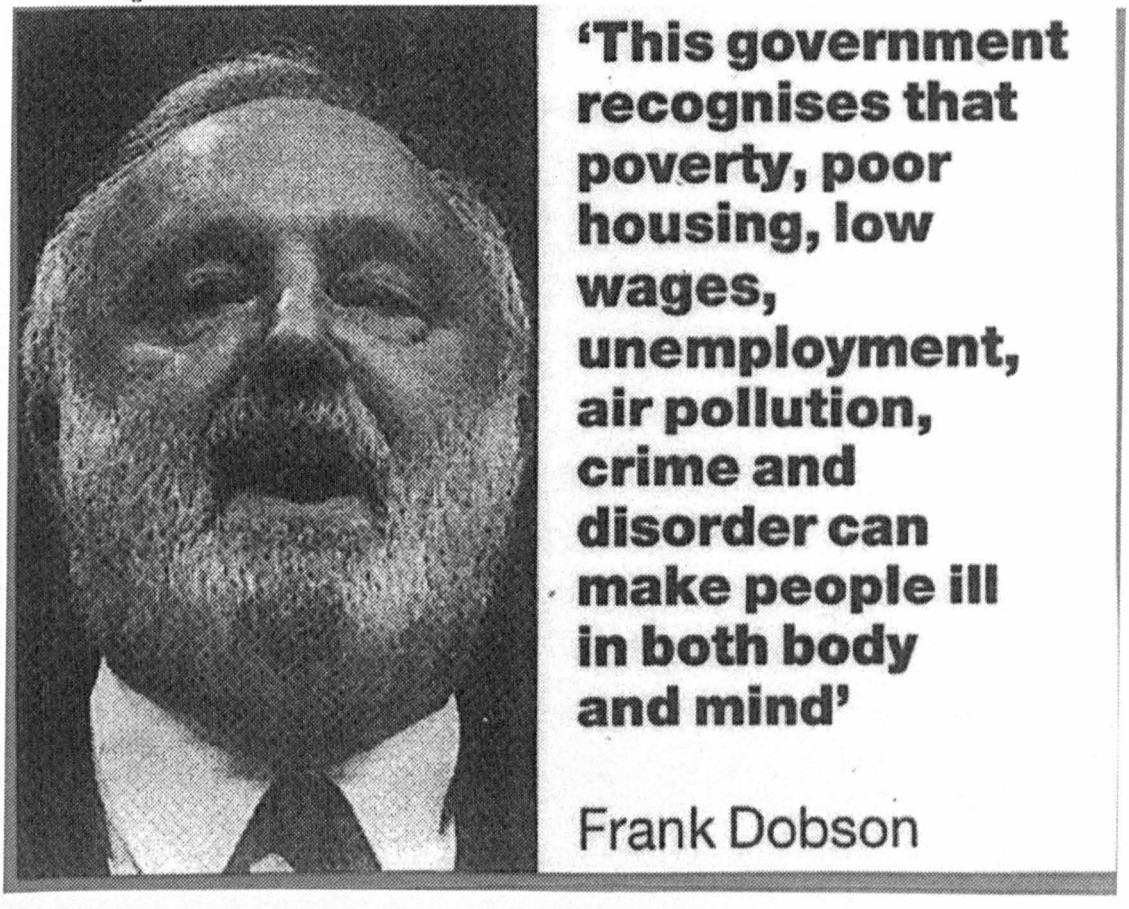


Figure 15

Figure 18



within groups and the context in which remarks were made. Such an approach can be used to illustrate a sense of 'dynamic change' during discussion as 'people shift their position, accommodate to, or challenge one another' (Kitzinger and Barbour 1999, p. 16-17). The method went beyond simple thematic content analysis by paying detailed attention to the *way* people talked. Particular attention was paid to the role of image and status, who people identified with, their aspirations, and the shifts and contradictions inherent in personal accounts and within groups.

Now that the methods for the media analysis and focus groups have been detailed, it is possible to go on to look first at the reporting and presentation of health inequalities in government documents and the media (chapters three to six), and secondly at the findings of the focus groups (chapters seven to nine).

Chapter Three

The English and Scottish Green Papers: Media coverage and representation of public health policy

3.1 Introduction

On the 5th February 1998 the newly elected Labour government published its first public health Green Papers in the UK. The English[20] Green Paper *Our Healthier Nation: A Contract for Health* (Department of Health 1998) and its Scottish equivalent *Working Together for a Healthier Scotland* (Scottish Office Department of Health 1998) were published in tandem[21]. The arrival of these consultative documents marked the new government's first significant contribution to public health policy, and their approach represented a radical departure from the previous public health strategy. The link between deprivation and ill-health, the acceptance that bad health can be caused by wider social influences and not simply certain health behaviours, plus the overriding aim to reduce inequalities in health could be seen as the defining differences between the 1998 Green Papers and their 1992 White Paper predecessors, issued by the prior Conservative Government.

This chapter will briefly summarise the previous government's 1992 public health White Papers before examining the emphasis and presentation of health inequalities in the 1998 Scottish and English Green Papers and their accompanying press releases. An analysis of the media coverage of the two 1998 documents follows in order to look at the presentation of health inequalities in the press.

3.1.1 The 1992 White Papers

The previous Conservative government favoured an individualistic, lifestyle-centred approach to public health. The majority of space in their public health policy

[20] For clarity, underlining is used in this chapter when referring to the English and Scottish Green Papers.

documents, *The Health of the Nation: A Strategy for Health in England* (Department of Health 1992), and *Scotland's Health: A Challenge to us All* (Scottish Office Department of Health 1992) is used for target setting in 27 different areas. The influence of wider circumstances receives only brief mention in the later stages of each White Paper. For example, the 1992 Scottish White Paper, under the heading 'Other Influences' states:

'Throughout the Western developed world...health varies according to socio-economic standing and wealth...The reasons for these variations have been much debated. Different commentators have placed emphasis on housing and other social circumstances, patterns of behaviour, cultural backgrounds, genetic endowment, personal autonomy, and other factors.' (Scottish Office Department of Health 1992)

In the 1992 English White Paper, it is in the last section, Appendix F, entitled 'Key Areas and the health of people in specific groups of the population' that socio-economic variations in health are briefly addressed (Department of Health 1992, Appendix F, 15-20)[22]. The relatively poor health experienced by ethnic minorities is also noted (Department of Health 1992). Whilst Labour, in opposition at this time, favoured social investment by way of helping the unemployed back to work and community level initiatives, the 1992 Conservative strategy sought to redress the balance with health education campaigns (Department of Health 1992). What was on the periphery of the 1992 strategy, becomes of central importance in 1998.

The change of approach in public health strategy in this six-year period is marked, yet some underlying similarities remain. Both the 1992 (Conservative) White Papers and 1998 (Labour) Green Papers call for everyone to take their share of responsibility, for everyone to work together, and for government departments to co-ordinate their policies in order to achieve the prescribed goals. The execution of policy is described according to different settings.

---

[21] Equivalent consultative documents were also published in Wales and Northern Ireland. These documents are not covered in this thesis.

[22] The 1991 English Green Paper includes tables illustrating country-wide health 'variations' in mortality rates from coronary heart disease and cervical cancer (Department of Health, 1991, p. 10, Figures 10 & 11). The reasons for these variations are described as complex: 'The Government does not believe there is any panacea... either in terms of a full explanation or a single action which will eradicate the problem' (Department of Health, 1991, p. 19, para. 4.15). The 1992 White Paper does not include any tables illustrating country-wide differences in mortality rates, nor does it enter into discussion about 'variations'.

3.2 Our Healthier Nation: Reference to and emphasis on inequalities in health

This section examines the extent to which health inequalities feature in the English Green Paper. A brief overview of the document is provided in Appendix B. Throughout the ninety pages of the English Green Paper, the term 'inequalities' is explicitly referred to on fifty-eight occasions. This is a clear index of the fact that inequalities are discussed frequently and represent a major theme throughout the document. Perhaps more importantly, inequalities form the central focus of a number of the government's key public health policies such as Health Action Zones. The Summary section of the English Green Paper assesses the state of inequalities in Britain:

'Health inequalities are widening. The poorest in our society are hit harder than the well off by most of the major causes of death. In improving the health of the whole nation, a key priority will be better health for those who are worst off.' [Summary, p. 4]

The English Green Paper notes that there has been a 'growing gap in wealth between the best and worst off people and the best and worst off neighbourhoods' [1.8][23]. Linking this to health, paragraph 1.9 continues: 'The poorest in our society are hit harder than the well off by most of the major causes of death. Poor people are ill more often and die sooner' [1.9]. Acknowledging the widening gap the English Green Paper states that 'The life expectancy of those higher up the social scale (in professional and managerial jobs) has improved more than those lower down (in manual and unskilled jobs)' [1.9].

Tables accompanying the text illustrate the discrepancies in life expectancy between social classes [Figure 2, p. 9] as well as geographical inequalities in mortality [Figure 5, p. 11]. The countrywide geographical differences are described in paragraph 1.11: 'Parts of Tyne Tees, Greater Manchester, the West Midlands and London have some of the highest rates of early death, while most of East Anglia and the South West have the lowest' [1.11].

[23] Numbers in brackets indicate paragraphs from the English Green Paper *Our Healthier Nation: A Contract for Health.*

Inequalities are also shown in terms of gender differences in life expectancy [Figure 1, p.8], infant mortality rates [Figure 3, p. 10] and mortality from lung cancer by social class [Figure 4, p. 10]. Four paragraphs in chapter two, 'The Causes of Ill Health', address the issue further under the heading 'Inequalities in Health' [2.32-2.36]. More tables illustrate other aspects of inequality, such as variations in coronary heart disease by country of birth and child mortality by parental social class. The English Green Paper reinforces the unequal burden of illness for those living in poverty.

'There are many factors that appear to contribute to the differences in health that people experience. However the link between poverty and ill health is clear. In nearly every case the highest incidence of illness is experienced by the worst off social classes. That is why the Government's overall determination to tackle inequality and create opportunity will reduce the health gap.' [2.35]

The intention to narrow inequalities in health features in a number of policies. The government's 'Contract for Health' [3.6] intends to 'tackle' inequalities as part of its remit. Health Improvement Programmes will have a particular emphasis on 'addressing areas of major health inequality in local communities' [3.43, 4.45]. The NHS will help to reduce inequalities by 'ensuring services reach areas of greatest need' [3.47]. Health Action Zones will encourage the NHS, Local Authorities, and others to 'work together to achieve progress in addressing the causes of ill health and reducing health inequalities' [3.51]. The government's three 'Healthy Settings' – schools, workplaces, and neighbourhoods – are described as each 'having the opportunity to focus the drive against health inequalities and improve health overall' [3.71-3.81].

Inequalities in health are cited as a factor in the government's choice of health targets. For example, the accident rate in Britain has 'significant geographical inequalities' amongst young people [4.24-4.25]. The importance of reducing health inequalities in the other three target areas of coronary heart disease and stroke [4.18], cancer [4.31] and mental health [4.37] is also stressed.

Targets to reduce inequalities in health are discussed in the section 'Possible Local Priorities and Targets' [4.44-4.49] where the Green Paper states that Health

Improvement Programmes will identify additional priorities to redress particular local problems. Teenage pregnancy rates are used to explain why the government is reluctant to set national targets for reducing health inequalities:

'For example, although nationally we are concerned that teenage conceptions are damaging the health and social well-being of young mothers and their babies, the incidence is not spread evenly across the country, so setting a national target in this area might be less relevant in some localities. For others it will be a high priority and they will want to target this problem locally.' [4.45]

The section 'Targeting Inequality' discusses further the emphasis on local target setting for reducing inequalities in health. An Independent Inquiry into Health Inequalities (Acheson 1998) commissioned by the government in 1997 and led by former Chief Medical Officer Sir Donald Acheson is to assess the current inequalities situation. The Inquiry is to 'report on the main trends in health inequalities and to identify the areas of policy which evidence suggests are most likely to make a difference' [4.51].

3.2.1 Our Healthier Nation[24], *the English Green Paper press release: Summary and reference to health inequalities*

The press release accompanying the publication of the English Green Paper, also entitled *Our Healthier Nation*, was released on the day of the document's launch, the 5th February 1998. It summarises the government's key aims and initiatives. The four target areas for reducing mortality rates (heart disease and stroke, accidents, cancer, mental health) are outlined as part of the new 'contract' for health which 'sets out the balance between government action, local action and informed individual action in improving health: the third way for public health'. The contractual nature of the government's strategy is emphasised most out of all initiatives described. It concludes by calling for a concerted and co-ordinated drive against poor health', enabled by the contract which sets out 'mutual responsibilities'.

The 'twin aims' of improving population health overall and narrowing the 'health gap' are mentioned, as well as the three prescribed 'key settings for action'; Healthy

[24] The press release can be found at http://www.coi.gov.uk

schools, Healthy workplaces, and Healthy neighbourhoods. Health Improvement Programmes, Health Action Zones and Healthy Living Centres each have a paragraph devoted to them, describing the main features of each initiative.

The press release concludes with comments from two British television celebrities. Statements from Derrick Evans, also known as Mr Motivator, an aerobics instructor on a morning television programme, and Ainsley Harriot, a celebrity chef, praise the approach of the English Green Paper. Their comments are described as a 'warm welcome' amongst a 'wealth of enthusiastic responses to the Green Paper'.

Inequalities are explicitly referred to on three occasions in the press release. The first instance occurs in the opening paragraph where the two principle aims of the English Green Paper are described: 'Extending years of fit and healthy life for us all and tackling inequalities in health are the two aims set out in the Government's new health strategy'.

The third paragraph of the press release places inequalities at the forefront of the government's overall agenda and emphasises the English Green Paper's holistic approach to health: 'Tackling inequality sits at the heart of this Government's promise of a modern and fair Britain. Welfare reform, tackling social exclusion, rebuilding communities free of the fear of crime, raising standards of education are all good for health'.

Inequalities are referred to once again in the description of Health Action Zones. Health Action Zones will target health inequalities by bringing local institutions and groups together to work in partnership to 'seek measurable improvement in the health of the local population'.

3.2.2 Summary

The 1998 English Green Paper is the first major public health policy statement issued by the new Labour administration, elected in 1997. It marks a substantial shift in emphasis concerning the causes of ill-health and the initiatives put forward to rectify

the situation. It adopts a more holistic model of health, acknowledging that many factors may compromise health rather than the individual being responsible for ill-health as a result of specific health behaviours. In other respects, however Labour's approach has become more streamlined. The Conservative's 27 health targets have been narrowed down to four. A strong theme of accountability runs throughout the document as the roles of government, local organisations and individuals are set out.

The English Green Paper refers to inequalities in health extensively both in terms of rhetoric used and initiatives proposed. In fact, the reduction of the 'health gap' (the second of the English Green Paper's twin aims) underpins the proposed public health strategy as well as informing wider government policy. Furthermore, the aim of reducing inequalities in health is communicated clearly in the press release accompanying the English Green Paper. Having reviewed the presentation of health inequalities in the English Green Paper and its press release, the following section will address the Scottish Green Paper, which was published on the same day.

3.3 Working Together for a Healthier Scotland: Reference to and emphasis on inequalities in health

The extent to which health inequalities are featured throughout the Scottish Green Paper is now examined. A brief overview of the document is provided in Appendix C. Health inequalities are referred to on 39 occasions throughout the 74-page Scottish Green Paper document. Inequalities in health are acknowledged and condemned and their reduction is prioritised as an overriding aim of Scottish public health policy. It is stated in Chapter Four 'The Government's Approach', that 'The Government view as unacceptable the inequalities in health which exist in Scotland'. Furthermore, the mental health and social circumstances of the individual are stressed on a number of occasions. A key task, the Scottish Green Paper states, 'is to help strengthen communities in need, promoting a sense of belonging, hope, self-esteem and confidence'. Such an approach is described as 'fundamental to the well-being of families and individuals and their capacity to act on health education messages' [86][25].

[25] Numbers in brackets indicate paragraphs from the Scottish Green Paper *Working Together for a Healthier Scotland.*

The Scottish Green Paper states that the 'overarching priority' in each of the six Priority Health Topic areas (see Appendix C) is to 'reduce inequalities'. However, inequalities are referred to less in relation to actual proposed initiatives than in the English Green Paper. Assessing the current state of Scotland's health, the Scottish Green Paper describes 'dramatic improvements' in the nation's health, yet:

'Overall progress, nationally, also masks increasing health inequalities between social classes and wealthy and poor areas. Health inequalities also reflect gender and ethnicity. Environmental and social conditions in many areas of Scotland still fall below standards acceptable in a modern society and, where deprivation exists, health is much poorer.' [2]

Chapter two, 'Scotland's Health', puts the health inequalities debate in context. Paragraphs 33 to 43 refer to the findings of the Black Report [33] (Black, Morris *et al.* 1988), originally published in 1980, and subsequent studies which confirm the Report's conclusions [34] (Carstairs and Morris 1991, Macintyre 1994). The widening gap in mortality rates between the most and least affluent is then detailed. Referring to a King's Fund publication, the Scottish Green Paper describes how 'in Britain, death rates were 2-3 times higher among disadvantaged social groups than among the more affluent, and the disadvantaged were likely to die about 8 years earlier' (Benzeval, Judge *et al.* 1995). The link between deprivation and ill-health is further stressed with use of Scottish statistics depicting inequalities between social classes:

'It has been calculated that, in Lothian during 1995, 460 premature deaths would have been avoided if the entire population had shared the mortality experience of the most affluent. Similarly, more than £8m would have been saved if the overall rate of emergency hospital admissions had been as low as that of the most affluent.' [36]

A series of tables illustrate inequalities in perinatal mortality by social class [Figure 7, p. 14], standardised mortality rates (SMR) by area [Figure 8, p. 15], SMRs for cancer and coronary heart disease by area [Figure 9, p. 15], and the gap in health between people living in the most affluent and the most deprived areas [Figure 10, p. 16].

Another 'Inequalities' section [77-80] in Chapter three, 'Influences on Scotland's Health', turns the focus away from inequalities in health to 'differences in lifestyle'.

Paragraph 77 states: 'Just as there are inequalities in health, so there are marked differences in lifestyle between socio-economic groups, geographical location and other groupings'. Here, health behaviours such as smoking [77] and dietary habits [78] are linked to social class. However, the Scottish Green Paper is quick to emphasise that such factors do not fully account for inequalities in health, stating:

'Disadvantaged life circumstances, although having a major bearing on lifestyle, have in themselves, a harmful effect on health. Low income or poorly located housing can affect access to a range of health promoting venues and facilities. There is evidence that the availability of general medical care tends to vary inversely with health need in the population served.' [79]

The Scottish Green Paper refers to the forthcoming Acheson Report more frequently (four occasions) than its English counterpart[26]. Together with responses to the Scottish Green Paper, it is stated that 'Sir Donald's report will help inform the development of our health strategy' [80]. This could be considered surprising as the Acheson Report was commissioned to 'summarise the evidence of inequalities of health and expectation of life in England' (Acheson 1998, Annex B, p. 156). In terms of setting targets for reducing inequalities, the Scottish Green Paper 'awaits' the results of the Acheson Report: 'While there are a range of indicators which measure health and inequalities, a research programme should begin by building on the work of the Acheson Inquiry' [215].

Health inequalities are also referred to in relation to a number of proposed initiatives. The government's area regeneration plans are described in the Scottish Green Paper as initiatives which 'offer scope for the development of work to tackle health inequalities' [117]. For example, Priority Partnership Areas are 'required to establish baseline data on health indicators, and to set targets for health gain', enabling the impact of the regeneration process on health in deprived communities to be monitored [115]. Health Improvement Programmes (HIP) are to be set up in each Health Board area and will, the Scottish Green Paper states, cover all aspects of NHS activity including the goal of tackling health inequalities [160]. Health promotion specialists based in Health Boards, Trusts and locality teams are described as possessing the 'expertise to develop initiatives aimed at tackling health inequalities and to train those

[26] The Acheson Report is referred to twice in the English Green Paper, but only once by name.

working in disadvantaged communities' [162]. In terms of health education, the Health Education Board for Scotland (HEBS), although serving the population as a whole, is expected to 'give high priority to tackling inequalities through ascertaining and addressing the circumstances of groups and communities with the greatest needs' [183].

The Scottish Green Paper actively seeks views on target setting in the area of inequalities [209]. It is stated that national targets should be set, but within them 'targets bearing on, for example, socio-economic class or geographical location, could also be set in order to trace progress in addressing inequalities' [199].

3.3.1 Helping Scots to Live a Life Less Ordinary[27], *the Scottish Green Paper press release: Summary and reference to health inequalities.*

The Scottish Green Paper's press release, *Helping Scots to Live a Life Less Ordinary*, outlines the key initiatives set out in the document. The 613-word release was issued on the 5th February 1998 to publicise the launch of *Working Together for a Healthier Scotland.* The majority of the press release takes the form of a statement from the then Scottish Health Minister, Sam Galbraith MP, after which six of the Scottish Green Paper initiatives are listed to conclude the release. The opening sentence sets the scene of a 'self-confident Scot free from the spectre of poverty, unemployment, shabby housing and pollution', who, in such a positive predicament, will 'choose life rather than being forced into ill-health'. The title and opening sentence of the press release borrow phrasing from two films featuring the Scottish actor Ewen McGregor, *A Life Less Ordinary* (a film released in 1997) and the phrase 'choose life', widely associated with the cult film *Trainspotting* (released in 1996).

The sub-heading to the press release describes how 'Healthy Living Centres [are] at [the] Heart of [the] Initiative', despite the Scottish Green Paper devoting only one paragraph to the Centres [118]. Within the body of the text (approximately three quarters of the way through), the government states its view that everyone should 'have the information and economic ability to choose for themselves'. This intention

[27] The press release can be found at http://www.scotland.gov.uk

will be facilitated by Healthy Living Centres, which will be located 'in the heart of our deprived communities'. The funding for the Centres will be 'around £300 million' made available from the Lottery, of which Scotland will receive a 'substantial share'.

The holistic view of the Scottish Green Paper document is emphasised in Galbraith's statement in the second paragraph of the press release, as are the two perspectives from which the government is operating:

'Health in a modern Scotland is about much more than avoiding disease. It is about improving the whole quality of our lives, of our friends and families, and the type of community in which we want to live. But many people face barriers to good health which they cannot overcome themselves. That is why we intend to tackle ill health from two perspectives – the social circumstances in which we live, and our lifestyles as individuals.'

Existing investment in a number of other policy areas is detailed: an 'additional £230 million, for schools; £50 million in the following year (1999) for housing, £16 million to 'tackle rough sleepers'; and £300 million for the New Deal (an initiative aimed at helping the young unemployed back into work). Gaining employment is described as 'the single most important change that improves an individual's lifestyle'. However, the press release emphasises that there is 'also a challenge for the individual'. Social investment is underlined by the intention 'not [to] nanny or nag people but instead empower and encourage them to make the right choices'.

Making improvements are described as a 'challenge for the nation...a challenge we must tackle together', before seven of the government's initiatives conclude the press release:

- .... 'health impact assessments' looking at the health consequences of all major policies
- creating a health promotion post in COSLA ....
- consultation on new, credible health and lifestyle targets
- possibility of fluoridation of water supplies and measures to tackle teenage pregnancies
- how to make excessive drinking as socially unacceptable as drink driving ....
- proposing Directors of Public Health become ad hoc members of relevant local authority committees.'

The term 'inequalities in health' is not used directly at any point in the Scottish Green Paper's press release. However, examples of inequalities in health are used. The press

release refers to the findings of the Scottish Health Survey which 'showed that people disadvantaged by poverty, unemployment, poor housing and poor environment live shorter lives in poorer health'. Two examples are cited which describe the disparities in mortality rates between affluent and deprived individuals and areas:

'...in Lothian 460 premature deaths would have been avoided in 1995 if all the people had shared the same mortality rate of the affluent[28]. Early deaths in prosperous Bearsden are 40 per cent below the national average, while those struggling in Drumchapel are 60 per cent above[29]. These figures are compelling proof that deprivation is linked to ill health.'

3.3.2 Summary

Working Towards a Healthier Scotland marks a substantial shift in direction from previous public health policy. Similar in approach and outlook to its English equivalent, the Scottish Green Paper links deprivation to ill-health and places less emphasis on individual health behaviours, favouring a more holistic approach whereby a variety of social and environmental factors may also impact on health. Inequalities in health are acknowledged throughout the document and their reduction is the 'overarching priority' of the government's 'priority health topics'. Inequalities in health are referred to in relation to a number of Scottish Green Paper proposals, such as Health Improvement Programmes, but the linkage is perhaps less strong (or less conspicuous) than in the English document.

The accompanying press release surprisingly places Healthy Living Centres as a flagship policy ('at Heart of Initiative') despite only one paragraph being devoted to the initiative in the Scottish Green Paper itself. Similarly, although inequalities are frequently referred to throughout the Scottish Green Paper, their importance as an 'overarching priority' is lost in the press release. In contrast, the English Green Paper's press release more closely mirrors the content and emphasis inherent in the document.

[28] Taken from paragraph 36 of the Scottish Green Paper
[29] Taken from paragraph 39 of the Scottish Green Paper, although the areas Drumchapel and Bearsden are not referred to by name.

3.4 Coverage and representation of the English and Scottish Green Papers in the press

This section begins by briefly outlining the competing news stories at the time of the Green Papers' launches, and then goes on to examine the extent of coverage of the government's key initiatives in the press. The coverage of the Green Papers is then analysed, both in terms of presentation by journalists and sources utilised by them for comment on government public health policy, with a particular focus on health inequalities.

3.4.1 The wider context

In the week of the Green Papers' launches in February 1998, a substantial amount of British news coverage was devoted to allegations concerning Saddam Hussein and his suspected arsenal of biological weapons. Troops in the United States were reportedly on standby after concerns that Hussein had been increasing the Iraqi stock pile of potentially harmful biological materials. Meanwhile, the close political ties between Mr Blair, the British Prime Minister, and Mr Clinton, the US President, were highlighted as the leaders held talks on Iraq. A number of news reports also include the increasing speculation surrounding Mr Clinton's alleged affair with a former White House intern, Monica Lewinsky. The conspiracy theories and the circumstances surrounding the accident that lead to the death of Diana, Princess of Wales and Dodi Al Fayed were also prominent, as was Prince Charles' official visit to Sri Lanka.

In the Scottish media many column inches were devoted to the mounting pressure on Dr Ian Oliver, Chief of Police in Grampian, to resign after allegations of an extra-marital affair. Following the death of a thirteen year-old boy from a heroin overdose in Cranhill, a deprived area of Glasgow, many news reports feature mothers from the area holding a 'drugs vigil' to drive drug dealers away from their estate. Other prominent stories include the jailing of a notorious sex offender for nine years, and the launch of a 'Sport for All' initiative in Scottish schools.

3.4.2 Overview of items reporting on the English and Scottish Green Papers

There were 21 items about the English and Scottish Green Papers in the press. The majority of items (19 out of 21 articles) found during the twenty-eight day sample period were published on Friday 6th February 1998, the day after the English and Scottish Green Papers were launched. Two items (one on the English Green Paper, one on the Scottish) appeared on the launch day. Headlines of items reporting on the English Green Paper included 'Four goals for healthier Britain could save 15,000 lives' and 'Targets: four leading causes of death'. Headlines such as 'Scottish health action plan to target poverty' and '£300m plan to help Scots live longer' appeared in the Scottish-based press. Only one Scottish Green Paper item made it onto a front page during the sample period. Compellingly entitled 'Living in Glasgow takes 5 years off your life', the item was a leading story in the *Scotsman* on Friday 6th February 1998.

Within the sample period, the English Green Paper featured in ten news reports and one editorial [n = 11]. The Scottish Green Paper was the subject of eight news reports and two editorials [n = 10]. Table 3.1 and 3.2 list all the sample articles in detail. The *Independent* and *Guardian* newspapers reported on the English Green Paper most extensively with three news reports apiece (See items EGP1-6 in table 3.1). The English Green Paper was also the subject of a *Guardian* editorial (item EGP7, table 3.1). The Scottish Green Paper was reported most extensively in the *Scotsman* and the *Herald.* Both newspapers featured three reports in addition to the document being the subject of the *Herald's* editorial (items SGP1-7, table 3.2).

All the daily broadsheet newspapers in the sample featured Green Paper coverage. However, a number of newspapers had no coverage of the publication of the Green Papers. Tabloid newspapers with no coverage were the *Sun, Star, Daily Record* and *Evening Times.* None of the Sunday newspapers, broadsheet or tabloid, covered the story despite the fact that the Green Papers were published a couple of days before the weekend.

3.4.3 Newspaper coverage of the English Green Paper's key initiatives

This section examines the extent to which the English Green Paper's key initiatives were reported in the press. Table 3.3 illustrates which items covered the English Green Paper's key initiatives (the shaded areas of the table indicate that an article reported on a specific initiative). The government's four targets were the most consistently mentioned policy area. All the newspapers in the sample which included coverage of the English Green Paper mentioned the four targets in at least one of their news reports. The *Guardian's* news report 'Dobson pledges to cut illness gap' reported most comprehensively, referring to eight of the English Green Paper's policy areas (EGP4), whilst the *Daily Express* reported on two (EGP11).

The government's two key aims of 'Extending years of fit and healthy life... and tackling inequalities in health'[30] are reported only in the *Guardian* (EGP4) and *Independent* (EGP2) newspapers. This reflects a wider trend (see table 3.3) whereby the left-of-centre papers (i.e. *Guardian*) are highlighting initiatives targeted at deprived sections of the population, whereas the right-of-centre newspapers (i.e. *Daily Telegraph, The Times*) steer toward reporting more health behaviour-based proposals.

3.4.4 Newspaper coverage of the Scottish Green Paper's key initiatives

Table 3.4 illustrates which of the ten items reporting publication of the Scottish Green Paper covered its key initiatives (the shaded areas indicate an initiative has been reported on in a particular article). All newspapers reporting on the Scottish Green Paper mentioned the government's Priority Health Topics in at least one of their articles. The *Herald* and *Scotsman* newspapers provided the most comprehensive coverage of the Scottish Green Paper. Looking at specific articles, the *Herald's* 'Homes and jobs to build a better tomorrow' (SPG5) reported on ten of the government's initiatives. The *Scotman's* 'War on root causes of ill health' (SGP3) referred to nine. The *Daily Mail* described five initiatives in 'Wealth is the key to health, says Dr Galbraith' (SGP8). The *Mirror*, the only 'red top' tabloid to cover the

[30] English Green Paper press release http://www.coi.gov.uk

Table 3.1: Items reporting on the English Green Paper during the sample period

No.	Date	Format	Paper	Page no.	Page type	Journalist	Journalist's specialism	Headline
EGP 1	5/2/98	news report	*Independent*	5	'News'	Jeremy Laurance	Health Editor	**Fluoride fear condemns children to tooth decay**
EGP 2	6/2/98	news report	*Independent*	6	'News'	Jeremy Laurance	Health Editor	**Four goals for healthier Britain could save 15,000 lives**
EGP 3	6/2/98	news report	*Independent*	6	'News'	Jeremy Laurance	Health Editor	**A shot in the arm for campaign trail**
EGP 4	6/2/98	news report	*Guardian*	10	'Policy & Politics'	Sarah Boseley	unspecified	**Dobson pledges to cut illness gap**
EGP 5	6/2/98	news report	*Guardian*	10	'Policy & Politics'	Sarah Boseley	unspecified	**Targets: four leading causes of early death**
EGP 6	6/2/98	news report	*Guardian*	10	'Policy & Politics'	Sarah Hall	unspecified	**There's a complex mesh of factors that cause poor health, but poverty is the key to it**
EGP 7	6/2/98	editorial	*Guardian*	18	Unspecified	----------	----------	**Prevention is better than cure**
EGP 8	6/2/98	news report	*Daily Telegraph*	8	'News'	Celia Hall	Medical Editor	**Labour 'ends the Nanny State' with new health targets**
EGP 9	6/2/69	news report	*Daily Telegraph*	8	'News'	Celia Hall	Medical Editor	**Success 'is dependent on rationing resources'**
EGP 10	6/2/98	news report	*The Times*	3	'Politics'	Ian Murray	Medical Correspondent	**Dobson starts a class war to improve health**
EGP 11	6/2/98	news report	*Daily Express*	19	Unspecified	Helene Feger	Health Correspondent	**Now nanny backs off in health war**

Table 3.2: Items reporting on the Scottish Green Paper during the sample period

No.	Date	Format	Paper	Page no.	Page type	Journalist	Journalist's specialism	Headline
SGP 1	5/2/98	news report	*Scotsman*	2	'News'	Jennifer Trueland	Health Correspondent	**Scottish health action plan to target poverty**
SGP 2	6/2/98	news report	*Scotsman*	1 (front)	Unspecified	Jennifer Trueland	Health Correspondent	**Living in Glasgow takes 5 years off your life**
SGP 3	6/2/98	news report	*Scotsman*	12	'News'	Jennifer Trueland	Health Correspondent	**War on root causes of ill health**
SGP 4	6/2/98	news report	*Herald*	7	'Politics'	Alan MacDermid	Medical Correspondent	**United for a healthier future**
SGP 5	6/2/98	news report	*Herald*	7	'Politics'	Chris Starrs	Unspecified	**Homes and jobs to build a better tomorrow**
SGP 6	6/2/98	news report	*Herald*	7	'Politics'	Alan MacDermid	Medical Correspondent	**Network of centres funded by lottery windfall**
SGP 7	6/2/98	editorial	*Herald*	22	'Opinion'	----------	----------	**Far from a panacea**
SGP 8	6/2/98	news report	*Daily Mail*	28-29	Unspecified	Chris Deerin	Unspecified	**Wealth is the key to health, says Dr Galbraith**
SGP 9	6/2/98	news report	*Mirror*	4	Unspecified	Stuart Cameron	Unspecified	**£300m plan to help Scots live longer**
SGP 10	6/2/98	editorial	*Mirror*	6	Unspecified	----------	----------	**A healthy future for the nation**

Scottish Green Paper, reported on three initiatives in '£300m plan to help Scots live longer' (SGP9) and a fourth initiative, the Priority Health topics, in an editorial, 'A healthy future for the nation' (SGP10). The *Mirror* focused much of its attention on health behaviours in terms both of the initiatives reported on and the commentary surrounding them. This could be considered surprising due to its traditionally left-wing bias.

In a similar fashion to the English coverage, whilst the government's 'Priority Health Topics' are mentioned in all the newspapers reporting on the Scottish Green Paper, the Green Paper's 'two perspectives' ('the social circumstances in which we live, and our lifestyles as individuals'[31]) feature only in the *Daily Mail* (SGP8). However, unlike the English coverage, there appears to be very little association between the political stance of a newspaper and the initiatives it chooses to cover. Coverage of the Scottish Green Paper also featured substantially less comment-based or context-setting articles when compared to the English coverage.

3.4.5 Media representation of the English Green Paper in press coverage

Now that the wider media context in which the Green Papers were received has been outlined, and the extent to which the key initiatives were reported on in the press has been quantified, it is possible to examine how the English Green Paper was received and interpreted by journalists. The *Independent* news report published on the English Green Paper's launch date focuses on a single issue, the addition of fluoride to water supplies (EGP1). The sub headline captures the journalist's view stating: 'A government Green Paper on public health published today will ignore one of the simplest, most effective ways of tackling health inequalities: adding fluoride to drinking water'.

Ministers have been 'forced', the report continues, to delay plans to extend fluoridation of Britain's water supplies because of 'Fears of a public backlash'. The

[31] Scottish Green Paper press release http://www.scotland.gov.uk

Table 3.3: Newspaper coverage of the English Green Paper's key initiatives

No.	Newspaper	4 Targets	Two key aims	Health Improvement Programmes	Health Action Zones	Healthy Living Centres	fluoride in water	inter-Government responsibility
EGP 1	*Independent* (news report)						√	
EGP 2	*Independent* (news report [a])	√	√	√				
EGP 3	*Independent* (news report [b])							
EGP 4	*Guardian* (news report [a])	√	√		√	√		√
EGP 5	*Guardian* (news report [b])	√						
EGP 6	*Guardian* (news report [c])							
EGP 7	*Guardian* (editorial)	√					√	
EGP 8	*Daily Telegraph* (news report [a])	√						
EGP 9	*Daily Telegraph* (news report [b])	√						
EGP 10	*The Times* (news report)	√						
EGP 11	*Daily Express* (news report)	√						

Table 3.3 (cont): Newspaper coverage of the English Green Paper's key initiatives

No.	newspaper	'Contract': partnership with local authorities	Healthy Settings	Food Standards Agency	increase cigarette prices/ banning advertising	crime reduction	Integrated Transport Policy
EGP 1	*Independent* (news report)						
EGP 2	*Independent* (news report [a])	√					
EGP 3	*Independent* (news report [b])						
EGP 4	*Guardian* (news report [a])	√	√	√			
EGP 5	*Guardian* (news report [b])						
EGP 6	*Guardian* (news report [c])						
EGP 7	*Guardian* (editorial)	√					
EGP 8	*Daily Telegraph* (news report [a])	√			√		
EGP 9	*Daily Telegraph* (news report [b])						
EGP 10	*The Times* (news report)			√		√	√
EGP 11	*Daily Express* (news report)	√					

Table 3.4: Newspaper coverage of the Scottish Green Paper's key initiatives

No.	Newspaper	Priority Health Topics	Two perspectives	Health Improvement Programmes	Healthy Living Centres	Health Impact Assessments	inter-Government responsibility	partnership with local Government	fluoride in water
SGP 1	*Scotsman* (news report)	√					√	√	
SGP 2	*Scotsman* (news report [a])								
SGP 3	*Scotsman* (news report [b])	√			√	√	√	√	
SGP 4	*Herald* (news report [a])	√			√			√	
SGP 5	*Herald* (news report [b])	√		√				√	√
SGP 6	*Herald* (news report [c])				√				
SGP 7	*Herald* (editorial)	√			√				
SGP 8	*Daily Mail* (news report)	√	√		√		√		
SGP 9	*Mirror* (news report)				√				
SGP 10	*Mirror* (editorial)	√							

Table 3.4 (cont): Newspaper coverage of the Scottish Green Paper's key initiatives

No.	newspaper	Health Promoting Schools	COSLA health promotion post	Directors of public health on local authority committees	area regeneration	teenage pregnancies	excessive drinking	use of technology in health promotion
SGP 1	*Scotsman* (news report)							
SGP 2	*Scotsman* (news report [a])							
SGP 3	*Scotsman* (news report [b])	√	√	√				√
SGP 4	*Herald* (news report [a])							
SGP 5	*Herald* (news report [b])	√	√	√	√	√	√	
SGP 6	*Herald* (news report [c])							
SGP 7	*Herald* (editorial)							
SGP 8	*Daily Mail* (news report)		√					
SGP 9	*Mirror* (news report)					√	√	
SGP 10	*Mirror* (editorial)							

article goes on to cite evidence suggesting that fears surrounding fluoridated water are unfounded.

The remaining articles reporting on the English Green Paper are also predominantly critical in tone, particularly concerning the absence of target setting in certain specific areas. Continuing its critical stance from the previous day, the *Independent* observes that there is no national aim set for reducing health inequalities, teenage pregnancies or smoking in 'Four goals for healthier Britain could save 15,000 lives' (EGP2). Discussion of health inequalities is, the journalist writes, 'confined to three paragraphs'[32]. The absence of a target to reduce teenage pregnancies is described as 'surprising' considering Tessa Jowell (the then public health minister) had signalled the problem 'as among the most important indicators of social disadvantage'. Although noting that a target has not been set for reducing smoking, the journalist writes that it is to be the subject of a separate White Paper. The four Green Paper targets are described as 'more modest than expected, reflecting the difficulty ministers see in changing individual habits, social pressures and environmental influences'. The majority of the 27 targets set by the Conservatives, the journalist writes, 'have been or are about to be achieved'. However, it is in the target areas which the journalist believes are being neglected that problems remain: 'some [targets] will be badly missed including those on obesity, teenage pregnancy and teenage smoking'.

The accompanying article in the *Independent*, 'A shot in the arm for campaign trail' (EGP3), refers again to the perceived modesty of the government's targets when comparing the Green Paper with previous public health policy. Although the English Green Paper is the first public health strategy to acknowledge the link between ill health and poverty, it is described as 'notably cautious about how far the health gap between the rich and the poor can be narrowed'. However, the journalist qualifies this by writing: 'Caution is advisable. The lesson of the past 20 years is that improvements in public health, while desirable, are extraordinarily hard to achieve'.

The government, the *Guardian* notes in 'Dobson pledges to cut illness gap' (EGP4), 'firmly pledged yesterday to tackle the big social issues...that it acknowledges to be at the root of inequalities in health'. The 'Tory targets' have been 'shelved', allowing for a local strategy. This article also notes the absence of targets in the areas of teenage pregnancy, smoking and

obesity. However, it is in the *Guardian's* editorial, 'Prevention is better than cure' (EGP7), where criticisms really surface. After welcoming the 'open admission of the social causes of ill health', the editorial concludes that the government is 'wrong to shrink the number of targets from 27 to four'. The government is also 'wrong to leave so much to local authorities' and to delay the fluoridation of water supplies. However, the editorial views as 'most serious of all' the absence of targets for reducing health inequalities and insists that there 'must be a specific commitment to close the gap'.

The *Daily Telegraph* describes, in 'Labour 'ends the Nanny State' with new health targets' (EGP8), how the English Green Paper 'does not tell people what to eat or how much to drink and has no targets to tackle rising obesity, reducing teenage pregnancies or sexually transmitted diseases'. The 27 targets previously set by Virginia Bottomley[33] have been 'abandoned'. The English Green Paper receives some praise in the accompanying article, 'Success 'is dependent on rationing resources' (EGP9). Stephen Thornton, chief executive of the NHS Confederation, is positive ('the most radical set of proposals for health in 20 years') but, as the headline suggests, he believes rationing resources will be the only way to implement the proposals (see section 3.5.1). The use of quotation marks in both these headlines in the *Daily Telegraph* – particularly 'Labour 'ends the Nanny State' with new health targets' – suggests a distancing of the newspaper or journalist from government policy.

The Times describes a 'public health drive' to be implemented despite there being 'little extra money on offer', in an article entitled 'Dobson starts a class war to improve health' (EGP10). John Maples, the then Shadow Health Secretary, is described as being 'surprised' that the government has cut so many of the Conservatives' health targets. As with the *Daily Telegraph*, the extra strain on resources is emphasised in a quote from Stephen Thornton.

After detailing the government's new targets, the *Daily Express* article, 'Now nanny backs off in health war' (EGP11), states how 'critics were quick to point out that key targets were missing under Labour's new national plan including reducing smoking and teenage pregnancies'. The report concedes, however, that these problems 'will be addressed in separate initiatives'. The previous Conservative strategy is referred to, as the article reflects

[32] Inequalities are referred to on fifty-eight occasions in the English Green Paper.
[33] Virginia Bottomley was a Minister for Health in the previous Conservative government. The 27 targets were set in the 1992 White Paper, *Health of the Nation* Department of Health (1992).

on the difficulties of target setting: 'In their 1992 Health of the Nation plan, the Tories sought to address many of the same problems such as obesity, excessive drinking and smoking. But many of the key targets have never been met'. The article concludes on a behavioural note, ruminating over the UK's unenviable health record: 'Britain is still a nation of junk-food junkies who take little exercise. Smoking is on the rise among teenagers and many women are drinking too much. Teenage pregnancies in Britain are the highest in Europe'.

3.4.6 Media representation of the Scottish Green Paper in press coverage

Similar criticisms surrounding a lack of target setting surface in coverage of the Scottish Green Paper. However, less attention is paid to this issue as a number of the articles reporting on the Scottish Green Paper focus instead on how the new consultation document aims to improve 'Scotland's appalling health record'. As a result, the Scottish Green Paper coverage is more positive in tone when compared to coverage of the English Green Paper. Any criticisms featured tended to come from sources used by journalists for their comments on the government's strategy.

Five of the ten items reporting on the Scottish Green Paper refer to Scotland's disappointing health. For example, one of the *Herald's* articles (SGP5) opens by stating: 'Poor housing, unemployment and a clean environment have been targeted for the first time in the fight to end Scotland's hold on one of the world's worst records of deaths from heart disease and cancer'. A couple of paragraphs on, Scotland's unenviable health record is reinforced: '...the country still has some of the highest mortality rates in the world for [CHD and cancer], and life expectancy is one of the lowest in the industrialised world'.

The *Herald's* editorial, 'Far from a panacea' (SGP7), notes that 'We are getting healthier and living longer but that generalisation hides some dreadful statistics of chronic ill-health'. Explaining the rationale behind the Scottish Green Paper, the editorial reasons: 'Since there is nothing much to look forward to, what is the point of worrying about smoking, drinking, diet or drugs? Ministers believe such deep-seated, negative attitudes can be addressed by improving circumstances through worthwhile jobs, a decent home, a good education, and a clean environment'.

The *Daily Mail* is perhaps most damning in its appraisal of the nation's health, stating how 'Scotland's abysmal health record will be turned around by tackling poverty and unemployment instead of telling people to improve their diet' (SGP8). The findings of the Scottish Health Survey (Scottish Office Department of Health 1997), the article continues, 'shocked Ministers'. The survey reveals that 'half of all Scots are overweight'. The article then reflects on the high levels of tobacco-related illness, poor diet, drinking habits and the little or no exercise undertaken by the population as a whole.

Three articles frame the government's proposals in relation to the previous Conservative government's public health strategy. The *Scotsman* describes the Scottish Green Paper as a 'move away from the last administration's approach, which blamed unhealthy lifestyles for causing poor public health' (SGP1). The *Herald* is strongest in its criticism of the previous government and in its praise for the Scottish Green Paper in 'United for a healthier future' (SGP4). Using strong language the article describes the Green Paper as 'striking as possibly the first government publication to cite a reference to the Black Report on Inequalities in Health, commissioned by the last Labour government and strangled at birth by the incoming Thatcher administration'. The *Herald's* editorial (SGP7) refers to a government 'hamstrung on Tory spending limits'.

The combination of a heightened awareness of Scotland's poor health, coupled with an often welcome change of direction away from Conservative policy leads to strong praise for the Scottish Green Paper in certain quarters of the press. The *Herald's* 'United for a healthier future' (SGP4) bears the sub-headline: 'After 19 years of denial, the link between poverty and sickness is now officially recognised'. The second paragraph states how 'The document...enshrines the Labour doctrine that lecturing people on their lifestyles is futile while they are unemployed, illiterate and living in slums'. The two accompanying articles, 'Homes and jobs to build a better tomorrow' (SGP5) and 'Network of centres funded by lottery windfall' (SGP6) add more detail on the Scottish Green Paper, while the headlines retain a positive tone.

On a more critical note, one journalist observes that there are no targets for reducing inequalities in health. The *Scotsman's* Jennifer Trueland writes that the Scottish Green Paper 'will not set specific targets for beating health inequalities', apparently because 'Ministers believe setting targets could mask local inequalities and give a false impression of

improvement' (SGP1). The following day the same observation is made in the same newspaper in 'War on root causes of ill health' (SGP3).

3.5 Coverage of the Green Papers: Emphasis on inequalities in the press

Now that the reporting of the Scottish and English Green Papers has been examined, this chapter goes on to look at the presentation of health inequalities in the items collected during the sample period.

3.5.1 The English Green Paper

The English Green Paper places the reduction of inequalities as a central focus of the government's health strategy. As noted earlier, inequalities are referred to on fifty-eight occasions throughout the document. This emphasis also featured in the English Green Paper's press release. This section now turns to look at whether the government's emphasis on health inequalities was conveyed in the press coverage of the English Green Paper.

The *Independent* casts a critical eye over the government's approach to reducing inequalities in health. As a consequence, the analytical tone of their Green Paper coverage contains far less of the government's voice and therefore less government rhetoric than other newspapers in the sample period. The problem of inequalities in health is identified as a central issue throughout the *Independent's* coverage of the English Green Paper. The item 'Fluoride fear condemns children to tooth decay' (EGP1) reports specifically on inequalities in dental health and the issues surrounding water fluoridation. The journalist, Jeremy Laurance, casts a critical eye over what he perceives as government caution over the issue. Water fluoridation is viewed as a logical and relatively unproblematic way of evening out dental health inequalities. It is the only item to include lay views in the English Green Paper sample period. The vastly differing experiences of two families are featured in excerpts accompanying the article (on either side of an image of a child brushing their teeth). Entitled 'Painful lesson' and 'Perfect teeth', the excerpts recount experiences of living in fluoridated and non-fluoridated areas. The government's official line on health inequalities is absent, and the *Independent's* analysis of policy on this issue leaves little room for government rhetoric in subsequent reports. Rather than praising the shift in emphasis of government policy, the *Independent's* coverage points to all that is missing from the new strategy.

The item 'Four goals for a healthier Britain could save 15,000 lives' (EGP2) published the following day in the *Independent*, highlights the fact that the government has failed to set targets to reduce the 'health gap between rich and poor'. Although the news report points to the fact that Ministers are awaiting the results of the Acheson Inquiry into Inequalities in Health, the item notes misleadingly that discussion of inequalities in the Green Paper itself is 'confined to three paragraphs'. To add weight to the journalist's standpoint, which appears to be predominantly cynical about the government's efforts, health professionals critical of the absence of targets to reduce inequalities are quoted. Rabbi Julia Neuberger, chief executive of the King's Fund (a health policy think tank), warns: 'We do have to measure progress on reducing inequalities, otherwise there is a danger that no one will take responsibility and be held to account'. Along a similar vein, Karen Caines, director of the Institute of Health Services Management, states: '[Ministers] have peered over the precipice and drawn back a step or two. On this most critical issue they have bottled out. Without measurable targets, even over a long timescale there will be less pressure for change'. Despite the *Independent's* emphasis on inequalities, the item lends some emphasis to the role of health behaviours with the accompanying image depicting a man eating chips and drinking beer [Fig. 3].

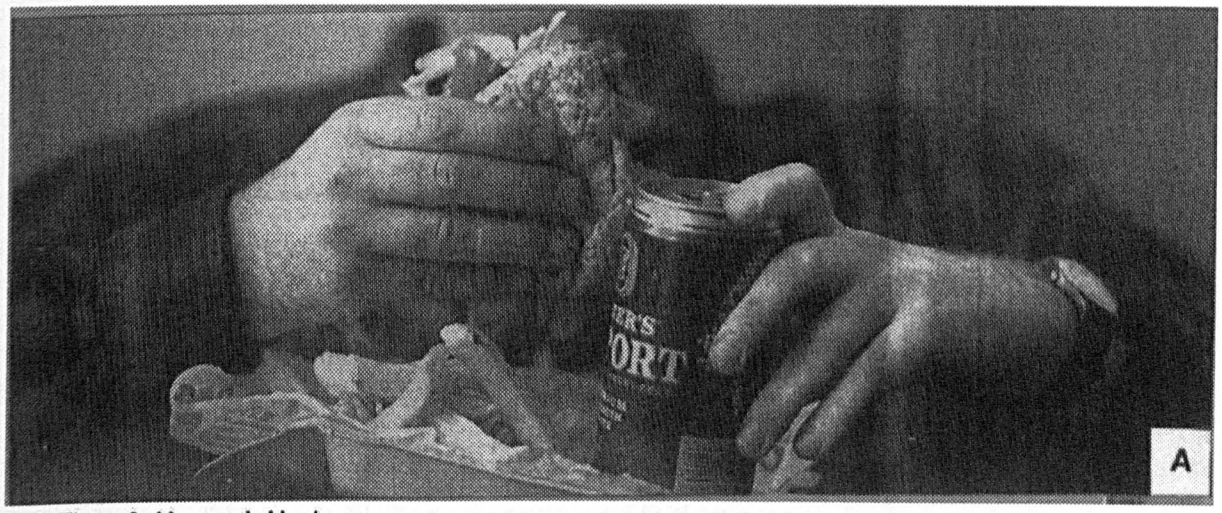


Figure 3 ' beer and chips '

The government sought to position itself as the bearer of a very different public health strategy from the previous Conservative administration. However, the *Independent* seems to have consciously avoided taking this on board, instead highlighting what the journalist perceives as the fundamental weaknesses of the strategy. In complete contrast to the way in which the government might have hoped to be presented by the media, the *Independent* goes as far as to observe an 'uncanny resemblance' between the Green Paper and former public

health documents in the news report 'A shot in the arm for campaign trail' (EGP3). The item does acknowledge the English Green Paper's link between ill health and poverty (and that this differs from previous (Conservative) strategies), but the English Green Paper is described as 'notably cautious about how far the health gap between rich and poor can be narrowed'.

By contrast, the English Green Paper's acknowledgement of a link between poverty and ill health is strongly endorsed and reinforced in the *Guardian's* coverage. The *Guardian's* three news reports are framed around what the newspaper appears to view as a positive step in the right direction. The government's intention to focus on 'the greatest inequality of them all' - inequalities in health - is reported in the *Guardian's* leading article 'Dobson pledges to cut illness gap' (EGP4). Examples of health inequalities are prominent, with data taken from the English Green Paper detailing how a man in Manchester can expect to live five years less than a man living Oxfordshire[34]. Also included are statistics showing that 'death rates from lung cancer are 20 per cent higher in the North than the national average' (Department of Health 1998, par. 2.34). The sources used in the *Guardian's* leading article (EGP4) balance their praise of the English Green Paper with criticisms over lack of target-setting in certain areas, as well as a possible lack of resources. Karen Caines' views criticising the absence of targets to reduce health inequalities again are featured. Nevertheless, the item conveys a government committed to reducing inequalities in health.

The second item in the *Guardian's* coverage, 'Targets: four leading causes of early death' (EGP5), outlines the inequalities in health outcomes faced by those in unskilled and manual labour in the government's four target areas of heart disease and stroke, accidents, cancer, and suicide. The item cites statistics revealing how unskilled male workers are more than twice as likely to commit suicide than men of working age as a whole (Department of Health 1998, par. 4.37); and that women born in Sri Lanka, India and the East African Commonwealth are approximately 50% more likely to commit suicide than women in the population as a whole (Department of Health 1998) par. 4.37)[35]. The item sets out the statistics of inequality, but does not relate them to the government's Green Paper proposals or add additional comment.

[34] The English Green Paper details geographical differences in mortality rates (Department of Health, 1998, para. 1.11) but does not specify Manchester or Oxfordshire or the specific estimate of 5 years.

[35] These and other statistics are used to justify the government's four target areas of heart disease and stroke, accidents, cancer, and mental health. They can be found in paragraphs 4.18, 4.24, 4.31 and 4.37 of the English Green Paper (Department of Health 1998).

The third *Guardian* news report highlights the link between poverty and ill health made by the English Green Paper. The item, 'There's a complex mesh of factors that cause poor health, but poverty is the key to it' (EGP6), uses an interview with an East London GP to present a sympathetic view of the health problems faced by those on low incomes. The journalist describes a scenario where 'Each day, the 45-year old GP battles the legacy of poor diet and damp, over-crowded housing, and counters the response to unemployment – drug abuse and depression'.

Inequalities in health are again the focus in the *Guardian's* editorial, 'Prevention is better than cure' (EGP7). The editorial welcomes the emphasis on social issues in government public health policy and cites the widening gap in death rates between men of different social classes, as well as the stark variations in mortality rates for men in different areas of Sheffield. Although there is praise for the government throughout the *Guardian* coverage, criticism is levelled in the editorial at a number of areas of public health policy, not least the absence of targets for reducing health inequalities. The editorial concludes that, with regard to inequalities, 'There must be a specific commitment to close the gap'.

The *Daily Telegraph* refers to the government's aim of narrowing 'the health gap between rich and poor' in the item 'Labour 'ends the Nanny State' with new health targets' (EGP8). The item describes the government taking 'on board social problems, poor housing, unemployment and low pay which [are] linked to illness'. The *Daily Telegraph* provides a lot of detail on the English Green Paper, yet the item fails to make explicit reference to inequalities in health despite the prevalence of the term (and issue) in the Green Papers, press releases and launch statements. However, the accompanying article, 'Success 'is dependent on rationing resources' (EGP9) features Mr Thornton of the NHS Confederation speaking forcefully in the language of inequality, stating: 'Targeting resources in a cash-limited system means robbing Peter to pay Paul. In this case Paul lives in a poor community and has no voice. Peter is middle class, vocal and articulate and living in a marginal constituency.' Mr Thornton touches on the subject of inequalities in health care provision rather than inequalities in health outcomes. He argues that the Green Paper's plans to focus care on the most needy is problematic as it raises moral and ethical questions concerning the rationing of resources.

Inequalities are explicitly referred to in 'Dobson starts a class war to improve health' (EGP10) as *The Times* quotes both Frank Dobson directly and the government's aim to reduce inequalities in health. The Health Secretary describes the government's four targets, in the journalist's words, as 'at the heart of the government's drive to reduce the inequalities of health caused by poverty'. The journalist criticises the government's strategy on the basis that 'there is little extra money on offer'. The government's message is clearly communicated but is not elaborated on. Instead, a critical eye is cast over the English Green Paper's initiatives before a sizeable proportion of the report is taken up with the views of John Maples. The then Shadow Health Secretary emphasises the importance of behavioural factors rather than life circumstances in the causation of ill health: 'In many cases people can and must take more responsibility for their own health. The Government must not give people an alibi for their own bad habits by allowing them to blame circumstances'. This choice and reliance on a particular source from the Conservative Party indicates that *The Times* is unsympathetic to the government's arguments concerning the causes of ill health.

The *Daily Express* emphasises the government's desire to distance itself from previous Conservative 'nanny state' policy in the news report 'Now nanny backs off in health war' (EGP11). It describes how, for the 'first time', ill health has been linked to social problems. Inequalities in health are explicitly referred to as the article quotes from Mr Dobson's Commons statement. The item contextualises the issue, noting that the situation has worsened in the past 20 years. The image of a caricatured nanny [Fig. 4] (and headline) consolidates Labour's aim of forging a new direction in public health policy from the previous right-wing administration. However, the *Daily Express's* perception of Britain as 'a nation of junk food junkies who take little exercise' places the emphasis firmly back on health behaviours.

The language of inequality is present in all newspapers reporting on the English Green Paper launch. However, traditionally right-wing newspapers such as the *Daily Telegraph* place less emphasis on health inequalities as an issue, describing a 'health gap between rich and poor' rather than explicitly using the term 'inequality' (SGP8). The inequalities debate is communicated most strongly, and the government's efforts are most critically assessed, in the *Independent's* coverage. The government's strategy surrounding inequalities is received most favourably overall in coverage appearing in the *Guardian* newspaper, although the editorial (SGP7) is critical of the absence of targets for reducing health inequalities.

Figure 4 ' nanny '

3.5.2 The Scottish Green Paper

As noted earlier, the Scottish Green Paper makes a link between deprivation and ill health and acknowledges that ill health can be dictated by a range of social and environmental factors. The government's stated overriding aim is to reduce inequalities in health. Did the government succeed in communicating this message to the media? Curiously, the Scottish Green Paper press release does not use the term 'inequality' despite its prominence in the document itself. However, the press release does refer to examples of inequality in Lothian and the West of Scotland. Yet the emphasis is on how these figures 'are compelling proof that deprivation is linked to ill health' rather than on the intention to eradicate inequalities (a clear aim of the Scottish Green Paper).

The government's aim of reducing inequalities is communicated clearly in the *Scotsman's* coverage of the Scottish Green Paper. The headlines 'Scottish health action plan to target poverty' (SGP1) and 'War on root causes of ill health' (SGP3) convey the intention to eradicate deprivation, a factor which the government acknowledges is a key determinant in improving population health. In the course of reporting the government's public health proposals, inequalities are referred to explicitly on a number of occasions. Both items refer to the impact of inequalities in health by citing the disparities in mortality rates taken from the press release[36]. The absence of government targets for reducing inequalities is noted in both news reports, and 'War on root causes of ill health' (SGP3) features critical comments from Mary Scanlon, shadow health spokeswoman for the Scottish Conservatives.

The government's focus on inequalities is elaborated upon in the *Scotsman* with a memorably entitled item, 'Living in Glasgow takes five years off your life' (SGP2). The item refers to research published some years previously which suggests that men living in Edinburgh are likely to live four to five years longer than men in 'more deprived' Glasgow. University of Glasgow academics Professor Graham Watt and Dr Russell Ecob's research on the life expectancy of men at age 35, the journalist writes, shows that 'in the west, men will die in their early seventies and in Edinburgh several years later'[37]. The *Scotsman* journalist quotes Dr Phil Hanlon's view (then a senior lecturer in public health at the University of Glasgow

[36] The item 'Scottish health action plan to target poverty' refers to the premature deaths rates in Lothian. 'War on root causes of ill health' cites both the example of Lothian and the stark differences in mortality rates between affluent Bearsden and neighbouring deprived Drumchapel.

and consultant with Greater Glasgow Health Board) that 'health inequalities between rich and poor [are] worsening'. A news report focusing solely on inequalities in health obviously serves to further highlight the issue. Moreover, the comparison between Edinburgh and Glasgow taps into the long-running rivalry between the two cities, adding further meaning to the subject for the *Scotsman's* readership[38].

The *Herald's* coverage not only communicates the Scottish Green Paper's intent to reduce inequalities, it also firmly positions the newspaper as a champion of the government's cause. Using language normally associated with tabloid coverage, the leading item 'United for a healthier future' (SGP4) states how the Labour doctrine is epitomised in the Scottish Green Paper: 'Lecturing people on their lifestyles is futile while they are unemployed, illiterate and living in slums'. Inequalities are explicitly referred to, and examples include the Lothian, Bearsden and Drumchapel statistics from the Scottish Green Paper's press release. Despite the *Herald's* apparent endorsement of government policy, it balances its coverage with a statement from Mary Scanlon, health spokeswoman for the Scottish Conservatives. Ms Scanlon's comments also appear in the *Daily Mail* and the *Scotsman*, but are featured in their most unabridged form in the *Herald*. The *Herald* journalist describes the Conservatives as 'unrepentant in their attack on the thrust of the Green Paper', before Ms Scanlon is quoted as saying:

'I think it is wrong to say that poor health is directly linked to poverty and low incomes. It is linked with poor eating and lifestyle habits which can be changed with greater public awareness. The Health Education Board for Scotland was generously funded by the last Government to carry forward this process of informing people about making health lifestyle choices. The Labour Government should also look at channelling more resources down this road, promoting prevention rather than cure.'

Statements are also included from Kay Ullrich (health and policy spokeswoman, SNP) and Michael Moore MP (health spokesman, Scottish Liberal Democrats). Both are critical of the government's strategy but neither refer to health inequalities. The chairman of the Health Education Board for Scotland (HEBS), David Campbell, puts the focus back on inequalities by stating: 'The Green Paper rightly puts the spotlight on the roots of Scotland's unenviable health problems and worsening health inequalities – on issues such as unemployment, poverty

[37] See, for example, Watt, G. and R. Ecob (1992). "Mortality in Glasgow and Edinburgh: a paradigm of inequality in health." Journal of Epidemiology and Community Health **46**: 498-505.
[38] Reactions of focus group participants to this headline are discussed in chapter 7.

[and] social exclusion...'. The journalist further reinforces Mr Campbell's views by stating: '...among doctors working in public health in Scotland, the green paper's analysis was welcomed as vindication of the sentiments they have expressed – often under their breath – for nearly 20 years'. In 'United for a healthier future' (EGP4), the government's course of action is put into context with reference to the Black Report and the Thatcher administration, who 'strangled [it] at birth'. This perspective is coupled with the sense of a radical shift in political direction as the link between poverty and sickness is recognised after 'nineteen years of denial'. The strong rhetoric is not however supported by the choice of image, Sam Galbraith posing with a child, accompanying the *Herald's* news reports.

The government's link between deprivation and ill health is praised in the *Herald's* editorial 'Far from a Panacea' (EGP7). The perception that we as a nation are getting healthier, the editorial states, 'hides some dreadful statistics of chronic ill-health' amongst the most disadvantaged. The item refers to the discrepancies in mortality rates highlighted by the Bearsden/Drumchapel statistics, commenting: 'Such depressingly glaring discrepancies as early deaths being 40% below the national average in affluent areas and 60% above it in the poorest confirm that no other approach is feasible. 'Far from a Panacea' (EGP7) is certainly conversing in the language of inequalities, as well as supporting the government's line. In terms of the government's approach, the editorial views any improvements in Scotland's health as an uphill struggle, a 'long haul'. Although the *Herald's* coverage perceives the shift away from Conservative health policy very positively, doubts are expressed in the concluding paragraph as to whether the government is committed enough to solving Scotland's health problems in its allocation of resources: '...we seriously wonder whether a combination of lottery funding, windfall taxation, and raiding a reduced Scottish block is the panacea'.

The government's emphasis on inequalities is also communicated clearly in the *Daily Mail* (SGP8), which relies heavily on the Scottish Green Paper press release. The term 'health inequalities' is not used but the Bearsden/Drumchapel statistics are cited. Similarly, excerpts from Sam Galbraith's launch speech convey the government's focus on poverty and deprivation. The *Daily Mail* also reports that Labour's approach is a 'significant shift' from the previous Conservative government's linkage of lifestyle to ill health. Yet the headlines, choice of image and discourse of the news report is firmly rooted in behavioural concepts. The headline 'Wealth is the key to health, says Dr Galbraith' misses the point. Wealth creation is not the message the government is trying to convey, rather that poverty and ill-

health are inextricably linked. Similarly, the image of a man riding a bike through leafy suburbia and the insert entitled 'Habits that are killing us' reinforces the news report's lifestyle-bias. The views of the Conservatives are well represented, with the inclusion of the critical statement by Mary Scanlon in addition to the views of John Maples. The journalist notes 'a similar paper was launched for England and Wales'[39] before quoting his statement made to the Commons: 'In many cases people can and must take more responsibility for their own health. The Government must not give people an alibi for their own bad habits' (SGP8).

The *Mirror's* coverage (SGP9, SGP10) centres around behaviours damaging to health and policies aimed at promoting healthier living. Even initiatives hailed by the government as routes to reducing health inequalities, such as Healthy Living Centres, are framed in terms of health behaviours. As a consequence, a defining element of government public health policy, the reduction of inequalities in health, is absent from the *Mirror's* coverage of the Scottish Green Paper.

Thus, the government's recognition of a link between deprivation and ill health and its aim to tackle inequalities in health are communicated most strongly in the *Scotsman* and *Herald* newspapers. The *Daily Mail* and *Mirror* do not explicitly refer to inequalities at all. However, the government's intention to tackle poverty is reported in both publications. The *Daily Mail's* reporting is very lifestyle-biased. The *Mirror's* coverage is even more so, describing the government's campaign to 'drum home the healthy living message'. Whilst the Scotland-based broadsheet newspapers embraced the more complex linkage of not only lifestyle but also life circumstances contributing to ill health, the *Mirror* appeared to have lost this message. Its coverage is rooted in concepts of lifestyle and health behaviours. The *Daily Mail* appeared to be communicating conflicting messages by acknowledging the government's approach but focusing still on health behaviours.

3.5.3 The Green Paper coverage: Summary and Conclusions

The English and Scottish Green Papers mark a substantial shift in public health policy. The English Green Paper makes it an aim to improve the health of the worst off in society and narrow the health gap. For the first time deprivation is linked to ill health. Inequalities in health form a central focus of the document and a number of the government's key public

[39] The Welsh Green Paper was in fact released at a separate time, as was the Green Paper for Northern Ireland.

health policies, such as Health Action Zones, are aimed at reducing inequalities. The government's aim of reducing inequalities in health is communicated clearly in the accompanying press release 'Our Healthier Nation'. Similarly, addressing inequalities in health is the Scottish Green Paper's 'overriding aim'. Although the intention to tackle inequalities comes across clearly in the Scottish Green Paper itself, the message is somewhat diluted in the document's press release. As a result, the government's overriding aim to tackle inequalities in health is not clear from the press release alone.

Consequently a good proportion of coverage of the Scottish Green Paper is descriptive, reporting on the government's key proposals. Coverage of the English Green Paper was broader in scope than reporting of its Scottish equivalent. A range of views and differing aspects of the English Green Paper were reported in depth with the use of interviews and statistics, or putting the current proposals in context with previous public health policy. This in-depth coverage tended to appear in the left-of-centre broadsheet newspapers and was a feature of the English-based UK national press. Green Paper coverage in the Scottish-based press was, on the whole, descriptive rather than analysis or commentaries.

There appears to be an association between the political stance of a given newspaper and the government initiatives it chooses to highlight. Left-of-centre newspapers such as the *Guardian* reported more extensively on initiatives to be targeted at deprived sections of the population. By contrast, the more right-wing papers such as the *Daily Telegraph* and *The Times* focused more intently on proposals aimed at improving health behaviours.

Coverage of the Scottish Green Paper tended to focus on how the government's strategy would improve Scotland's 'appalling health record'. Perhaps as a result of this emphasis, criticism of the Scottish Green Paper strategy itself seemed to be diluted. England's past health record is less of an issue, and escaped the scrutiny imposed on the Scots. However, the English-based UK national media was more critical of government policy as a whole, particularly the lack of target setting in specific areas (such as health inequalities, smoking and teenage pregnancies).

Those newspapers which may have been expected to praise the government's shift in emphasis were in fact critical. For the *Independent* and the *Guardian*, the strategy does not go far enough. Journalists appear to source information from the English Green Paper itself

rather than the accompanying press release. This is in contrast to the Scottish coverage where the press release is quoted extensively. Journalists covering the English Green Paper also used a greater number of direct quotes from Health Ministers Frank Dobson and Tessa Jowell.

The majority of Scottish articles framed the government's philosophical shift in public health policy as its intention not to 'nanny or nag' the public (the term used by the government itself). The nannying theme is present in the English Green Paper coverage in a number of forms. Tessa Jowell is quoted in various newspapers, seeking to distance the government from the 'Nanny State' tag associated with Conservative policy.

Reporting of the English Green Paper was broader in scope in terms of the extent to which different aspects of proposals were explored. However the use of political spokespersons was markedly absent throughout the majority of coverage. Only *The Times* called on a political source (other than the government) for comment on Labour's health policy, liberally quoting the views of John Maples, Shadow Health Secretary. In contrast, journalists reporting on the Scottish Green Paper regularly used a number of political sources for comment in items. Other spokespeople featured in coverage of the Scottish Green Paper from interest groups and public bodies tended to focus their comments around rationing and the lack of commitment (lack of targets) to reduce inequalities in health.

Images used in the English Green Paper coverage vary from the conventional (such as Ministers attending the English Green Paper launch), to caricature (the stereotyped nanny figure). Conflicting messages are also apparent. For example, the *Independent's* emphasis on inequalities is undermined by the inclusion of a picture depicting behaviours 'bad' for health ('beer and chips' image, Fig. 3). Image choice in reporting of the Scottish Green Paper tended to consist of photos taken on the launch day, although one lifestyle-oriented image was used of a man cycling.

The issues of inequalities in health, poverty and deprivation are central to Green Paper coverage in the left-of-centre broadsheet press. Although supporting the government's emphasis on inequality and poverty, the left-of-centre broadsheets were critical of a perceived lack of commitment to the issue, highlighting particularly the absence of a target for reducing inequalities. In particular the *Independent*, although in agreement with the government in principle, is consistently critical of the government's handling of the issue. Consequently,

minimal government rhetoric was included as the *Independent* chose to assess how much of an effect this sea change in public health policy would actually have.

Despite welcoming this change in direction (although not necessarily the means by which the government seeks to effect change), conflicting messages prevailed in some of the broadsheets. The *Independent* chose a stereotyped image depicting behaviours 'bad' for health to accompany its two main items, thus reflecting neither the items' tone nor the philosophy behind the Green Papers. Such mixed messages appeared to be a feature of much of the reporting.

Inequalities in health appear less of an abstract term and more of a tangible issue in reporting of the Scottish Green Paper due to the inclusion in the press release of examples of inequality throughout different areas of Scotland. These examples appear throughout reporting of the Scottish Green Paper and allow the reader to quantify what the government means by the term 'inequalities in health'. Only one such example is featured in the English-based UK press's reporting of the English Green Paper, in the *Guardian*.

Inequalities in health are communicated most forcefully in an item reporting on the Scottish Green Paper, 'Living in Glasgow takes 5 years off your life' (SGP2). As a memorable headline and a front-page story focusing solely on health inequalities, the item is recalled by, and has most resonance with, focus group participants (see Chapter seven). Such a strong headline contrasts with the *Daily Telegraph*, for example, which neglects to refer to inequalities in health at all despite their prominence in government literature.

In conclusion, the government's intention to reduce health inequalities as presented in the 1998 English and Scottish Green Papers on public health was communicated in vastly differing ways across the press spectrum. Conflicting messages were apparent, with some newspapers clearly conveying the government's emphasis on inequality and deprivation, yet framing their coverage in the context of health behaviours. However, the government's message is conveyed (to varying degrees) in all publications with the exception of one newspaper. The *Mirror* (SGP9, SGP10) gives only passing mention to government plans to tackle poverty in coverage firmly rooted in a lifestyle paradigm. Therefore the newspaper with potentially the largest readership (of those reporting on the Green Papers) fails to communicate the radical change in public health policy the government is seeking to convey.

The *Sun*, *Star*, *Daily Record* and *Evening Times* did not cover the Green Papers, as did any of the Sunday newspapers. So although the Green Papers were covered in detail in some sections of the press, they were overlooked in others.

Chapter Four

Independent Inquiry into Inequalities in Health: The Acheson Report

4.1 Introduction

On the 10th July 1997, just two months after New Labour came to power in a landslide victory, Tessa Jowell, then Minister for Public Health, commissioned Sir Donald Acheson (Chairman of the International Centre for Health & Society at University College, London)[40] to chair an independent inquiry into Inequalities in Health in England. The last Labour government had commissioned a similar inquiry in 1977, which has since become a landmark in the inequalities debate. However, when the results of this inquiry, the Black Report (Black, Morris *et al.* 1988), were actually published in 1980, political priorities had radically shifted. The newly elected (1979) Thatcher-led Conservative administration pushed the Black Report far down the political agenda, with little or no acknowledgement of the inequalities in health debate during their 18 years of office.

4.2 The Acheson Report: An Independent Inquiry into Inequalities in Health

In her 1997 letter to Donald Acheson, Tessa Jowell identified the 'terms of reference' to be addressed in the proposed review of inequalities in health (Acheson 1998, Annex A, p. 155). The Public Health Minister expressed the need to keep 'in very close touch' with the emerging findings of the Acheson inquiry so that 'these can be taken into account in the drafting of the Health Strategy White Paper' which was intended for publication in the 'middle' of 1999. The Preface of the Acheson Report (Acheson 1998 p. V.) describes how 'From its earliest days in office, the government has expressed its concern about inequalities in health and in February 1998 translated this concern into a central premise of its consultation (Green) paper *Our Healthier Nation*'[41] (Department of Health 1998).

[40] Sir Donald Acheson was also Chief Medical Officer in the Department of Health from 1984 to 1991, under the previous, Conservative, government.

[41] The Preface emphasises the ongoing commitment of the government to inequalities in health in the following sentence, stating: 'This has been followed not only by the 1998 Budget but by a succession of consultation documents and White Papers relevant to our inquiry' (p. v).

The introduction of the Acheson Report refers positively to the English Green Paper on a number of occasions, commending it as an 'important landmark' (Acheson 1998, p.3). The inquiry team welcome 'the setting up of the Chief Medical Officer's working group which will consider targets, including those which address inequalities in health, as part of the work on *Our Healthier Nation*' (Acheson 1998, p. 3). The inquiry itself was not involved in setting targets concerned with reducing inequalities in health. The introduction to the Acheson Report quotes a central English Green Paper tenet, describing the document as identifying 'the need *"to improve the health of the worst off in society and to narrow the health gap"* as an overriding principle' (Acheson 1998, p. 3). The Inquiry team also shares the English Green Paper's approach in 'its determination to tackle the *"the root causes of ill health"*' (Acheson 1998, p. 7). The Acheson Report takes into account 'the main features of *Our Healthier Nation* as they affect inequalities'. Inequalities are discussed in the settings highlighted in the English Green Paper, 'schools, the workplace and neighbourhoods', and in relation to Health Improvement Programmes and Health Action Zones (Acheson 1998, p. 4.).

The Acheson Report highlights three guiding principles as crucial in the reduction of health inequalities:

- 'all policies likely to have an impact on health should be evaluated in terms of their impact on health inequalities;
- a high priority should be given to the health of families with children;
- further steps should be taken to reduce income inequalities and improve the living standards of poor households.' (Acheson 1998, p. XI.)

Areas for future policy development were detailed with respect to: poverty, income, tax and benefits [pp. 32-36]; education [pp. 36-44]; employment [pp. 44-50]; housing and the environment [pp. 50-55]; mobility, transport and pollution [pp. 55-61]; and nutrition [pp. 62-67]. Further recommendations focus on stages of the life course – mothers, children and families [pp. 67-77]; young people and adults of working age [pp. 77-87]; and older people [pp. 87-92] – as well as focusing on ethnicity [pp. 92-100] and gender inequalities [pp. 100-110]. Possible steps within the National Health Service [pp. 111-119] to reduce inequalities are also identified.

4.2.1 Absolute and relative inequalities

The sections of the Acheson Report dealing with absolute and relative inequalities are particularly important as they relate directly to some of the lay views expressed in the focus groups to be discussed in later chapters (chapters 7-9). On the subject of absolute and relative inequalities, the Acheson Report states: 'The penalties of inequalities in health affect the whole social hierarchy and usually increase from the top to the bottom'. An important aspect of the Report's recommendations is their intention to encompass all of society rather than being aimed solely at those living in poverty. In light of this they state that, 'although the least well off may properly be given priority, if policies only address those at the bottom of the social hierarchy, inequalities will still exist' (Acheson 1998, p. 8).

Research is cited in the Report which suggests that 'societies in which there is a wide gap between the rich and the poor suffer additional social problems, for instance, through high rates of violence and crime, and truancy' (Acheson 1998, p. X). Other research suggests that 'people with good social networks live longer, are at reduced risk of coronary heart disease, are less likely to report being depressed, or to suffer a recurrence of cancer and are less susceptible to infectious illness than those with poor networks' (Acheson 1998). Crime, violence, self-harm and isolation – the 'manifestations of exclusion' – will be reduced, the reports states, with 'Freedom from prejudice or discrimination, a respect for individual worth and a sense of belonging to society' (Acheson 1998, p. 9).

4.2.2 The Acheson Report and Government policy

As well as praising the English Green Paper's emphasis on inequalities in health, and using the Green Paper's settings of schools, workplaces and neighbourhoods in framing its recommendations, the Acheson Report refers favourably to other government policies. Under the section 'Poverty, Income Tax and Benefits', the Acheson Report welcomes the government's 'declared intention to redress income inequalities through the establishment of a national minimum wage, 'Welfare to Work' and other measures' (Acheson 1998, p. 33). However, the Report continues, this approach 'should be accompanied by efforts to redistribute resources, in cash or in kind, to those who, for reasons such as age or disability, are unable to work, and to those families for whom work is not available or appropriate'. It is implied that the existing government initiatives will not be enough: 'We consider that without

a shift of resources to the less well off, both in and out of work, little will be accomplished in terms of a reduction of health inequalities by interventions' (Acheson 1998, p. 33).

4.2.3 The Acheson Report's press release[42]: Summary and analysis of the Government's interpretation of the Inquiry.

This section will summarise the press release for the Acheson Report and assess the government's interpretation of its recommendations. The 902 word press release, entitled *'Government committed to greatest ever reduction in health inequalities' says Dobson*, was issued on 26th November 1998. Unlike the press releases accompanying the Green (see chapter three) and White public health papers (see chapters five and six), the Acheson Report's press release divulges very little of the contents of the document. Instead, the press release appears to be an opportunity for the government to list existing policies.

The press release takes the form of a statement from Mr Frank Dobson, then Secretary of State for Health. The Working Families Tax Credit and the Minimum Wage will, Mr Dobson states, 'pay a guaranteed minimum of £190 a week for a family'. The £540 million Sure Start programme 'will give young children and their parents the child care and support they need, so that every child in our country gets the best start in life'. Other initiatives listed include more money for schools ('£250 million aimed at children who are disaffected with school or society at large'), pensioners (a £2.5 billion 'pensions boost' and annual winter fuel payments), housing (£5 billion for improving existing homes), and the NHS (a £21 billion 'boost' over the next three years). £3 billion will be invested in the New Deal for Regeneration to 'regenerate the most deprived areas' and the New Deal for Communities 'to help some of the country's most deprived neighbourhoods'. The Social Exclusion Unit will 'continue to co-ordinate a national drive to support people who have been cut off from the mainstream of society'.

Inequalities in health are referred to on ten occasions in the press release. These are clustered at the beginning and the end, concentrated in the opening and closing rhetoric of the document. Two government policies are linked explicitly to inequalities in health. Healthy Living Centres are described as 'working on the ground to improve the health of the worst off in society', and Health Action Zones are described as 'designed specifically to tackle health

inequalities in areas including inner cities, coalfield communities, struggling rural areas, and places where wealth and poverty live cheek by jowl'. The 'cheek by jowl' phrase conjures strong imagery of well-off and deprived communities located extremely close together.

The press release opens with the assurance that 'The whole government, led from the top by the Prime Minister, is committed to the greatest ever reduction in health inequalities'. Mr Dobson, on the subject of the commissioning of the Report[43], states that the government 'was determined to make an early start on our mission to reduce inequalities in health as part of our overall programme to improve the health of the nation'. The Acheson Report is described as a 'further stage in our unprecedented commitment to tackle inequalities in health'. Mr Dobson claims that 'No previous government has ever set itself such ambitious targets', yet by the end of the press release it is still unclear what exactly these targets are. Neither the government nor the Acheson Report sets out specific targets for reducing health inequalities.

Discussion of inequalities features again in the last couple of paragraphs of the press release. It is at this stage that Mr Dobson refers explicitly to the Acheson Report for the first and only time: 'As the report points out, tackling health inequalities will require action across the whole of government'. Yet there is a 'but' involved as the sentence concludes: 'but there is an important role for the Department of Health'. Attention then turns to focus on modernising the NHS.

In the final paragraph of the press release, Mr Dobson states that 'The Green Paper, *Our Healthier Nation*, made clear our commitment to tackling health inequalities'. The work of the Acheson Report, he continues, will now be used to 'ensure that the White Paper on public health...will be based on the best available scientific evidence'. The final sentence states that: 'Sir Donald's work will be a key influence on our long term strategy to narrow the health gap'.

4.2.4 Summary

The Acheson Report recommends proposals in a broad range of areas (i.e. education, housing and transport) in its remit to reduce inequalities in health, as well as directly addressing

[42] The Acheson Report's press release can be found at http://www.doh.gov.uk/dhhome.htm

vulnerable population groups living in poverty. However, the Report seeks to recommend policies which encompass society as a whole, rather than only targeting those most deprived, as it argues that otherwise inequalities will increase further. Despite the initial remit to conduct a review 'within the broad framework of the government's overall financial strategy' and to develop 'cost effective and affordable interventions to reduce inequalities' (Acheson 1998, Annex A, p. 155.), the Acheson Report does not 'cost' or take into account the financial implications of its recommendations. This may in part explain why the Acheson Report had less impact on government policy than might otherwise have been expected (see Chapters five and six for an assessment of how inequalities were prioritised in government policy). The fact that the press release of the Acheson Report highlighted existing policies rather than referring in any length to the Report's recommendations already suggests that the government had sidelined the report.

4.3 Coverage and representation of the Acheson Report in the press

This section begins by describing pre-publication coverage of the Acheson Inquiry. An overview of competing news stories at the time of the Acheson Report's publication is provided before examining the extent to which the Inquiry's key recommendations are reported in the press. The coverage of the Acheson Inquiry is then analysed in terms of presentation by journalists and sources utilised for comment.

4.3.1 The wider context

Newspaper coverage was collected from the day of publication of the Acheson Report for a twenty-eight day period (see Methodology, chapter two). However, one newspaper – the *Independent* – featured substantial coverage of the Report and issues arising from it during October and early November, prior to the Report's publication. To keep the method uniform throughout content analysis of all documents, the decision was made to summarise the *Independent's* pre-publication coverage separately. However, the nine pre-publication items are still taken into account when looking at media coverage of the Acheson Report (See section 4.3.4).

[43] Correspondence included in the Appendices of the Acheson Report indicate that it was in fact Tessa Jowell who was involved in commissioning the Inquiry from Sir Donald Acheson (1998, p. 155).

4.3.1.1 Pre-publication coverage of the Acheson Report

A summary now follows of the items appearing in the press before the Acheson Report's publication. Attention was drawn to the fact that the *Independent* was previewing the yet-to-be published Acheson Report. Coverage was collected from 15/10/98 to 22/11/98. Nine articles appeared during this time. The *Independent* ran all but one item found during this period, running four news reports, one editorial, two feature articles and one column. A number of these articles formed a series entitled *Breadline Britain*, which attempted to explore the impact of living on a low income. It reported that a substantial section of the population is malnourished, women and children in particular, due to the difficulties in obtaining healthy low-cost food. The *Independent* argues that as the large supermarkets have moved out of towns and cities, 'food deserts' have been created in inner-city areas. Those on low incomes and without private transport are most affected. Often, people finding themselves in this situation have no option but to shop in inadequately stocked, expensive corner shops. Accompanying the *Independent* coverage are a series of strong images depicting urban poverty, and more curiously, a Dickensian-style poverty. Three of the images appearing in the *Independent* at this time were used in the focus groups [Fig. 8 'child with plate', Fig. 9 'woman with pushchair', Fig. 11 'supermarkets']. The remaining item ran in the *Observer*, a Sunday broadsheet, four days before the Acheson Report's publication. This brief news report, entitled 'Call for free nicotine patches' [*Observer*, 22nd November 1998, news report] focuses on the Inquiry team's call for nicotine patches to be available on the NHS and how this would benefit those on low incomes.

The first item found, entitled 'The poor of Britain are going hungry, health chief warns' [*Independent*, 15th October 1998a, news report], is based on a speech made by Sir Donald Acheson to the Royal College of Physicians. The front-page article appears with a second item, 'No idea what the bairns will get for tea', which details the struggle of two single mothers trying to get by on current benefit levels [*Independent*, 15th October 1998b, news report]. Accompanying the article is a Dickensian image of children at a dinner table [Fig. 8], which could arguably have been taken at any point during the twentieth century. One child appears to be standing on the table, plate in hand, looking directly at the camera in a pose reminiscent of the famous scene in Oliver Twist when the child asks 'Please sir, can I have some more?' (focus group participants' responses to this image feature in chapters seven to nine). The caption reads: 'Children in a hostel for homeless families in Blackpool. Poorer

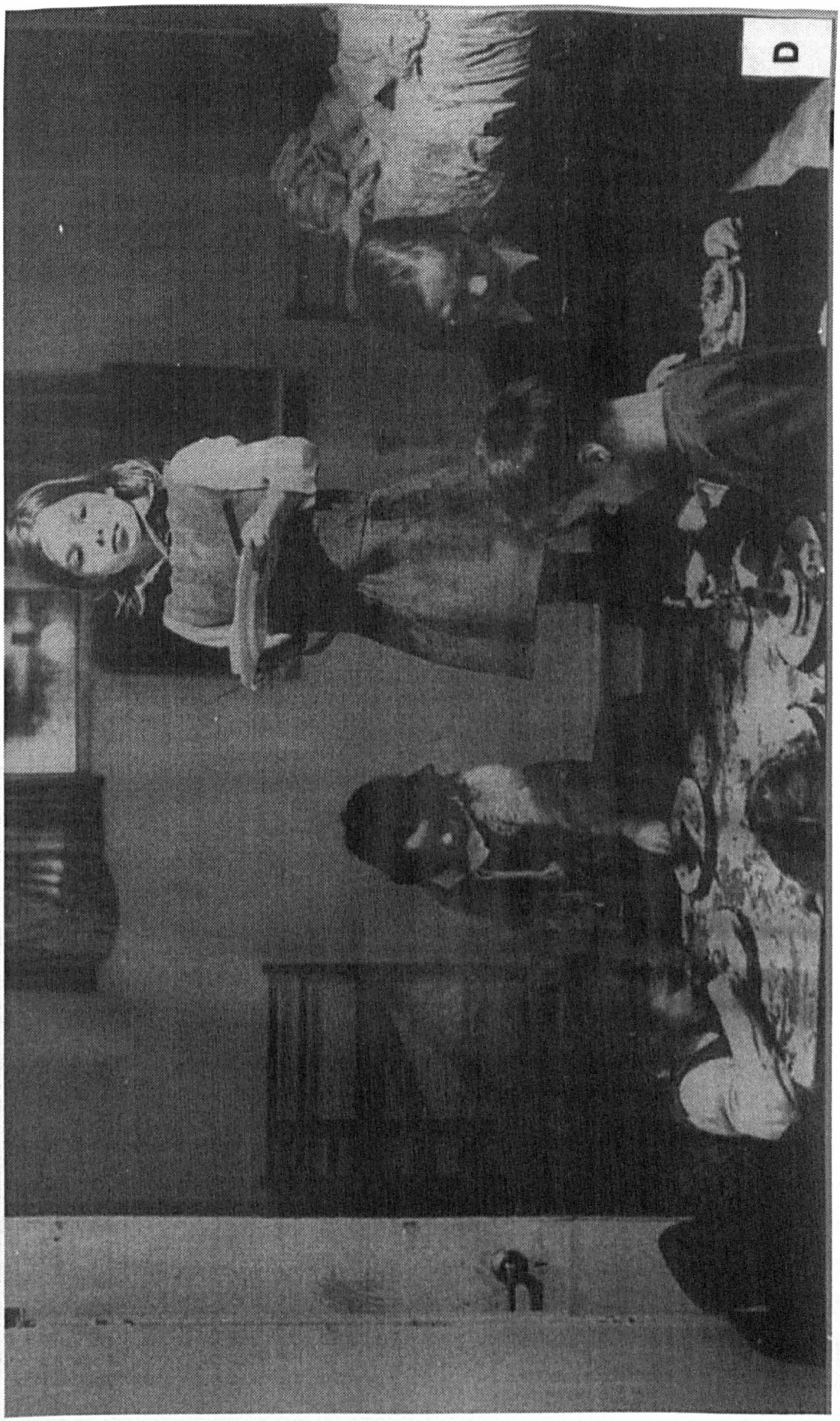


Figure 8 ' child with plate '

households face a 'food desert' because cheap food is available only to those who can get to out-of-town supermarkets'. A small cartoon by 'Tim' is inset into the text. It depicts a mother and child looking at a newsagent's headline board, the daily headline being 'SINGLE MUMS STARVE SHOCK'. The mother in the cartoon comments 'More third world than third way', a play on words utilising Tony Blair's much publicised 'Third way' philosophy.

The following day, the *Independent* ran another front-page report, 'Huge rise in child poverty' [*Independent*, 16th October 1998, news report]. To reinforce the sobering implications of the Acheson Report, the article quotes Department of Social Security statistics which show that, between 1979 and 1997, the number of children living in families with below half average income in Britain rose by nine per cent to 34 per cent (when living costs were taken into account). The Acheson Inquiry is described in the article as being 'riven by dissent' and it is said that the Report 'has not impressed ministers'. The *Breadline Britain* logo is inset into the text, featuring a child holding a plate (Fig. 8, taken from the image appearing the previous day).

Page five of the same edition of the *Independent* runs the feature article 'Are we really what we eat?'. The columnist Suzanne Moore argues in the sub-headline that 'It will take guts for those with bloated stomachs to confront the reality of so many empty ones'. She argues that food, or choice of food specifically, is a form of social capital reinforced by well-known chefs such as 'goddess' Nigella Lawson and Delia Smith in 'back-to-basics dominatrix mode', the sub-text being that there really is no excuse for eating badly. The article refers to social exclusion, the widening gap between rich and poor, and our implicit acceptance of living in an increasingly segregated society (making Donald Acheson's findings more 'shocking'). Another Dickensian image is used, this time a close-up of a young, forlorn-looking child eating. The caption underneath observes: 'A child eats breakfast in her bedroom in a Blackpool hostel for homeless families'.

The themes of malnutrition and lack of access to healthy foods are continued in an article on the following page (p. 6), entitled 'Just a single orange in the fridge: the facts of life in a 'food desert''. The experiences of living in a 'food desert' are recounted in interviews with two lone parents, a shop owner and a dietician based on the Kingsmead estate in Hackney, East London. The *Breadline Britain* logo is used again and a picture of a woman with a pushchair

walking along a rundown street strewn with litter accompanies the article (Fig. 9, see chapters seven to nine for focus group participants' responses to this image). The caption underneath

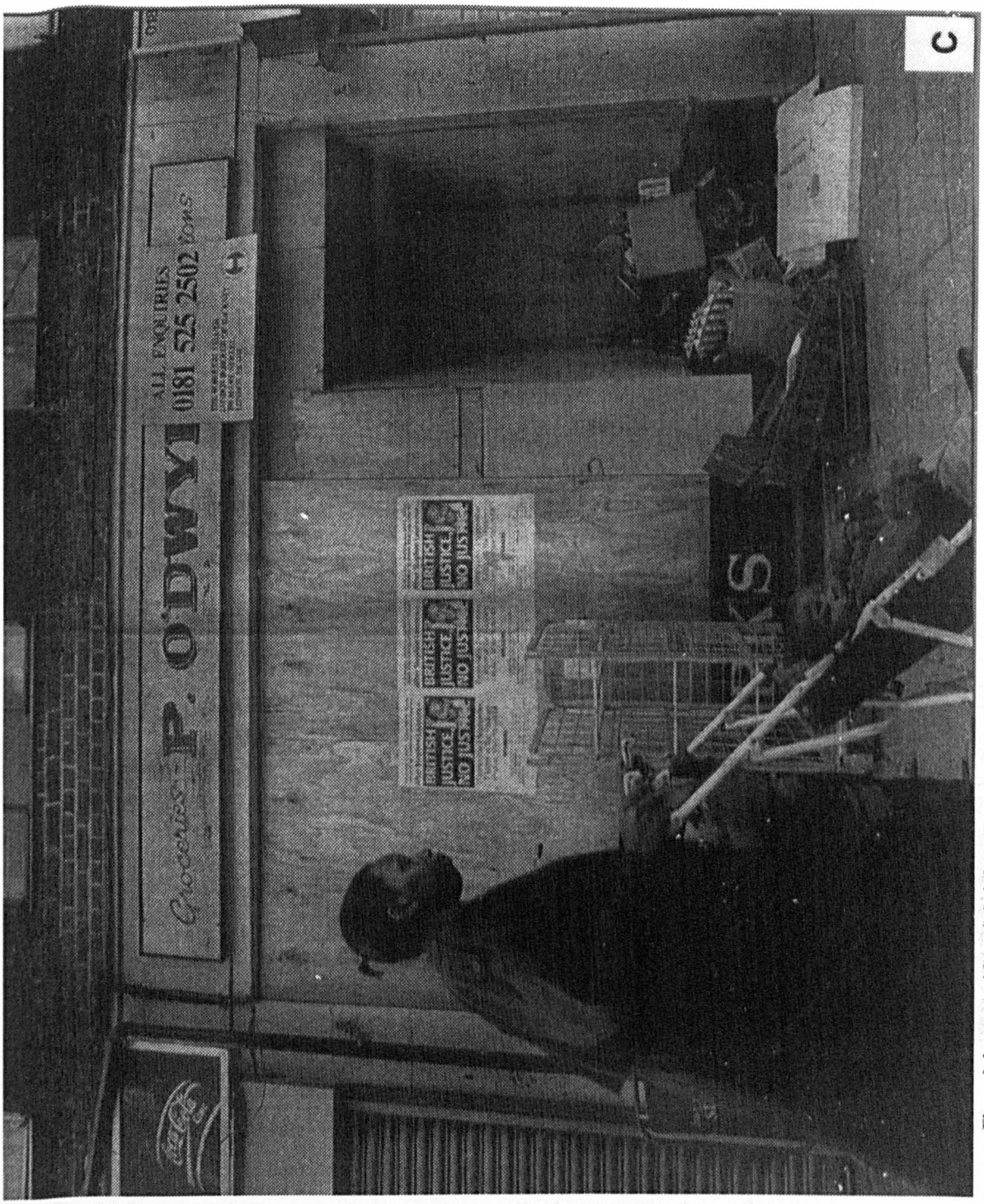


Figure 9 ' woman with pushchair'

states: 'Single mother Salomy Mirembe on the Kingsmead estate in Hackney. Few can afford transport to supermarkets for cheaper fresh fruit and vegetables'.

The editorial 'Social inequalities that impoverish the entire nation' is the last item on the Acheson Report to appear in the *Independent's* 16th October 1998 issue. The government's

'open' approach to reducing inequalities is welcomed in a climate where most of us live in 'woeful ignorance of the depth of poverty in our midst'. The 'thrust' of the employment strategy, New Deal, is supported, as is the government's attempt to address the 'multiple causes of people's unequal life chances' through the Social Exclusion Unit.

The *Breadline Britain* series of articles is continued five days later with the report 'Poor left begging as stores leave town' [*Independent*, 21st October 1998]. The article contrasts Tesco's unveiling of its showpiece supermarket in affluent Kensington, West London with the threatened closure of a Safeway supermarket located on the deprived Wester Hailes housing estate in Edinburgh [Fig. 11]. The 'ethical' stance of supermarket chains Sainsbury and Tesco's is called into question. 'Food deserts' are highlighted again as the massive expansion of superstores in the past decade has coincided with the closure of 50,000 small grocery stores. Images of the threatened stores are juxtaposed with the flagship Tesco store in Kensington.

Figure 11 'supermarkets'

Appearing the next month, the news report 'Experts' 10 steps to health equality' [*Independent*, 12th November 1998] provides more detail of the Acheson Report's recommendations. The measures, which are worked out with a 'complex formula to assess the strength of the evidence, the scale of likely benefit, the fit with government policy and the ease and cost of implementation' are listed in a separate box below the article. Recommendations listed in this article include nicotine gum and patches free on the NHS, fluoridation of drinking water and free school milk.

Thus the articles appearing in the *Independent* prior to the publication of the Acheson Report highlight a number of key issues. The malnutrition experienced by those living in poverty is reported, as are the difficulties faced by those in deprived areas in obtaining a healthy diet. Worrying social trends, such as the increase in child poverty in recent years and growing social inequalities in the UK, are also featured. Comment on the recommendations of the Inquiry are limited, as the articles are written on the basis of restricted pre-publication information. One item, 'The poor of Britain are going hungry, health chief warns' writes of Mr Dobson's determination to 'reduce inequalities, promote social justice and restore fairness'. However, the journalist goes on to speculate: 'Whether these promises turn to dust will depend on the practicality and affordability of Sir Donald's recommendations'.

The item 'Experts' 10 steps to health equality' provides the most detailed information on the Acheson Report's recommendations prior to publication [*Independent*, 12th November 1998, news report]. Dr Richard Smith of the British Medical Journal[44] is reported to have said that the recommendations could be criticised for concentrating on relatively small medical interventions (rather than broader macro-economic changes, such as adjustments to the tax and benefits system), but the Inquiry team felt the evidence was strongest in these areas. The *Independent's* pre-publication coverage supported the anticipated aims of the Acheson Report (on the basis of the information the newspaper had at that time), but the seeds of criticism were already sown as this last item suggests. In addition, the *Independent's* pre-coverage highlighted the plight of those on low incomes as well as the consequences of living in poverty.

Pre-publication coverage appearing in the *Independent* was overwhelmingly sympathetic to the plight of those living on low incomes. Inequalities are highlighted with frequent mention of the fact that those on the lowest incomes are worse off in real terms than in 1979. Images accompanying the coverage depicting child poverty and urban deprivation are a stark contrast to the Green Paper coverage, the aim being presumably to document a social situation in Britain which the *Independent* finds unacceptable. The fact that the Acheson Inquiry made the front page on two days running (Thursday 15th October and Friday 16th October) is testament to how highly this issue was regarded at the time.

[44] One of two medical journals, the other being the *Lancet*, which assessed a range of studies on health inequalities and ranked the measures the expert groups recommended according to their chances of success.

Pre-publication coverage contextualised the current government's approach with the previous Thatcher and Major administrations. To an extent there appeared to be relief that inequalities are once again high on the agenda, but this was tempered by a sense of unease about an Inquiry 'riven by dissent'. At this early stage, the *Independent* describes how the Acheson Report had left Ministers unimpressed. Political unease has been sensed by journalists, as well an early reluctance by the government to take the Inquiry's recommendations on board. The perceived lack of 'new solutions' is described, setting the scene for what was to come, a situation allowing Ministers to publicise existing initiatives at the expense of more radical alternatives (which comes across strongly in the press release accompanying the Acheson Report). The sense of optimism generated by a government committed to reducing inequalities was, at an early stage, already marred by scepticism and mistrust.

4.3.2 Overview of items reporting on the Acheson Inquiry

The majority of items (nine out of ten articles) published during the twenty-eight day sample period were printed on Friday 27th November 1998, the day following the publication of the Acheson Report. No items appeared in the weekend newspapers or the following week. However, a letter was printed in the *Observer* the weekend after, on Sunday 6th December 1998. Poverty is at the forefront of many headlines during the sample period, for example, '39 radical steps to improving health of poor', 'Big benefit rises 'can help poor to bridge health gap'', 'Radical reform urged on killer poverty', and 'Curse of poverty'. One headline makes explicit reference to inequality, the *Independent's* 'Children at risk as health inequality between rich and poor increases'.

In the week of the Acheson Report's publication, political history was made as Tony Blair became the first British Prime Minister to address an Irish Assembly. The long-running story over the fate of General Pinochet continued. Home Secretary Jack Straw requested an extra week to decide whether the General, currently detained in the UK, should be extradited to be tried for war crimes in his native Chile, or brought before the courts in Spain. Another main political story featured the warnings of John Prescott, the Deputy Prime Minister, to train company bosses over poor rail performances and his promises of improvements in rail services. Other prominent stories include the anger and dismay of British Prisoners of War as their compensation claims were rejected by the Tokyo courts. The American actor Michael J. Fox revealed he had Parkinson's disease. Back in Britain, a woman was charged with

abandoning her daughter and causing grievous bodily harm, and the Millennium Dome was previewed for the first time with 400 days to go until the year 2000.

The Acheson Report was picked up exclusively by broadsheet newspapers[45], leaving a number of newspapers with no coverage. None of the tabloids covered the story, nor did two of the broadsheets, the *Daily Telegraph* and the *Herald.* The only Sunday newspaper to feature anything on the Inquiry was the *Observer.*

Within the sample period (26/11/98-23/12/98) ten items were found, consisting of seven news reports, two editorials and one letter (see table 4.1). The *Guardian* had the most extensive coverage with two news reports and an editorial all appearing the day after the Acheson Report's release (see table 4.1, AR5, AR6, AR7). The *Observer*, the *Guardian's* sister Sunday paper, featured one item, a letter appearing ten days after publication (AR10). *The Times* featured two news reports (AR1, AR2), as did the *Scotsman* (AR3, AR4). The *Independent* ran one news report (AR8), and the Acheson Inquiry was one of the subjects included in the paper's editorial (AR9), located in the *Independent Review* section.

4.3.3 Newspaper coverage of the Acheson Report's key recommendations

The extent to which the Acheson Report's key recommendations were covered in the press is examined in this section. Table 4.2 illustrates which items in the sample covered specific recommendations from the Acheson Report. The *Guardian's* 'Radical reform urged on killer poverty' (AR5) and the *Independent's* 'Children at risk as health inequality between rich and poor increases' (AR8) were most comprehensive in their coverage of the Acheson Report's recommendations. Both articles also mention the Report's recommendation that 'all policies likely to have a direct or indirect effect on health should be evaluated in terms of their impact on health inequalities' (Acheson 1998, p. 30). The *Independent's* news

[45] This observation is made on the basis of a sample consisting of UK-wide national daily tabloids and broadsheets (Scottish editions where applicable), and Scottish national newspapers. It is worth noting, however, that variations in coverage did occur between Scottish and English editions. For example, the *Scottish Daily Express* featured no coverage of the Acheson Inquiry, but the *English Daily Express* ran a news report entitled 'Wealthy stay healthy but the poor get more poorly' on 27th November 1998.

Table 4.1: Items reporting on the Acheson Inquiry during the sample period

No.	Date	Format	Paper	Page no.	Page type	Journalist	Journalist's specialism	Headline
AR1	27/11/98	news report	*Times*	11	'Home News'	Ian Murray	unspecified	**39 radical steps to improving health of poor**
AR2	27/11/98	news report	*Times*	11	'Home News'	Ian Murray	Medical Correspondent	**scientist who is stickler for truth**
AR3	27/11/98	news report	*Scotsman*	7	'News'	Cahal Milmo	unspecified	**Big benefit rises 'can help Britain's poor to bridge health gap'**
AR4	27/11/98	news report	*Scotsman*	7	'News'	Andrew Walker	unspecified	**Good food advice falls on deaf ears**
AR5	27/11/98	news report	*Guardian*	3	'News'	Sarah Boseley	Health Correspondent	**Radical reform urged on killer poverty**
AR6	27/11/98	news report	*Guardian*	3	'News'	Martin Wainwright	unspecified	**A diet of chips, beans and reduced food**
AR7	27/11/98	editorial	*Guardian*	25	unspecified	----------	----------	**The health gap**
AR8	27/11/98	news report	*Independent*	6	'Home News'	Jeremy Laurance	Health Editor	**Children at risk as health inequality between rich and poor increases**
AR9	27/11/98	editorial	*Independent Review*	3	'Leaders & Comment'	----------	----------	**A sense of déjà vu – but this time let's act**
AR10	6/12/98	letter	*Observer*	30	unspecified	Jenny Rose (letter writer)	----------	**Curse of poverty**

report goes further, including the Acheson Report's recommendation that more NHS resources should be allocated to disadvantaged areas (Acheson 1998, p. 115). The only other article to report on the NHS recommendations was the *Scotsman's* 'Big benefit rises 'can help Britain's poor to bridge health gap'' (AR3). This lack of reporting could be seen as surprising considering the size of the section of the Acheson Report devoted to the NHS (Acheson 1998, pp. 111-119). Moreover, issues surrounding the health service could arguably be considered to be emotive, and therefore more newsworthy, to the public.

The *Scotsman* (AR3) and *The Times* (AR1) cover the same recommendations concerning benefit and pension increases, priority to maternal and child health (and women of childbearing age), public transport, water fluoridation, improved nutrition (review of the Common Agricultural Policy, reduction of salt in processed foods), and increasing tobacco prices alongside the provision of nicotine replacement therapy on the NHS. In addition, the *Scotsman* refers to the recommendation to encourage walking and cycling (AR3). The other item to refer to recommendations of the Acheson Report is the *Independent Review's* 'A sense of deja vu – but this time let's act' (AR9). The editorial comments on the recommendation to increase benefits for families with young children.

The remaining items in the sample are all comment-based pieces, either editorials, letters or news reports accompanying one of the articles summarising the Acheson Report's main recommendations. For example, below *The Times* article '39 radical steps to improving health of the poor' (AR1), there is a short piece on Sir Donald Acheson entitled 'Scientist who is stickler for truth' (AR2) which summarises his career to date but does not reiterate the Report's recommendations. Similarly, the *Scotsman's* 'Big benefit rises 'can help Britain's poor to bridge health gap'' (AR3) is accompanied by an article looking at the eating habits of those on low incomes, 'Good food advice falls on deaf ears' (AR4).

4.3.4 Media representation of the Acheson Report in press coverage

The representation and interpretation by journalists of the Acheson Report is dealt with in this section, now that the wider media context has been detailed and the extent to which the Inquiry's recommendations were reported has been quantified.

Table 4.2 Newspaper coverage of the Acheson Report's main recommendations

No.	Newspaper	higher benefits/ pensions	Priority of mothers & children (inc. encouraging breast feeding, free school meals & fresh fruit	Affordable, high quality childcare	pre-school education	increase employment & training	improve housing
AR1	*The Times* (news report [a])	√	√			√	√
AR2	*The Times* (news report [b])						
AR3	*Scotsman* (news report [a])	√	√				
AR4	*Scotsman* (news report [b])						
AR5	*Guardian* (news report [a])	√	√	√	√	√	√
AR6	*Guardian* (news report [b])						
AR7	*Guardian* (editorial)						
AR8	*Independent* (news report)	√	√	√	√	√	√
AR9	*Independent Review* (editorial)	√					
AR10	*Observer* (letter)						

Table 4.2 (cont): Newspaper coverage of the Acheson Report's main recommendations

No.	Newspaper	services sensitive/ accessible to ethnic minorities	high quality affordable public transport	Fluoridation of water supply	increase in tobacco prices/ nicotine replacement therapy on NHS	young people: suicide prevention (young men) & sexual health promotion	improved nutrition (inc. reduction in salt in processed food/ review of Common Agricultural Policy)
AR1	*The Times* (news report [a])		√	√	√		√
AR2	*The Times* (news report [b])						
AR3	*Scotsman* (news report [a])		√		√		√
AR4	*Scotsman* (news report [b])						
AR5	*Guardian* (news report [a])	√	√	√	√	√	√
AR6	*Guardian* (news report [b])						
AR7	*Guardian* (editorial)						
AR8	*Independent* (news report)	√	√	√	√	√	√
AR9	*Independent Review* (editorial)						
AR10	*Observer* (letter)						

The majority of articles commenting on the Acheson Report during the sample period are critical of the Inquiry's efforts, although the criticisms made are tempered by the political stance of the newspaper running the article. The right-wing *Times* describes a '39-step cure'[46] relying on a 'wholesale distribution of wealth' (AR1). The Inquiry team, the journalist continues, 'makes no recommendations about how the reforms are to be funded'. Sir Donald's team is described as being composed entirely of scientists 'and did not include an economist so nothing had been costed'. However, the journalist paraphrases Sir Donald as saying: 'early indications [are] that the Government [is] prepared to follow the recommendations and [is] in fact already implementing some of them'. Frank Dobson is described as giving the Report a 'warm welcome'.

The Times journalist notes disparagingly that the 'only recommendation' about taxation in the Report calls for 'swingeing increases in the amount levied on tobacco'. Linking this to the Inquiry, and the view that Income Support fails to provide an adequate standard of living, the Acheson Report is then quoted: 'Not surprisingly, therefore, low income households where the parents smoke are much more likely to be lacking in basic amenities, including food, shoes and coats than non-smoking parents on Income Support' (Acheson 1998, p. 84). '39 radical steps to improving health of poor' (AR1) features the views of Anna Coote (director of the public health programme, King's Fund), who states: 'The real test of the Government's commitment to tackling health inequalities is whether it can now ensure policies and practices are clearly focused, vigorously pursued and effectively co-ordinated'.

In the accompanying article 'Scientist who is stickler for truth' (AR2), Sir Donald is described as being 'relieved' to hear the Inquiry team he envisaged in the early stages was too large as it enabled him to 'dispense with the economist'. The resulting Report 'assumed a world in which financial constraints played no part'. Acheson is quoted as saying: 'I feel I'm putting my reputation on the line in public quite frequently in this job. If my scientific credibility goes, nobody will believe me so I must satisfy myself on the evidence of every issue'. Despite these assertions, *The Times* journalist appears

[46] The '39 steps' phrase originates from a novel of the same name by John Buchan, later turned into a film by Alfred Hitchcock. The phrase is likely to have originated from the press conference for the Acheson Report as it is referred to by other journalists, yet does not appear in either the Report itself or the accompanying press release.

never to take the Acheson Report too seriously due to the perceived lack of an economic backbone. Alongside *The Times* items there is an image of a baby, held aloft by a mother figure (Fig. 6. See chapters seven to nine for focus group participants' reactions to this image). The baby looks as though it is yawning rather than crying,and appears well nourished.

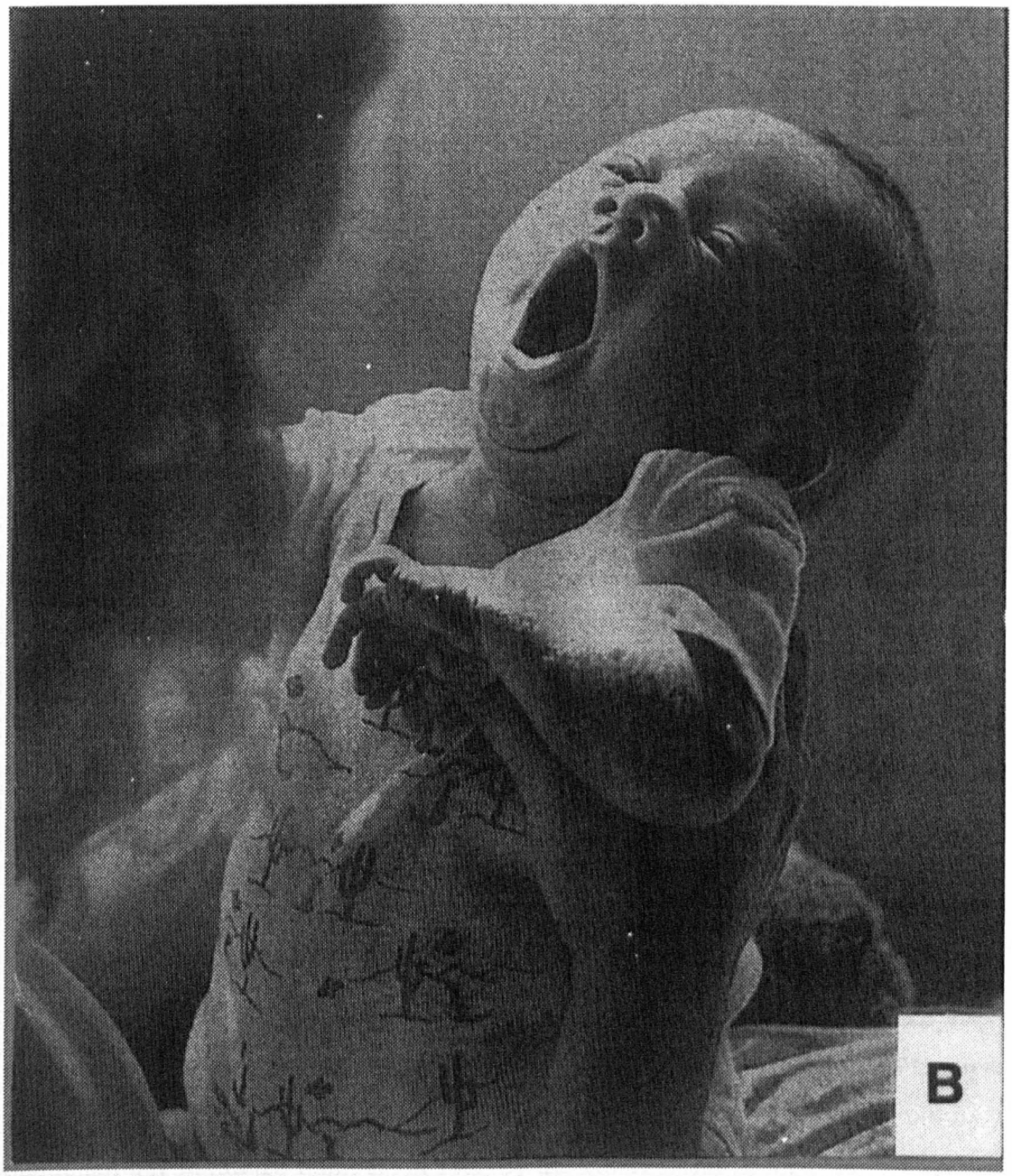


Figure 6 ' infant '

On the matter of cost, the *Scotsman* reports in more neutral terms that 'Decisions on affordability were a matter for the Government' in 'Big benefit rises 'can help Britain's poor to bridge health gap' (AR3). Positive comments are included from

Rodney Bickerstaff (general secretary of the public service union, Unison), who describes the Report as 'authoritative and far-reaching... setting out a progressive and positive agenda for tackling poverty and ill health'. However, the accompanying article, entitled 'Good food advice falls on deaf ears' (AR4) suggests that people ignore healthy eating messages as opposed to just not being able to afford, or gain access to, nutritious food. The journalist reports that 'People living in some of Scotland's poorest housing estates have little knowledge about the health risks associated with their eating habits'.

The *Guardian's* description of the Acheson Report as a 'radical blueprint for social change' (AR5) is dampened by a number of criticisms and reservations. Although, the journalist writes, the Report 'urges' that benefits should be increased, it 'stops short of recommending higher taxes for the rich to close the wealth and health gap'. It is observed that the Acheson Report 'also attracted criticism for not costing its proposals'. The scope of the Report, the 'Acheson vision', is described as 'huge' and the recommendations as 'inevitably... costly'. The sources used in 'Radical reform urged on killer poverty' (AR5) view the Acheson Report as confirmation of what is already known. Anna Coote (also quoted in *The Times*) states that the Inquiry has provided 'incontrovertible evidence that people pay the price of poverty with their health and their lives'. The *Guardian* also features quotes from the Child Poverty Action Group (which describes the Report as 'a wake-up call to the Government and to all politicians. It is a scandal that poor parents go without food so that their children can eat'), and James Appleyard, spokesperson for the BMA (who comments that the government 'must have known that a radical agenda to tackle poverty was the only logical outcome of such a review').

Later in the *Guardian* item, the Acheson Inquiry is put in context, coming '18 years after the ground-breaking Black Report, commissioned by the Labour government which then fell'. The Black Report is described as being 'famously slipped out on a public holiday in limited numbers in 1980 by the Tories trying to bury the link spelled out by Sir Douglas Black between poverty and ill-health'. Yet since that time, the journalist continues, 'Britain has steadily become an even more unequal society. And as the gap between the wealth at the top and the bottom of the ladder has widened, so the disparities in health have become more marked'. The *Guardian* journalist reports

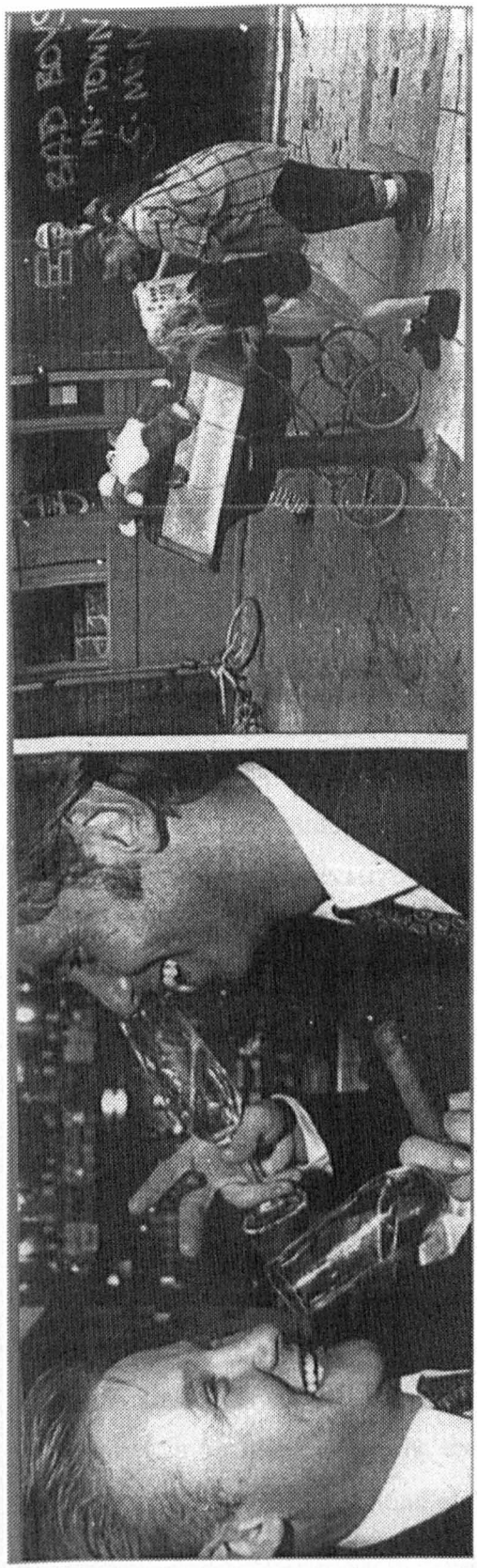


Figure 10

further that Professor Hilary Graham, Director of the Economic and Social Research Council's Health Variations Programme, had suggested at the launch of the Acheson Report that benefits might need to be increased by 25 per cent.

Visually the most striking in its use of images, the *Guardian* uses two contrasting pictures (Fig. 10. See chapter seven to nine for focus group participants' reactions to these images). One depicts two businessmen laughing over glasses of champagne, the other shows a woman pushing a pram full of miscellaneous items. She is helped along by a child. The area is run down and there is graffiti scrawled on a wall, 'Bad boys in town'. Underneath the pictures the caption states: 'The increasing gap between rich and poor means disparities in health have become more marked. Frank Dobson said yesterday the Acheson report was an ambitious attempt to tackle the problem'. Alongside the article, five graphs illustrate disparities in disposable income and between occupational classes in terms of mortality rates from all causes, lung cancer and coronary heart disease.

The *Guardian* also features lay experiences of living on a low income in an item entitled 'A diet of chips, beans and Reduced food' (AR6). Angela Hankey, from a 'bleak' council estate in Bury, Greater Manchester, 'bears out much of the reasoning in Sir Donald Acheson's report'. The reduction in her benefits has 'affected her health

and possibly her family's'. The journalist describes how Ms Hankey still feels the 'humiliation of the medicals she had to take' to have her benefits reinstated. Her three children all had low birth weights, 'another phenomenon noted by Sir Donald'. Her daughter is described as showing 'signs of being affected by the stress' and possibly the 'dietary shortfalls which alarm Sir Donald'. On the subject of the government, she says: 'I feel so angry about [the government] suggesting single women are scroungers and I wrote to Tony Blair. I told him I've got a job – it's called Being a Mother, and it's a lot more tiring and hard work than loads of 'real' jobs'. On the Acheson Report's recommendation that benefits should be increased, Ms Hankey remarks: 'I'm glad he's saying they should change the tax system and put more money into benefits. But will they? Will they heck'.

The bittersweet coverage of the Acheson Report is also reflected in the *Guardian's* editorial, 'The health gap', published on the same day (AR7). The editorial argues that Labour has responded 'with extreme caution' to the inequalities issue since taking office. Yet, in opposition 'No one shouted louder... about Britain's widening inequalities'. The Conservatives are described, as they are in the *Guardian's* news report (AR5), as the party who 'tried unsuccessfully to bury the Black Report'. The then Tory government, under the leadership of Margaret Thatcher, 'not only refused to tackle [inequalities] but would not even set long-term targets to reduce them. Furthermore, as time has passed 'What was already serious when Black was set up in 1977, has become even more critical in 1998'. The editorial views the initial actions of the Labour government as 'promising'. The appointment of Britain's first public health minister, and setting up of the Acheson Inquiry are praised. However, both initiatives were 'subjected to tight constraints'. The editorial points out that the Inquiry team was told to work within the broad framework of the government's financial strategy, as well as receiving instruction not to set targets to reduce inequalities in health. Meanwhile, the economist was 'bounc[ed]' off the committee. The editorial views these actions as 'absurd'. Criticism is also directed towards the government's decision to reduce the previous 27 (Conservative) public health targets to four, in addition to 'duck[ing]' out of setting national targets for reducing health inequalities.

Widening poverty is, the *Guardian* editorial argues, one of the 'root causes of our widening health inequalities'. But there are also wider causes such as 'unemployment, bad housing, poor transport, inadequate food, polluted environment [and] unhealthy lifestyles'. As the causes are so far-reaching, the editorial praises the Acheson Report for setting out proposals in eleven separate areas. The article refers to those who cannot work, a group for which - in the writer's view – little has been done whilst working benefits have improved. While Sir Donald, the editorial declares, acknowledges those unable to work, he does not 'insist on giving them first priority because of the ministerial ban on priorities'. Concluding, the editorial opines that Acheson 'should have ignored the injunction' given the furore surrounding the cover up of the Black Report: 'Ministers would have never dared – after the fuss over the suppression of Black – to censor his supposedly independent report'.

The *Independent* describes the Acheson Report as a 'socialist style programme for redistributing resources from the rich to the less well off' in 'Children at risk as health inequality between rich and poor increases' (AR8). Similar to previous observations, the *Independent* journalist writes that the Report was 'immediately criticised for producing a set of vague, uncosted recommendations which ministers may use as a shopping list, selecting for implementation those that are cheap and simple and suit their political goals'. Like the *Guardian*, the dismissal of the Black Report is recounted:

> '...the eminent physician, Sir Douglas Black, found wide differences in death rates between the rich and poor and recommended measures costing £2bn to address them. The report was dismissed by the then Conservative social services secretary, Patrick Jenkin.'

This version of events is used to justify Sir Donald's actions, as the journalist describes Acheson's determination 'that his inquiry, which found the health gap has widened since the Black report, would avoid the same fate and produced no costings for his recommendations'. The *Independent* accompanies this item with the bleak image of children playing around a burnt-out car on a deprived estate [Fig. 7].

The fact that Sir Donald has not put 'price tags' on his recommendations is perceived by the *Independent's* editorial, 'A sense of déjà vu – but this time let's act', as

Figure 7 ' estate '

precisely the reason why the Report will be overlooked rather than acted upon (AR9). Such an approach 'allows the Government the easy way out, which is to welcome the report and point to all the things that are already being done to tackle social exclusion'. The article points to the uncanny similarity between the Black and Acheson Reports. Both feature an 'eminent doctor' recommending rises in child benefit, only Sir Douglas Black 'urged a specific figure for child benefit'. The editorial recounts how 'one member of Sir Donald's committee [Hilary Graham] suggested... that benefits for families with children needed to rise by a quarter'. Such a comment 'should force the Government to engage with the argument'. The government's strategy of getting lone parents and the unemployed into work is, the editorial views, 'the right way to deal with benefit-dependency'. Yet, echoing the *Guardian* editorial's words (AR7), 'there are other groups for whom the labour market cannot be the ladder out of poverty: poor pensioners and the disabled'. The government, the editorial reasons, has 'yet to define what "welfare reform" means for them, and how it will strike the balance between means-testing and universality'. Within this climate, the writer concludes, 'If Sir Donald succeeds in prompting a

specific response from the Government in respect of these groups, his 16 months' work will have been well worthwhile'.

The only letter to appear in the sample period 'Curse of poverty' (AR10) conveys the struggle of a lone parent trying to provide an adequate standard of living for herself and her three sons. She writes: 'to buoy us up, I constantly (and exasperatingly) insist that we're not really poor, compared with the children on rubbish dumps in Central America, or the people who struggled in post-war Britain', but this strategy 'has become an empty consolation'. Despite the letter-writer's admission that 'resourcefulness is now my job' (growing vegetables, shopping late in supermarkets for reduced items, scouring charity shops and car boot sales), she still struggles to make ends meet, and feels her family is permanently excluded from mainstream society.

4.4 How was the inequalities debate presented in the press?

The press sought the attention of its audience by using well-known cultural references in their headlines, such as '39 radical steps to improving health of poor', or using strong, eye-catching, or emotive language in headlines (e.g. 'Radical reform urged on killer poverty'). A distancing of a newspaper from a particular viewpoint can be inferred from the utilisation of quotes in the headlines, emphasising that the view of the Report is not necessarily that of the journalist/newspaper i.e. The *Scotsman's* 'Big benefit rises 'can help Britain's poor to bridge health gap''.

The right-of-centre press appears to view the Acheson Report as a plan with little basis in reality. The impact of inequalities in health is downplayed whilst the lack of financial planning is highlighted, as well as what is perceived as a 'massive redistribution of wealth'. *The Times* veers between admiration for a well-respected scientist and dismissiveness over an Inquiry with no financial constraints imposed.

The *Scotsman* portrays the Acheson Inquiry as a welcome agenda with a broad coalition of support from government, however the undertones in the *Scotsman's* coverage aren't quite so positive. The 'health gap' is highlighted but at a cost of 'Big benefit rises'. The Inquiry's recommendations regarding tobacco are emphasised,

framing the debate in terms of health behaviours. The experience of those living on low incomes is somewhat ghettoised in the *Scotsman* coverage, epitomised with the headline 'Good food advice falls on deaf ears'. The fact that the Inquiry applies only to England and Wales leaves the *Scotsman* undeterred. No mention is made of this and the discourse of 'Scotland's appalling health record' is aired once more.

The *Scotsman's* format of a lead article accompanied by an item focusing on the food choices of those living on low incomes is similar to that found in the *Guardian* newspaper. However, the similarity ends there as the *Guardian* takes a wholly more supportive and sympathetic approach. This is reflected most obviously in the headlines 'Radical reform urged on killer poverty' (AR5) (with the sub-headline 'How policies can change and save lives in our unfair society'). What is described as a 'radical uncosted plan' in *The Times* is interpreted more optimistically and reverentially in the *Guardian* as a 'radical blueprint for social change'.

Rather than the perception of inequality in society as an abstract yet inevitable problem as occurs in more right-wing sections of the press, inequalities are presented as a moral issue which society has a responsibility to respond to in newspapers such as the *Guardian* and *Independent.* Inequalities are forcefully depicted in the *Guardian's* coverage, with the use of images conveying inequality – the juxtaposition of affluent men drinking champagne beside a scene of urban deprivation – as well as graphics illustrating the stark differences in disposable income, income inequality and inequalities in death rates. Lay views are also included to reinforce the hardship of living on current levels of benefit and consequently the difficulties of trying to live healthily. The *Independent* and *Guardian* use editorial space for comment on the Acheson Report (with the *Independent* also devoting many column inches prior to the Report's launch), whereas the *Scotsman* and *The Times* cover the Acheson Report in a news report format only. The *Daily Telegraph* did not cover the publication of the Acheson Report; nor did any of the tabloids.

The support given to the Acheson Inquiry in left-of-centre sections of the press does not readily translate into praise for government action. The government's spotlight on inequality does not alleviate scepticism over perceived political posturing. The *Guardian* in particular is critical of the way in which the government is choosing to

tackle the issue although it supports the thrust of the Acheson Inquiry and the monumental shift in priorities in the context of the previous Conservative administration.

Continuing the tone of its pre-publication coverage, the *Independent* is both welcoming and sceptical of the Acheson Inquiry. However, the biggest dose of scepticism is reserved for the government's handling of the numerous recommendations made in the Report. Inequality is once again at the forefront of coverage, for example, with the headline 'Children at risk as health inequality between rich and poor increases' and image of children playing around a burnt out car in a deprived housing estate [Fig. 7]. Yet the government has been given the easy option according to the *Independent*, a state of affairs the newspaper had long-since predicted, as however far reaching Sir Donald's recommendations are, they have been delivered 'without price tags'.

Whilst the more right-wing press have presented the inequalities debate as essentially an abstract problem with little bearing on reality, newspapers to the left of the political spectrum have presented a sympathetic portrait of what it means to be living on a low income in contemporary Britain. The use of images, strong headlines and lay views have reinforced this. A letter appearing in the *Observer* in which a mother details her experiences of living in poverty sums up this viewpoint. The writer expresses her frustration stating how 'poverty marginalises, stigmatises and ultimately paralyses us as a family'. Sadly, such views appear only in the left-of-centre broadsheet press, leaving a wide gulf in which the experience of many remains underrepresented. This is particularly the case with the distinct lack of coverage of the Acheson Inquiry in the tabloids – a situation which arguably leaves the vast majority of Britain's readership unaware of the inequalities debate.

Chapter Five

The Scottish White Paper: Media coverage and representation of public health policy

5.1 Introduction

Towards a Healthier Scotland, the Scottish White Paper, was published on the 17th February 1999 (Scottish Office Department of Health 1999). A brief overview of the document is provided in Appendix D. Twelve months had elapsed since the launch of *Working Together for a Healthier Scotland*, Scotland's consultative Green Paper (Scottish Office Department of Health 1998). In the White Paper, inequalities in health remained high on the agenda (see below); however their impact was arguably more forceful as their emphasis in the White Paper document is carried over to the accompanying press release. The Scottish White Paper's demonstration projects - 'Starting Well', 'Healthy Respect', 'The Heart of Scotland' and 'The Cancer Challenge' – have the dual aim of achieving the government's health targets and reducing inequalities. Stronger emphasis was placed on child health as a result of the consultation period following the publication of the Scottish Green Paper.

5.2 Towards a Healthier Scotland: Reference to and emphasis on inequalities in health

This section examines how prominently inequalities in health feature throughout the Scottish White Paper, and goes on to ask: Has the priority given to inequalities in the Green Paper proposals translated across into White Paper policy?

Inequalities are referred to throughout the Scottish White Paper, and inequalities are referred to explicitly on many occasions in the Scottish White Paper (30 times) and related to a broad cross-section of policies, rather than being confined to one section of the document. The prominence given to health inequalities is apparent from the beginning of the document. Donald Dewar, Secretary of State for Scotland, writes in the first paragraph of the Foreword that: 'Being well is part of the pattern of opportunity and achievement we want for Scotland, as we start a new century. Being

ill makes inequalities between people and groups in Scotland worse, and harder to bear' [p. v].

Similarly chapter one, paragraph one describes how the consultation process facilitated by the Scottish Green Paper 'revealed how deeply people care about improving health in Scotland...and agreement that we should no longer tolerate inequalities in health' [1][47]. Moreover, the Acheson Report (Acheson 1998) is referred to in chapter one (one of three occasions in the Scottish White Paper). The Acheson Inquiry is perceived as being responsible for emphasising the 'wide gap between rich and poor in England', and has 'helped inform' the Scottish White Paper [4]. Chapter two states how 'Hope is stronger when social and economic prospects are bright. Inequality breeds despondency and pessimism, and health suffers' [10]. The Scottish White Paper is willing to state that inequalities themselves can have an adverse effect on health.

The strong rhetoric is not confined to ideological discussion. Inequalities are mentioned alongside many initiatives, as well as being placed at the core of government policy. For example, the three Action Levels have an 'overarching aim' to tackle inequalities [12]. For each of the 'Headline Targets', the Scottish White Paper describes how the inequalities gap will be 'regularly measured to assess progress in reducing the disparity in health status between different socio-economic groups' [16]. Chapter three closes – under the section 'Action: Life Circumstances' – stating that 'Together, pursued strongly, all these initiatives will reduce inequalities and help to change lives in ways that are conducive to good health' [35]. Inequalities are also mentioned in relation to smoking [36], and child health [49]. The role of government in tackling inequalities is discussed in chapter six [76], as is the role of the NHS [78, 84-87] and the role of local government [90]. A key objective of the government's Health Demonstration Projects is to reduce inequalities in health [111,113]. Inequalities are mentioned on four occasions in chapter eight, 'Research, Evaluation, Targets and Monitoring [118,121-122]. The success of policies, and their success in reducing inequalities are to be quantified with Health Impact Assessments [98].

[47] Numbers in brackets indicate paragraphs from the Scottish White Paper *Towards a Healthier Scotland.*

By the conclusion, the document states what is already now clear: 'The White Paper refers repeatedly to the overriding importance of tackling health inequality and describes a comprehensive and co-ordinated use of health resources, relevant agencies and a raft of social and economic measures which will sustain the drive for better health for all our people'.

5.2.1 2010 – Towards a Healthier Scotland[48], *the Scottish White Paper press release: Summary and reference to health inequalities*

The Scottish White Paper's press release (855 words in length) gives prominence to the health of children and young people, cancer, and CHD. It is no surprise that these areas are emphasised, given the priority afforded to them within the White Paper itself. The press release opens by stating: 'A new drive to improve the health and well-being of Scotland's one million children and young people by the year 2010, tops Government priorities for a healthier nation launched today'. The press release then bullet points other key aspects of the government's health policy, namely the prevention and detection of cancer and CHD, and the 'Headline Targets' to assess the impact of these measures by 2010.

A statement from Sam Galbraith (then Minister for Health and the Arts) follows. Cancer is linked to smoking and heart disease to 'poor diet and inactivity'. However, the next sentence states that 'Too many lives [are] scarred by the unmistakable stamp of poverty and deprivation.' The Scottish government's 'multi-billion pound' investments in childcare and family centres, community schools, housing partnerships and the Welfare to Work initiative are compared in their capacity to effect change in the 21st Century to 'measures to improve public sanitation and slum housing' in the 20th Century'. Furthermore, the press release describes the need for a 'truly national commitment from public, private, voluntary and community bodies and – as individuals – from all of us lucky enough to be free from the constraints of poverty'.

A sizeable proportion of the press release is devoted to summaries of the government's demonstration projects and the money to be invested in them. The

[48] the press release can be located on the Department of Health website at: http://www.coi.gov.uk/coi/depts/GDH/GDH.html

fifteen million pounds to be invested in the demonstration projects is mentioned on two occasions in two consecutive paragraphs. The projects are described in the press release as 'cutting edge...beacons of best-practice and innovation'. Details of 'Starting Well', 'Healthy Respect', 'Cancer Challenge' and 'Heart of Scotland' also allow an opportunity for the press release to list the Scottish White Paper's 'headline targets' for reducing rates of dental disease, smoking during pregnancy, teenage pregnancy, cancer, smoking and coronary heart disease.

Inequalities are referred to on two occasions in the press release. A 'key measure' of the new public health strategy is '...an all-encompassing attack on the health inequalities between Scotland's well-off and deprived communities'. The demonstration projects are described as all having a 'specific focus on tackling inequalities'. Whereas in the press release for the Scottish Green Paper, a reference to inequalities is conspicuously absent, the Scottish White Paper press release redresses the balance. The reduction of inequalities in health is given prominence, both in terms of an overarching aim but also in relation to specific initiatives.

5.2.2 Summary

Inequalities in health remain high on the agenda, and permeate right through the Scottish White Paper. This is further reflected in the accompanying press release, where an 'all-encompassing attack' on health inequalities is promised (unlike the Green Paper press release where inequalities in health are not referred to at all, despite their high priority in the Green Paper document itself). The Scottish White Paper has resisted downgrading the inequalities issue, an observation which is strengthened by the strong rhetoric employed by Sam Galbraith.

5.3 Coverage and representation of the Scottish White Paper in the press

This section begins by giving a summary of the other news stories competing for column inches at the time of the Scottish White Paper launch. Level of coverage of the government's various public health policies is then quantified, before the coverage of the document is studied in terms of its presentation by journalists.

5.3.1 The wider context

The White Paper was published in a week where a group of Kurds staged a siege of the Greek Embassy in London in protest against the kidnapping of their leader. The ensuing world-wide protests over his capture were also prominent in the headlines. It was also a week in which two companies were fined over their mismanagement of genetically modified crops. The mounting concern over GM foods put the government under further pressure to re-think its policy on GM crops. Disappointment for British holidaymakers was also reported as the European Parliament rejected an appeal against the ban of duty free goods. The imminent appointment of Kevin Keagan as England Manager by the Football Association prompted intense media speculation.

Stories in the Scottish media included growing criticism over government plans to close two coastguard stations which opponents claimed would put lives at risk. Arctic weather conditions in the North-east of Scotland also featured prominently, as did the Duty Free story with the news of the expected loss of 600 Scottish jobs. However, job creation was the focus of a story about the expansion of the Hong Kong and Shanghai Bank into Scotland, boosting the country's profile as a strong finance centre.

5.3.2 Overview of items reporting on the Scottish White Paper

All items reporting on the Scottish White Paper in the sample period were published on Thursday 18th February 1999, the day after its launch. No coverage appeared in the following weekend's newspapers. Fourteen items were found, eight running in broadsheet publications, six in the tabloids. Many headlines accompanying items reflect the trend in reporting, which was to concentrate on specific policy areas. As a result, editors interpreted government policy with headlines such as 'Fight to stub out ill health', 'Screen test a life saver', 'Curing the smoking habit on the NHS', 'Milk to contain fluoride', 'A pinch of salt to put back sparkle in children's smiles' and 'More money on table for under-age sex clinics'. Two headlines refer to government targets, or Scotland's 'big three', cancer, heart disease and stroke; 'Labour takes on killers' and 'Heartening attack on big killers'. One headline alludes to Scotland's disappointing health record, 'Government's cure for sick Scots'. None of the Scottish

White Paper headlines during the sample period make reference to inequalities in health.

The Scottish White Paper featured in twelve news reports and two editorials within the sample period (see table 5.1). The *Herald* newspaper reported on the Scottish White Paper most extensively with six news reports and an editorial (SWP1-7), whereas the *Scotsman* featured only one news report (SWP8). Of the tabloid publications, the *Daily Mail* ran two news reports (SWP9, SWP10), and the *Daily Record* featured one (SWP11). Two 'red top' tabloids, the *Mirror* and the *Sun*, featured Scottish White Paper stories (SWP12-14).

5.3.3 Newspaper coverage of the Scottish White Paper's key policies

The extent to which the Scottish White Paper's key policies were reported is quantified in this section. Table 5.2 illustrates which items covered the Scottish White Paper's key policies (the shaded areas of the table indicate that an item reported on a specific policy area). The *Herald's* leading article, 'Fight to stub out ill health,' (SWP1) reports on the broadest range of initiatives (despite the smoking-oriented headline), eight of which are shown in table 5.2. The other *Herald* news reports running alongside (SWP2-6) largely focus on specific policy areas, such as colo-rectal screening (SWP2) and child/adolescent health (SWP5). Scotland's other national daily broadsheet newspaper, the *Scotsman*, reported on nine key policy areas (SWP8) in its sole article on the Scottish White Paper.

Turning to the Scottish tabloids, the *Daily Mail* appeared to focus, and at times sensationalise, specific government initiatives. 'A pinch of salt to put back sparkle into children's smiles' (SWP9) reports on the proposed addition of fluoride to water supplies, salt or milk. The provocatively titled article 'More money on table for under-age sex clinics' (SWP10) focuses attention on initiatives aimed at improving teenage sexual health, including the reduction of teenage pregnancies. The news report also briefly details the £15 million made available in 'four areas of public health', the government's demonstration projects.

The *Daily Record* summarises seven of the White Paper's policy areas in the news

report 'We'll improve health from 'womb to grave'' (SWP11). The *Mirror* reports on five initiatives in the item 'Labour takes on killers' (SWP12). The accompanying editorial, 'Heartening attack on big killers', refers to a further three (SWP13). The *Sun* focuses solely on the proposal to add fluoride either to the water supply or milk (SWP14).

Comparing the coverage of the Scottish White Paper's policy areas to coverage of the Scottish Green Paper's proposals, it is apparent that reporting of certain initiatives has decreased or been overlooked (see table 5.2). Healthy Living Centres are not reported, although this is hardly surprising as the prominence given to them in the Scottish Green Paper's press release does not translate across to the press release accompanying the Scottish White Paper. Furthermore, reporting of the Scottish White Paper's demonstration projects overshadowed initiatives or proposals highlighted in the Scottish Green Paper coverage. This was the case particularly with proposals concerning the creation of a COSLA health promotion post and the appointment of directors of public health to local authority committees. However, the demonstration projects could arguably be perceived by journalists as more newsworthy, tangible and easily digestible for their readership. Similarly, the emphasis on inter-government responsibility and partnerships with local government has weakened, but again, such proposals are far less tangible than a snappily titled demonstration project. There appears to be no strong correlation between the political stance of a particular newspaper and the policy areas covered (see table 5.2).

5.3.4 Media representation of the Scottish White Paper in press coverage

Now that the wider media context has been outlined and level of coverage of particular aspects of Scottish public health policy has been assessed, it is possible to look at how the document was received and interpreted by journalists.

Political sources are given prominence in the reporting of the Scottish White Paper. With impending Scottish Parliamentary elections, passionate political input is hardly surprising. David McLetchie, leader of the Scottish Conservatives, features in the *Scotsman*, *Herald* and *Daily Record*. Kay Ullrich, health spokesperson for the SNP, is

Table 5.1: Items reporting on the Scottish White Paper during the sample period

No.	Date	Format	Paper	Page no.	Page type	Journalist	Journalist's specialism	Headline
SWP 1	18/2/99	news report [a]	*Herald*	1 (front) & 8	unspecified	Alan MacDermid	Medical Correspondent	**Fight to stub out ill health**
SWP 2	18/2/99	news report [b]	*Herald*	8	'News Focus'	Alan MacDermid	Medical Correspondent	**Screen test a life saver**
SWP 3	18/2/99	news report [c]	*Herald*	8	'News Focus'	Alan MacDermid	Medical Correspondent	**Curing the smoking habit on the NHS**
SWP 4	18/2/99	news report [d]	*Herald*	8	'News Focus'	Valerie Hannah	----------	**Poverty**
SWP 5	18/2/99	news report [e]	*Herald*	8	'News Focus'	Valerie Hannah	----------	**Young people**
SWP 6	18/2/99	news report [f]	*Herald*	8	'News Focus'	Valerie Hannah	----------	**Alcohol**
SWP 7	18/2/99	editorial	*Herald*	18	'Opinion'	----------	----------	**Health of the nation**
SWP 8	18/2/99	news report	*Scotsman*	5	'News'	Jennifer Trueland	Health Correspondent	**Government's cure for sick Scots**
SWP 9	18/2/99	news report [a]	*Daily Mail*	6	unspecified	'Daily Mail Reporter'	----------	**A pinch of salt to put back sparkle in children's smiles**
SWP 10	18/2/99	news report [b]	*Daily Mail*	6	unspecified	Hamish MacDonell	Scottish Political Editor	**More money on table for under-age sex clinics**
SWP 11	18/2/99	news report	*Daily Record*	9	unspecified	Jim McLean	----------	**We'll improve health from 'womb to grave'**
SWP 12	18/2/99	news report	*Mirror*	2	unspecified	Heather Ramsay	unspecified	**Labour takes on killers**
SWP 13	18/2/99	editorial	*Mirror*	6	unspecified	----------	----------	**Heartening attack on big killers**
SWP 14	18/2/99	news report	*Sun*	2	unspecified	Andrew Nicoll	Scottish Political Reporter	**Milk to contain fluoride**

Table 5.2: Newspaper coverage of the Scottish White Paper's key policy areas

No.	Newspaper	cancer/ CHD targets	'Starting Well'/ child health	'Healthy Respect'/ sexual health/ teen pregnancies	'Cancer Challenge'/ colo-rectal screening	'Heart of Scotland'/ coronary heart disease	fluoride in water supply/ milk/ salt	smoking: nicotine replacement therapy/ advertising bans/ health campaigns	alcohol: prevention/ & treatment/ underage drinking
SWP1	*Herald* (news report [a])	√	√	√	√		√	√	√
SWP2	*Herald* (news report [b])				√				
SWP3	*Herald* (news report [c])							√	
SWP4	*Herald* (news report [d])		√						
SWP5	*Herald* (news report [e])		√	√					
SWP6	*Herald* (news report [f])								√
SWP7	*Herald* (editorial)				√			√	
SWP8	*Scotsman* (news report)	√	√	√	√	√	√	√	
SWP9	*Daily Mail* (news report [a])						√		
SWP10	*Daily Mail* (news report [b])		√	√	√	√			
SWP11	*Daily Record* (news report)	√	√	√			√	√	√
SWP12	*Mirror* (news report)	√	√		√				
SWP13	*Mirror* (editorial)	√						√	
SWP14	*Sun* (news report)						√		

Table 5.2 (cont): Newspaper coverage of the Scottish White Paper's key policy areas

No.	Newspaper	diet: Scottish Community Diet Project	exercise: National Physical Activity Strategy	drug misuse	Social inclusion/ New Deal for communities	Welfare to Work	Housing Partnerships	Co-ordination across Government Departments
SWP1	*Herald* (news report [a])	√	√	√				
SWP2	*Herald* (news report [b])							
SWP3	*Herald* (news report [c])							
SWP4	*Herald* (news report [d])				√			
SWP5	*Herald* (news report [e])							
SWP6	*Herald* (news report [f])	√	√					
SWP7	*Herald* (editorial)							√
SWP8	*Scotsman* (news report)	√	√					
SWP9	*Daily Mail* (news report [a])							
SWP10	*Daily Mail* (news report [b])							
SWP11	*Daily Record* (news report)	√						
SWP12	*Mirror* (news report)					√	√	
SWP13	*Mirror* (editorial)	√	√					
SWP14	*Sun* (news report)							

quoted in the *Mirror*, *Herald* and *Scotsman*. Margaret Smith, health spokesperson for the Scottish Liberal Democrats, appears in the *Scotsman*. All three focus their criticisms at the Labour Party rather than the government's newly unveiled health policy.

Both the *Herald* and *Scotsman* comment on government targets. The *Herald* item entitled 'Alcohol' (SWP6) opens by noting: 'Alcohol misuse continues to be such a problem in Scotland that the Government expects to reduce it by only 2% for men and 1% for women in the next ten years'. Commenting on previous targets to be achieved by the year 2000, the news report continues: '...a steady increase in drinking means that the year 2000 targets – a 20% reduction in the number of adults exceeding weekly limits – will not be met'. On a more positive note, the *Scotsman* observes that Scotland is 'on course' to achieve targets set for cutting premature deaths from heart disease and cancer (SWP8). However, the *Scotsman* also notes that 'targets on alcohol misuse and dental decay among children will not be met'.

Scotland's poor health record is referred to in three newspapers. The *Scotsman* (SWP8) frames the new government health targets in the context of the nation's reputation as the 'sick man of Europe'. Sam Galbraith is quoted as saying: 'I am sick and tired of Scots always being labelled the sick man of Europe. We're better than that'. The *Herald* describes the Scots as the 'sick men and women of the developed world' in its editorial (SWP7). The *Sun* refers to Scotland's 'dismal' health record in the news report 'Milk to contain fluoride' (SWP14).

Media reaction to the Scottish White Paper was framed in strong rhetoric, in part due to the nation's perceived unenviable health record. The *Herald's* editorial (SWP7) views the government's strategy as somewhat 'Jesuitical'. However, such labelling is not meant in a critical manner as the editorial believes there is merit in the Jesuit maxim, 'give me a boy until he is seven and he is mine for life'. The editorial welcomes the Scottish White Paper's acknowledgement of the role that life circumstances (i.e. a job, good housing, and so on) play in maintaining good health. The sub-heading states that 'Agencies face a daunting challenge', however, the editorial adds that the Scottish White Paper: '...wisely recognises all the agencies involved, from the police and the social services to the health boards and the local

authorities, must work in tandem if the targets for a generation of fitter Scots are to be met'.

Further praise is reserved for the provision of nicotine replacement therapy on the NHS and the introduction of colo-rectal screening. However, the Scottish White Paper does not escape without criticism. The *Herald* editorial states that: 'Given the numbers involved in underage drinking and drug misuse, some new initiatives would have been welcome.' Instead, the strategy is presented as a 'mix of new and old initiatives as well as a mix of old and new money'. Returning to the pivotal role of life circumstances in determining health chances, the editorial concludes that 'so much of the health issue is out of the hands of the health professionals.'

From measured responses to a more sensationalist approach, the *Daily Mail* interprets the government's sexual health strategy as a scheme 'to make it easier for children to get contraceptives'. The news report, 'More money on table for under-age sex clinics' (SWP10) describes Mr Galbraith as 'unrepentant' despite family groups and churches 'fiercely condemn[ing]' the government's strategy which 'could see clinics handing out free condoms and pills to children as young as 13'. Running alongside, the second *Daily Mail* item (SWP9), opens by describing the government's plans to add fluoride to milk and salt as 'controversial', and says that they 'immediately came under fire' from anti-fluoride campaigners.

The *Mirror* describes a £72 million 'assault' on health in 'Labour takes on killers' (SWP12) (the word 'assault' is flagged up from the text, underlined and in bold type). Continuing the use of violent adjectives, the *Mirror's* editorial leads with the headline 'Heartening attack on big killers' (SWP13). Echoing its headline, the editorial comments that it is 'heartening' the government is 'tackling [cancer and heart disease] head-on'. These diseases are 'Scotland's two worst killers [which] leave no lives untouched'. Recounting the government's targets, the editorial employs an illness metaphor, describing how they will 'eat considerably into the cancer fatalities which plague us'. The *Mirror* believes the government has, on this occasion, 'got it right', and emotively refers to child health when praising the proposed ban on tobacco advertising and the targets set for cancer and heart disease. Tobacco-related initiatives will, the editorial states, 'nail the hypnotic effects of the weed before our children take their first puff on a cigarette'.

5.4 Coverage of the Scottish White Paper: Emphasis on inequalities in the press

To what extent did the government's inequalities message get communicated in the press? Coverage of inequalities could, at best, be described as modest. Health inequalities are referred to in two out of fourteen items during the sample period. A further three items refer to the government's acknowledgement of a link between poverty and ill health. Inequalities in health are referred to frequently throughout the Scottish White Paper and the accompanying press release. Despite this, explicit reference to inequalities in health, or a 'language' of inequalities, remains absent from much of the newspaper coverage. This is in contrast to previous coverage of the Scottish Green Paper. In this case the press release featured examples of inequality, such as the differences in death rates between men residing in Bearsden and Drumchapel respectively (see Chapter three). This approach appeared to be more successful as coverage of inequalities was more pervasive in reporting of the Scottish Green Paper in the press.

The *Herald* does refer explicitly to health inequalities in relation to tobacco smoking (SWP3). Linking the issue of inequalities in health overwhelmingly to health behaviours, the article states: 'Tobacco smoking is the most important preventable cause of ill-health and premature death in Scotland, the White Paper points out. It accounts for at least two thirds of the excess in deaths attributable to inequalities in health'. Sam Galbraith puts this view into context, with the reminder that adverse circumstances can 'drive' people to smoke and consequently the government will be addressing the issue from a broader perspective.

On a more ideological and rhetorical level, The *Daily Mail* emphasises the government's aim to reduce inequalities both by relaying the government's intentions and quoting Sam Galbraith (SWP11). The journalist describes the Scottish White Paper as an 'action plan in the war on health inequalities between well-off and deprived communities' before the Health Minister is quoted stating:

'The proposals are a sustained attack on inequality, social exclusion and poverty. Reducing whatever we can differences in opportunity and experience as measured by income, gender and environment will be at the heart of work to improve Scotland's health.'

Whilst inequalities in health remain under-reported (proportionate to the emphasis placed on them in the government's strategy), a further three articles, all appearing in the *Herald*, report on issues inextricably linked to inequalities, namely social exclusion and poverty. The *Herald* notes that the 'fight' against poverty and deprivation is 'firmly linked by the Government to poor health' (SWP1). Running alongside, a news report entitled 'Poverty' (SWP4) lists Social Exclusion Partnerships and a 'Social Inclusion Strategy' amongst other initiatives designed to benefit deprived communities aimed at 'improving health by targeting poverty'. The *Herald's* editorial observes that health 'is inextricably linked to social class' (SWP7).

Images accompanying the Scottish White Paper coverage are wholly descriptive rather than an opportunity to convey depictions of inequalities (when compared, for example to coverage of the Acheson Inquiry, see Chapter four). Although the *Herald* refers to inequalities in health (albeit in relation to smoking) and the link between deprivation and ill-health, the picture used to accompany its news reports is one of consultant colo-rectal surgeon Mr John Anderson, who is interviewed in 'Screen test a life saver' (SWP2). The one headline attempting to convey the government's emphasis on improving the health of those on low incomes appears in the *Herald* and is entitled simply 'Poverty' (SWP4).

In conclusion, despite the strong rhetoric around inequalities employed by the government, all but two newspapers overlooked the issue. Even the *Herald*, whose Green Paper coverage strongly highlighted inequalities, relates the issue only to smoking in its reporting of the White Paper. The lack of actual examples of inequality in the White Paper's press release (such as the Bearsden/Drumchapel comparison of mortality rates appearing in the Scottish Green Paper press release) left another avenue through which to express inequalities closed to journalists. The press tended to focus on specific initiatives and the government's 'big' targets to reduce heart disease and cancer, with the spectre of Scotland's poor health reputation often setting the context.

5.4.1 The Scottish White Paper coverage: Summary and Conclusions

The intention to tackle inequalities in health is carried through from the Scottish Green Paper to its successor, the Scottish White Paper. Inequalities are referred to numerous times in the Scottish White Paper, and are related to a broad cross-section of policies. The aim of reducing inequalities in health is stated clearly in the Scottish White Paper press release, both in terms of an overarching aim but also in relation to specific initiatives. However, no examples of inequalities in health are given akin to the Bearsden/Drumchapel statistics quoted in the Scottish Green Paper press release.

Coverage of the Scottish White Paper mirrored that of the Scottish Green Paper as reporting of the document was, on the whole, descriptive rather than analysis or commentaries. There appears to be no strong correlation between the political stance of a newspaper and the Scottish White Paper initiatives it chooses to cover. Tabloid newspapers such as the *Sun* and *Daily Record* had a tendency to focus on a specific initiative (such as water fluoridation or sexual health).

In terms of media representation, Scotland's 'appalling' health record is emphasised less in the Scottish White Paper coverage (in contrast to Scottish Green Paper coverage). The concept of 'nannying' also receives far less coverage in the press. No overriding themes pervade the coverage, however strong rhetoric and language is used in many items in the sample. No reference is made to previous Conservative health policy, and no attempts are made to contrast Conservative health policy with the Labour government's approach. Images used in the Scottish White Paper coverage were, as with reporting of the Scottish Green Paper, wholly descriptive of the articles they accompanied. Political sources, who were particularly critical of the Labour government, featured prominently.

The government's intention to tackle inequalities in health is communicated in only two of fourteen items. Bucking previous trends, it is a tabloid (*Daily Record*) which makes explicit reference to the government's aim to tackle inequalities whereas a traditionally left-wing broadsheet (*Herald*) frames its single mention of inequalities in the context of health behaviours.

Whereas in the Scottish Green Paper coverage, the *Scotsman* had referred to inequalities in health frequently, the issue was absent in its reporting of the Scottish White Paper. Despite the *Herald's* reporting of poverty and social exclusion, the previous enthusiasm shown for the government's shift in direction has wavered. Coverage in the *Herald* centres overwhelmingly on nicotine replacement therapy and colo-rectal screening. The remaining newspapers reporting on the White Paper, the *Daily Mail*, *Mirror*, and *Sun*, made no reference to inequalities.

In conclusion, the strong stance taken by the Scottish White Paper in dealing with poverty and inequality, reflected by the use of powerful rhetoric in the government's public setting-out of policy, does not transfer into the press. Bucking the previous trend, only one tabloid newspaper communicates the government's intent to reduce health inequalities. This development seems all the more surprising considering the recent publication of the Acheson Inquiry's recommendations was reported in one Scottish-based broadsheet (*Scotsman*). Newspapers previously highlighting health inequalities in terms of a policy issue and a wider public debate have moved their attention to reporting specific government initiatives at the expense of health inequalities.

Chapter Six
The English White Paper: Media coverage and representation of public health policy

6.1 Introduction

The UK government published its long awaited policy document on public health on Tuesday 6th July 1999. Sixteen months had passed since the unveiling of the government's initial proposals, the Green Paper, *Our Healthier Nation: A Contract for Health* (Department of Health 1998). The White Paper, *Saving Lives: Our Healthier Nation* featured more ambitious targets than its Green Paper predecessor (Department of Health 1999). The overriding aim of the government's 'action plan' is to improve the health of everyone, and the health of the worst off in particular (Department of Health 1999, p. viii, Executive Summary). A brief overview of the document is provided in Appendix E.

6.2 Saving Lives: Our Healthier Nation*: Reference to and emphasis on inequalities in health*

Has the prominence placed on narrowing health inequalities in the English Green Paper been maintained in the White Paper? Inequalities in health were referred to from the outset. 'Widespread' health inequalities are described in the Executive Summary of the English White Paper. Such inequalities, it says, have resulted in the disadvantaged having 'suffered the most from poor health'. The White Paper describes how the government's current proposals are addressing inequality with initiatives in 'education, welfare-to-work, housing, neighbourhoods, transport and the environment' (Department of Health 1999, p. x).

Throughout the document as a whole, inequalities are referred to on 52 occasions, six less than in the English Green Paper. Health inequalities are principally addressed in chapter four, 'Communities: tackling the wider causes of ill health' [4.1-4.47][49]. Paragraph 4.4 states that:

[49] Numbers in brackets indicate paragraphs taken from the English White Paper *Saving Lives: Our Healthier Nation.*

'The impact that could be made by an attack on inequality is clear. For example, if the death rates of all men of working age were the same as those in professional and managerial jobs, about 17,000 deaths would be avoided each year of which about 75 per cent would be in our four priority areas: cancer, coronary heart disease and stroke, accidents and suicide' (Department of Health 1999, p. 42).

On the same page, statistics depicting inequalities are quoted. For example, 'men aged between 20 and 64 from the bottom social class are three times more likely to die from coronary heart disease and stroke than those in the top social class' (p. 42). Paragraph 4.5 refers to the Acheson Inquiry, which 'confirmed that for many aspects of health, inequality has generally worsened in the last few decades, especially in the 1980s and early 1990s' (p. 42). The following paragraph [4.6] outlines a government 'action plan' on health inequality to be published in addition to the White Paper. The plan addresses the 'social, economic and environmental factors and the part they play in poor health'. A section on 'Evening up opportunity' describes the government's commitment to 'tackling' social exclusion with the establishment of a Social Exclusion Unit [4.10]. Gender inequalities will be addressed by The Women's Unit [4.11] and health needs and different aspects of social exclusion will be covered in an Urban White Paper and a Rural White Paper [4.12].

A section entitled 'Security and health' links low income with ill health and outlines reforms to ensure a guaranteed minimum income [4.13]. Under 'Education and Health', paragraph 4.16 states that 'People with low levels of educational achievement are more likely to have poor health as adults. So by improving education for all we will tackle one of the main causes of inequality in health'. A *Healthy Schools* programme has been set up to 'provide the context and support for a healthy environment for school communities' [4.17] and a range of supporting projects such as *Wired for Health* (a website for schools encouraging young people to make informed decisions about their health), *Cooking for kids* (teaching basic cooking and food preparation skills) and Safer Travel to School scheme (encouraging children to walk or cycle to school along safe routes) [4.18].

The *New Deal* is referred to, as well as the *Welfare to Work* programme as ways of getting people to work under the heading *Employment and Health.* Paragraph 4.26 states that 'Some work conditions can have a profound impact on health' and a

description of a *Healthy Workplace* initiative follows [4.27]. Further initiatives for reducing inequalities in health are featured under 'Housing and Health' [4.28-4.31], 'Homelessness' [4.32-4.33], 'Healthy Neighbourhoods' [4.34-4.40], 'Environment and Health' [4.41-4.44], and 'Health Impact Assessment' [4.45-4.47].

However, although inequalities in health are referred to in a number of policy areas, a subtle marginalisation of the issue has arguably occurred with the publication of an 'action plan' separate from the main body of public health policy. Details of the plan are confined to two sentences in the English White Paper. However, inequalities are emphasised in the document in other ways, such as the use of statistics illustrating disparities in mortality rates between social classes.

6.2.1 Biggest Ever Crusade for Health to Cut Preventable Deaths by 300,000 within ten years[50]*, the English White Paper press release: Summary and reference to health inequalities.*

The press release *Biggest Ever Crusade for Health to Cut Preventable Deaths by 300,000 within ten years* was published to accompany the English White Paper's launch. The main initiatives presented in the document are summarised. These include, in order of appearance, *Expert Patients*, *Health Skills*, Public Health Development Fund, *Survival Skills* and first aid programmes for eleven year-olds, increased education and training for health and public health observatories, defibrillators, the Health Development Agency, Health Impact Assessments, and *Smoking Kills*. The press release also details the most wide-ranging proposals for improving health in the White Paper, such as the *New Deal*, the Minimum Wage, the Working Families Tax Credit and the million council house building programme. In more general terms, the press release cites 'Better transport and environmental policies to reduce air pollution and noise pollution', and 'Action to reduce crime and disorder' as other routes by which the government hopes to improve health.

The four targets (to reduce the death rate from cancer in people under 75 by at least a fifth, to reduce the death rate from coronary heart disease and stroke in people under

[50] the press release can be found at http://www.coi.gov.uk

75 by at least two fifths, to reduce the death rate from accidents by at least a fifth, and to reduce the death rate from suicide and undetermined injury by at least a fifth) are described as 'significantly tougher' than those set in the English Green Paper, and are detailed in the press release. The language used in the press release varies slightly from the language used in the White Paper itself. The first paragraph describes a 'New three-way deal for health' (comprising of national action, individual responsibility and local implementation) as the 'forging of a dynamic partnership at national, local and individual level'. The English White Paper's measures are described with gusto as the 'biggest crusade for health ever undertaken by a British Government'. Underlying the strategy's success is an 'unprecedented drive to tackle the reasons why people become ill.'

Reference to health inequalities is restricted in the press release to the *Smoking Kills* initiative, which is the last specific 'health' initiative to be described. *Smoking Kills* is described as 'the most comprehensive plan to tackle smoking ever' which will 'help prevent children start smoking and help the 2 out of 3 adult smokers who say they want to quit'. It is then stated that '...smoking is the single greatest cause of preventable death and health inequality'. The separate health inequality 'action plan' is mentioned in a 'Notes to Editors' section at the end of the press release where it is stated that media copies of 'Reducing Health Inequality' are available from the Department of Health Press Office.

6.2.2 Summary

Publication of the English White Paper on public health, *Saving Lives: Our Healthier Nation* has seen a toughening of the four targets originally proposed by the English Green Paper in February 1998. The *Expert Patients* and *Health Skills* programmes as well as the Public Health Development Fund and Health Development Agency, *Survival Skills*, increased education and training, public health observatories, *Smoking Kills*, and defibrillators are all new to the White Paper. This illustrates the shift that has occurred between publication of the English Green Paper and White Paper; health inequalities have slipped down the agenda. Initiatives such as Health Impact Assessments, Healthy Living Centres and Health Action Zones – moves to reduce and monitor inequalities – are somewhat overshadowed. The government claims to be

implementing policies that are addressing inequalities, but the bold Green Paper aim of reducing the 'health gap' has been forfeited for a less controversial tone. The fact that a plan on health inequalities is published separately from the English White Paper, rather than included within it, also indicates how far priorities have shifted. Inequalities no longer feature as a central tenet of the current government's public health policy.

6.3 Coverage and representation of the English White Paper in the press

This section first summarises the breaking news stories coinciding with the English White Paper's launch. After setting the context, the level of coverage of the government's key policy areas is quantified, along with their presentation and interpretation by journalists. The scene is then set to ask the question; how has the inequalities debate been presented in the press, given their lessening prominence in government policy, and particularly with the Acheson Inquiry's findings in the public domain?

6.3.1 The wider context

The English White Paper was published in a week awash with medical and health-related stories and controversies. As a result, it was sidelined in many newspapers. Other, more 'newsworthy', stories occupied the headlines. Frank Dobson, Health Secretary of the UK government[51], was associated more with an organ donation story than with the launch of the English White Paper. The organ controversy arose when a Sheffield hospital agreed to accept kidneys donated for use only in white patients.

The launch of the White Paper coincided with junior doctors winning backing in their call for industrial action during the BMA's (British Medical Association's) annual conference. The conference made headlines with doctors making pleas for change to their working conditions. BMA Chairman Ian Bogle accused Mr Blair (Britain's Prime Minister) of 'alienat[ing] the entire medical profession'. Other stories

[51] Frank Dobson held the Secretary of State for Health post until 12/10/99. Alan Milburn was appointed as Health Secretary in a cabinet reshuffle on the above date, leaving (a reluctant) Mr Dobson free to run in the forthcoming elections for Mayor of London.

prominent during this period included Tony Blair's efforts to save the stalled Northern Ireland peace agreement, and a former council housing officer's £67,000 compensation for mental stress. Growing tension was also reported between Tony Blair and John Prescott (the Deputy Prime Minister) after the Prime Minister criticised public-sector workers for being resistant to change.

6.3.2 Overview of items reporting on the English White Paper

Out of 27 items found, sixteen were published the day after the English White Paper's launch, Wednesday 7th July 1999 (see table 6.1). Items appeared over a seven day period with the story extending into the weekend newspapers. Many headlines accompanying items referred to specific policy areas, for example, accident lessons for children; 'Children to have lessons in avoiding accidents' and 'Children to assist in crusade to save lives'. Defibrillators are referred to in headlines such as 'Public to operate heart machines' and 'Going public to save heart-attack victims'. The government's principal targets are described in headlines such as 'Big five killers targeted to save 300,000 lives' and 'Dobson targets the four deadly scourges to save 300,000 lives'.

Unlike previous sample periods, a political uncertainty and cynicism is reflected in a number of headlines, often employing phrases analogous with ill health, i.e. 'Dobson's throat-clearing raises blood pressures', 'An unhealthy dose of bile from ratty Frank Dobson', 'Dobson sees his political life threatened by loss of health' and 'Frankly, Dobbo, it's a fiasco'. Reference is also made to the wider political context with the headlines 'Outrage as Blair attacks public sector' and 'Doctors are sick of Labour'. Further negativity toward the government is clear with headlines stating ominously 'The peoples' road to hell is paved with Government advice', 'An unhealthy state' and 'Cold comfort'. Inequalities in health care provision are alluded to with the headline 'Resource gaps turn healthcare into a lottery'. One headline refers specifically to the government targeting the health of the less well-off, 'Dobson's £96m crusade to help poor live longer'.

Within the sample period, the English White Paper featured in thirteen news reports, five editorials, four feature articles, four columns, and one letter. Table 6.1 shows items found during the sample period in detail. *The Times* reported on the English White Paper most extensively, running five news reports, one editorial, and one column (EWP2, EWP3, EWP14-17). In addition, the *Sunday Times* referred to the English White Paper in two features and an editorial (EWP24-26).

The *Guardian* ran six items; three news reports, two columns and one editorial. One news report appeared in the newspaper's weekly insert, the *Editor* (a supplement summarising the 'best of the world's media') (EWP1, EWP7-9, EWP20, EWP22). The *Daily Telegraph* reported on the English White Paper in five items; three news reports, one editorial and one feature (EWP10-13, EWP23). Four items covered the English White Paper in the *Independent,* a news report, a column, an editorial and a letter (EWP4-6, EWP27). The *Scotsman* and *Daily Express* ran one English White Paper item apiece, a feature article and a news report respectively (EWP21, EWP19). *The Times* and *Guardian* were swiftest in reporting the English White Paper, covering the document on the day of its launch. Only one tabloid, the *Daily Express*, ran a story on the English White Paper.

6.3.3 Newspaper coverage of the English White Paper's key policies

This section goes on to examine the extent to which the English White Paper's key policies were reported in the press. Table 6.2 illustrates which items in the sample period covered the English White Paper's key policy areas. As with coverage of the English Green Paper, the most consistently reported area was the government's commitment to reduce mortality rates in four specific areas. Indeed, all newspapers, bar the *Scotsman*, referred to the government's four targets and/or the projected 300,000 lives saved as a result.

The *Daily Express* reports on the English White Paper's different policy areas most comprehensively, referring to eight key initiatives (EWP19). The *Guardian* and *Scotsman* report on seven key areas apiece. However, whilst the *Guardian* (EWP7) follows the trend of the majority of newspapers, reporting on tangible, 'visible' initiatives such as defibrillators and accident prevention, the *Scotsman* (SWP21) –

Table 6.1: Items reporting on the English White Paper during the sample period

No.	Date	Format	Newspaper	Page no.	Page type	Journalist	Journalist's specialism	Headline
EWP 1	6/7/99	news report	*Guardian*	2	'News'	Michael White	Political Editor	**Public to operate heart machines**
EWP 2	6/7/99	news report [a]	*The Times*	1 (front)	Unspecified	Tom Baldwin & Jill Sherman	unspecified	**Children to have lessons in avoiding accidents**
EWP 3	6/7/99	news report [b]	*The Times*	24 (back)	'Times Today'	----------	----------	**Safety lessons for children**
EWP 4	7/7/99	news report	*Independent*	1 (front)	Unspecified	Colin Brown & Jeremy Laurance	unspecified	**Outrage as Blair attacks public sector**
EWP 5	7/7/99	column	*Independent*	8	'Parliament'	Thomas Sutcliffe	unspecified	**An unhealthy dose of bile from ratty Frank Dobson**
EWP 6	7/7/99	editorial	*Independent (Weds Review)*	3	Unspecified	----------	----------	**The peoples' road to hell is paved with government advice**
EWP 7	7/7/99	news report	*Guardian*	6	'National News'	David Brindle	Social Services Correspondent	**Children to assist in crusade to save lives**
EWP 8	7/7/99	column	*Guardian*	8	'Policy & Politics'	Simon Hoggart	unspecified	**Dobson's throat-clearing raises blood pressures**
EWP 9	7/7/99	editorial	*Guardian*	19	Unspecified	----------	----------	**Our national health**
EWP 10	7/7/99	news report [a]	*Daily Telegraph*	1 (front)	Unspecified	George Jones	Political Editor	**Public may vote on putting fluoride in tap water**
EWP 11	7/7/99	news report [b]	*Daily Telegraph*	2	Unspecified	----------	----------	**Dobson reveals longer hospital waiting lists**
EWP 12	7/7/99	news report [c]	*Daily Telegraph*	6	Unspecified	Robert Shrimsley	Chief Political Correspondent	**Big five killers targeted to save 300,000 lives**
EWP 13	7/7/99	editorial	*Daily Telegraph*	25	Unspecified'	----------	----------	**Rising temperatures**

Table 6.1 (cont): Items reporting on the English White Paper during the sample period

No.	Date	Format	Newspaper	Page no.	Page type	Journalist	Journalist's specialism	Headline
EWP 14	7/7/99	column	*The Times*	2	'News'	Mathew Parris	unspecified	**Dobson sees his political life threatened by loss of health**
EWP 15	7/7/99	news report [a]	*The Times*	8	'News'	Jill Sherman	Whitehall Editor	**Dobson's £96m crusade to help poor live longer**
EWP 16	7/7/99	news report [b]	*The Times*	8	'News'	Tracy Connor	unspecified	**Going public to save heart-attack victims**
EWP 17	7/7/99	news report [c]	*The Times*	8	'News'	Robin Young	unspecified	**Wartime diet is recipe for better national health**
EWP 18	7/7/99	editorial	*The Times*	21	Unspecified	----------	----------	**Not Frank Enough**
EWP 19	7/7/99	news report	*Daily Express*	8	Unspecified	Alison Lyttle	unspecified	**Dobson targets the four deadly scourges to save 300,000 lives**
EWP 20	8/7/99	column	*Guardian*	20	'Comment & Analysis'	George Monbiot	unspecified	**Corporate causes of cancer**
EWP 21	8/7/99	feature	*Scotsman*	17	'Opinion'	Tim Williams	unspecified	**Frankly, Dobbo, it's a fiasco**
EWP 22	9/7/99	news report	*Editor (Guardian)*	5	Unspecified	----------	----------	**Doctors are sick of Labour**
EWP 23	10/7/99	feature	*Daily Telegraph*	21	'News Review'	Alice Thomson	unspecified	**Running for mayor may be bad for one's health**
EWP 24	11/7/99	feature [a]	*Sunday Times*	12-13	'Focus'	Lois Rogers	unspecified	**The sickness at the heart of our NHS**
EWP 25	11/7/99	feature [b]	*Sunday Times*	13	'Focus'	Lois Rogers	unspecified	**Resource gaps turn healthcare into a lottery**
EWP 26	11/7/99	editorial	*Sunday Times*	16	'Comment'	----------	----------	**An unhealthy state**
EWP 27	12/7/99	letter	*Independent (Monday Review)*	2	Unspecified	Hayley Trueman	----------	**Cold comfort**

although also referring to such initiatives – refers to policy areas geared at 'deprived areas and designed to reduce health inequalities' i.e. Health Action Zones and Health Improvement Programmes.

The trend observed during the English Green Paper coverage of left-of-centre newspapers (e.g. *Guardian*) highlighting initiatives targeted at the deprived and right-of-centre newspapers (e.g. *Daily Telegraph*) reporting on more health behaviour-based proposals appears to have all but disappeared. Instead newspapers running coverage of the White Paper tended to concentrate reporting on defibrillators, accident prevention, first aid training, and Public Health Observatories. Initiatives designed to reduce inequalities receive far less reporting as a result, and a political bias appears less prevalent. For example, Health Action Zones are referred to in five newspapers spanning the political spectrum (*Independent*, *Daily Telegraph*, *The Times*, *Scotsman* and *Guardian*) and Healthy Living Centres are reported on in the *Guardian* and the *Sunday Times*.

However, coverage of the English White Paper contains by far the most commentary and analysis when compared to the previous three sample periods, and reporting of policy takes a back seat. The political climate is emphasised greatly, particularly at a time of perceived instability for Mr Dobson and the government as a whole. Intense speculation surrounds Mr Dobson's future role and Mr Blair is heavily criticised by the medical profession. Resource gaps in healthcare are also highlighted when the NHS is compared with the healthcare systems of our European counterparts. The following section describes these items in more detail whilst looking at media representation of the English White Paper as a whole.

6.3.4 Media representation of the English White Paper in press coverage

As already hinted, the English White Paper was launched into a precarious political climate. Labour was having a 'bad week'. Some items focus directly on this conflict, others on the perceived instability of Frank Dobson's position as Health Minister. Much of the political commentary paints a bleak future for Mr Dobson. The NHS receives a great deal more attention in the course of reporting government policy than

in the previous sample periods. The shortfalls of the health service in relation to the government's public relations 'spin' surrounding public health policy is made painfully clear. Beyond the staples of reporting the government line, coverage of the English White Paper branches out in a number of directions. This is perhaps a reflection on the status of the English White Paper as a policy document, and furthermore, one which covers the vast majority of the British population.

The Times, *Guardian* and *Daily Telegraph* all run leading front page stories on the English White Paper, with headlines focusing on a specific government initiative (EWP1, EWP2, EWP10). Alongside a summary of the English White Paper's contents, the *Guardian* coverage (EWP1, EWP7-9) conveys the political instability surrounding pressurised policy making. The government is concerned with distancing itself from 'nanny state' connotations, as seen in reporting of the English Green Paper. Mr Dobson is described in the *Guardian* as an 'avowed populist who is keen to avoid charges of being a "food fascist"'. The final draft of *Saving Lives* is described as the subject of 'protracted tussles' with Tessa Jowell, the Public Health Minister. The English White Paper's policies are perceived as crucial in their potential impact 'With Tony Blair anxious to signal to Labour's wavering "core voters" that his team is delivering on their agenda'. One such policy, *NHS Direct*, has already been singled out for criticism at the BMA's conference in Belfast. The *Guardian* journalist describes an 'unrest' in the medical profession over the telephone helpline as well as other government policies.

This political and professional unrest is the subject of a number of items appearing in the *Daily Telegraph*. Aside from a brief front page item reporting on the government's water fluoridation plans (EWP10), the *Daily Telegraph* devotes generous column inches to the perceived backlash against Labour at the BMA's annual conference. An item on the English White Paper, 'Big five killers targeted to save 300,000 lives' (EWP12), occupies third place in a page spread featuring items entitled 'Blair tells BMA critics that reforms will go on', and 'Junior doctors win backing for hospital strikes'. Inset between the items is a scene from the BMA conference. Dr Andrew Hobart – who had made an impassioned speech on the plight of junior doctors – is pictured holding a crying child. The caption underneath reads:

Table 6.2: Newspaper coverage of the English White Paper's key policy areas

No.	newspaper	4 targets	Defibrill -ators	Accident Prevention / First Aid	Public Health Observatories	Fluoride in water	Health Development Agency	Partner-ship	Health Action Zones	NHS Direct	'Expert Patients' Programme	Public Health Dev. Fund	Health Impact Assessments	Healthy Living Centres
EWP1	*Guardian* (news report)		√		√					√				
EWP2	*The Times* (news report [a])	√		√						√				
EWP3	*The Times* (news report [b])			√										
EWP4	*Independent* (news report)	√	√											
EWP5	*Independent* (column)								√					
EWP6	*Independent Review* (editorial)							√						
EWP7	*Guardian* (news report)	√	√	√	√	√					√	√		
EWP8	*Guardian* (column)						√							
EWP9	*Guardian* (editorial)	√				√	√	√			√		√	
EWP10	*Daily Telegraph* (news report [a])					√								
EWP11	*Daily Telegraph* (news report [b])													
EWP12	*Daily Telegraph* (news report [c])	√	√	√	√			√	√					
EWP13	*Daily Telegraph* (editorial)													
EWP14	*The Times* (column)	√					√							

Table 6.2 (cont): Newspaper coverage of the English White Paper's key policy areas

No.	newspaper	4 targets	Defibrill -ators	Accident Prevention / First Aid	Public Health Observatories	Fluoride in water	Health Development Agency	Partner-ship	Health Action Zones	NHS Direct	'Expert Patients' Programme	Public Health Dev. Fund	Health Impact Assessments	Healthy Living Centres
EWP15	*The Times* (news report [a])	√		√	√		√		√			√		
EWP16	*The Times* (news report [b])		√											
EWP17	*The Times* (news report [c])													
EWP18	*The Times* (editorial)	√	√	√	√									
EWP19	*Daily Express* (news report)	√	√	√	√	√	√	√						
EWP20	*Guardian* (column)	√	√			√			√					√
EWP21	*Scotsman* (feature)		√			√	√	√	√			√	√	
EWP22	*Guardian Editor* (news report)	√												
EWP23	*Daily Telegraph* (feature)													
EWP24	*Sunday Times* (feature [a])	√												
EWP25	*Sunday Times* (feature [b])													
EWP26	*Sunday Times* (editorial)									√				√
EWP27	*Independent Review* (letter)													

'Emotional debate: Dr Andrew Hobart with Catherine O'Kane, nine months, in a crèche at the conference'.

The *Daily Telegraph* has more bad news to report in the 'Bulletin' section of the paper. 'Dobson reveals longer hospital waiting lists' (EWP11) details the 'embarrassment' the Health Minister had to suffer in delivering this news. The brief item notes that this increase has occurred despite the government spending £320 million to shorten waiting times, one of its five key election pledges. Furthermore, the Opposition is described as 'attack[ing]' the decision to publish waiting list figures 'on a day when they were bound to be overshadowed by the publication of Mr Dobson's £96 million *Saving Lives: Our Healthier Nation* blueprint for improving the country's health'.

Similar to the *Daily Telegraph's* style of coverage, the *Daily Express* reports on the English White Paper amidst stories describing a health service in crisis. The *Express,* the only tabloid to cover the English White Paper, appears initially to put a positive spin on the story with an item entitled 'Dobson targets the four deadly scourges to save 300,000 lives' (EWP19). However the report is one of three stories featured on page nine of the newspaper, all placed under the banner 'SUICIDE, HEART DISEASE, ACCIDENTS AND CANCER TO BE TACKLED BUT HEALTH STAFF STILL SUFFER'. A personal angle offering an insight into the difficulties faced by nursing staff – in this case a nurse struggling to find employment in Britain after working abroad rather than the more familiar story of staff shortages – is featured in the item 'How Cherie's Beirut angel crash landed'. The headline refers to the nurse's nomination as 'heroine nurse' by Cherie Booth (the Prime Minister's wife). The Liberal Democrats are quoted as describing the government's strategy as 'timid'. A third item reports on the BMA's dissatisfaction with government policy. The headline sums up the frustration felt amongst the medical profession: 'Junior doctors could earn more at McDonald's'.

The Times follows its leading item on accident prevention (EWP2) with a more comprehensive summary of government public health policy on Wednesday 7th July. Three items on the English White Paper appear on page eight, a markedly different

approach to the *Daily Telegraph's* overshadowing of government policy in favour of turmoil in political and medical spheres. The leading item, 'Dobson's £96m crusade to help poor live longer' (EWP15) reports on the Health Secretary's announcement of 'tougher targets than expected'. Responding, the journalist writes, to 'widespread criticism that Labour's targets were weaker than those set by the Tories', Mr Dobson has 'disclosed the more ambitious targets for a wider age group which may be difficult to achieve'. The community-based nature of the strategy is, the journalist reports, the government's attempt to 'avoid accusations of a nannying state by not dictating what people should eat or drink'. Like the *Guardian*, *The Times'* coverage features a picture of a defibrillator being demonstrated. However, whilst the *Guardian* item states neutrally, 'Public to operate health machines' (EWP1), *The Times* opts for a more heroic image, running an item entitled 'Going public to save heart-attack victims' (EWP16).

A final item, 'Wartime diet is recipe for better national health' (EWP17), surveys attempts, spanning from the nineteenth century, to change the nation's diet. The piece sits uneasily with the previous two items in that it makes no direct reference to the English White Paper and is not consistent with the document's wider agenda. However, a tenuous connection is made to the 'nanny state' concept as the item concludes that 'Despite efforts to promote sensible eating, Governments have been loath to intervene directly or to limit the power of food manufacture'. Inset into the item are examples of health education campaigns on physical health (with captions 'A physical fitness guide for the lazy, overweight, beer drinking smoker who wouldn't jog if you paid him' and 'Is your body coming between you and the opposite sex?') and passive smoking ('How many cigarettes a day does your child smoke?'). The caption underneath reads 'Public health advice has failed to alter lifestyles'. Such an item, although not conveying current government policy, fits with *The Times'* traditionally right-wing behavioural approach to the health of the masses.

The *Independent* runs a front page story on Mr Blair's criticisms of the public sector in which the English White Paper gets a passing mention. Again, the launch of the English White Paper is overshadowed by conflicts in which the government has become

embroiled. The item details the offence caused by the Prime Minster whilst addressing a City of London audience (EWP4). Mr Blair is reported to have said he bore 'the scars on my back' after, the journalist continues, 'two years of trying to force change on the public sector'. Moving on to unrest in the medical profession, the item puts the English White Paper into context:

'As the Government launched a White Paper setting out targets for cutting deaths from cancer and heart disease, anger at the long hours and poor pay suffered by junior doctors spilled over again at the BMA's annual conference in Belfast.'

The Times, *Guardian* and *Independent* all devote political columns to the English White Paper launch. These items give more attention to Frank Dobson's mood at the despatch box and his seemingly precarious job situation at the expense of the newly unveiled health policy. In *The Times*, the writer of 'Dobson sees his political life threatened by loss of health' (EWP14) asks 'Who rattled Frank Dobson's cage?'. The 'normally jovial' Mr Dobson is, the columnist observes, in a 'foul mood' as he delivers 'one of those lacklustre preventative healthcare statements that come around in every parliament and sink without trace'. Mr Dobson's statement to the Commons is recounted amongst cutting comments concerning the direction of his career. Mr Dobson 'desperately wants to stay in health' whereas Downing Street wants him to run for mayor of London. Whilst, the columnist notes pithily, 'We are enjoined to eat less cheese and finger ourselves for lumps', Mr Dobson is 'being fingered where it hurts'. Referring to vocabulary used in Mr Dobson's Commons statement, the columnist observes 'How well [he] knows the first law of Ministerial statements: the more frequent the occurrence of "action" or "tackle", the less is promised'. The item concludes by attempting to sum up the mood in the Commons with a satirical twist:

'Somehow Dobson made it through, slumping back on the bench. Hardly a cheer. Louder was the roar of aircraft engines, Alistair Campbell's bark – "jump you bugger, jump" – the hiss of the wind. Liam Fox, the Tories' new Health Shadow, leapt up. "Normally a farewell performance gets a better cheer," he sneered. Cruel.'

The *Guardian's* political sketch, 'Dobson's throat-clearing raises blood pressures' (EWP8) continues along a similar vein. Mr Dobson's Commons statement is described as 'ferocious' whilst the Commons itself was in an 'aggressive, bad tempered mood'. Simon Hughes, spokesman for the Liberal Democrats, is quoted, finding Dobson's words 'sticking in [his] gullet'. Employing unsavoury body metaphors similar to those found in *The Times's* political column, the writer notes how the Health Secretary had 'cleared his tubes in the morning by being nasty to Sue McGregor on the *Today* programme'. Then, later on in the day, Mr Dobson had 'disgorged the remainder of the bile-filled mucus in the chamber after lunch'. The furious exchanges between MP's is detailed as the columnist comments:

'There's nothing like a discussion on *Our Healthier Nation* to get everyone so fighting mad that, if the scenes had taken place in a pub near closing time, someone would have prudently called the ambulances before the glassing began.'

The critical mood of the Commons coupled with the very critical eye of the columnist is readily apparent in the *Independent's* political sketch 'An unhealthy dose of bile from ratty Frank Dobson' (EWP5). Mr Dobson, in a 'ratty and distracted mood', is described as the Labour Party's very own 'Morning After Pill'. After Mr Dobson's well publicised 'monstering' by the chairman of the BMA, the Health Minister opts, according to the columnist, for 'bile with a smile, the rictus in question being one of those tense grimaces with which ministers try to pretend that opposition attacks are risibly predictable'. Bodily metaphors are exchanged for cutting criticism as the columnist observes how target setting has become an 'increasingly popular pastime with Labour ministers since it operates as a kind of Hire Purchase arrangement for future achievements'. Referring presumably to the government's perceived preoccupation with 'spin', the columnist reasons:

'In the past, politicians would have to first take a series of actions and only when the task had actually been satisfactorily completed would they be able to go back to the voters and exchange it for political credit. Now they can take the pain of waiting out of the process, slowly morphing from the future tense into the past, as projected deeds almost imperceptibly become realised ones.'

In relation to the promises made, the columnist ponders whether such statements are 'Future Optimistic or Political Indefinite?'

Returning to a more formal appraisal of the government's performance, editorials collected during the sample period all tend to make similar observations. On the whole, there is serious doubt whether the rhetoric surrounding the government's public health strategy will translate into action. This reflects a wider criticism of the Labour Party as a government reliant on spin-doctors to manufacture a glossy image. The *Independent* notes that 'The language, as always with New Labour, has changed more than the realities have' (EWP6). The *Daily Telegraph* states that 'Labour is all spin and no substance (EWP13). *The Times* describes the English White Paper as 'stronger on good intentions than policy'. On Frank Dobson's desire to see healthier people in a healthier country' the editorial concludes that the Health Minister 'added too little to that debate' (EWP18). The *Sunday Times* notes that 'In health, as in education and transport, Labour promised much but is finding it hard to deliver' (EWP26). The *Guardian* is least cutting in this respect – and the least critical of the editorials – stating that the government's preoccupation with target setting offers 'cold comfort' (EWP9).

Discussion of the English White Paper is inextricably linked with the NHS, a situation compounded by the timing of the BMA's annual conference. Again, comments are overwhelmingly critical in tone. The *Daily Telegraph* observes that after 18 years of Conservative rule, the medical profession had expected Labour to be 'different' in their management of the NHS (EWP13). Doctors, the editorial continues, 'need to ask themselves why they ever thought Labour would make much difference. Considering the low level of GDP that we devote to health care, the NHS provides a surprisingly good service'. Controversially, the editorial suggests that despite complaints concerning bureaucracy, it is doctors 'who are really in charge', Concluding, the editorial states: 'Despite the ideological fury, Labour and Conservatives always end up running the health service in much the same way. Anything more, any radical reform, is ruled out by the doctors themselves'.

The Times expresses doubt over whether the NHS can find the staff to meet government's targets (EWP18). The *Sunday Times* also focuses on Britain's poor healthcare performance internationally (EWP26). The current government has had the same fate befall them as their predecessors, according to the newspaper: 'Labour, like the Tories in power before them, is on the rack over the NHS'. Echoing the statistics quoted in two items featured in this edition of the *Sunday Times* – 'The sickness at the heart of our NHS' (EWP24) and 'Resource gaps turn healthcare into a lottery' (EWP25)[52] – the editorial details:

'British sufferers from breast and colon cancer have a lower chance of survival than in most of western Europe. Anyone with heart, respiratory or kidney disease is also at a disadvantage in Britain. Patients can generally wait up to nine months for an outpatient appointment with a consultant.'

An observation made in the editorial is consistent with the overall tone of the English White Paper coverage: 'Labour's honeymoon with the public sector unions and professions is over' (EWP26).

Other items in the days following the English White Paper launch tended to focus on different aspects of the government and government policy and all but one are critical. 'Corporate causes of cancer' (EWP20), a column running two days after the White Paper's publication, expresses the views of a writer wholeheartedly disillusioned with Labour. Running throughout is the faded expectation that Labour would pursue a different course from the Conservatives once in power. The writer describes *Saving Lives* as 'the most mendacious public document this administration has ever produced'. At first, the White Paper 'appears to provide a powerful antidote to the institutional corruption which infected Tory public health policies'. A balance appeared to have been negotiated between individual responsibility and broader social factors.

It is good, the writer opines, that the government is 'taking cancer so seriously, for it is spreading though the industrialised world at horrifying rates'. However, according to the columnist, the White Paper fails to inform us that 'the largest ever ministerial conference

[52] The English White Paper is referred to briefly in both items.

on environment and health' described in *Saving Lives*, dropped the links between cancer and industrial pollution from the agenda 'soon before the meeting began'. Furthermore, the only atmospheric pollutant named in the White Paper – radon – is, according to the columnist, 'the only major pollutant in Britain which does not result from the activities of large corporations'. As a result of the English White Paper's 'creative' use of language, the document gives the impression that 'breathing or ingesting pollution is something we can avoid'. The writer also points out that adding fluoride to water, a White Paper proposal, could have a negative impact on cancer rates. Perhaps most damning is the fact that in a week where the government promised to tackle cancer 'as never before', Labour has, according to the journalist, 'announced its intention to allow up to 130 new incinerators to be built in Britain by 2015'.

The *Scotsman* looks critically at events south of the border in 'Frankly, Dobbo, it's a fiasco' (EWP21). The writer is highly critical of English White Paper policies (on the subject of Health Action Zones he writes, 'guff, no extra money on public health and more guff') and questions the logic of having a Scottish Parliament if the Scots merely follow an English blueprint when formulating health policies. The bad news, according to the writer, is that the English White Paper is a 'fiasco'. The good news is 'the nonsense has been kept out of Scotland, for the time being anyway'. The perspective from which the writer is arguing suggests that Scotland has yet to set out its public health strategy, when in fact Scotland's equivalent document was published earlier in the same year[53]. The *Scotsman* journalist describes a government which is 'so often...tough-minded in analysis but weak in delivery'. The writer comments cynically on White Paper initiatives:

'Smoking? Let's get school nurses – who probably enjoy a Marlboro Light or two, beer in hand, when off duty – to talk to the blighters behind the bike shed. That'll be effective, clearly. Drinking too much (whatever that means), eating underclass soul food (Mars bars, intravenous lard, lashings of monosodium glutamate and so on) and taking only enough exercise required to produce the next generation of corpulent trailer-park trash? Why, improved health education of course, combined with brand new Health Impact Assessments, skills development plans and no doubt subsided entry to the local gym or jazz dance studio. Way to go Frank.'

The spotlight is again turned on the government as a whole in the *Guardian* supplement, the *Editor* with the item 'Doctors are sick of Labour' (EWP22), sub-headline 'The medical profession turns against the Government'. Extracts from various sources reporting on the launch of *Saving Lives* are introduced with a paragraph observing that 'The Government was lambasted this week by doctors at the annual meeting of the British Medical Association'. Despite damning criticisms, an 'Undeterred Health Secretary Frank Dobson unveiled a white paper with 'bold' targets for reducing deaths by 300,000 over the next 10 years'. Alongside the item is the image of a young doctor, sleeping head in hands around plastic cups and food wrappers. The caption notes wryly: 'The glamour of being a junior doctor'.

A profile of Frank Dobson appears in the *Daily Telegraph's* 10th July edition, entitled 'Running for mayor may be bad for one's health' (EWP23). As observed in items earlier in the week, Mr Dobson is described as 'griping and grumbling all week, snapping on the radio and sniping at the despatch box'. However, the writer spares Frank Dobson the scathing style of the political columns, reducing the White Paper to a Health Minister standing 'at the despatch box to exhort the nation to eat fewer doughnuts'. This misleading simplification of government health policy is redressed with comments made by Frank Dobson later in the feature [see section 6.4].

6.4 Coverage of the English White Paper: Emphasis on inequalities in the press

Against this backdrop of criticism and cynicism about the government's health policy initiatives, to what extent do health inequalities feature in reporting of the English White Paper? Perhaps an indicator of the conflicting priorities of the government and the Health Minister, it is Mr Dobson who emphasises inequalities in his launch speech, not the press release accompanying the English White Paper. A heated debate ensues, as reported in the political columns, whereby the Conservative shadow health spokesman interprets Mr Dobson's admission of inequalities as a sign of government incompetence. Most

[53] *Towards a Healthier Scotland* was published in February 1999 (Scottish Office Department of Health). See chapter five for press coverage and representation of the document.

crucially, these exchanges illustrate that a dialogue on inequalities is taking place between the major political parties and that this dialogue is being reported in the national press.

Without Frank Dobson as the catalyst, such debates would probably not have taken place. Although health inequalities maintain their importance in the English White Paper itself, the press release overlooks this emphasis, referring to inequalities in relation only to smoking in the 'Notes to Editors' section (see 6.2.1).

Only one non-political source used referred to inequalities, reflecting a wider trend whereby the use of non-political sources in English White Paper coverage was generally limited. Interestingly, the one source commenting on inequalities, Anna Coote of the King's Fund, features in *The Times*, a newspaper which gave little prominence to inequalities in its coverage of the earlier documents examined (see chapters three to five). However, this appears to reflect a wider trend in which some of the more right-wing newspapers give greater prominence to inequalities in health than might reasonably be expected given their past style of reporting in this area.

Along with reporting the ensuing political debate on the back of Mr Dobson's comments, a number of newspapers actually cite examples of inequality. This approach is more characteristic of previous Scottish coverage and allows the reader to more concretely conceptualise the inequalities debate. *The Times* reports 'Ministers' observations that:

'...the incidence of heart disease is three times higher in Manchester than in the suburbs such as Kingston and that a boy of wealthy parents is likely to live five years longer than a boy born into poverty.'

The item (EWP2) also notes that the government's plans 'are part of a strategy aimed at deprived areas' and, in the same breath, 'at the mentally ill'. Again citing statistics, the item continues, 'The campaign is aimed directly at poorer areas in the wake of statistics showing that children from unskilled backgrounds are five times more likely than those from middle class families to die in an accident.'

Perhaps the idea that children are affected by such inequalities makes the idea of tackling them more compelling. The choice of headline, 'Children to have lessons in avoiding accidents', certainly emphasises youth, and a cartoon accompanying the item depicts a classroom scene. However, despite the subject on the blackboard, 'Lessons in safety', the teacher comically misses the point, throwing the blackboard eraser at one of his pupils. The caption underneath reads 'Pay attention, Musgrove' (EWP2).

The following day, *The Times* item 'Dobson's £96m crusade to help poor live longer' refers to inequalities on a number of occasions (EWP15). Viewing one of the government's flagship policies in negative terms, the journalist describes how:

'The Government has set up 26 Health Action Zones in the most deprived areas of England which already get extra funding. The zones cover 13 million people – less than a quarter of the population – and ministers expect most of the initiatives to be set up in these areas.'

However, in more neutral terms, the journalist notes earlier that 'most of the money would go to the poorest areas in England to address health inequalities'. The journalist notes that the 'strategy was broadly welcomed by health organisations and charities which approved of the Government's decision to try to narrow the health gap between the rich and the poor'. Anna Coote is then quoted as saying:

'The commitment to tackling inequalities in health is particularly welcome. We have moved a very long way from the days when it was forbidden in official circles to even talk about inequalities. We are at the beginning of a very long process to narrow the widening gap between the health expectations of the richer and poorer groups in society.'

The journalist continues by paraphrasing her, adding that 'the promotion of healthy lifestyles had to be integrated with action to tackle the underlying influences on health, such as income, environment and affordable nourishing food'. Moving away from the item's negative tone in the opening paragraphs, the journalist cites statistics backing up the inequalities highlighted by government. Similar in tone to *The Times* item appearing the previous day (EWP2), it is reported that:

'The White Paper shows that those from low-income groups generally die about five years sooner than those who are comfortably off. Studies have shown they stand a greater chance of dying from cancer, and men whose fathers had manual jobs are almost a third more likely to have a heart condition than those from white-collar backgrounds.'

The Times editorial 'Not Frank Enough' continues the dialogue on inequalities, comparing the current government's desire to improve the health outcomes of low income groups to the '19th century holistic approach to the poor's ill-health' (EWP18). Mr Dobson 'echoed' previous public health attempts when he 'referred to the need to reduce low pay, poor housing, unemployment and thereby tackle ill-health'. The Health Minister resolves to tackle 'grotesque inequalities' in health by ensuring that the well being of constituents 'in Surrey or Sutton Coldfield is shared by people we represent in Barnsley or Bethnal Green'. However, the means by which the government intends to reduce inequalities in health is questioned in the latter part of the editorial. Practical measures, such as the installation of defibrillators in public places, 'might save lives in emergencies, but will not address the causes of ill-health, nor inequalities within society'. Instead, the Health Minister has 'deftly passed much of the responsibility for doing so on to health authorities'. The editorial then goes further, citing examples of inequalities which, in the writer's view, are being neglected by government:

'...although the rate of infant mortality is higher in Britain than in many other developed countries, its reduction is not one of the four explicit aims. Nor is it clear how the NHS is to find the staff to meet these targets. While Britain's 150 cancer specialists see an average of 700 new patients each year, their counterparts in The Netherlands treat about 300.'

The *Daily Telegraph*, also not known for championing inequalities in previous sample periods, quotes statistics illustrating inequalities in health in its coverage of the English White Paper. However, it is clear the *Daily Telegraph* is suspicious of the government's motives and consequently follows its previous pattern of reporting in giving the inequalities debate little prominence overall. The item 'Big five killers targeted to save 300,000 lives' does not refer to the term 'inequalities', but does note that 'Much of the [English White Paper] focuses on improving the health of the poorest people' (EWP12).

The item then refers to statistics quoted in *Saving Lives*: 'It says that in the 45-64 age group, 25 per cent of professional women and 17 per cent of professional men report a long-standing illness, compared with 45 and 48 per cent among unskilled workers'. Continuing into the next paragraph, the item reports:

'People from low income groups generally die about five years sooner than those who are comfortably off, and are more likely to die from cancer. Men whose fathers had manual jobs are almost a third more likely to have a heart condition than those from white-collar backgrounds.'

The accompanying editorial (EWP13) views Mr Dobson's comparisons of Barnsley and Bethnal Green with the 'comfortably off and pretty healthy' in Conservative areas as 'offensive'. As for the comment that the NHS should concentrate its resources in deprived areas, the editorial responds coldly: 'Manipulation of their work for crude party political advantage is the last thing doctors want'.

The *Daily Telegraph* item 'Running for mayor may be bad for one's health' (EWP23] takes the form of a one-to-one interview with Mr Dobson and a journalist, and thus lacks the soundbites familiar from the launch speech. Mr Dobson is quizzed on a number of subjects. However, what is interesting is the change in language when the Health Minister is asked about 'the next Dobson project?' At this point Frank Dobson appears to revert to established government rhetoric:

'Poor people are ill more often and die sooner. We must raise their living standards to save their lives. If a middle-aged man loses his job, he doubles his chances of dying in the next five years. Young men are demoralised. The New Deal will help that. And then there's the national minimum wage which is putting money into the handbags of the lowest paid. And of course there's housing. If you live in sub-standard housing it's bad for your health. We're spending £5 billion a year doing up houses.'

Pursuing a line of questioning which presumably must frustrate Mr Dobson, the journalist asks if he will exhort the country to eat more greens or promote health campaigns on prunes. In response, Mr Dobson states: 'Health campaigns are written by the bourgeoisie for the bourgeoisie and only serve to increase the health gap between rich and poor folk'.

The strong stance taken on inequalities by the *Independent* in previous sample periods[54] is not echoed in its coverage of the English White Paper. The stark images of urban deprivation and reporting of the plight of those living on low incomes is exchanged for a more liberal viewpoint and satirical approach. In the course of covering the English White Paper, both the Black and Acheson Reports are used to contextualise the government's actions. In the item 'Outrage as Blair attacks public sector' (EWP4), the English White Paper seems almost an afterthought. The concluding paragraph notes that, 'Targets set in the white paper, *Saving Lives*, are aimed at Britain's most deprived areas, narrowing the health gap between rich and poor'.

Mr Dobson's intention to 'end the divisions which mar our society' are communicated in the *Independent* (EWP5). The Conservatives are 'caricatured' according to the columnist, as 'cold-hearted bourgeois, ignoring the tubercular hackings of the poor in the knowledge that their middle-class voters were all with Bupa anyway'. The comments of Dr Liam Fox, the Conservatives' newly appointed shadow Health Minister, centre on Frank Dobson's assertions that inequalities still exist in Britain. However, he interprets the issue in relation to resource allocation, enquiring: 'Is he actually stating that there's regional inequality in NHS funding?' The Conservative spokesperson goes on, lambasting Mr Dobson for his 'class warfare rhetoric'.

The accompanying *Independent* editorial, 'The peoples' road to hell is paved with government advice' (EWP6), goes on to do some caricaturing of its own:

> 'The rocket-eating classes may walk through the poorer streets of our cities, horrified at the junk-food, couch-potato obesity that is beginning to be a classic sign of poverty here... They may raise their eyebrows at all the young women smoking (social taboos shift, but they never go away)...but it is as well to remember that once the warnings have been sounded, people have the right to go to hell their own way.'

It is emphasised that, amongst all the healthy-living messages, individuals can still choose how to conduct themselves. In fact, the editorial emphasises individual choice, and counters this view against the findings of the Black Report:

[54] See Chapter 4 (The Acheson Report).

'Determinists, like the authors of the famous 1980 Black report on inequalities in health, might say that almost all the discrepancies relate to the wages people get (or don't get), the houses they live in, and the schooling they receive. But, within those parameters, individuals do make choices. The new proposals could help some individuals to make them more wisely. It is as well, however, to be aware of the limits.'

A letter appearing in the *Independent Review* section a few days later relates the White Paper to the Acheson Inquiry. This is only one of two occasions the Acheson Report is referred to in the English White Paper sample period. Under the heading 'Cold comfort' (EWP27) the letter writer asks:

'Why does Frank Dobson's White Paper, *Our Healthier Nation*, ignore the recommendations of his own independent inquiry into health inequalities, chaired by Sir Donald Acheson? The Acheson report recommended in three places that home insulation was needed to reduce health inequalities caused by fuel poverty ... Yet *Our Health Nation* provides for no role for health authorities in tackling what is admitted to be a severe problem.'

The *Guardian* gives surprisingly little mention to health inequalities in its news reports on the English White Paper. However, it is in the newspaper's editorial where a verdict is given on the government's actions. The item 'Public to operate heart machines' (EWP1) mentions only that the document is to 'focus attention on the poorest social groups, whose health risks are usually well above average'. The following day, inequalities are given more prominence in the item 'Children to assist in crusade to save lives' (EWP7). The sub-headline states: 'Dobson reveals measures to reduce deaths by 316,000 over the next decade in a move to close the health gap between rich and poor'. Although the government's desire to close the 'health gap' is repeated in the item itself, little else is reported on the subject. It is stated only that 'The strategy was broadly welcomed by health campaigners, but there was criticism of the focus on disease, instead of on more general health inequality'. However, sources making these criticisms are not included in the item.

The satirising of Mr Dobson's desire to see people in Barnsley and Bethnal Green as healthy as those in Surrey or Sutton Coldfield in the *Guardian's* political column (EWP8) is neutralised in the editorial appearing in the same edition. The sub-heading to 'Our

national health' sums up the *Guardian* editorial's view: 'Good ideas, but plans dodge inequality' (EWP9). Amidst a number of doubts expressed about government policy, the item states that there is:

'...cause for concern on what is the most pressing issue on [the] nation's health agenda: the widening health inequality between the richest and the poorest outlined in the report of the Acheson Commission last November.'

The item then cites statistics to emphasise the worrying nature of inequalities:

'Infant mortality rates in unskilled families are more than twice as high as in professional families; life expectancy is eight years shorter in poor inner-city neighbourhoods. Yet the white paper gives no strategy or targets for reducing inequality.'

Responding to the argument that national targets would be meaningless, the editorial states, '...a national strategy and target gives the issue high profile, and focuses political will. It is a lamentable gap'. The following day, it is enough for the writer of 'Corporate causes of cancer' that the government has put inequalities on their agenda (EWP20):

'The government recognises that better public health means correcting inequality and social exclusion, as well as bad personal habits. It is investing hundreds of millions of pounds in "healthy living centres", "health action zones" and a programme to help people give up smoking.'

The *Scotsman*, the only Scottish-based newspaper to report on *Saving Lives*, is not convinced by the government's intentions to reduce inequalities in health. It describes Mr Dobson's statement to the Commons as having an '...un-Blairite stress on social class and inequalities in health – which may not play very well in Middle England but is undoubtedly rooted in reality' (EWP21). Trying to explain such inequalities in part, the writer continues:

'This is the deep truth about all British public services: intended to equalise, they have in fact acted as hand-outs to the middle-classes who no longer have to pay for, for example, education and medical treatment which they access more successfully – which is to say unequally – than those who need it most.'

Rather than actually taking steps to reduce inequality, the writer views Labour in the most cynical light: 'Worse, let's blather hypocritically about inequalities without genuinely reducing them'. Although doubt has been expressed about the government's resolve in previous items, both in this sample period and past ones, the *Scotsman* columnist goes further, listing the actions he views will make a difference:

'But then to do that [reducing inequalities] would mean, yes, hard thinking about rationing in the NHS tied to a huge expansion in spending on primary care in communities which need it most. It would mean better public transport so that poor people could actually get to supermarkets with the best, cheapest food as well as to hospitals with the best record of treatment. It would mean a minimum wage that is not an insult to a civilised society. It would mean taking on the food companies who peddle pap to the proles while buying influence over New Labour. It would mean a well-funded and rigorous educational system – which gave young people access to modern skills and a higher standard of living. It would mean significant investment in social housing. And all that would mean more people living longer and better, whether or not they make it to the gym or Gregano's.'

However, the writer concludes that New Labour 'won't actually do most of this'. Accompanying the item is a picture which would not look out of place in the coverage of the Acheson Inquiry (see chapter four). The image shows a man eating a chip supper outside a betting shop; in the foreground a boy looks as though he is tucking into something equally greasy. The caption reads, 'Snack time in Greenock, voted as one of Britain's unhealthiest places: can Scotland's parliament make a difference?'

The only tabloid to report on the publication of the English White Paper, the *Daily Express*, includes Frank Dobson's assertions that the government's policies 'are designed to improve most of all the health of the least healthy' (EWP19). The journalist describes how Dobson 'clashed with the Opposition when he said he aimed to drive up standards so people in Labour heartlands got the same care as those in 'comfortably off' Tory areas'. In response, Dr Liam Fox, shadow Health Minister, interprets Mr Dobson's argument as an attack on resources:

'Frank Dobson has effectively declared war on health funding. His implication that more affluent areas are over-funded will send shivers of fear through patients and doctors alike in many parts of the country.'

6.4.1 The English White Paper coverage: Summary and Conclusions

Items reporting on the English White Paper during the sample period were plentiful, yet as in the previous sample periods, coverage was restricted overwhelmingly to broadsheet publications. The *Daily Express* was the only tabloid to report on *Saving Lives*. Reporting of the English White Paper was somewhat overshadowed by the BMA's annual conference.

The patterns of reporting observed in previous sample periods are not as apparent in the English White Paper sample period. The *Guardian* takes a less enthusiastic role than previously in the inequalities debate. However, what is notable is the prominence given to the issue in a right-of-centre newspaper such as *The Times*. Whilst the *Independent* championed the plight of those on low incomes in its coverage of the Acheson Report, their stance changes dramatically in reporting the English White Paper. Individual choice and freedom to choose are highlighted ('people have a right to go to hell their own way'), a far cry from the testimonies of those living in deprived areas featured at the time of the Acheson Report's publication. Even the *Sunday Times* gets in on the inequalities debate, looking at Britain's performance in terms of healthcare provision when compared to other European countries as well as UK-wide disparities.

Whatever the difference in reporting of inequalities between newspapers, one trend is clear. Running through all coverage (mainly broadsheets) is the reporting of government rhetoric surrounding health inequalities, at the very least, and the government's intentions are communicated clearly in coverage of the English White Paper launch. Different aspects of the reporting of inequalities in health in previous sample periods come together in the English White Paper sample period. The government's voice is heard thanks to Mr Dobson (and his own personal conviction surrounding the issue), as well as reference to statistics demonstrating the inequalities in health experienced by low income groups. Furthermore, a political dialogue on the subject is prominent with the ensuing inequalities debate reported between the Health Minister and spokespersons from other major political parties. This is all despite a largely hostile and cynical backdrop to the reporting,

with its strong focus on government weaknesses and inconsistencies.

So it can be concluded that in their coverage of the English White Paper, the UK national press entered into the inequalities debate rather than merely relaying the government line. By constrast, coverage in previous sample periods had a tendency to report the government's message with a less critical eye. However, the notable absence of tabloid coverage meant that a whole section of the press went without reporting on inequalities at all, and the launch of the English White Paper was often overshadowed by other news stories.

A dimension to the English White Paper coverage not seen in previous sample periods is the satirical tone apparent in a number of items. This may have had a detrimental effect, trivialising the inequalities debate in the public domain. In particular, the political columns do not help the government's cause and Mr Dobson's conviction to reduce inequalities is reduced to humour. The 'haves' in 'Tory' areas versus the 'have-nots' in Labour heartlands are satirised, perhaps resulting in the issue not being treated with the seriousness it deserves. So, although a number of aspects of inequalities reporting come together in coverage of the English White Paper, some of these aspects may have had a detrimental effect on public perceptions of the issue.

Now that I have given an analysis of the presentation of inequalities in the press surrounding five key health policy 'news events' (the publication of the English and Scottish Green and White Papers on public health, and the report of the government-instigated inquiry into health inequalities in England), I now turn in the next three chapters to consider lay views on the media coverage of inequalities, and of health inequalities more broadly.

Chapter Seven

Living as equals or fundamentally unfair? Lay awareness and perceptions of inequalities

7.1 Introduction

The following three chapters present the data collected from focus group discussions for this study on lay perceptions of health inequalities (see chapter two for details of methods). Chapter seven establishes whether people are aware of inequalities, and how they conceptualise them. Chapter eight examines the language used by participants in their discussions of inequalities, their image management, self presentation and awareness of status. Chapter nine determines whether participants relate their experience of inequalities to their own health and well-being, their perceptions of the Labour government and of the media, and their insights and suggested solutions. To facilitate discussion on inequalities, a selection of images and headlines from the content analysis sample periods were used in the focus groups. Employing a 'funnel' approach (see chapter two, methods), discussion began on a general level with a warm-up exercise using the headlines **War on root causes of ill health** [Fig. 1][55] and **Four goals for a healthier Britain could save 15,000 lives** [Fig. 2]. The following section (7.2) details the ways in which participants conceptualise inequalities.

7.2 'Haves' and 'have-nots'? How do participants conceptualise inequality?

The concept of inequity in society is hardly new. The existence of 'rich' and 'poor' is an age-old worldview normally framed as the rich establishment (monarchy, landowners, government) contrasted against the struggling masses. With this in mind, a focus of this research was to ascertain whether participants perceived the situation to be worsening or to be merely maintaining the status quo. Pete[56], a participant from a low income group

[55] Focus group materials are labeled as 'Figures' according to their running order (see table 2.5 'focus group exercises and materials used' in chapter two, p. 72).
[56] All names are pseudonyms and local place names have been omitted to protect the identities of people participating in this study.

responded to the 'estate' image [Fig. 7][57], believing it to be a scene from '... any housing scheme in Scotland'. The group as a whole appeared to be in agreement with this view, and Scott, a charity officer based in the community centre where the group was held, elaborated further:

R4 [Scott]:'I think one of the things it relates to me, and I'm trying to think of it in a very, in a broader issue is – I tend to think there's two types of people now: the haves and have-nots. Now, I think that employment's a big issue in it, and whether that's low-paid employment or not.'
[FG5:6, lower SES, Greater Glasgow]

Figure 7 'estate'

Later in the group Scott continues along similar lines:

[57] Figure 7 is an image of a run down estate with a number of children playing on and around a dilapidated car.

R4 [Scott]:'If you want a minibus now under the New Labour government, you buy the *Evening Times* and save coupons for the disabled. If you want a computer for the schools, shop in Asda. If you want books for the schools, buy Walker's fucking crisps, right. Where's it all going to? Something tells me at the end of the day – the image we were given last year was that the haves were getting more and the have-nots were getting less. Now, I think it's time they redistributed the wealth a wee bit.' [FG5:22, lower SES, Greater Glasgow]

When making these distinctions, it appeared at times as if participants were merely responding to the headlines and repeating a well-worn rhetoric. However, participants from the lower income groups readily backed up their assertions of a widening economic divide with compelling first-hand accounts of their experiences. In a group of lone parents receiving benefits, I ask whether there is any truth in the headline **Gap between rich and poor widens again** [Fig. 15]. First, there is general agreement on its validity before Jane speaks from personal experience:

R1 [Kay]: 'Well it's like the saying, the rich get richer, the poor get poorer.

R5 [Jane]: Cause they're lining their own pockets...they're benefiting themselves, not benefiting us. Whatever they do, it all comes back to them, not us. For instance, all the projects being cut.' [FG1:39, lower SES, Greater Glasgow]

Jane refers to funding cuts, a subject which will be discussed in greater detail later in the chapter. What is important to note now is the drawing on personal experience of an increasingly unequal society. Of the ten groups which discussed the existence of a gap between rich and poor, or 'haves' and 'have-nots', eight were based in relatively deprived areas with the participants living on low incomes (the remaining four groups who did not describe a 'gap' were all relatively affluent). Of the two groups based in more affluent areas, one in particular identified a 'gap' from the outset and went on to unpack in detail what such a divide actually meant. Detailing her 'root causes' of ill health, Marion not only introduces the idea of a societal divide, her answer also briefly speculates on the consequences of such a gap:

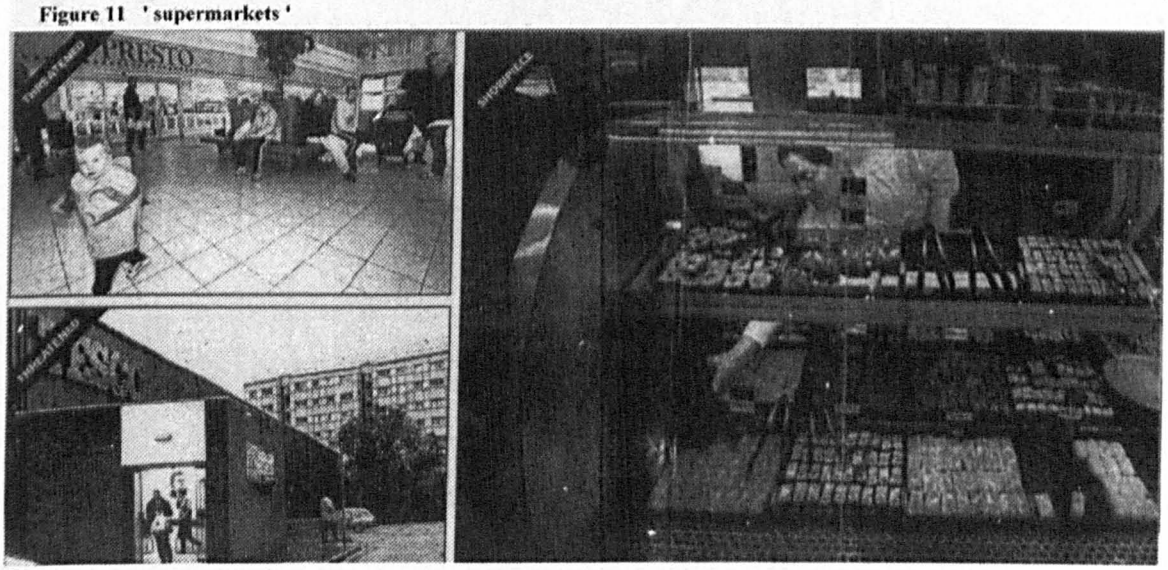
R3 [Marion]: '...I've got lack of meaningful employment, gap between rich and poor, anomie and alienation, which I suppose is part of the same thing...' [FG13:1, higher SES, Aberdeenshire]

The idea of a 'gap' or 'divide' between rich and poor has yet to be introduced formally to the group with the headlines, yet Marion and Sheena are already using the images presented to them in the focus group to illustrate the concept:

R3 [Marion]: 'Yes, bad housing, lack of shops, 'cause that's the only thing isn't it, that a lot of these sort of poorer areas, shops can't afford to keep going. So the only shops that will be there are probably quite expensive, 'cause places like Sainsbury's – supermarkets are out of town aren't they. These people can't get there, um unless, whoever, Sainsbury's put bus services on, so the quality... [referring to Fig. 11, 'supermarkets'[58]]

R1 [Sheena]: I think the whole thing is about this gap between rich and poor, and what this baby is being born into [indicating Fig 6, 'infant'[59]], because all the pictures are basically of poverty aren't they.' [FG13:10, higher SES, Aberdeenshire]

Figure 11 'supermarkets'



Sheena and Marion, unusually as members of focus groups in more affluent areas, speak knowledgeably and empathetically about the challenges faced by those living in deprived areas. Sheena works extensively in the community on a diverse range of projects whilst

[58] Figure 11 is an image juxtaposing two supermarkets labeled 'Threatened' with a 'Showpiece' supermarket featuring a delicatessen displaying luxury items.
[59] Figure 6 is an image of (yawning) baby held upright by a mother-like figure.

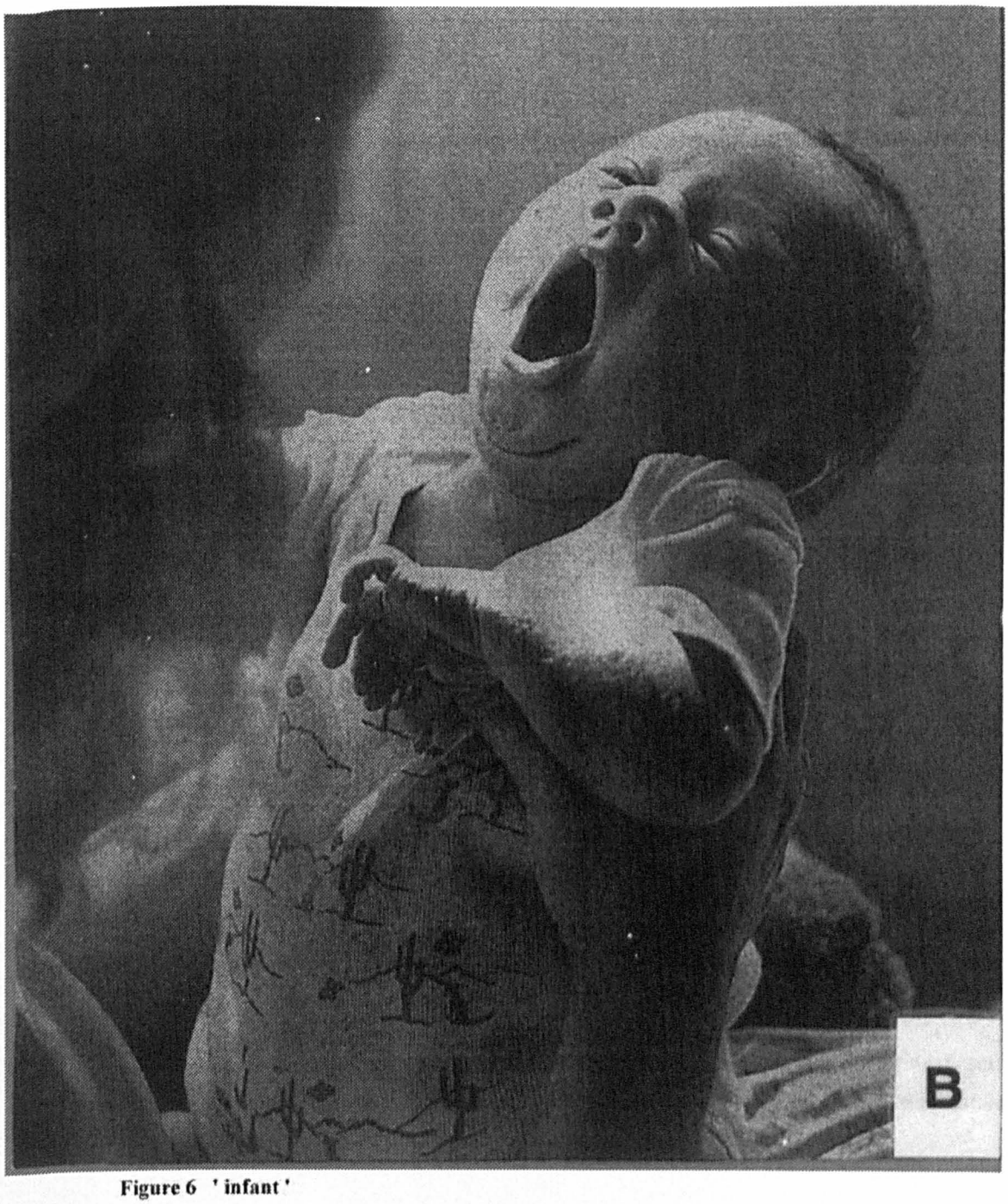


Figure 6 ' infant '

Marion worked for a Social Security Department earlier in her career. This professional experience seemed pivotal in how these - and other – participants from more affluent backgrounds talked about those less materially fortunate than themselves. It also allowed participants such as Marion and Sheena room to speculate on how their more affluent peers viewed those on low incomes:

R1 [Sheena]: 'Then we also know quite a few people in Aberdeen who are living in situations like this [referring to images depicting deprivation], and it's a terrible struggle because first of all your address makes it difficult for you to get employment because 'oh you come from such and such an estate'. You're likely to have had poorer schooling because you come from that particular area. Your parents don't move to get you to a better school or anything.

R3 [Marion]: Because they just can't.

R1 [Sheena]: And generally you're just on the way down. Meanwhile, people here in [Aberdeenshire], on the whole, are doing quite nicely, thank you. And I can see it increasing, there's less and less in common between the haves and have nots. And I think you were right when you were talking about the war experience [referring to R4, Constance's comments made earlier in the group], there were a lot of horrible things happening. I personally didn't suffer but everybody was in that more or less together.

R4 [Constance]: They pulled together.

R1 [Sheena]: Yeah, yeah. A common cause. This isn't the case now, on the whole, not all, but a lot of people who are well-off are sort of, 'well thank you very much, we're alright'.'
[FG13:11-12, higher SES, Aberdeenshire]

Speculation on how others view those less fortunate than themselves as well as awareness of deprivation in the first instance occurred in another higher income group. Bearing out the idea that personal experience is instrumental to attitude, Brendan states:

R1 [Brendan]: 'I don't think people realise the extent of the poverty – unless you actually live or work, sort of have anything to do with the areas. You know, why would, you wouldn't. People live in sort of bubbles from each other.' [FG14:6, higher SES, Greater Glasgow]

Brendan recounts later in the group his experiences of attending a working class school in a deprived area of London. It is unclear on this occasion whether another participant, Niall, has had such direct experience, yet he reinforces Brendan's opinion:

R4 [Niall]: 'Also estates in Glasgow – Manchester in Hulme, Mosside. I think they're real portrayals [referring to images] of how people are living in quite – and they're not in isolated areas, much more prevalent than we'd like to believe.' [FG14:6, higher SES, Greater Glasgow]

This group identifies a widening gap in society when discussing the 'supermarkets' image [Fig. 11], which is interpreted as a sushi counter (the image shows Sainbury's flagship store in South Kensington, West London):

R3 [Sheetal]: 'It seems to be about the sort of widening gap between poverty and...

R2 [Sian]: The sushi bar, d'you know what I mean [Fig. 11]. I mean how many people are going to sushi bars.

R4 [Niall]: It's the haves and have nots isn't it, you know.'[FG14:7, higher SES, Greater Glasgow]

When questioning Sheetal's view of a widening gap between rich and poor, it is clear that Sian's conception at least, is strikingly different to participants from lower income groups. She takes the comparison to the extreme, discussing the rise of young internet millionaires:

I: 'And why do you say widening gap? What makes you think that?

R3 [Sheetal]: Well just the rising increase in gap.

R2 [Sian]: It's getting worse and worse and worse, and I think there is a small percentage, even within sort of I.T. things, the amount of young millionaires now, who have access to sort of, travel, different countries. They want food from different countries, different, different wines, and there's those who don't get that opportunity, and its just getting bigger and bigger.'
[FG14:7-8, higher SES, Greater Glasgow]

As with the previous higher income group (FG13), this group speculates on the impact of this divide:

I: 'And what if that is the case, what do you think the impact is on society as a whole, if the gap is widening, what do you think that means?

R4 [Niall]: Creates two nations rather than one, creates two societies. You have the 'have' society and the 'have not' society and they have their own rules.

R3 [Sheetal]: Create frictions.

R4: [Niall]: Social unrest.' [FG14:8, higher SES, Greater Glasgow]

The idea of a excluded society within society, or poverty as a sub-culture, is expanded upon earlier in the group in relation to drug misuse:

R4 [Niall]: 'I think there's a blanket mentality, I think once you're in it, you don't get out. It's hard to escape, I think there's a sense that you're trapped within it. And I think what happens is that it forms its own societies within those areas, which is why the schemes of Glasgow you have such a massive drug problem because it contains itself within it, it doesn't impact on the West End or on Pollokshields [affluent areas]. But within areas of Drumchapel, areas of Castlemilk, areas of Easterhouse, you know, you have drug taking of such high proportions because it becomes, it creates its own society.' [FG14:6-7, higher SES, Greater Glasgow]

Britain's criminal justice system was the subject of criticism in a number of groups. Participants often linked the existence of a gap between rich and poor in society with a perceived class bias within the judicial system. Deep feelings of injustice and unfairness appeared to link the two together. In one group this was confined to a comment when discussing the murder of Stephen Lawrence[60][61]; 'Ah right, it's like poor people canny get justice' [FG6:24, lower SES, Greater Glasgow]. A group of elderly participants living in

[60] The still unsolved murder of black south London teenager Stephen Lawrence provoked a full scale enquiry of the Metropolitan police force. The enquiry found there to be 'institutionalised racism' within the Metropolitan police force (MacPherson, S. W. (1999). The Stephen Lawrence Inquiry. London, Stationary Office).

[61] The Stephen Lawrence case was often discussed with the introduction of Fig. 9 ['woman with pushchair']. A black woman is shown pushing a child in a pram through a deprived London estate. Participants appeared to link the racial identity of the woman and the deprived area in which she is shown with the perceived injustice of the Lawrence case. Participants did not talk in depth about racial or gender inequalities. The Stephen Lawrence case was the sole exception to this.

a deprived inner city area in Glasgow believed the criminal justice system to be heavily influenced by class and income:

R3 [Margaret]: 'But I mean, going back onto rich and poor again, there is a stigma there too because if you're rich, and you commit an offence, you seem to be able to get off with it, now it's been proved if you've read the paper lately about all these people and all the damage they've done, and look at that chap...

R1 [Betty]: Very lenient with him.

R3 [Margaret]: A-hah, they walked away, them three boys that murdered that other boy because they're all very very well-to-do people, and I think that's a wee bit unfair.

R1 [Betty]: We have a situation in [local area] where a woman, [local area] – you know where you lived Margaret – near the pump well, this woman was coming out her door, her house door, to go downstairs and she caught this young boy interfering with a wee girl, and she managed to grab him and shout and bawl, they got the cops to him, and he, when he came to court... the judge said, well whoever said it was, he from a very good family, his father is a Councillor, a local Councillor, now he was eighteen, seventeen or eighteen, and that guy got – what would he get then – he wasnae, it wasnae even probation, he was to be monitored or something. And I said, 'If that had been wee Jimmy Smith fae Possil, he'd have been in the jail'.

R3 [Margaret]: Oh aye, his feet wouldnae have touched the ground.'
[FG3:47-48, lower SES, Greater Glasgow]

During a discussion about children lacking supervision and vandalising property, Lizzie comments: 'people must think it's an unfair world, how it's divided between the rich and the poor' [FG3:44, lower SES, Greater Glasgow]. The discussion subsequently moves on to how the judicial system metes out justice in very different ways according to social class and status:

R1 [Sandy]: 'I mean, this guy, this guy walked away. He'd interfered with the wee lassie, and because he came from a better, sort of like, maybe say Kilsyth or something like you know, his father was a local councillor, and that boy, nothing happened to him at all.

R3 [Agnes]: That's the gap between rich and poor, you see.' [FG3: 48, lower SES, Greater Glasgow]

Discussion of favouritism toward the wealthy was not confined to low income groups. An affluent group sympathetic to the idea of a 'wealth gap' and existence of a sizeable socially excluded section of society discuss how the rich receive preferential treatment in the courts. Ironically, Marion uses the example of Jeffrey Archer, a millionaire novelist and ex-politician who, at the time of the group, had escaped prosecution despite the widely held belief that he had been involved in illegal activities[62]:

R3 [Marion]: 'Well also, I think, you read so much in the press about these well-off people. But well-off because they're criminal really, like Jeffrey Archer. I mean they are crooks, I mean, they – okay – it's probably, criminals' perhaps a bit extreme, but they have defrauded the system. They've lied and cheated, and of course people who read this, and think, 'well why should I stay on the straight and narrow?' You know, because these are people held up to be examples, you know, popular figures, and they're doing this. So, you know, even more reason if you live on a deprived estate and you think you can go and rob somebody's car.

R1 [Sheena]: Or even take someone else's benefit. I mean, this is seen as such a major crime, and yet compared with the thousands that some stockbrokers and others are fiddling, it's all out of proportion really.' [FG13:12, higher SES, Aberdeenshire]

The perception that there are two extremes of society has been clearly illustrated here. However, a closer examination of the language employed by participants and the image management within groups reveals a more complex picture to be explored in far greater detail later in chapter eight. It is worth briefly noting here that participants did not always conceptualise inequality in such stark terms. The idea of a gradient or 'continuum' as one participant puts it, existing parallel to the concept of the 'haves' and 'have-nots' is also present:

R3 [Marion]: 'And it's almost like there's two extremes isn't it, or maybe it's a continuum. You know, at one end you are powerless 'cause you're poor. But the other end, you could be powerless 'cause you're rich because you tend to sort of live up to your income, don't you.'
[FG13:25, higher SES, Aberdeenshire]

[62] However in July 2001 Jeffrey Archer was sentenced to four years in prison for perjury and obstructing the course of justice.

7.3 Living in Glasgow takes five years off your life?

Discussion generated by the headline **Living in Glasgow takes 5 years off your life** [Fig. 14] yielded interesting observations. What was most striking was the complete acceptance of the concept by a number of the lower income groups. Even when the basis for this figure of five years was explained in more detail, i.e. an average compiled of mortality statistics for all areas of the city, with deprived areas faring far worse than the five-year estimate, the reaction was not one of shock or surprise, but of acceptance. Lower income groups routinely increased the figure to between ten and fifteen years, as the following extract demonstrates:

I: 'So if someone in Drumchapel lived less because of these factors, how much less d'you think they would live, an estimate, would it be months less? Would it be...?

R6 [Pat]: I think it would be a few year, if you'd a good life and everything, a good life.

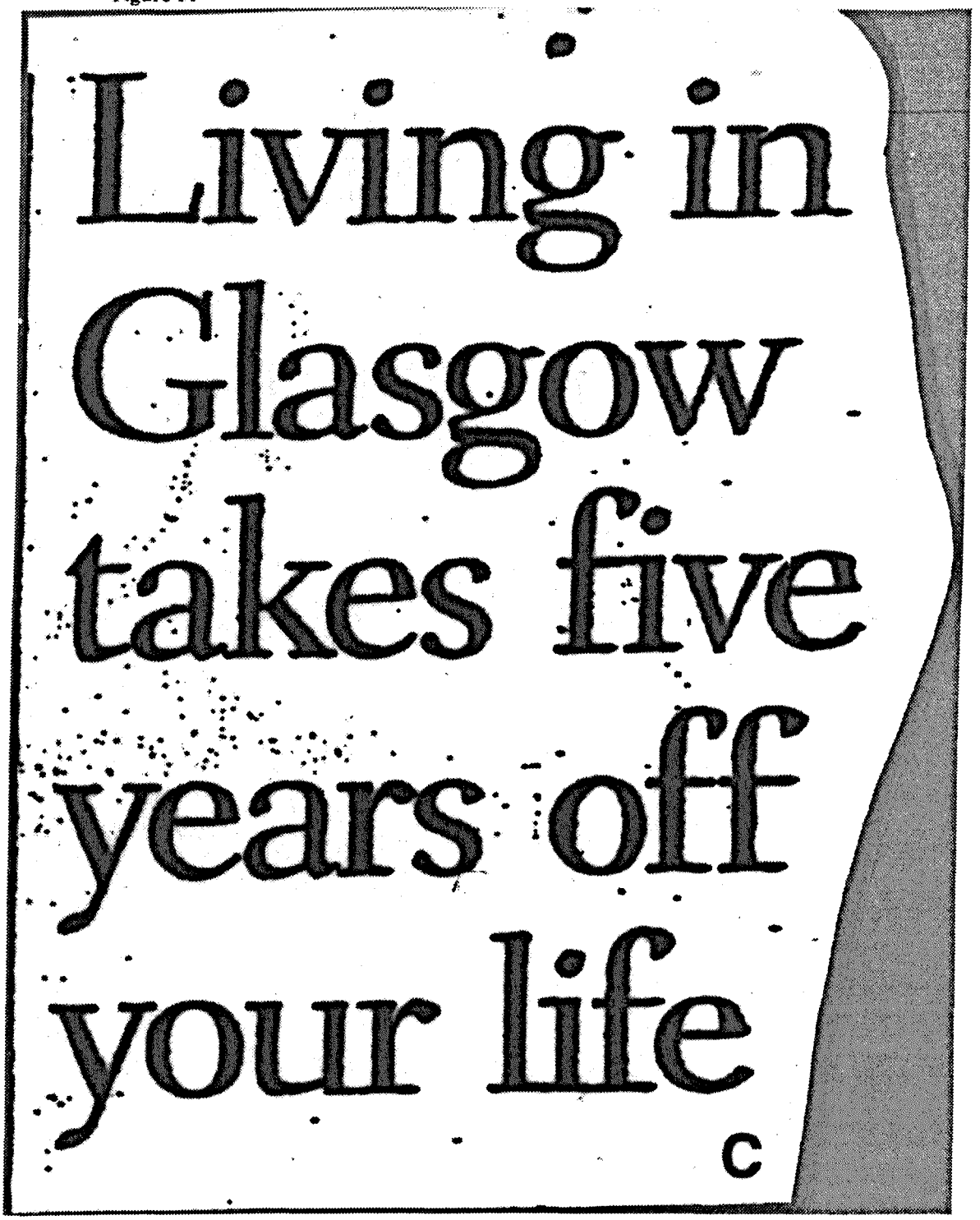
R3 [Alison]: Aye, I think it would be a few year Pat.

R5 [Jean]: If you're good to yourself, you know what I mean.

R3 [Alison]: 'Cause you don't feel fear and you're no threatened and [agreement in background], and you see maybe women wi' a couple of wains and they're out doing crappy wee jobs, and they actually look a hell of a lot older than what they actually are, or maybe about 10, 15 year older. And when you find out the age, you go 'ooch'.' [FG10:28, lower SES, Greater Glasgow]

These women seem to be suggesting that years would be added on to life expectancy if someone had enjoyed a 'good life', as much as that years would be lost from enduring a harsh existence. Alison also focuses on the toll taken on appearance rather than life expectancy, the 'visible signs' of lost years. However, a discussion follows where the women estimate the life expectancy of people residing in areas of Glasgow of varying affluence:

Figure 14



I: 'So could you give me a definite estimate on someone from Drumchapel, how much less they would live?

R1 [Lisa]: I would say in their seventies, they'd probably live to maybe about seventies, eighty at the most.

R5 [Jean]: In years, I'd say between five and ten years, if you've got a good life.

R1 [Lisa]: Maybe somebody in, what, Bearsden, maybe lived to their nineties, nae worries, good pensions.

R6 [Pat]: I'd say a lot of years, nae worries.' [FG10:29, lower SES, Greater Glasgow]

A group of similar status, based in another deprived area of Glasgow, actually laugh when presented with the headline. This reaction is not uncommon, as later groups will illustrate. There is speculation within the group as to whom the headline is referring to, followed by a matter-of-fact, almost resigned tone that such a statistic could only refer to them:

R2 [John]:'The previous, the 'three nations of Scotland' [Fig. 13], you probably say the same of Glasgow as well. So you have the working-class types in Glasgow like ourselves, and you've got middle-classes and you get upper-class people in Glasgow, I mean there's different status, I mean...

R4 [Richard]: Who is it aimed at? Who loses five years off their lives?

R2 [John]: Us.

R1 [Andrea]: Aye, depends on where you live. I think we were second top to Finland or something for heart disease.

R3 [Ed]: Oh well right, that is a heart disease thing.

I: There has been a lot of research on differences between areas, I mean life expectancy and so on. If you think there are differences between areas, how much difference? I mean do you think it would be five years or do you think it might be months or years or more?

R3 [Ed]: That's probably correct, about five years maybe. You get people say in Newton Mearns or Milngavie [two affluent areas around Glasgow City], that sort of place, they may have more money by implication of where they're living, and they can afford to buy the health foods and live the healthy lifestyle, go on their nice holidays. They can afford to go to counsellors that can help them live their life if they've got problems and so on. Money does help problems, they say it doesnae... maybe cannae buy you love sort of thing, but it can help you with everything else...' [FG6:41-42, lower SES, Greater Glasgow]

When asked if five years was an accurate estimate, another group automatically linked reduced life expectancy to the housing conditions endured by their peers:

I: 'So do you think five years is a good estimate or would you change that?

R2 [Jean]: No I would change it, yeah.

R4 [Val]: Aye.

R3 [Sheena]: Look at down the high flats when the doctor went in there to see our Ann-Marie, our Ann-Marie's doctor, he was like that, this is a disgrace for anybody to live in. Says she could get dysentery out of there, in these flats.

R2 [Jean]: I mean that's people keeping clean houses but as soon as you're opening your front door, you're in an enclosed area and it's stinking.' [FG2:13, lower SES, Greater Glasgow]

Later in the discussion, participants are again asked to put a figure on how much they think life expectancy would be reduced, based on the prior assumption they appeared to have that those living on estates would live shorter lives:

I: 'So if you think that people would die earlier in schemes [housing estates largely constructed to re-house from slum clearance areas], how much earlier do you think they would die?

R2 [Jean]: About ten years.

R3 [Sheena]: Aye ten-year would be taken off your life.' [FG2: 22, lower SES, Greater Glasgow]

When participants in this group are told that their estimates are not so far from the truth for those living in deprived areas they laugh. They then go on to cite the factors they think create such a situation:

Figure 12

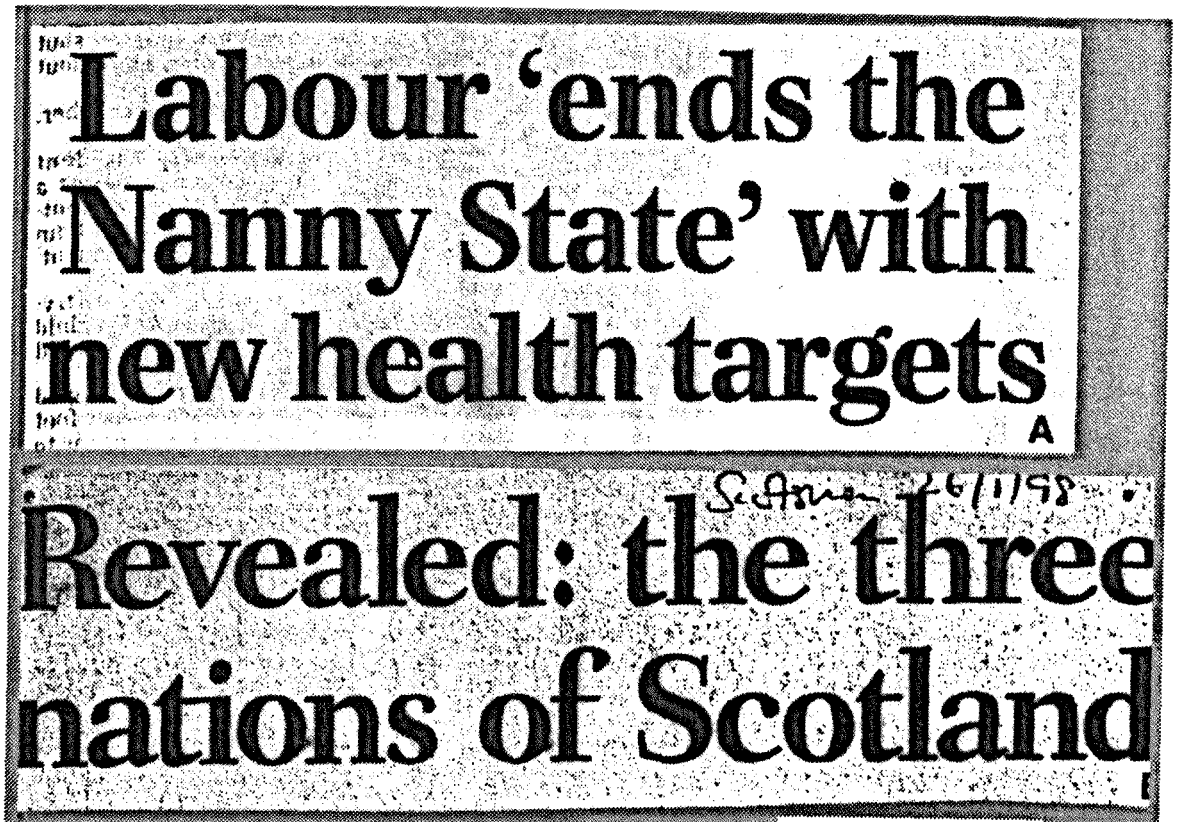


Figure 13

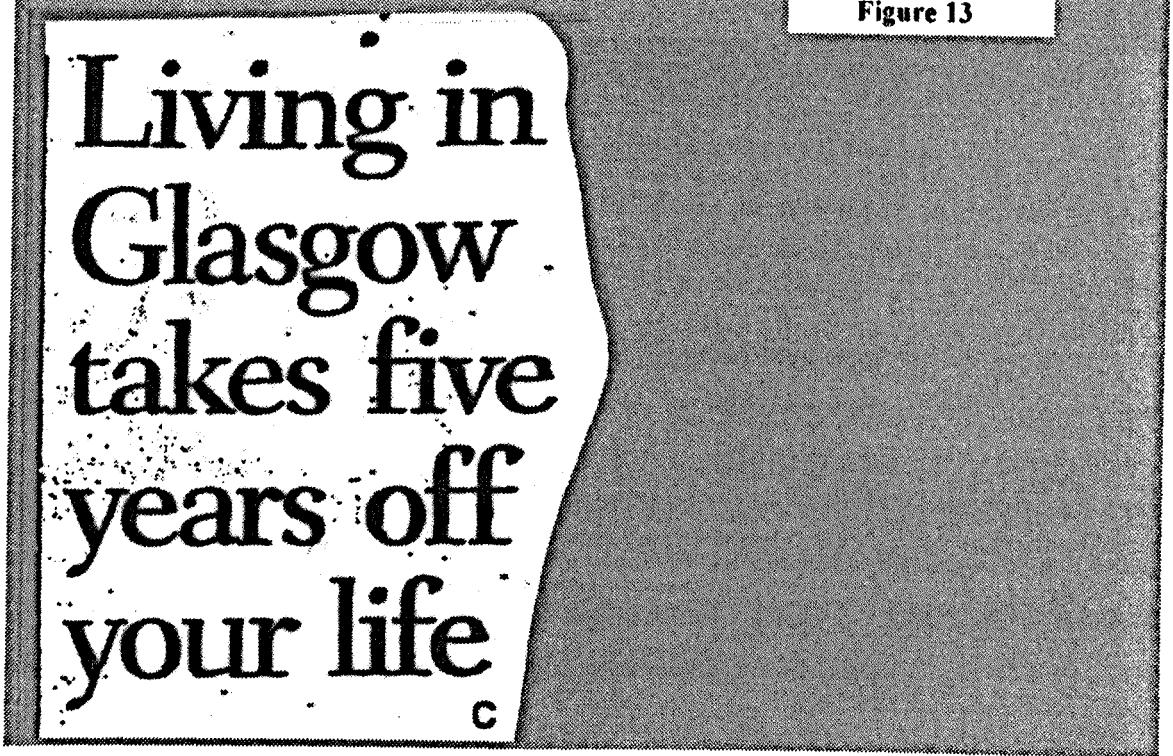


Figure 14

I: 'It is ten years, except it's approximately eight years for women but ten years for men. So why do you think, I know I keep going over it, but why do you think there's such differences in life expectancy between areas?

R1 [Bob]:Again poor housing and then...

R3 [Sheena]:'Cause in Bearsden they've got all the jobs and all that and their motors and everything.

R2 [Jean]: They can afford to live a healthier life.

R3 [Sheena]: And like folk that live in the housing schemes, the men havenae got jobs so they're out drinking and god knows what, stoning about all day.

R4 [Val]: And the rich areas, I bet you there's no as much drugs either as what goes on in these wee places.

R3 [Sheena]: They're drinking and taking drugs and that's like the men are, that's taking more off their life than what it is for the rich ones, isn't it, 'cause they're at work.

R2 [Jean]: They can afford to go away with their saunas and keep fit classes and all the rest of it.

R3 [Sheena]: Whereas the poor have no got any work so, all they do is take drink and drugs isn't it?

R1 [Bob]: That's right.

R2 [Jean]: To pass the time possibly.

R1 [Bob]: Aye, to forg*et all* their worries, just take the drugs and take the drink.'
[FG2:22-23, lower SES, Greater Glasgow]

A low income group conducted in Greater Manchester (in a centre for unemployed men, although the group was mixed) immediately relate the headline **Living in Glasgow takes five years off your life** [Fig. 14] to their own area. Again, the statistics are greeted humorously before Jake adds a more serious tone to the proceedings:

I: 'I've got one last headline, Living in Glasgow takes five years off your life.

R6 [Sonia]: If you live on [local] Lane, ten years off your life [laughter].

I: There's a lot of statistics and reports coming out in recent times looking at how people in cities generally seem to suffer worse health, but it's not just living in sort of highly populated areas. There's big differences in death rates between people who live in poorer areas than those in richer areas, so that's where this headline comes from. Now when it says it takes five years off your life, do you think that's realistic?

R1 [Jerry]: Yeah I do.

R6 [Sonia]: Yeah, yeah

R3 [Jake]: Actually I don't think it's that realistic. I think it's wrong. I don't think you're looking at five, I think more like fifteen. Not ten, fifteen maybe twenty years off your life. 'Cause the older you get, the more susceptible you are to stress. As soon as you're getting, let's say 'a problem', let's say a minor thing like rheumatism or something like that, which creates worry, and then next thing you start worrying about 'oh I'm going to have a heart attack' and this, that and the other. And then with the added stress of where you're living, is going to reduce your, you know, lifespan.' [FG9:42-43, lower SES, Greater Manchester]

Jake emphasises the effects of stress and worry on health and well-being. Cassie, another participant in this Salford group, explains the disparity in mortality rates in terms of health behaviours. However, the conversation seems to go full circle with participants relating lifestyle choices to the need to reduce stress and alleviate anxiety:

I: 'So do you think then about – you're saying ten, fifteen years – any other estimates?

R5 [Cassie]: I think if you averaged it out over the population within a given area, probably five is maybe right because it's going to affect different people differently, within that given area. But somebody who's, people who've been abusive to themselves since being rockaby babies, the baby, and they've learnt how to abuse their bodies through poor diet, alcohol, cigarettes, drugs, whatever. I mean, it can half your life.

R3 [Jake]: I'm glad you said that.

R5 [Cassie]: So yeah. Well, me as well Jake, I'm well aware that this is knocking seconds off me life every time I take a puff [indicating her cigarette], it's doing my head in.

R6 [Sonia]: But it calms you down, it keeps you, don't it. It does.'
[FG9:42, lower SES, Greater Manchester]

A sense of outrage or anger at the headline was surprisingly absent from the majority of the groups. As the previous examples have demonstrated, participants responded by making light of the statistic, or by employing black humour. The weary acceptance of many in the deprived groups that five years or more could be 'taken off' life expectancy suggests that the merriment concealed far stronger, negative emotions. Alternatively, perhaps the statistics had a dehumansing effect, causing participants to not fully engage with the issue. However, it is the former rather than the latter view which holds more credence when considering the reactions of other groups. Anger at the statistic was apparent in a couple of the lower income groups as participants readily related the statistics to their own lives. In one such group, laughter was mixed with the anger, suggesting a negative rather than positive response. To laugh at the situation was to make light of it, to prevent those in the group from dwelling on feelings of desperation. After brief speculation over what the headline **Living in Glasgow takes five years off your life** [Fig. 14] actually means, Jane describes the anguish she has felt at times, after which Kay tries to lighten the tone:

R5 [Jane]: 'It depends on how you look at that, it's funnily worded.

R3 [Doreen]: Lost five years?

R5 [Jane]: Aye we've lost five years off our life, well I have.

I: In what way do you think you have?

R5 [Jane]: One, because I'm a single parent and the age I am. Two, because of the area I'm staying in, and the fighting I've had to do to get what I've needed for the house. The amount of times I've been so depressed because of the way the house is has been unbelievable, that's their fault. I begged for help, they never gave me it. I begged for help and they shut the door in my face. I begged for help

and the councillors werenae there. So you come to the end of the rope eventually, and you've got nowhere else to go, so you do get depressed. But whose fault is it, and that's theirs. So there is five years off my life, and you can't turn the page back, you cannae go back.

R1 [Kay]: You should just take five years off my age and I'll be quite happy [laughter].'
[FG1:36, lower SES, Greater Glasgow]

Even before the 'Living in Glasgow' headline is introduced, a community worker from another low income group introduces similar statistics into discussion:

R4 [Scott]: '...I can tell you now that if you live in Bearsden where they have amenities, they have a ten year longer lifespan than you do in Drumchapel which is less than a stone's throw away from the area. But there's this road that divides the middle of it.' [FG5:8, lower SES, Greater Glasgow]

Later in the group another participant, Sarah, matter-of-factly increases the headline's figure of five years to 'ten or fifteen' years of life expectancy lost [FG5:25, lower SES, Greater Glasgow].

By contrast, the more affluent groups in the sample tended to show an ambivalence toward the statistics. Such groups would modify their reasoning in the course of discussion from acknowledging the statistics as an accurate depiction of the toll taken on health from living in a deprived area, to questioning their validity. Again, this is testimony to the pivotal role of personal experience. Higher income groups who had direct experience with those living in deprived areas were in turn more likely to take the statistics presented in the headline seriously. Curiously, more affluent groups tended to cite pollution as a possible cause for mortality variations, yet participants rarely expanded on this suggestion. These themes are apparent in a group consisting of marketing and public relations professionals working in theatre:

R3 [Sheetal]: 'Well I think saying to everyone that for the sheer fact that you live in Glasgow is taking five years off your life, I mean it probably says a lot about pollution in Glasgow. But I think it's unreal, because someone living out in Milngavie or Bearsden, probably got a better chance of living longer than somebody from the East End of London, so...

R4 [Niall]: I think what this illustrates is that if you average out the whole population of Glasgow, the expected life, your life expectancy is on average five years shorter in Glasgow because, there is huge underbelly of society who are dying much younger because of all we've been talking about. The whole social conditions – the average, whereas for me, cosily ensconced in [affluent Glasgow area], it doesn't affect me particularly. You know, it doesn't, it won't take five years off my life and I live in Glasgow. But across the average of the city, the quality of life is so poor in large areas, that that's the net effect of it.' [FG14:20-21, higher SES, Greater Glasgow]

Higher income groups appear to conceptualise the inequality in mortality rates depicted in the headline on a UK-wide rather than a city-wide level. A comparison with London appears in another middle class group of young graduates, as well as conflict over the statistics themselves:

R6 [Sam]: 'I mean when you saw this headline did it surprise you, did you think mmm, or were you ...?

R5 [Sadie]: It's the way it's worded I s'pose that some people are ... mortality rates.

R6 [Sam]: If it was Glasgow compared to Edinburgh or compared ...

R3 [Sandra]: Or compared to London.

R6 [Sam]: Yeah, as opposed to different areas of Glasgow.

R1 [Hannah]: Which I don't think's true at all.

R6 [Sam]: Takes five years off your life, so just by living a few miles down the road you could live five years less?

R5 [Sadie]: I would say that's perfectly feasible.

R3 [Sandra]: I believe that.

I: You think what's not true [directing question at Hannah]?

R1 [Hannah]: No I don't think Glasgow's particularly – I know that they always say that the West of Scotland heart rate being so bad, but compared to London, there's terrible poverty down there.' [FG12:48, higher SES, Greater Glasgow]

The ambivalence of more affluent groups toward the 'Living in Glasgow' headline was often coupled with humour. This observation has already been made in relation to the lower income groups in the study. However the jokes made in the course of discussion in higher income groups were markedly different in tone. Initially, a group of young graduates based in an affluent part of the Lothian Region accepted the premise that living in Glasgow could lower life expectancy. Later in discussion when the group is asked to estimate whether a five-year reduction in life expectancy seems accurate to them, they become critical of the statistics behind the headline:

I: 'There's been a lot of research done about how people, the life expectancy of people in affluent areas compared to people in deprived areas, and I was wondering whether you think five years is a good estimate, or whether you think it's maybe, somebody living in an affluent area might expect to live, I don't know, weeks longer, months longer, years longer, what do you think?

R4 [Catriona]: Depends on the individual.

R2 [Geena]: I don't think that's necessarily true 'cause...

R3 [Philipa]: It's a very sweeping statement I think. I don't know how they've managed to get away with making a statement like that...Just because you live in a well-off area doesn't mean to say...

R1 [Jill]: You can have a hereditary disease, or you can have alcohol problems.

R3 [Philipa]: Yeah, uh-huh, 'cause it was alcohol and drug problems like we were saying before were moving more and more into...

R4 [Catriona]: The upper class.

R3 [Philipa]: ...the upper class, so I don't think you can separate it into class problems that way. I mean, things like cancer you just don't know who's going to carry it, or M.E. or...

R1 [Jill]: I don't think, research does show eh some things, pollution and things affects asthma, or lung cancer.' [FG8:30, higher SES, Lothian Region]

When it is suggested that the figure of five years has been calculated as an average of all areas, and that in fact people in deprived areas are predicted to die between eight and ten years earlier than those in affluent areas, the group begin to joke about the statistics:

I: '...A man would die ten years earlier on average in a deprived area than a man in an affluent area, and it's eight years for a woman. Which is again going on statistics and averages, but there seems to be a clear difference between the areas.

R3 [Philipa]: Probably because they've been shot [laughter].

R2 [Geena]: They've been drugged or shot [laughter].

R3 [Philipa]: ...stabbed. But I mean, does that take into account things like that? Shootings, stabbings, drug overdoses, or is that just natural deaths?

I: Mmm, I think it's probably all causes, it would be everything.

R2 [Geena]: Sixty years then [laughs].

R4 [Catriona]: They all get gunned down at twenty.

R2 [Geena]: I know [laughs].' [FG8:31, higher SES, Lothian Region]

A group of office workers appear to accept the statistics behind the headline and suggest spontaneously that the five year figure could be an average hiding starker differences in life expectancy. However, the humour displayed is very similar to the previous group:

I: '...Maybe you think it's weeks or months or years that someone might expect to live longer in an affluent area, compared to a deprived area, what do you think?

R1 [Denise]: Well maybe two or three years difference.

R3 [Janice]: I think it would be greater than that, I think it would be more than five years.

R4 [Debbie]: It would be, well...

R3 [Janice]: I would say it would be more like ten because five's the average.

R4 [Debbie]: I think if it was five on average I would set the rest of Glasgow back, you know, the more affluent part of Glasgow back with the rest of this.' [FG7:11, higher SES, Aberdeenshire]

The group are then asked what factors might cause such variation in mortality rates between areas, to which Janice replies:

R3 [Janice]: 'Diet, cigarettes, alcohol, stress, drugs, prostitution [laughter], they've got to be, they're all real.' [FG7: 11-12, higher SES, Aberdeenshire]

In groups containing participants of pensionable age, the ambivalence expressed by the more affluent groups was replaced by disbelief as the implications behind the statistics sank in. Such a reaction appears to be based on older participants recalling a time when 'real' poverty existed. Within this frame of reference, inequality as a social problem had little impact. Nobody, in their view, was 'that' poor and therefore inequalities became meaningless. Sheena, a community worker in her seventies sets the tone in the next group, commenting that the headline conveyed 'just a statistic' [FG13:29, higher SES, Aberdeenshire]. Whilst Sheena and the rest of those participating in the group appear to empathise with the concepts of relative deprivation and social exclusion, Constance finds it difficult to reconcile her right-wing beliefs in order to agree with the group as a whole. She has witnessed decades of enormous social change which have in turn brought inconceivable improvements to living standards:

R4 [Constance]:'I suppose it could be years, but the only other side of it I would say, again trying to be optimistic, is that on the whole, everybody lives longer than they used to. So that the poor would have died earlier. I'm not saying that there aren't poor people who die earlier than rich people now, but they would have died even earlier, so that hopefully it's moving forward.'
[FG13:33, higher SES, Aberdeenshire]

Earlier in the group, Constance had questioned whether the economic gap between the affluent and deprived had increased at all:

R4 [Constance]:'Do you think really overall, the gap has increased? There are a lot of people who are much better off than they were, and are there so many people in real, abject poverty as there used to be? Bearing in mind of course that the population has increased enormously. If you go back to Victorian times for instance, where there was real poverty and people with masses of money, has the gap really increased overall?' [FG13:21, higher SES, Aberdeenshire]

A group of pensioners living in a deprived area of Glasgow spend the latter stages of their discussion deconstructing the 'Living in Glasgow' headline. Again, they are less likely to entertain ideas of poverty and inequality. Pollution is cited as a possible cause of disparities in mortality rates, but distrust of statistics wins through, with the focus this time on the 'average' wage:

R5 [Mary]: 'Statistics is rubbish.

R6 [Robert]: That's another thing. Average, average is only a word.

R5 [Mary]: Aye, on the average wage you take the highly paid and the poorly paid and add them together and tell you the average wage is such-and-such a thing which...

R4 [Bob]: And it's half that.

R5 [Mary]: My husband's never earned in his life, what they tell you is the average wage.

R6 [Robert]: Averages, averages doesnae apply to anything feasible. I mean if you go along to a dress shop and she says 'go out, go out and measure all the women – a hundred women'. And she goes out, she goes 'there's fifty women at six feet and fifty at five feet, so the average is five feet six'. So she makes a hundred dresses at five feet six and it fits naebody. [laughter]

I: Right, right. So you're very sceptical about these figures.

R6 [Robert]: Yes, uh-huh, yes.

R4 [Bob]: As Bill says, figures lie.

R6 [Robert]: I mean you, you take, now you talk about the average wage, say the average wage was a hundred pound a week. That means that some men's getting seventy and some men's getting a hundred and thirty. Now, imagine a man that gets seventy pound a week, he comes in, his wife's just read the paper. The average wage is a hundred and thirty pound – he comes in with seventy. He gets a belting – where's the other sixty pound coming, you know. She thinks he's keeping it.

I: What, as in he kind of feels robbed because he's not earning what everyone else is.

R6 [Robert]: That's right. It's only a word, it doesn't mean anything. It's just a word.'
[FG4:66-67, lower SES, Greater Glasgow]

What is interesting in this discussion is the visualisation, and implicit acceptance of, a gap. The 'average' does not exist, but the man earning seventy pounds a week, and the man earning one hundred and thirty, are held up as the reality.

So far this section has highlighted the tendency of participants to identify a 'gap' between rich and poor in contemporary Britain. Many, though not all, see the divide increasing; a seemingly irreversible polarisation of the affluent and deprived. Reaction to the headline **Living in Glasgow takes five years off your life** [Fig. 14] appeared to vary according to the socio-economic status. Participants from lower income groups reacted with little surprise (and often complete acceptance) to the statistics, whereas an ambivalence toward the figures was apparent in the more affluent groups.

7.4 The Queen Mother and skipping the queue: Inequalities in healthcare

Discussion on inequalities was not confined solely to health outcomes. A clear finding from the group discussions was that, before the 'Living in Glasgow' headline [Fig. 14] was introduced, participants did not spontaneously discuss health inequalities in terms of variations in mortality rates. In fact, participants often talked with more spontaneity about perceived injustices in Britain's healthcare system. Inequalities in healthcare provision and resources, and the duality of a public/private system seemed to be tangible topics of

discussion that attracted established viewpoints. Particularly potent was the idea that people could queue-jump in order to receive medical treatment. Strong feelings of injustice were expressed. Participants on low incomes tended to position their accounts in relation to those who could afford private, preferential treatment, and jump the queue. Whilst an aetiology of individual diseases, and with it a discussion of celebrity accounts of illness, was not a strong feature in this study, occasional references to well-known figures were made. In a discussion of waiting lists, a low income group compares their experience of the NHS whilst speculating on the standard of treatment the Queen Mother received:

R5 [Jane]: '...too long for a child. I'm not saying it should be longer for an adult but I think children should have priority. But he [Jane's son] waited nearly eight months, in fact it was longer than that I think... I think that was a long period to leave a child.

R6 [Helena]: See the Queen Mother, she got her hip replacement right away practically.

R5 [Jane]: She's paying for it, she's paying for it. But saying that if they've got a list, whether you're paying or not, it should go by who was in first should be served first.'
[FG1:47-48, lower SES, Greater Glasgow]

A group of similar socio-economic status also express their concern about people moving to the front of hospital waiting lists because they have private health insurance or can afford to pay. A well known public figure is mentioned in the course of discussion, but nobody can recall who this figure is:

R2 [Jean]: 'Because people that's got money they can just go in and pay for it, get their operations there and then.

R1 [Bob]: Aye, aye jump the queue and that no

R3 [Sheena]: They can go to their private, they can go to...

R2 [Jean]: Cause it was in the paper not long ago that somebody just went in, some old guy was waiting on an operation for I think it was nearly a year or something and this guy went in and paid for it and got it there and then ... that was a couple of weeks ago ...

R3 [Sheena]: And yet there's folk that's dying with it.

R1 [Bob]: He jumped the queue too.

R3 [Sheena]: And the folk that are dying canny afford to pay for it.'
[FG2:18-19, lower SES, Greater Glasgow]

A nurse working for the National Health Service adds her professional insight into the subject as part of a more affluent group. The same sense of injustice and unfairness comes through in her account:

R3 [Philipa]: 'I think as well if you've got the money you can afford to go private for health care, and things like that and ...

R4 [Catriona]: They skip the queue, the wealthy people skip the queue. So that's basically what they're doing.

R3 [Philipa]: You and Jill should know about this [speaking to R1], being a nurse.

R1 [Jill]: But they still get treated in NHS hospitals, like, if they had surgery or something they would go to like Murrayfield to get it done, but then they would come back, still and the same consultant in an NHS hospital, and like NHS nurses would be caring for them, even though the doctor would be getting paid for it ...

R4 [Catriona]: I agree with that because there's no extra staff for these people ...

R1 [Jill]: And then plus you've got other patients on the ward, and perhaps – these patients do need a lot of time and that, and you're neglecting your other patients who aren't paying ...

R4 [Catriona]: 'cause you're expected to be, like spend more time.

R1 [Jill]: Yeah, uh-huh, you're expected as well like, to be nice to them and the consultant'll come down personally and see these patients. They won't come down and see the other patients, but they will see these patients to make sure they get their fucking money.'
[FG8:22-23, higher SES, Lothian Region]

Another affluent group describes such a scenario in far more neutral terms:

R4 [Debbie]: 'I mean, as well, em people that are better off have health insurance or can go privately, you know, if they have problems. Whereas I suppose the poor can only wait on the National Health waiting list if they need to go into hospital for anything.' [FG7:7, higher SES, Aberdeenshire]

A similar conclusion is formed by Jean, a participant from one of the low income groups:

R2 [Jean]: 'But I think a lot of the things to do with this and all and I don't blame... I'm no blaming the nurses or anything, but a lot of them are overworked so you're no getting...

R4 [Val]: The care that you should.

R2 [Jean]: Aye, the care that you should get. I mean half of the doctors in the hospital are working there in the health service right, but then at night they're going to their private practices and working there and all, so they're kind of rushing through our lot and then going to a job that they know they're getting the money there and then.' [FG2:20, lower SES, Greater Glasgow]

Another participant described the NHS as having 'two-tier health facilities' [FG6:2, lower SES, Greater Glasgow], and participants often felt that it was the 'undeserving' that skipped waiting lists and received free treatment. Mary, a woman in her seventies from a deprived area of Glasgow, felt aggrieved at having to pay for medical services and treatment:

R5 [Mary]: 'I find it's, a lot of this, it's people that's worked and saved that are still the culprits, 'cause they've got to pay for all this. It's the people that don't work *get all* that treatment free.'
[FG4:45, lower SES, Greater Glasgow]

Others in the group disagree with Mary, believing the provision of health centres and services in the area to be excellent. However, Mary continues with her line of argument:

R5 [Mary]: 'I've still got to pay, I've got to pay over a hundred pounds for glasses and I need glasses every year and I'm a pensioner. I don't get anything. Not a thing. The only thing I got was a free, free eye test. I was over a hundred pound for false teeth and all.'
[FG4:46, lower SES, Greater Glasgow]

The identity of those seen to be getting medical treatment or services free of charge is speculated upon further in other groups. Participants tended to single out certain 'problem groups' in society, namely lone parents, 'feckless' young women and drug users. Such comments arose in a couple of groups of varying socio-economic status. However, the more affluent of the two groups appeared to be harsher in their judgement. The lower income group, based in a deprived inner city area of Glasgow, refers to pensioners in a manner similar to Mary in the last extract, in this case in contrast to the 'undeserving':

R2 [Ian]: 'There's a lot of people who deserve, and need more, pensioners and whatever, don't get it, and others. There's countless stories of young girls getting pregnant and then... [R3 agreeing in background]

R3 [Margaret]: Exactly, and houses and what have you, aye, jumping the thingmy.

R5 [Carole]: But then the housing tell them to do that. 'Get pregnant and you'll get a house.'

R1 [Betty]: That's right, that's right.

R3 [Margaret]: Aye, but even you've heard people that's really ill, waiting for operations, and they're told, oh, you'll not get an operation for four or five years, and yet... what I really get a wee bit annoyed about is the people that are using drugs *get all* the attention they can get, sometimes they abuse it, like everything else... I mean they don't have to wait on the waiting list. Everything's all fit into their hands, you know.' [FG3:10, lower SES, Greater Glasgow]

Affluent participants from another group seem particularly harsh in their judgement of particular groups of patients, in this case women seeking to terminate a pregnancy.

Women having abortions were 'clogging up the system', taking resources away from 'deserving' citizens:

R5 [Alice]: '...but why should we keep paying for people to have abortions when there's people who have paid into the health system all their lives, they want new hips, they want this, they want that.

R4 [Connie]: And they can't get them, yes.

R5 [Alice]: They can't get it because a lot of these girls are queuing up for abortions...

R3 [Elaine]: I didn't think they were queuing up. I thought they were all having babies [laughter].'
[FG11:21-22, higher SES, Greater Manchester]

Not all the more affluent groups were as unsympathetic in their discussion of unequal access to healthcare. Other participants expressed views which were more balanced and empathetic in tone. A group of young graduates speculate on how those in deprived areas might expect to receive less in terms of healthcare provision:

R2 [Geena]: 'Yeah, I don't know, if they're in poorer areas...health visitors and things, I don't know. Maybe concentrating more on people in the rich areas. They're maybe neglected.

R4 [Catriona]: Plus, poorer areas won't be able to afford six pound, however much it is, for a prescription [agreement] so they'll just, yeah, stay in bed for another week or two.'
[FG8:27, higher SES, Lothian Region]

Another, less direct way in which those from deprived backgrounds may be discriminated against is discussed in the affluent Aberdeenshire group. Speculation in this case is reinforced by first-hand experience:

R3 [Marion]: 'I wonder that, 'cause I think, I think there is a tendency from what I've seen from [doctors] to be much more sort of controlling and not explain things. I mean it's like, right go away and take these pink pills. And if some doctor said that to me I'd want to know all – okay, well what are they [agreement]? What are the side effects? You know, what will happen if I don't take them? But I think there's a sort of tendency to treat people as...

R1 [Sheena]: A conspiracy.

R3 [Marion]: Yes, yes [laughs]

R4 [Constance]: Well they often, they don't ask.

R3 [Marion]: Well exactly.

R4 [Constance]: Well either they don't have the confidence to ask. Or they're so used to just doing as they're told, um, and maybe the doctor thinks anyway they wouldn't understand if they were told [agreement].

R1 [Sheena]: But most people do know. I mean if they've got a television you can learn a lot about your health [laughs] from television. We've heard of someone lately who has had very poor treatment from someone that we respect very highly [laughs] as one of our local doctors...'
[FG13:18, higher SES, Aberdeenshire]

A sense of injustice comes across strongly in discussions of unequal provision or access to healthcare. The manner in which this inequality is expressed varied from group to group and by socio-economic status. Whilst participants in more deprived areas focus on those with money being able to jump waiting lists and receive treatment first, a harsher, more judgmental tone emerges in some of the more affluent groups. However, there is a divergence in the higher income groups, with some participants discussing the challenges faced by those less fortunate.

7.5 '...it's not available to me': Broader perceptions of inequality

Participants often conceptualised inequalities in a variety of different ways via anecdotes and stories. It was through personal accounts that participants were able to express what inequality meant to them. A number of participants living in deprived areas expressed concern that their unfavourable living conditions were being hidden by superficial repairs and maintenance so that their area would seem 'acceptable' to outsiders. Consequently they were acutely aware of their status and felt they had a fundamental lack of control over their surroundings. Accounts were also given of funding going elsewhere on what

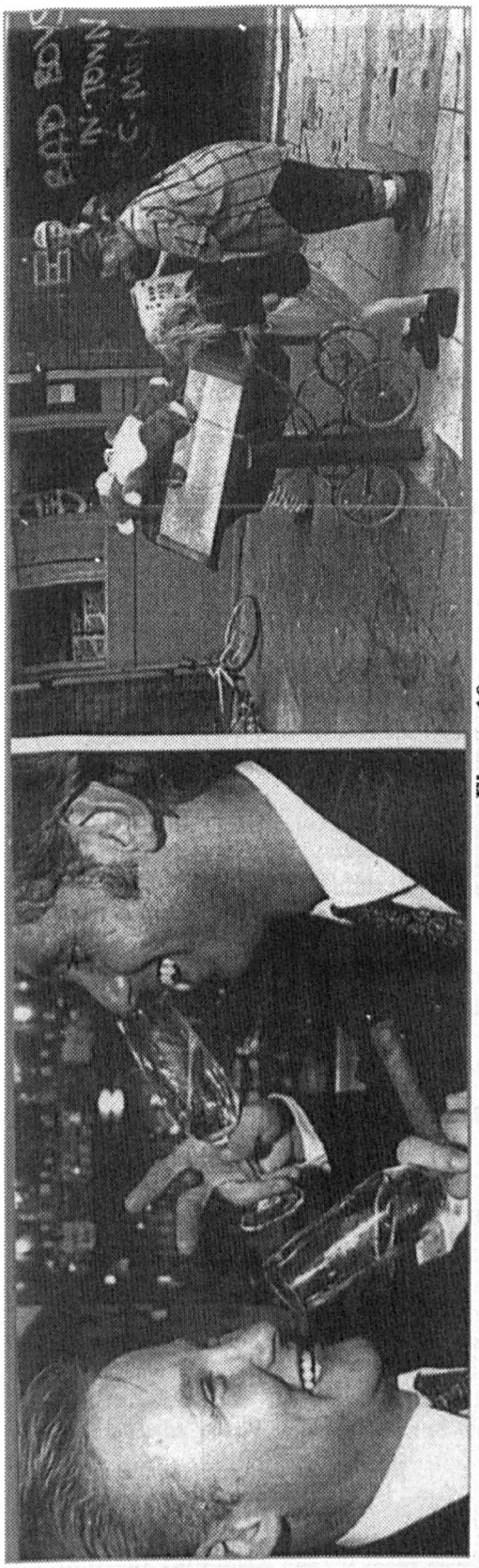


Figure 10

were perceived as frivolous projects whilst the facilities fundamental to the day-to-day lives of participants were under constant threat of closure. An overriding feeling of shame, anger and frustration often accompanied such accounts. A group of women from a deprived area of Glasgow vented their frustration on funding being allocated to a graffiti cleaning project whilst they had to continually fight for their community centre to remain open:

R5 [Jane]: '...could they clean up the streets a wee bit more, get rid of all this graffiti [irony – referring to 'workers drinking/estate', Fig. 10[63]]. I mean they're getting eighty-seven thousand pounds for bloody Graffiti Force and look at that [laughs].

I: What, is that to clean the graffiti?

R1 [Kay]: A hundred and eighty.

R5 [Jane]: [cutting in] - a hundred and eighty th – thank you. I knew it was something like that.

I: Is this for this area?

R5 [Jane]: Well that's the Graffiti Task Force.

R1 [Kay]: Task Force, but we don't know where any of it's going.

R5 [Jane]: And that's what they're getting for – to clean up the – and you still walk about with this...' [referring to Fig. 7 'children on estate'] [FG1:19, lower SES, Greater Glasgow]

[63] Figure 10 is an image juxtaposing two men drinking champagne with a woman and child in a deprived area.

Figure 7 'estate'

The women go on to talk about their frustration about other projects receiving funding, both local and national. The observation has already been made by this point that shops and projects in the area are closing down, whilst the community centre the women heavily rely on is under constant threat of closure:

R1 [Kay]: 'Well they're saying it's a recession we're in again, they just cannae afford, people just cannae afford to keep shops open.

R3 [Dorreen]: And the councillors spend money on stupid things like Millennium domes and all that stuff.

R5 [Jane]: Thank you. Which is, at the end of the day, a pure – who wants it? Nobody wants it, why should we [speaking over each other].

R3 [Dorreen]: How much was our statue next door?

R5 [Jane]:They never asked us if they wanted it, did they?

R1 [Kay]: The statue next door was sixty-four thousand pounds for our birds next door in the swing park.

R3 [Dorreen]: Spending silly money like that.

R1 [Kay]: Four birds in the play park, and it was sixty-four thousand pounds, these four birds.

R5 [Jane]: And the kids don't even know what it is, they sit on it.

R1 [Kay]: And [the money] had to be used in some art way, and I said well you should just have let the weans paint the park or something because it would have been a lot better than a statue of four seagulls that the kids don't know anything about.

R5 [Jane]: In fact it took the kids weeks to recognise – and the mothers – eh, to recognise what it was, I mean, then somebody drew on it, put an eye on it, and thought, oh it's a seagull.' [laughter] [FG1:22-23, lower SES, Greater Glasgow]

The participants are asked how they feel about this situation:

I: 'So what do you think of what's going on then, if they're spending money on that, and you're saying say about [local area], say funding for this centre is...

R5 [Jane]: What do we feel or what do we think?

I: Both. What do you think, what do you feel?

R5 [Jane]: We feel as if we've been...

R2 [Katie]: I think we should have more say on what the money's been spent on.

R5 [Jane]: We've been rejected basically.' [FG1:23, lower SES, Greater Glasgow]

Similar issues are raised in another Glasgow-based low income group. Pete, manager of community projects involving disabled residents, recounts how a grass embankment was landscaped for a Royal visit in which the Queen was due to pass through the area:

R5 [Pete]: 'You go down the road there and there was housing – flats – and they'd put quite a lot of people with problems into these flats. And there was a Royal visit to [local area]. So what do they do? The grass embankment in front of the flats, they made it bigger.

R4 [Scott]: What you're saying is, we hide the problem – it's not there if you don't see it. It's because they're embarrassed.

R6 [Sarah]: If you're sitting in a house, like say that picture ['child with plate', Fig. 8], it's [not] going to make you happier, the outside of the building being painted or the grass verge in front of your building being made larger. What you need is a larger house and you need more help for your kids. A lick of paint when you're building's not going to do that.

R4 [Scott]: I think it's as simple as when the Year of Culture and the Garden Festival was here, and every Christmas the local authority finds beds and places for the homeless in the centre of the city to take them off the street, so's they're not seen.' [FG5:7-8, lower SES, Greater Glasgow]

The group speculates as to why short-term solutions are favoured above other options. Interestingly Scott states that the local children don't have a play area, echoing the women quoted earlier who referred to their children's play park when discussing allocation of funds:

R6 [Sarah]: 'Well, if you're the Queen and you're going to John Browns, and you pass by and you see a nice building all freshly painted, you'd go like 'well, that's nice'. But the Queen never gets to see inside these things, and neither does a lot of people.

R4 [Scott]: The Scottish Development Agency, through the local enterprise company, over the last ten years, has spent absolutely millions landscaping the Dumbarton Road corridor and the approach to what they termed as the industrial, the 'new Clydebank', right. We've got a defunct industrial heritage here of shipbuilding – there's another one going this week, right. So at the end of the day, they spend millions landscaping that. Meanwhile the kids, and this estate that he's talked to you about here, don't have a swingpark.' [FG5:8, lower SES, Greater Glasgow]

Figure 8 ' child with plate '

Focusing their attention on why their area has become run down as opposed to focusing on those with money and power to change the situation, another group discuss the ongoing battle between the graffiti writers and the graffiti cleaners:

R1 [Lisa]: 'At least, I mean that looks bad, you know, this lying about [Fig. 7, 'estate']. I mean where we are, its all shutters pulled down [Fig. 9, 'woman with pushchair'[64]]. But what they're doing is they're going around and painting them all. Getting rid of all the graffiti. It looks good for a couple of days and then it's all back again. Because, I mean, if people have nae money they're disheartened and they just don't care. They tend to let their weans run riot [agreement]. Because there is nothing to lose. I mean, I think that's how there's a lot of these wee bandits running about, running amok, because mothers just don't care – they've gave up [agreement].

I: And when you're saying about places getting painted over and then things going back to the way they were. I mean doesn't the council realise that that happens do you think... ?

R4 [Norma]: Aye the Housing Association, they just send their workers out again to paint over it again, that'll last another 48 hours and then they do it again.' [FG10:8, lower SES, Greater Glasgow]

Groups residing in deprived areas often spoke of inequality in terms of lack of opportunity and access to resources. It was unusual to hear similar discussion in more affluent groups, although one such group did reflect on the impact of limited resources and access on low income families. The idea that children could be affected in this way seemed particularly emotive to participants. It appeared, however, that although some higher income groups could identify with those on low incomes, others could be wholly unsympathetic. One group in particular blankly dismissed the suggestion that anyone in modern Britain could be considered 'disadvantaged' [FG11]. In contrast, participants from a community group based in a deprived area of Glasgow recount from first-hand experience how children from low income families are affected:

R2 [John]: 'Cause I found as well you know through football was that two or three times over the year it's happened that a young boy has come along and he's wanting to play football and then all of a sudden he's no turning up and then when I speak to him, turns out that...

[64] Figure 9 is an image showing a woman from an ethnic minority with a child in a pushchair, walking by posters featuring Stephen Lawrence.

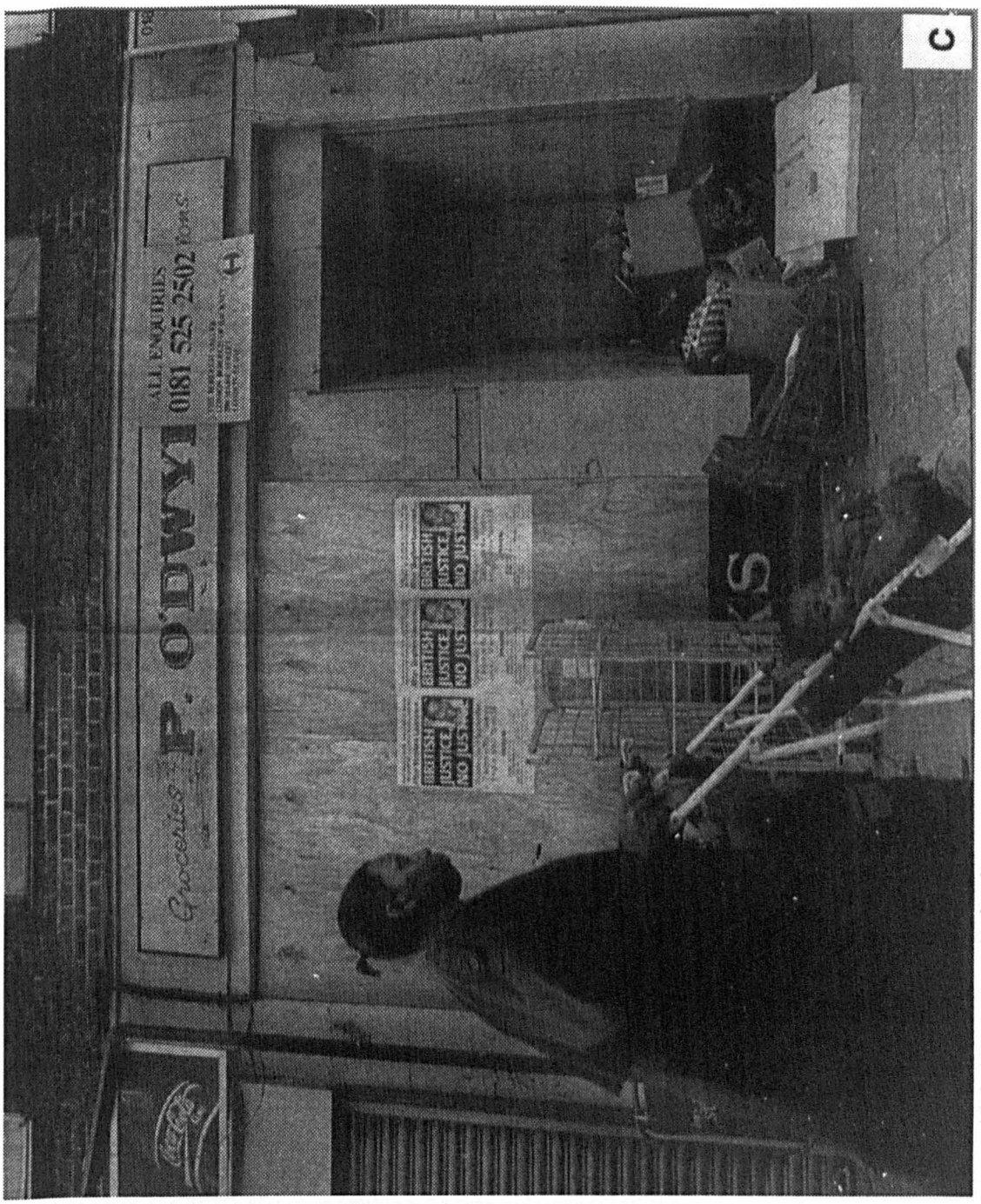


Figure 9 ' woman with pushchair '

R1 [Andrea]: Didn't have the money for the boots or something?

R2 [John]: No, no, you take a pound off them for playing and training two days a week... they get for a pound and it turns out that they canny afford the pound and you think who nowadays couldnae afford a pound? Then you go up to speak to the parent and okay, they don't come out and say that, well, you know 'Your son's already told...', I say that's fine, he can still come, just forget about the pound, but there are still people that are...

R1 [Andrea]: With that is the embarrassment as well, coming forward and saying 'I can't afford a pound to come here'. And people just won't join clubs because...it's an extra burden on the household, maybe that it's only the father working and the mother isn't and there's only so much to go round and they have four children.' [FG6:45-6, lower SES, Greater Glasgow]

Again focusing on children missing out, Scott (group five) angrily recounts his experiences. On this occasion he was successful , although he seems to have fought hard for short-term gain with no guarantee of long-term improvements. He identifies from the outset that it is more opportunity, not money, that is badly needed:

R4 [Scott]: 'I don't think it's more money people need; it's more opportunity. And I'll tell you where I'm coming from. Last week – my brother's a millionaire – his kids go to private schools. Two things I discovered. Laurelbank school, which is a private school, got a million pounds worth of Lottery money because it's a registered charity as a school. The schools here aren't allowed to apply for Lottery money, because they're public [state] schools and they're not registered charities. Fact. Last week I went to the council and I kicked up shit, because my brother's boy is getting a subsidised ticket to go and see the Scottish Opera through Glasgow Academy. Kids here wanted to go and see 'Annie'. But they've not got twenty-two pounds [for] a seat. So we went to say, 'Look, the council subsidises the King's Theatre – where's our tickets?' And nobody'd ever done that before. So they gave us thirty tickets that day, so we all went to see a theatre show which isn't normally afforded here. People here go to the theatre at pantomime time, know what I mean, when it's Dick Turpin or... But we'd like to go to the Citizen's Theatre.' [FG5:19, lower SES, Greater Glasgow]

Cassie, a woman living in a deprived area of Salford, explains how her situation allowed her to get by with a minimal disposable income. She perceives many activities to be unavailable to her and her children, and that this situation is worsening:

R5 [Cassie]: 'If you're on Family Credit for instance, which tops up your income like what I'm on. For me to get off Family Credit, I have got to earn at least seventeen grand a year, and I don't. And the chances of getting that...

R6 [Sonia]: Is nil.

R5 [Cassie]: So you've got to be able to earn an awful lot of money out there to get yourself out of the benefits situation, and when you work out how much you've got in real money, and I'm talking disposable income to spend on shopping and education for my kids and after school activities, that sort of thing. I know I've got seventy-five pounds, which is why I use the bike to come to work because otherwise it would be thirteen quid. So, although there's all these wonderful things out there like this lovely food in Tesco's [referring to 'supermarkets' image, Fig. 11]...

R6 [Sonia]: You can't afford to.

R5 [Cassie]: ...it's not available to me, it really isn't. I'd love to take the kids more to the ballet, I'd love to take them to the classical concerts I'd love to take them to Tatem for the last night at the proms. Brilliant, twenty-five pound a ticket.

R6 [Sonia]: You can't afford to.

R5 [Cassie]: So the gap, in those sort of terms, is widening. There's less that we can't have, and because we know we can't have it, we tend to not even bother looking anymore.'
[FG9:38, lower SES, Greater Manchester]

Jerry, a pensioner in this group, goes on to question the idea that anybody today is 'deprived'. However Cassie sticks to her point:

R1 [Jerry]: 'I've heard these cases where people consider they're erm deprived, you know, and what they call deprived today is when you haven't got a television set.

R6 [Sonia]: Yeah. Well in our days a lot of people didn't have tellies though, did they.

R1 [Jerry]: We didn't even have a wireless.

R5 [Cassie]: I think that's dead interesting really because I mean, I do see this gap between er the people who have access to, and the people who haven't, is just getting bigger all the time.'
[FG9:39, lower SES, Greater Manchester]

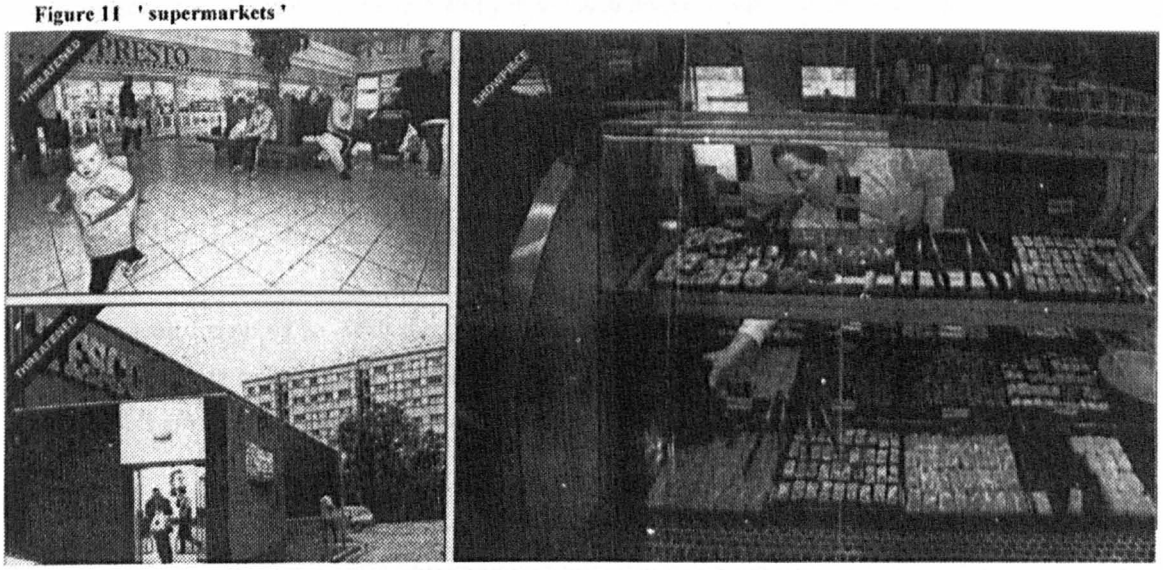
The views of more affluent groups on equality of opportunity and access varied considerably. A group of new graduates living in a suburb of Edinburgh assume that access, to the supermarket at least, was universal:

R1 [Jill]: 'Also another trend nowadays is you don't go to every, like single shop in the high street. You don't get your groceries out of somewhere and your produce from somewhere else. You just go to the supermarkets because you can get everything there.

R3 [Philipa]: I don't know why it says 'Threatened' [Fig. 11 'supermarkets'] because, to me, like you said, people are going more to the supermarket than to go along the street and have to go to five different shops, because they park basically right next to the front door, go in and get everything under one roof, earn with Club Card points or whatever, and there's more benefits to going to a supermarket, so, I don't...

R2 [Geena]: You'd expect them [supermarkets] to be the threats.' [FG8:6, higher SES, Lothian Region]

Figure 11 'supermarkets'



A woman residing in an affluent area in Aberdeenshire gives a first-hand account of the difficulties in establishing activities in deprived communities:

R1 [Sheena]:'...but things like guiding and all those activities are not activities that do well in deprived communities because they're establishment and they require a certain amount of clothing [laughs] and, you know, leadership. They're short of leaders and so on, there always has to be someone going in from outside.

R3 [Marion]: Yeah, if they go in from outside they're never going to be accepted are they.

R1 [Sheena]: No no. I felt this very much, it's to do with the arts rather than health, but I think there's a lot of interlinking. When I was on Deeside Arts Forum, the Arts Officer was trying desperately to do

> things for Portlethan, because a large area of Portlethan is – not all – but a large part is deprived. And he couldn't find leaders within the community because either both parents were working and hadn't got time to do other sorts of leadership. Or people just hadn't got money to take, 'cause you need a certain amount of money to be a volunteer.' [FG13:16-17, higher SES, Aberdeenshire]

Even a member of the group dismissing the existence of deprivation in contemporary Britain seems to alter her views when the idea that children might suffer arises. The thought that there would be any inequity of opportunity or access for children appears to strike a chord:

> R4 [Constance]: 'I mean, what do you do, for instance, now we're seeing the children who have got a computer or whatever, at home will get on much better at school than those who haven't. This was on the television not long ago [agreement]. Well this, I mean what do you do about this sort of thing because you can't stop it. And therefore the children who come from parents who can't afford it are going to suffer.
>
> R1 [Sheena]: Even more alienated [agreement].
>
> R4 [Constance]: I suppose so. Well there must be ways round it, whether you can have more opportunity for children to have evening classes...or – it is so wrong to feel that these children whose, who can't afford it, are going to suffer.' [FG13:23, higher SES, Aberdeenshire]

Other participants showed no empathy at all for those living on low incomes, principally because it was perceived that their incomes could not really be that low. Any discussion therefore, of restricted opportunities or access to resources never arose. A group of participants from relatively middle class, professional backgrounds living in Greater Manchester, often spoke of the deprived in very negative terms [FG11]. Within the context of access and opportunity, a subject which had provoked such strong responses from lower income participants, the Greater Manchester group showed little understanding. They could not conceptualise such a scenario as for them it just did not exist. Elaine compares her mother's recollection of the welfare state to her own perception of current benefit provision:

R3 [Elaine]: '...Whereas now you can get benefits without actually having done anything to get them, and also you – where people didn't have anything and they were destitute, and they couldn't even afford to buy food, all these young kids with supposedly no money – young women and young men – they've all got designer gear on and they're all wearing these clothes, and they're carrying mobile phones and things. And they've all got televisions and videos, and yet they're all supposed to be so desperately poor and everybody's supposed to like be, em, we should be helping them but...' [FG11:24, higher SES, Greater Manchester]

Elaine then compares her own childhood to her perception of modern families:

R3 [Elaine]: 'And that was the other thing, what we've just said [referring to R5, Alice]. We've both just said, when we were little we didn't have much money and we didn't have sweets. That doesn't apply anymore. You can be in the same situation and be, you know, one of six kids in a family. They're all eating chocolate and things like that.'[FG11:27, higher SES, Greater Manchester]

A myriad of assumptions inform Elaine's views. She assumes that people's priorities have changed and that those on low incomes can't manage their finances:

R3 [Elaine]: 'You'd think – I'm just wondering, you know like we're talking about these people supposedly on the poverty line – they all seem to still have all this stuff. Is it because their priorities have changed. I've always been brought up that you pay your bills first and *then* what's left over you can do what you like with. But it's the other way round now. They seem to sort of like, there's no stigma in – you don't get your gas cut-off – and if you do, they put it, you know, there's a million reasons why they can put it back on again. There's no threat if you don't pay your bills or...

R4 [Connie]: It's live now, pay later.' [FG11:35, higher SES, Greater Manchester]

A number of participants from varying socio-economic backgrounds grounded their awareness of inequality by comparing their neighbourhood with surrounding local areas, or commenting on how their area had changed over time. The last excerpt demonstrated how participants from a relatively affluent area (particularly Elaine) possessed a very one-dimensional understanding of those living in deprived areas. Perhaps the strong opinions expressed by Elaine were fuelled partly by experiences of living in an area

where affluent and deprived neighbourhoods are situated closely together. Connie likens the 'estate' image [Fig. 7], to a deprived area nearby. Alice and Bob go on to describe the area in further detail:

R4 [Connie]: 'Yes, yes. This is more Ordsall [Fig. 7], I would say with the, you know, this sort of thing with cars and children out at all hours.

R1 [Bob]: It's illustrating deprivation wherever it is.

R5 [Alice]: And [local area] actually. I mean, be perfectly honest, you needn't go very far down the road to see people living in awful conditions.

R4 [Connie]: It's getting that way, yes.

R1 [Bob]: [local area] has got – you know I showed you Ordsall as we came through. Ordsall is a very concentrated mass of that type of problem unfortunately, hemmed-in by affluence of the Quays and other areas.' [FG11:13-14, higher SES, Greater Manchester]

Ed, living in an area not unlike Ordsall, observes the same situation:

R3 [Ed]: 'You get people who can't do the things that somebody who lives maybe two or three miles away might be able to afford to do eh, and so on, that sort of thing...'
[FG6:39, lower SES, Greater Glasgow]

In another more affluent group, social class was linked directly with area of residence:

R3 [Philipa]: 'Somebody who lived in Kettleston Mains, you would call upper class. Somebody that lived in Springhood you'd call middle class, and somebody lived in Braehead you'd call lower class.'
[FG8:16, higher SES, Lothian Region]

There was a recurrent observation in the group discussions that widespread degeneration was occurring. For low income participants, it was often the area in which they lived that was declining. For the more affluent, it was the areas round about them. There was a strong sense that the situation was worsening rather than improving. This view persisted

despite the general perception that living conditions had radically improved over the past fifty years. Drugs, more often than not, were seen to be at the root of this social decline. The lower income group from Greater Manchester lament the decline of certain parts of their community:

R1 [Bob]: 'Oh, [local area] has got its problems, yeah.

R4 [Connie]: Oh yes.

I: And has that been a recent development?

R5 [Alice]: It has really, it's gone downhill very quickly.

R4 [Connie]: In the last few years.

R3 [Elaine]: Yes, I would say it has gone down. But I mean, there's always been areas where there've been poor people in [local area]. I mean, that's, you know, the history of the place. But I would say that certainly you see more places boarded-up, you see more places where you think, 'well I wouldn't like to go there at night', or even during the afternoon, em, you know, definitely.

R4 [Connie]: The drugs have a lot to do with the quick decline, I think, don't you?

R5 [Alice]: Well I think a lot has had to do with, the decline of everything, is a lot of – they don't – they're getting rid of houses where people lived in communities, like almost back-to-back houses. They were poor but they were happy, and now...they put them in to high rise flats or big estates with no services.' [FG11:14, higher SES, Greater Manchester]

A similar view is expressed by a Glasgow group of equivalent socio-economic status. In this case, a couple of the participants had actually grown up on estates around Glasgow:

R4 [Rich]: 'Pretty rundown actually but, in saying that, the community when I was growing up was a lot stronger. It was a lot stronger then but it's not now because of the drug scene and stuff like that.

R5 [Sadie]: That's the same where I was brought up. It was brilliant, when I tell people where I was brought up like, it was a block of flats in Greenock it's like 'oh' and it was absolutely amazing I totally loved every minute and it's not just rose-tinted glasses, it was...

R6 [Sam]: All the kids run about together and...

R5 [Sadie]: The whole community just out, sitting about every night. Like all the families but now it's just like – I was there a few months ago and it's just like, a guy had been found overdosed the night before and the place smelled [of] bleach in the high flats. It was horrible, it was really, really scary.' [FG12:18, higher SES, Greater Glasgow]

Four groups in the sample (two affluent, two deprived) tended to qualify their views on poverty and inequality by saying, for example, 'there are poor people everywhere', or 'every big city has it's problems'. These comments suggest an awareness of a deep-rooted social problem on a large scale, as well as a weary, and/or apathetic acceptance of Britain's social structure. The comments made in these four groups also suggest a tendency to normalise social problems rather than getting angry about them. For those low income participants making comments of this nature, it is also perhaps an assurance to themselves that their situation is not uniquely terrible and shameful. Discussing drug use, a group from a deprived Glasgow area believe the problem to be universal:

R1 [Lisa]: 'But then it's in villages and everything now, you know what I mean.

R3 [Alison]: That's it, it's everywhere that.

R1 [Lisa]: You couldn't even say that about Possil Park.

R3 [Alison]: I mean even royalty are into it now [agreement].' [FG10:13-14, lower SES, Greater Glasgow]

Making international comparisons, another lower income group discusses America:

R2 [Ian]: '...and there were more beggars in that one stretch of street [in Orlando] than you'll see in Sauchiehall Street at any one time. Drunks lying in corners, so I mean, every country has got their problems. They've this great image of the great American life, but well they've still, they've still got huge social problems [agreement].

R4 [Irene]: It's the same everywhere.

R3 [Margaret]: 'If you go the highway down from Toronto, Canada all the way down in through New York – you veer off that – you're into ghettos very quickly, oil drums at the end of the street, all this sort of stuff. Everywhere's got its problems.' [FG3:21, lower SES, Greater Glasgow]

Speaking of the deprived areas that surround them in the east of Scotland, an affluent group reaffirms their perception that the rather depressing landscape about them is no different from anywhere else in Britain:

R1 [Jill]: '...but then there's always deprived areas round about.

R4 [Catriona]: No matter where you go.' [FG8:7, higher SES, Lothian Region]

R3 [Philipa]: 'But I think it's just across Britain, you could separate, you know, if you went in deep enough you could separate everyone into one of three categories [referring to **Revealed: the three nations of Scotland** headline, Fig. 13], and they could all exist independently.' [FG8:16, higher SES, Lothian Region]

An Aberdeenshire-based group generalise the stark poverty and affluence depicted in the 'workers drinking/estate' image [Fig. 10]. As the discussion progresses, Denise and Debbie arrive at a matter-of-fact conclusion:

R4 [Debbie]: 'Aye, I think they do exist but they'd be very unlikely that you would find both things in the same area. I think it just reflects the difference in, you know.

R1 [Denise]: You would find them in any town' [FG7:3, higher SES, Aberdeenshire]

R4 [Debbie]: '...I think there's more poor in Glasgow, but there is more poor people everywhere you go.' [FG7:12, higher SES, Aberdeenshire]

This chapter has shown that a large proportion of participants are aware of inequalities, both in societal and health terms. It has shown the varying ways in which people conceptualise inequalities, with socio-economic status (and to a lesser extent age) emerging as a pivotal factor. The existence of inequalities in health, a phenomena that has taken researchers many years to confirm, was greeted with little surprise by the majority

of the participants taking part in this study, particularly those from less affluent circumstances. The following chapter (eight) goes on to examine the language used by participants in their discussion of inequalities, their image management, self presentation and awareness of status.

Chapter Eight

'I can't make a connection with them mentally because I don't know where they're coming from': An exploration of language, status and self presentation in a group setting

8.1 Introduction

The first part of this chapter examines the language used by participants in their discussion of inequalities. Such an approach is intended to provide an insight into how participants view others as well as how they believe themselves to be perceived. It is shown how the type of language used differs markedly according to socio-economic status, reinforcing a sense of fundamental social divisions within society. The second part of the chapter examines the management of discussion within groups in order to build a picture of how sensitive participants are of status, and how they manage their self-image in the course of discussion.

8.2 A language of division? What kind of language do participants employ when discussing inequalities?

The sense of division apparent when lower income groups recount their experiences and express their views was palpable. Feelings of frustration and anger appear to never be far away. Discussing the social security system, Jane conveys a strong sense of 'them' and 'us':

R5 [Jane]: 'These people have got it into their heads that people like living on that kind of money. They've definitely got it in their heads, 'they must like living like that'. 'Cause they're doing it that long. We're doing it that long 'cause they've no got any jobs that would pay the bills. Some people have gone back from work and only ten pound better off, what's the point of that. When you go back to work you want to make sure that you're paying your bills, there's enough food in your fridge and

cupboards, and you can put clothes on your child's back, and still be able to have the odd treat.' [FG1:40, lower SES, Greater Glasgow]

A sense of injustice grows within the group as they continue to discuss benefit provision. A discussion on the non-means tested provision of child benefit to all families with dependent children provokes heated debate:

R5 [Jane]: 'The rich are, they can do whatever, can they, their kids got everything because they've got the money, we've no...

R1 [Kay]: And they've still got the cheek to get child benefit.

R5 [Jane]: Aye, exactly.

R1 [Kay]: I mean Princess Diana, and well Charles now, and everybody's entitled to benefit, they're entitled to child benefit.

R5 [Jane]: And what do they do with that, how do they no donate, they don't need it.

R1 [Kay]: They still get child benefit. Prince Andrew, everybody, gets child benefit. Prime Minister gets child benefit, d'you know what I mean, and so all the money goes to them as well.

R5 [Jane]: And she's [Cherie Blair] one of the top lawyers as well. You know, and then how do you think that makes people that comes fae poor places feel. That's just another notch in their belt.

R1 [Kay]: Aye, they give you it on one hand then take it out in the other.'
[FG1:40, lower SES, Greater Glasgow]

Violet, a pensioner on a low income participating in group four, repeats almost word-for-word the comments of Kay from group one, believing those in power give from one hand and take away with the other:

R5 [Mary]: 'They'll give theirself big rises, when they get a rise they get it right, but when we get a rise, we've got to wait 'till the following year.

R1 [Violet]: You get it in one hand, take it off the other.' [FG4:54, lower SES, Greater Glasgow]

The sense of injustice and anger is strong. In response to the headline **Wealthy stay healthy but the poor get more poorly** [Fig. 16], Jane (group one) continues:

R5 [Jane]: 'That's another one, they're lining their pockets and we're getting none of it.

R3 [Doreen]: 'They can afford to buy the best of foods.' [FG1:41, lower SES, Greater Glasgow]

Not only is there a sense of 'other' in terms of institutions and the affluent, there is a feeling of deliberately being kept down:

R3 [Doreen]: 'I think it's the system, because see when you try to better yourself they slap you back into place.

R5 [Jane]: Och, I know. You get two steps up and five steps back.

R3 [Doreen]: They put obstacles in your way. I mean they're saying you're entitled to Family Credit. Even when you get that Family Credit you're no entitled to free prescriptions, you're no entitled to free school meals, things like that.' [FG1:49, lower SES, Greater Glasgow]

A feeling of being alienated from the government is also expressed in the low income group from Greater Manchester. Rather than deliberately restricting opportunity, participants conclude that those in government are apathetic:

R3 [Jake]: 'I think the government denied a lot of things, and plus the fact they're in cloud cuckoo land. They don't know what's what...

R7 [Betty]: Well half of them are young people – they don't know what's going on, for what we've grown-up with [getting agitated].

R3 [Jake]: Even the younger ones, they've got plenty of money while...

R7 [Betty]: Yeah well they're not bothered about the outsiders are they?

R3 [Jake]: No, they're not.

R7 [Betty]: They're only worrying about theirself and how much money they're going to gain.'
[FG9:4, lower SES, Greater Manchester]

Figure 16

Figure 17

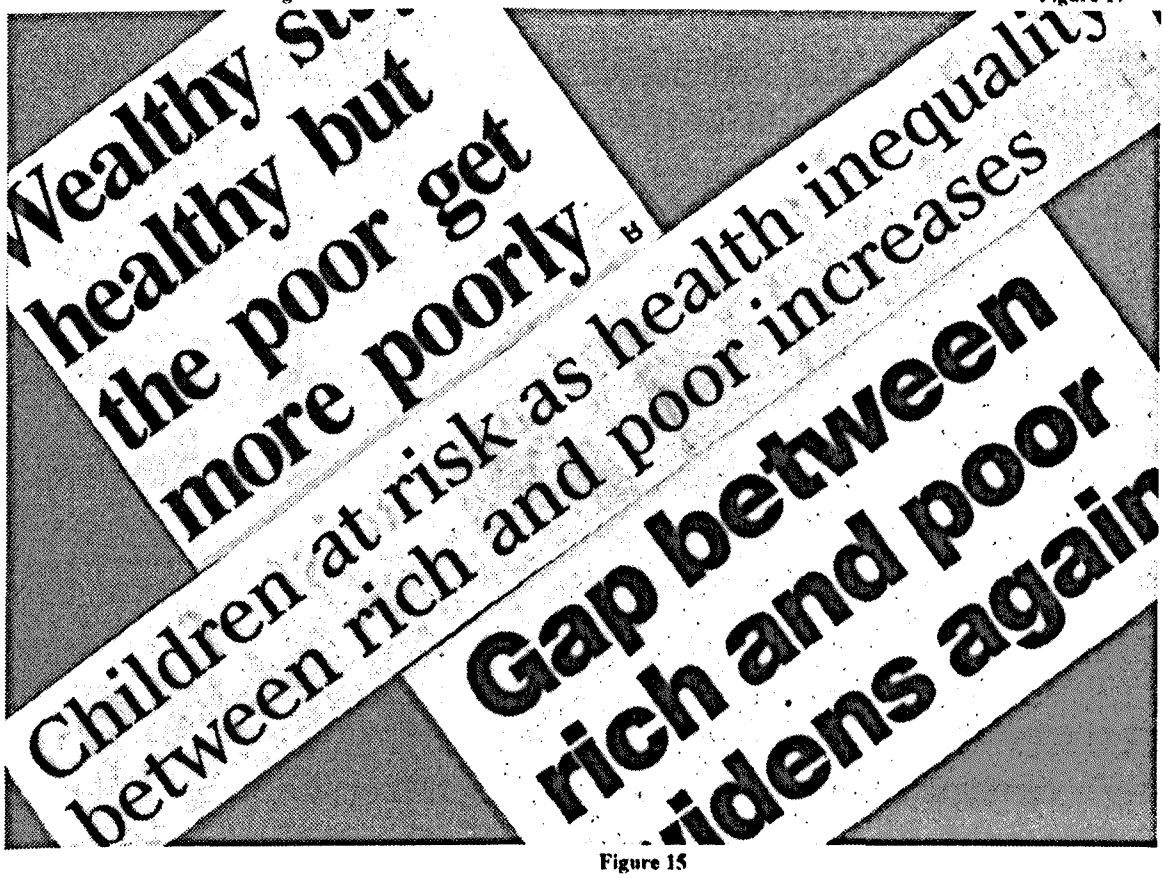


Figure 15

Whilst discussing the 'workers drinking/estate' image [Fig. 10], a group of pensioners link the two contrasting pictures, arriving at a very sobering conclusion:

R1 [Violet]: 'And the likes of this here, the kid'll probably get knocked down by the car.

R4 [Bob]: On the other hand, on the other hand, it could be they're very affluent, he's smoking a dirty big cigar here.

R1 [Violet]: That's what I'm saying, they're enjoying themselves, but they're forgetting they've got a car outside.

R4 [Bob]: He's above middle class, you would say.

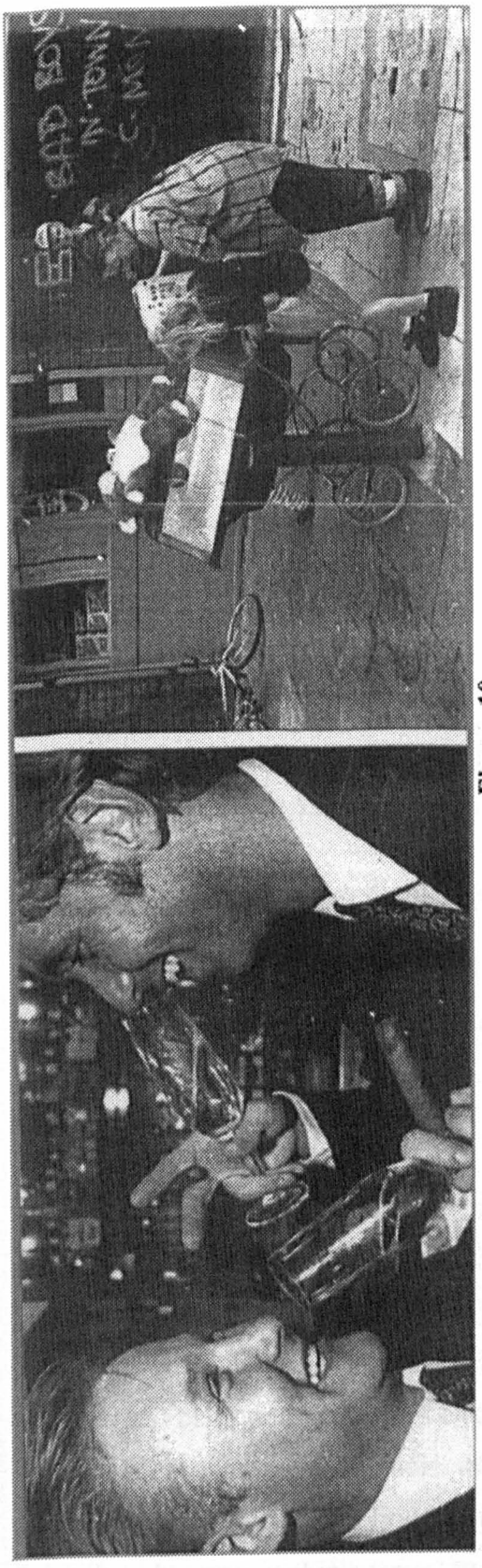


Figure 10

R1 [Violet]: Yes that's what I'm saying, they don't give a damn, he'll go out there and drive his big Mercedes.

R4 [Bob]: You don't know that.

R1 [Violet]: Killing these people that's walked past.' [FG4:17, lower SES, Greater Glasgow]

Later on, a woman in the same group also comes to the conclusion that the champagne drinkers [Fig. 10] will cause an accident:

R2 [Carol]: 'They're saying that they're going to drive [workers drinking in Fig. 10] and they're walking across the road [people on estate in Fig. 10], the zebra crossing, knock them down, something like that, that's my opinion.' [FG4:19, lower SES, Greater Glasgow]

Another Greater Glasgow group, living in the same deprived area as the pensioners above, respond in a similar way to the 'workers drinking/estate' image [Fig. 10]. The juxtaposition of these two contrasting images provokes strong responses:

R3 [Ed]: 'You got the poor woman, well I presume that she's poor with the pram.

R4 [Richard]: Aye, aye.

R3 [Ed]: And you got the two middle class types wasting their money on champagne.'
[FG6:25, lower SES, Greater Glasgow]

Joe judges the 'middle class types' even more harshly, speculating that the champagne drinkers in the image [Fig.10] are conning the people in the juxtaposed 'estate' image in some way:

R5 [Joe]: 'Probably they're waiting in there saying 'We'll screw them again.'
[FG6:26, lower SES, Greater Glasgow]

Animosity toward the middle classes was not prompted solely by the 'workers drinking/estate' image [Fig 10]. Participants would, on occasion, make observations revealing the perceptions they held about the affluent. One group consisting of women working as cleaners from a deprived Glasgow area describe the 'rich' as being a law unto themselves:

R3 [Alison]: 'See if you've got money, aye, money, you get away with a lot of things as well.

R5 [Jean]: She's saying she suffers, she works overtime and it's all away in tax. Whereas the rich do get richer [agreement], know what I mean.

R2 [Hilary]: And they can *get all* the tax dodges, and they can get their petrol, tax – petrol in their cars [agreement].

R5 [Jean]: They travel for less on aeroplanes and everything, business deals and...

R6 [Pat]: That's right, mm mm.' [FG10:31-32, lower SES. Greater Glasgow]

The binary language of 'haves' and 'have nots', and 'them' and 'us', takes on a different meaning as participants from low income groups distinguish themselves from the 'irresponsible poor' they perceive around them. When talking about themselves, and where they position themselves within this schema of rich and poor, the conceptualisation becomes less black and white. Participants tended to place themselves within a hierarchy, not only being aware of those more affluent, but also of others perceived to be worse-off than themselves. Participants from deprived areas regularly spoke of those worse-off than themselves in unsympathetic terms. People begging on the streets and the homeless were

perceived as particularly problematic, and were looked upon harshly by a number of participants. The elderly participants from an inner-city group recount their experiences below:

R4 [Irene]: 'I passed him last week, a young boy, I said to him no thanks, he says 'well can you give me money for a cup of tea'. I said no.

R5 [Carole]: They stand at cash points, he says 'can I use a tenner?' It was on the news.

R1 [Betty]: That's right, that's was on the telly the day.

R3 [Margaret]: All you can take out's a tenner, at the cash point.

R1 [Betty]: 'You got a spare tenner' [tuts].

R4 [Irene]: Get one if you go out and get a job and work like everybody else, you know.'
[FG3:51, lower SES, Greater Glasgow]

Betty highlights her own financial position in relation to the beggars later in the conversation by stating:

R1 [Betty]: 'I says where would we get the money, we're widows, we've nae money, you should try begging.' [FG3:52, lower SES, Greater Glasgow]

The Greater Manchester group consisting of both unemployed participants and those in low waged jobs, discussed the homeless in a similar manner, although a couple of dissenting voices emerged:

R6 [Sonia]: 'Yeah but they choose.

R7 [Betty]: They choose to live like that though, don't they. I mean, nobody else – we can't help them.

R2 [Simon]: I don't think everybody chooses to live like that. I think circumstances do change.

R7 [Betty]: Oh no, there's no need, no.

R3 [Jake]: Trumps change.

R7 [Betty]: There's places where they can go and live, hostels and things like that.'
[FG9:15-16, lower SES, Greater Manchester]

Later in the discussion, Cassie even suggests that being homeless is a fashion statement:

R5 [Cassie]: 'I think it's been accepted more, so people are allowed to be like that now, that's one reason – it's okay. You know, because it's quite fashionable at the moment to sit out there with your sign saying 'I don't live anywhere', and you've got your fashionable accessory which is your dog. So, that is almost an okay thing.' [FG9:17, lower SES, Greater Manchester]

It was not only beggars and the homeless that were looked down upon. Participants from a number of groups readily referred in negative terms to individuals in their neighbourhoods and communities. The low income Greater Manchester group blamed Housing Associations for bringing the 'scum of the earth' and 'low lifes' into their area [FG9:19, lower SES, Greater Manchester]. Making a distinction between themselves and these newcomers, one participant remarks that there are still 'a lot of decent people left' [FG9:27, lower SES, Greater Manchester]. Another group terms people who claim benefits fraudulently whilst working as 'low-life people' [FG5:6, lower SES, Greater Glasgow]. The distinction of a 'good' and a 'bad' poor is strongly made by a group of cleaners who are aware of people making fraudulent benefit claims in their community:

R2 [Hilary]: 'I get angry 'cause I'm out doing two jobs, and I see some of them sitting on their backsides no doing a thing, and they've got cars at their door [agreement], they can go abroad, and they've got their fancy houses.

R3 [Alison]: Aye, *they* kind of people, but *other* poor people, I'm sorry for them.

R2 [Hilary]: Oh aye, they've got a couple of weans, they've got nothing, fair enough. But you see them, and they get money fae every road that's coming, and they know all the dodges of the social, aye, they know everything [agreement].

R4 [Norma]: Aye all the ins and outs and everything.' [FG10:18, lower SES, Greater Glasgow]

Participants in two of the low income groups arrived at the conclusion that a certain proportion of people living in poverty were beyond help. Rather than defrauding the benefits system, or finding other illegal means by which to obtain money, they were portrayed as having not experienced the right upbringing or education:

R5 [Jane]: 'Some people just don't know how to, to work with their money. Some people arenae educated in that way. Their parents never showed them, so they've just plodded along. They don't know how to deal with their money, they don't know how to run the house properly, d'you know what I mean. So they just, they're just going along with how they were brought up, and carried on showing the family the same thing. But if you're, if you grow up...

R1 [Kay]: Surely people arenae like that.

R5 [Jane]: I'm telling you they are – I could take you up to two houses the now.'
[FG1:15, lower SES, Greater Glasgow]

In very blunt and cliched terms, Robert, a pensioner from a deprived area states:

R6 [Robert]: 'That's what I was saying, you can take people out the slums, but some folk, you can't take the slums out the people.' [FG4:43, lower SES, Greater Glasgow]

One low income group stands out in its discussion of excluded or marginalised people. Whilst maintaining a sense of 'them' and 'us', their judgement of 'them' is less harsh. Discussing how people develop an intricate knowledge of soap opera plots, participants speculate over the implications of this knowledge and how it could be better utilised:

R5 [Joe]: '...they havenae a clue about how the council works or how that works in with the rest of the government...

R3 [Ed]: Because they're no encouraged to, they're encouraged to look at people, see them down, and think of themselves and everything, but they're no encouraged to take an active part.

R5 [Joe]: See if that was depicted, see if a support group was depicted in the way they do these things now [meaning soap operas/television programmes], 'cause people are capable of keeping all these people's names and you know, intricate things that you couldnae really...they're no stupid.

R3 [Ed]: It shows you that they're no stupid, shows you that they're no stupid. They've got brains and they know how to use it. But to use it right, of course, who are we to say that they're using it wrong?' [FG6:36, lower SES, Greater Glasgow]

Later in the group Ed makes a distinction between the middle and working classes and an 'underclass'. He explains that the middle and working classes take an interest in their children's education, whilst the 'underclass' do not. Expressed in non-judgmental terms, he goes on to imagine the different life trajectories of people belonging to these classes:

R1 [Andrea]: 'Yeah, they take their kids out to museums...

R3 [Ed]: They have more interest in how their education of their child is doing, they go to the PTA's [Parent Teacher Association]...

R5 [Joe]: They have more of a positive attitude.

R3 [Ed]: The PTA's, the likes of working class, but we would say the underclass right, have that lack of interest, they may have.

R5 [Joe]: It's positive, it's a different way you've got at school. If you go to a middle class school, if you go to a really, a fee paying school or something like that, and you know it's always positive. I mean you grow up to be a leader. You go to up here [local area] and you're hammered and looked down on and you're just a pest. And it's like so you grow up with that kind of attitude, knowing your place, and if you don't, then you're a trouble-maker or you're a...

R1 [Andrea]: Aye, you're expected, you're not expected to go to university or anything.

R3 [Ed]: Or you're marked, as soon as you're born you're marked. That's your station in life, don't move out of it.' [FG6:43, lower SES, Greater Glasgow]

Employing powerful language, lower income participants readily set themselves apart from others, distinguishing the affluent and 'undeserving poor' as separate groups. However, did a willingness to talk about others translate into a willingness to talk about themselves? The last quote touches on this issue. When Ed says 'you're marked', is he describing his own situation, as well as the predicament of other people? On this it is only

possible to speculate, but Ed's socio-economic status suggests that he feels the exclusion he expresses. Within the group context, participants seemed reluctant to talk about themselves. Participants made only occasional references to themselves in a small number of groups within the sample. Discussing the price of school dinners at her child's school, Cassie states simply that 'I'm too poor to pay that' [FG9:4, lower SES, Greater Manchester]. Jane, a lone parent from another lower income group, appears to speak for the whole group when describing her financial circumstances. She starts off by saying 'we' but ends up speaking in the second person. Perhaps it feels too uncomfortable to express these views in terms of how *she* feels:

R5 [Jane]: 'The poor get poorer, or poorly, it's because we don't have – you're fighting to get your benefits. You get yourself into a state, you get depressed, stress sets in, because of the circumstances you're in.' [FG1:48, lower SES, Greater Glasgow]

Interestingly, Scott, a charity officer from one of the low income groups, sets himself (and presumably the others in the room) apart from the 'socially excluded', only to spend the rest of the discussion explaining the ways in which he, and people in his area, are robbed of opportunity and access:

R4 [Scott]: 'And you've got the large family who are obviously socially deprived... Their children are often picked on. When I say socially 'excluded', people who are in client groups which are not on a par with the rest of us.' [FG5:4, lower SES, Greater Glasgow]

Thus the way in which people express themselves was often complex and contradictory. It would appear easier for participants to talk about others than themselves, or to talk in the second person. This suggests a sensitivity surrounding the subject of inequalities, a topic that, at the same time, attracted such emotive debate.

With the more affluent groups in the study, a slightly different pattern emerged. As noted in the previous chapter (seven), participants tended to be harsher in their judgement if they had had no direct contact with either the unemployed, those living on low incomes and/or residing in a deprived area, and had no first-hand experience themselves. This was

also evident in the language they used. The more affluent often spoke of the deprived in derogatory, dehumanising terms, as exemplified by this example of a woman recounting the stories she had heard from a nearby school:

R2 [Lesley]: 'Well what we were saying this afternoon, the headmistress at the school governors was saying that, they have a problem keeping their targets up that they set them for these exams, because Mum will fall out with one boyfriend, she'll go and live with another one and then they'll just go to another and another and another. I mean it sounds a sort of, something that somebody's made up, but it actually has happened at another school... That was at the school in Gorton, and that is the sort of thing that goes on because I didn't realise. Families, well not families, but these people are just so mobile. Changing address all the time... You know like they say that moving house is like, number one on a list of stressful things to do. Well, I wouldn't want to move house so often, I don't know how they do it [laughter].

R5 [Alice]: They pack their bag, and their few belongings.' [FG11:18, higher SES, Greater Manchester]

Another woman in the group, Elaine, had initially appeared to take a sympathetic view of lone parenting ('Yeah, but you're assuming that they are nasty, horrible, you know, anti-social people but they're not, these are just kids' [FG11:20, higher SES, Greater Manchester]). However, as the others in the group increasingly demonized single mothers, Elaine became noticeably less charitable. In this case, the experience she had of going to visit houses in a deprived area had made her less sympathetic:

R3 [Elaine]: 'Well the ones I've seen in Ordsall, they're all going saying, when I used to do, like Tupperware parties and stuff like that, and occasionally I'd get invited to do one in Ordsall. And I thought, I'm wasting me time here they won't be able to afford anything, and they spent fortunes, and they were all saying... 'oh I'm going to buy a Sprayway jacket', whatever one of those is. And apparently they're like three hundred pounds, these jackets. But they want one, and that's what they have, and they didn't seem to, they had like, the worst possible furniture in it. It looked, you know, it was dreadful and there was hardly any furniture but they had the big telly.

R4 [Connie]: And all the gadgets.

R3 [Elaine]: They had the telly, the Sky TV thing and the video, but, and they were buying all these things – 'oh this is a good little gadget, and I like this Tupperware thing', and they were spending – and I

thought where have they got the money to spend. So they must be getting it from somewhere [incredulous].' [FG11:42, higher SES, Greater Manchester]

Summing up her views, Elaine says later:

R3 [Elaine]: 'They can't actually do anything about it for themselves. They can't, they don't know what to do. They want this wonderful life that's put to them on the television. They want twenty million pounds and they all want to be Mel C [former member of the pop group, the Spice Girls] or whatever, and they're not getting it. So therefore they feel they've underachieved in life. Instead of having enough money to pay your bills and a roof over your head, warm food in your stomach and a comfy bed. That is the lowest priority on their list. They want designer this, designer that, and a fast car and if they haven't got that then they feel they've underachieved in life, and they therefore, they feel depressed.' [FG11:56, higher SES, Greater Manchester]

A language of blame as well as division was used in this group as participants discussed those on low incomes. For some of the more affluent participants, it was a question of priorities which 'these people' had got fundamentally wrong:

R1 [Bob]: 'It's where they've put their priorities totally wrong, you know. I mean we've been in [Greater Manchester], people who haven't got two haypnee's to rub together, but they're smoking, and their breakfast is in their hand. It's a sausage roll from Greg's, and it's a typical role model you see everyday, [in local area]...' [FG11:25, higher SES, Greater Manchester]

A group consisting of employees from an accountant's office gave a similar response, readily identifying 'poor people'. Participants appeared to hold similar assumptions to the Greater Manchester group:

R1 [Denise]: 'I think it is education, I mean you know you'll still find that these poor people can afford their cigarettes.' [FG7:11, higher SES, Aberdeenshire]

Although there was a also sense of 'them' and 'us' in a group consisting of young graduates, there was an ambivalence toward people living in deprived circumstances. Participants in this group seem to be negotiating a path between how they really feel and a more politically correct way of perceiving the socially excluded. Describing the

residents of a deprived area in Glasgow, the participants build a picture of how they think they behave, and how this picture relates to themselves:

R1 [Jill]: 'They probably do though, 'cause they do come round and it's like 'I live in Braehead', you know what I mean, 'We're going to beat you up', kind of thing. But then maybe it's our fault in the first place, making them feel like outsiders. Not outsiders but that they're different.

R4 [Catriona]: You get the impression they're trying to prove...

R2 [Geena]: It's the way they've been brought up though, 'cause I mean, half these guys' dads are out with baseball bats at the weekend so how else are they going to be different.

R3 [Philipa]: Sometimes it's not at the weekend [laughter].

R4 [Catriona]: You don't have to go up there [speaking to interviewer].

R3 [Philipa]: You don't have to pass Braehead, you'll be fine [laughter]!

R4 [Catriona]: Just on the train [laughter].

R2 [Geena]: Bottles thrown.

R3 [Philipa]: Don't be surprised if it comes flying through the window [laughter]...To be snobby [laughter], there are exceptions to the rule but, they normally prove themselves.'
[FG8:12, higher SES, Lothian Region]

Geena, who had participated in this discussion, changes her attitude considerably when discussing two of the employees in her workplace. Again, the role of personal experience appears to radically modify views, or allows participants to simultaneously hold conflicting viewpoints:

R2 [Geena]: I've got like two wee valet boys at my work, and I keep trying to feed them and things like that [laughs]. I feel so sorry for them, I really do, but they're both, you know, they're both so thin, and they sit there and maybe have a portion of chips at lunchtime and I just go 'oh' – I just want to mother them. And it's not funny because the mechanics call them the soap dodgers. Maybe they do smell, but then they're out washing cars all day [laughter], you know what I mean, and I just

feel so sorry – even though they're sort of skinny, greasy, and you know fine well they're really nice guys. I would hope that, I mean I leave my bag, on my desk and they're in and out of my office all the time, and they've not stolen anything, you know... I do trust them, if you see what I mean. You wouldn't blame them in a way.' [FG8:14, higher SES, Lothian Region]

Philipa also modifies her tone after the group discusses Geena's experiences at work:

R3 [Philipa]: 'They're no different from anybody else apart from they're living in a poorer area.' [FG8:15, higher SES, Lothian Region]

Three affluent groups in the study did take a more empathetic view. A sense of 'them' and 'us' remained, but there was less of a sense of objectification, and of judgement being passed. Early on in the discussion, one group seems to make light of the situation, relying on negative stereotyping to make a joke:

R4 [Rich]: 'Most of it stems out a boredom because of the lack of finance.

R6 [Sam]: Yeah, if they could afford to take their kids to the zoo and...

R5 [Sadie]: Aye, so it shows you it as a plain bit of grass, and if it was a swing park [referring to 'estate' estate, Fig. 7]. If it was somewhere else they'd probably play on the swings but there's a, well, burnt-out car.

R3 [Sandra]: They'd probably be burning the swings [laughter], not playing on them.' [FG12:10-11, higher SES, Greater Glasgow]

Later, as the participants draw from personal experience of being unemployed, a different picture emerges. They seem less harsh in their judgement of the deprived when compared to the reactions of other groups of similar status:

R6 [Sam]: '...for the first month, all I was doing like, the first couple of weeks, all I was doing was like, staying in bed until lunchtime. And by the end of that first three weeks or something, I was like 'for god's sake', and I got to the point where I was so depressed I don't even want to look for a job anymore.

R4 [Rich]: Totally, James was unemployed for a year and a half.

R6 [Sam]: Oh my god, it drives you *insane.*

R3 [Sandra]: It wasn't even three weeks I was unemployed for – it seems like a lifetime.

R5 [Sadie]: Can you imagine thirty years?

R6 [Sam]: Uh-huh, exactly.

R3 [Sandra]: I mean, all you do is – you just feel worthless.' [FG12:28, higher SES, Greater Glasgow]

One woman in the group draws from her professional experience as a careers advisor based in a deprived area of Glasgow. Although aware that some people may be fraudulently claiming benefits, she still empathises with her clients:

R5 [Sadie]: 'Well I deal with them all the time [laughs], the ones that are working on the side and getting – you say to them like, 'What about this job, what about that job, it's perfect for you', and they work it out. They're total experts at working it out, 'well it wouldn't be worth my while signing off because I'm working part-time at the moment, getting a wee wage, getting my housing benefit paid, blah, blah. But, there's other people – I don't think there's like good unemployed and bad unemployed because I think at some level maybe that person hasn't got the self-esteem and they don't think they're capable of going in legitimately and getting a job. But, there are definitely people who, they really really want to get somewhere, but they just don't have enough faith in themselves, they don't have the motivation.' [FG12:31, higher SES, Greater Glasgow]

Marion, a participant from another affluent group, uses politically correct language to describe people in deprived circumstances. However, she backs this up with her personal experience as an ex-employee of the government's social security department. Tension emerges early in the group as it becomes apparent that not everyone holds such a charitable view. Constance uses more judgmental language in her response to Marion:

R3 [Marion]: 'Um, I think people who are described as not being stake holders in society. People who feel that they've got nothing to gain from being members of society. They don't have a meaningful job. Probably unemployment has existed in those families for at least one generation if not more.

> There's no real hope of them getting a meaningful role in society because jobs, currently more and more jobs require a level of training and education that a lot of people are never going to aspire to. So given that people feel that they've got no, that there are no incentives for them to remain healthy. I mean years ago I used to work for the Social Security Department and it would be very easy to be sort of dismissive, 'oh they spend all their social security on smoking or going to the pub', but then they haven't got anything else in their lives. I mean, which is not to excuse it, but I think that's just what was happening.

R4 [Constance]: It's very much related. I was saying the wrong use of income, but it's very often because they have nothing else to do and they buy televisions and things like that.'
[FG13:2, higher SES, Aberdeenshire]

Occasionally, participants put themselves in the position of another in order to understand their actions. Unsurprisingly, this approach was employed by some of the more liberal-minded, empathetic affluent groups. Discussing the 'workers drinking/estate' image [Fig. 10], Sian and Niall look at the opposing versions of reality offered by the picture, and appear to be being more descriptive than judgmental with their impressions:

R2 [Sian]: 'That's what I'm trying to say. Champagne and coke [cocaine], y'know what I mean. As people get more and more money, and then you've got this [referring to 'estate' part of image, Fig. 10] where you don't have a choice.

R4 [Niall]: And you're taking heroin just to get through the day ['estate'], just to kind of blank it out. Whereas that's – you take cocaine to heighten the experience of that life [workers drinking]. Whereas drugs can kill the experience of that life [estate].'
[FG14:10-11, higher SES, Greater Glasgow]

These extracts illustrate the sense of division felt by groups of varying socio-economic status. A feeling of 'them' and 'us' is conveyed strongly with the use of binary language. Lower income groups tended to react with frustration and anger when discussing their status in relation to the affluent on the one hand, and the 'undeserving' poor on the other. Lower income participants were also prepared on occasion to discuss candidly their position in relation to others, thereby acknowledging their perceived status. Generally speaking, tensions emerged within the affluent groups as to how those less fortunate than

themselves should be viewed. Three of the more affluent groups tended to speak in very detached terms about the more deprived. The remaining three affluent groups employed binary language, but would also attempt to identify with excluded sections of the population.

8.3 Keeping up with the Jones's? Image management, self presentation and awareness of status in a group setting

The sense of division so strongly conveyed in previous sections is explored further in this section. How do participants manage their own self image and present themselves to their respective groups and to the outside world? In order to explore the psycho-social mechanisms postulated by Wilkinson (Wilkinson 1992a, 1994b, 1996) linking social position to health, an examination of these aspects of group discussion and group dynamics is necessary.

All groups, in the course of discussion, talked about their status in relation to others. Lower income groups were especially sensitive about their neighbourhoods, particularly in relation to how those not local to the area might perceive them. Strong feelings of embarrassment and shame were often communicated, and have been suggested in the literature on psycho-social mechanisms (Wilkinson 1996, Wilkinson, Kawachi *et al.* 1998, Wilkinson 1999b). One group discuss the ramifications of living in their local area, a deprived Glasgow estate which has seen substantial regeneration in recent years. Despite improvements, the reputation of the area lingers:

R1 [Andrea]: 'I think there used to be, I think a lot of people felt if they went for a job and if they had a [local] postcode, they didnae have a hope...

R4 [Richard]: Aye, don't say you live in [local area], say you live in [cites postcode].

R5 [Joe]: That's still the case, still true.

R3 [Richard]: Like it's terrible.

R5 [Joe]: Don't say you live in [local area] or something similar, you know, that still exists so there's still that kind of thing so...' [FG6:11-12, lower SES, Greater Glasgow]

In order to remain impervious to the perceived opinions of onlookers, Joe suggests that it is important not to become 'too sensitive'. The group discuss the negative press coverage the area has received in recent years. However, Ed believes that it is not easy, for some people anyway, to be thick-skinned when their area is portrayed negatively by the media:

R1 [Andrea]: 'Cause we were trying to encourage people to come up here as well... and people would come up 'cause your prices are so blooming cheap that it does encourage people up into the scheme.

R5 [Joe]: I think you get, you just don't be too sensitive and, you know, about the area when you see these kind of things, I think you just live with it...

R3 [Ed]: But I think there are probably people that are sensitive to that sort of thing because they know it's totally not true. People work really, really hard to better [local area] and the health of people, all the things that are happening in [local area] just now, and it gets knocked down by just one wee headline.' [FG6:14, lower SES, Greater Glasgow]

A more forthright reaction occurs in the lower income Greater Manchester group. The local area is viewed in negative terms. There is an awareness of the extent to which the neighbourhood has degenerated, and there seems to be no sense of hope for the future. The idea that the community could be regenerated could not be further from the minds of the interviewees. Alongside this feeling of despair is the sensitivity engendered by speculating on visitors' reactions to their environment. Sonia starts the discussion, as a former resident who managed to move from the area:

R6 [Sonia]: 'D'you know when I used to live here, people asked me where I lived – I wouldn't tell them I lived on [local] Lane. I told them I lived near [area]. I was too ashamed of it, and I'd lived here 18 years, it was lovely when I first come here. Clean, you didn't see papers or nothing. People used to come out with their brushes. Then later on, nobody bothered coming out with their brush, sweeping. You know, I swept all them two car parks front and back of me. Nobody came up and done it.

R5 [Cassie]: I think this area now, if you say [local] Lane, they go 'oh my God' [laughs]...But I think people's, outside people's perceptions of this area and areas like it are like 'gosh, how do you live there, how do you put up with it?' [FG9:28-29, lower SES, Greater Manchester]

The way in which participants deal with the perceived reactions of outsiders varies considerably. Simon, who claims that he does not care what other people think, is in minority. The majority of participants in this group, however, voice their concerns about the impression their area leaves (or publicity generated about their area) and how it in turn impacts upon them:

R2 [Simon]: 'As soon as you mention the area [local] Lane, ninety per cent of the time, they're going to turn round and say, 'bloody hell, you don't live there do you?'

I: How does it make you feel, when people...?

R2 [Simon]: It doesn't bother me in the least.

R7 [Betty]: It just makes you feel awful.

R6 [Sonia]: I was ashamed me, because when I first come here, I wanted to come here with my kids when we lived in Kersel. I thought 'great', and the neighbours were fantastic. Everything was spotless, and I said the last two or three years it was going down. I mean really down.

R3 [Jake]: I mean, I've got one thing right. Me and Danny live on the same block.

R5 [Cassie]: It's embarrassing.

R1 [Jerry]: It is embar – it's embarrassing.

R6 [Sonia]: It is embarrassing.

R7 [Betty]: If you have had bad neighbours it makes you think you're all like they are.

R1 [Jerry]: That's right.

R6 [Sonia]: Yeah, but you get classed the same, you get tarred with the same brush.'
[FG9:30-31, lower SES, Greater Manchester]

A group of cleaners living in a deprived area of Glasgow discuss the status of their area in relation to the reality they perceive. They are sceptical of the regeneration taking place, as to them it does not solve the deep-rooted problems in existence:

R4 [Norma]: '...the minute you say you're fae [local area] it's 'oh' [agreement].

R5 [Jean]: I mean that's it. I mean the news, [local area's] always for drugs, know what I mean.

R4 [Norma]: And yet it was only a certain part of [local area] that the drugs were.

I: So if you were to describe [local area] to an outsider now, how would you describe it?

R5 [Jean]: Well what they've done is they've flattened the place, they've pulled all the buildings down, trying to improve...

R2 [Hilary]: Trying to rebuild.

R5 [Jean]: But then it doesnae change the people. It really doesnae. I've always said that [agreement].' [FG10:14, lower SES, Greater Glasgow]

Rather than dwelling on what the outside world think of them, the women concern themselves with the dynamics they observe within the area. They recount the tensions between those working and those receiving state benefits:

R3 [Alison]: 'But I think a lot of attitude is, see people are out working full-time. They're paying full rent, now the rents are extortionate in some of these flats and houses and what have you. Your next door neighbour could have three wains, unemployed, no paying any rent, they're running amok, messing the place.

R5 [Jean]: That's right, aye.

R3 [Alison]: So you say well why should I go out and do the close [stairway], they're only going to go out and mess it up. I knock my pan in to pay rent, council tax. They're paying nothing, you know. I mean, it does, it makes you angry [agreement].

R5 [Jean]: It does make you angry.

R4 [Norma]: Whereas if you thought everybody up the stair was a wee bit equal. Alright you don't mind the person next door being unemployed no paying rent, as long as they're no making a mess of the place [agreement]. And you're left to clean up after them.'
[FG10:16-17, lower SES, Greater Glasgow]

Norma expresses her wish that everyone 'was a wee bit equal', a sentiment underlying the frustration of many participants living in deprived areas. Jean and Sheena, from another Glasgow-based group of similar status, recall how the boathouses passing by their area could potentially impact on their future living arrangements. This story seems to highlight the feeling that they are totally disregarded and surplus to requirements:

R3 [Sheena]: 'There they pulled that house down at the corner, they moved the man, the guy out it remember, 'cause they says it's an eyesore for the boathouses, the ones that float by. It was an eyesore for them to look out at.

R2 [Jean]: And that's how I canny understand when they're [the council] saying they're no coming down [their houses], but I canny see them leaving them standing that way when they've got all these new, like there the boathouses, that they're wanting people to buy them. I mean people coming in with money is going to look and say 'I'm no buying a house next to that'. So I don't understand it.' [FG2:37, lower SES, Greater Glasgow]

Jean distrusts the council's assurance that their houses will remain standing due to a history of inadequate communication and misinformation from the local council, contributing to the group's sense of having little or no status. Group five, also from a more deprived area, expresses similar sentiments; however rather than the threat of demolition, they feel they have been literally hidden:

R3 [Grant]: 'They enlarged the embankment down there because the Queen was coming, the grass embankment, make it higher, so she didn't see what was behind it.

R6 [Sarah]: It's exactly what we're saying to you; if it's not there then it's not happening, it's cut off. So...

I: So do you think that, say, in - I don't know, not just in affluent areas of Glasgow, but other affluent areas in the country, people really – do they ignore it or do they really think that poverty doesn't exist any more, or...?

R6 [Sarah]: I believe that they do know that poverty does exist. But they just don't like to see it. Poverty is a big business. If you didnae have poverty in this country you wouldn't have as many social workers that you have –

R4 [Scott]: Earning twenty-odd grand.

R6 [Sarah]: I mean, we have social workers here and they're just a joke. A total joke.

R4 [Scott]: We'd a social worker here – and the people in this room were witness to it, right – and they formed a shortbread group, not a gingerbread group, because the women were short of bread. She then went out to the disabled group and got on the buses – the 'SAD' group. Strathclyde Action for Disabled. We managed to change it to 'CAD'. That's when we told her to leave the fucking building and don't return. I then had a six-month battle with social work who supplied her because we'd flung one of their social workers out of here. Once they went in to interview – if you don't mind me saying, Lizzy – 'You're a single parent, Lizzy, you must have problems'. Lizzy says, 'Aye, can you get me a da [father] for my wain? Can you get me house in Bearsden [affluent area] and get me a bigger giro.' And they just didn't see where we were coming from. At the end of the day I said it to you before we came in here that people are fed-up feeling like they're monkeys, Rosemary [addressing interviewer]. You're here on my credibility today or these people wouldn't talk to you, to be quite honest with you.' [FG5:21, lower SES, Greater Glasgow]

Further into the discussion, Scott likens the disposable nature of consumerist society to certain members of society itself:

R4 [Scott]: 'I mean, you get fling-away watches and you get fling-away umbrellas, I'm very sorry to tell you, but you've now got fling-away people...' [FG5:27, lower SES, Greater Glasgow]

That certain sections of society could feel they are perceived in this manner is reinforced by the comments of a woman from another of the lower income groups. Jane first lists the places in Glasgow that have been the focus of regeneration. Rather than comparing where she lives with traditionally more affluent areas, she appears to feel more aggrieved that areas of similar deprived status have received help whilst her local area has not. She then recounts her experience as a previously affluent individual who looked down upon areas like the one where she currently lives, at a time when she possessed only the impressionable view of an outsider. This viewpoint allows her to feel not only the

negativity of living in a neglected area, seemingly forgotten whilst similar areas receive help, but also to be aware of how outsiders must think, as she was in that position once herself:

R5 [Jane]: 'And the way we've all got to live up here. [Local area] gets left to the last. I mean, Easterhouse's been done, Castlemilk's getting done, and just because [local area's] here – it's the same with Blackhill, Blackhill was another place, like [local area], because of the name, Blackhill, it was tarnished because, oh god it must be all... I actually drove through Blackhill, oh in the eighties, and thought the same thing. You know I just took a look at the place and thought, scum, rubbish, these people like living like this. To come up here [local area] and realise, 'Jane, that was disgusting what you thought'. This is [an] example, this is how Blackhill looked, like the houses and all that and shutting all the houses and all that down, and now we're in the same position. And I thought, there are decent people in these houses, see when I close my door, when I go in, I pretend I'm not in [local area]. I used to come fae Clarkston, I used to have a house, had my back and front door, and my two cars, when I was married, years ago.

R3 [Doreen]: I don't say [local area], I always say Dennistoun.

R5: [Jane]: See, and that's a stammer you have in your mouth. People go, 'where do you come from?', [names street in local area, and says very quickly amidst laughter]...that's a silly thing to say 'cause you shouldn't be ashamed of where you come from.'
[FG1:37, lower SES, Greater Glasgow]

Whilst a significant number of the lower income groups express the shame, embarrassment, anger and frustration they feel, more affluent groups converse in far less emotive terms. In fact, discussion of status in higher income groups was either complex and contradictory or distanced and restrained. A group of graduates living in an affluent area of Glasgow speculate that those from the less affluent surrounding areas would perceive them as 'complete snobs' [FG12:13, higher SES, Greater Glasgow]. Yet the participants in this group seem to have the ability to distance themselves from the perceptions of outsiders in a way that the lower income participants cannot. Furthermore, the idea that they could be perceived as 'complete snobs' is looked upon humorously:

R6 [Sam]: 'They probably think we're all complete snobs [giggling, laughing].

R5 [Sadie]: And when I'm in work and I say I'm in the [local area] it's like 'ooh, you've just moved to the [local area]', I'm like well it's a rented flat, I'm no paying that much more. But it's like, this is like Cambuslang, it's a wee bit out. There was a lot of poverty in it I suppose, and they're all thinking 'ahh wee snob' [laughing]. Only I'm from Greenock [laughter].'
[FG12:13, higher SES, Greater Glasgow]

Sadie elaborates on her Greenock roots later in the discussion:

R5 [Sadie]: '...I mean I couldn't believe like, when I went into first year at university I knew Greenock was a bit rough and I was meeting folk from areas that I'd always considered like 'oh scary', you know. Folk think you're from Greenock, 'oh fucking hell', you know, 'you better watch her', and I'm like, what! Total discrimination [laughs].' [FG12:15, higher SES, Greater Glasgow]

Jane, from group one, and Sadie above seem to be making similar observations from different points on the social spectrum. Both of them started out in different backgrounds from the situations they find themselves in at present. The similarities end there however, as Sadie is now upwardly mobile whilst Jane has seen her status fall drastically. Similar to Sam and Sadie's comments in group twelve, another affluent group believe less affluent outsiders view them as the 'snobs of West Lothian' [FG8:8, higher SES, Lothian Region]. Participants in this group, like Sadie, distance themselves from such labelling. Rather than drawing from personal experience of a deprived background, participants in this group show their lack of 'snobbiness' by recounting their visits to budget supermarkets, where they buy 'Value' or 'Savers' goods (the low cost ranges most large supermarkets now commonly stock). They claim that shopping in such places doesn't bother them, and that they do not care what others think. To them, supermarket choice appears to be a powerful signifier of status, but as new graduates, with memories of student life still fresh, they have created a loophole which allows them to feel untouched by others' judgement of their shopping choices. Contradictions emerge at this point, as the excerpt below demonstrates:

R2 [Geena]: 'But then I have to admit, maybe I am a wee bit snobby but, see if I had people coming in for dinner, if it was 'Value' stuff, I'd take everything out the packet. I mean you lot, it wouldn't bother me, you know what I mean [laughter].' [FG8:24, higher SES, Lothian Region]

The in-depth discussion that follows on 'Value' goods illustrates how powerfully status can be conferred on seemingly everyday consumable goods:

R4 [Catriona]: 'It's like when people buy the Tesco 'Value' bread, you sometimes see them coming out and they say, 'oh this is for the ducks', or like the cooked chicken, 'this is for the dog', and I'm like, who cares? [laughter]

R2 [Geena]: I don't care what you do with it.

R3 [Philipa]: Or just use 'Value' bread for the kid's sandwiches or something, it's quite a pretence thing isn't it.

R4 [Catriona]: Uh-huh. They don't want to be seen buying it.

I: So do you think that's something that is, because of being in [local area], or do you think that happens in a lot of places?

R3 [Philipa]: It'll happen everywhere.

R4 [Catriona]: In a lot of places.

R3 [Philipa]: I think it'd be worse for somebody from Kettleston Mains [affluent area] going in to buy 'Value' bread – you'd look more down on that than you would somebody from Braehead [deprived area] who was buying it, you'd expect it. It is ignorant, I'm not saying it should be accepted but you would find that more acceptable if somebody from Kettleston Mains was buying it. You'd think, why are they really buying that when they can afford Kingsmill Gold or whatever.

R4 [Catriona]: They've been sacked [laughter].' [FG8:25-26, higher SES, Lothian Region]

Instead of engaging in a discussion on status, two of the affluent groups communicate in a very vague, distanced manner. These were the groups who tended to speak of those in less fortunate circumstances in a very offhand, alienating way. Debbie, who participated in Aberdeenshire-based group seven, vaguely recalls a story about 'working class people' in Glasgow:

R4 [Debbie]: 'What's it that people are saying that Glasgow – they've got a lot of – the older people who can't read and write to read newspapers to get a healthy message across, just working class people and that's been passed on to their children.' [FG7:5, higher SES, Aberdeenshire]

Alice, a participant from the higher income Manchester group, tries to speculate on the feelings of others less fortunate and appears unable to identify with them. Connie's subsequent comment underlies this distanced viewpoint:

R5 [Alice]: 'I think it's kind of em, prevalent now. People don't have a sense of pride, or they think nobody cares about them if you like, and I think if you, I don't know whether that's the reason for most people to feel helpless, but I mean I've passed people on the streets every day, em, working in Central Manchester and I can't, I mean, I can't make a kind of connection with them mentally because I don't know where they're coming from and I don't know why they're there. Um, and there are a lot of people like that in fact. And they're young, they look healthy – they look healthy – I mean, I don't know, physically they look healthy, but mentally I'm sure they're not and, I suppose, I tend to think well why are they there, you know, what happens to actually get like that.

R4 [Connie]: Yes, yes. I wonder why, you know, since Christmas we've been unable to get a window cleaner in this area, you know [chuckles]. I've got one now.'
[FG11:6, higher SES, Greater Manchester]

The data from this study has highlighted the refusal of some of the more affluent groups to acknowledge the existence of poverty and deprivation in contemporary Britain. They argue that the so-called 'poor' often have the trappings of a consumerist lifestyle – and therefore conspicuous wealth – by acquiring televisions, designer clothes, and so on. However, in the course of discussion on status, other affluent groups were prepared to look beyond material goods in their understandings of poverty and relative deprivation. Group fourteen, for example, argue that firstly, those on low incomes do not realise how big the divide between rich and poor actually is (although this could be contested with the observations of the low income groups). Secondly, participants in this group make a distinction between material goods and the lifestyle that is supposed to accompany them:

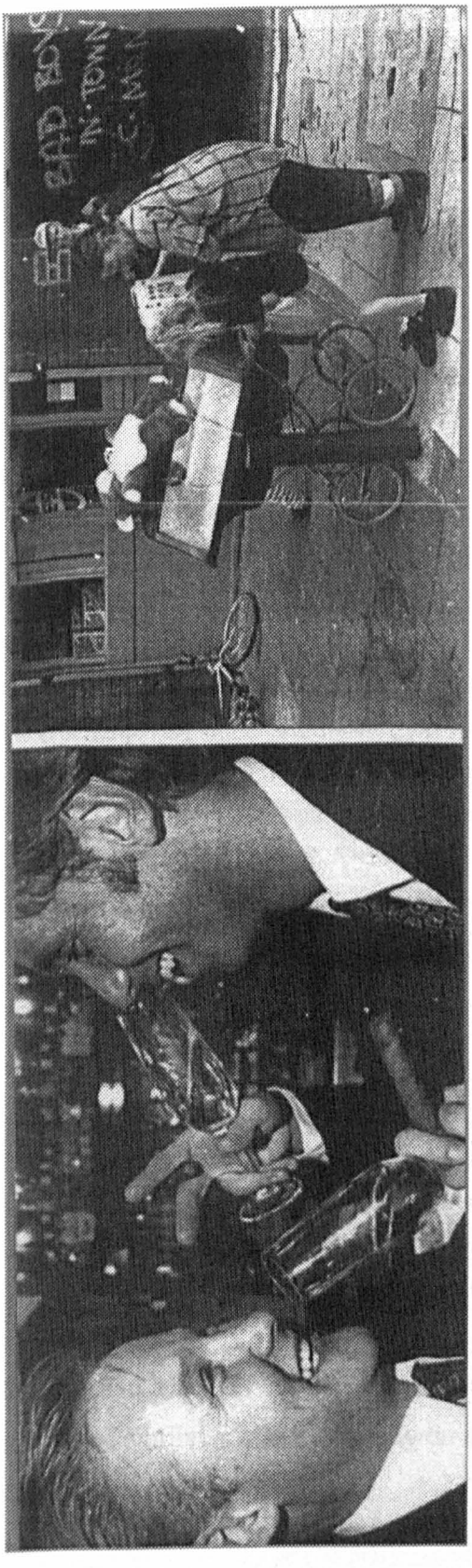


Figure 10

R1 [Brendan]: 'Well I think they're probably very aware of, you know, if you were to take someone around an average office in the city and find out that people were on six figure sums, you know, there's nothing sort of unusual about that, they would be absolutely astounded. And as you were saying about the sort of younger millionaires and stuff, I.T. and those sort of areas, I don't thing it does happen in reverse. I don't think there's a total understanding of how big the divide actually is.

R4 [Niall]: But I'm not sure there's an aspirational – I'm not sure that people live life that this, who grew up in that [referring to 'estate' image in Fig. 10, 'workers drinking/estate'], actually aspire to that ['workers drinking', Fig. 10]. They want the BMW, but they don't, they would never, they don't have the lifestyle, that goes, that creates that wealth, and that's the problem is that, you get into a kind of counter culture almost. You get money from other sources, whether it's crime, whether it's drugs, whether it's prostitution. And it isn't by going to work in the city and making a lot of money in that way, it's about getting it some other way. So you have the same goal in terms of certain material belongings, the lifestyle's completely different. Dinner parties on a Saturday night...' [FG14:9, higher SES, Greater Glasgow]

Niall later uses the example of the proliferation of satellite dishes on houses in deprived estates to reinforce his point:

R4 [Niall]: 'Yes it's the whole thing, you know when satellite dishes first came out, you know. You saw more satellite dishes in Possil Park than any other part of Glasgow...You create just the bits, you create the

objects of the life but not the life itself...you see the house, but you see the house the dish is attached to...' [FG14:16-17, higher SES, Greater Glasgow]

A fascinating insight is offered by Marion of the Aberdeenshire group, who had formerly worked in a social security department. She expresses the view that people are rewarded for 'being passive' and for not 'rocking the boat'. She even believes that it is 'almost easier to just be passive or to do a little bit of fiddling', as a result of the pressures and expectations that society imposes:

R3 [Marion]: 'But I think our whole sort of views as a society as to what's right and what's wrong are a bit odd. Because it seems to be right to have done well for yourself. We judge people by their jobs, if people don't have jobs we seem to think, you know, that there's something wrong.

R1 [Sheena]: They've failed.

R3 [Marion]: Yes, and so we're setting-up – I don't think it's intentional, but I think one of the results is we're setting up this sort of paradigm of how you should live, and if people can't fit into that then I think they see themselves as alienated and they think well, the rest of you are fair game.' [FG13:13, higher SES, Aberdeenshire]

These are the circumstances in which crime flourishes, according to Marion. Whilst adopting a caring attitude, she allows her opinions on the unemployed people she has encountered to filter through:

R3 [Marion]: 'I mean, having years ago, worked with these people, when I was sort of doling out social security, I mean they're not pleasant. They're not like the sort of Victorian deserving poor [laughs], you know. It's difficult to feel sympathy for them, but on the other hand if we don't try and attack the problem, I think crime is just going to...' [FG13:13, higher SES, Aberdeenshire]

Sheena and Marion position themselves as possessing a social conscience, amongst other people of similar social status who do not:

R1 [Sheena]: 'But I mean, there is some of that in people who possibly, people who haven't ever had wealth and now are doing quite well...I think there are quite a few people who don't really have a

social conscience about this sort of problem. I mean they're perfectly civil [laughs], pleasant people but you know, they just don't see...

R3 [Marion]: And also I think their children, and I'm a personal example of that because my son has a friend, well he's actually leaving the area quite shortly. And he's one of quite a large family, the father does not do a well paid job. I mean I don't want to sort of identify him, but I know what he does is socially great, but it doesn't have a lot of status. And my son's told me that the boys in his class are really nasty to this particular boy because he hasn't got the right designer [gear].

R1 [Sheena]: [Local area] particularly, Catherine who was in here, her two children suffer 'cause she's a single parent.

R3 [Marion]: I was so angry, I know, I phoned the Guidance Teacher and said, look you know, what are you doing about this, it's dreadful, you know, it shouldn't happen, it's bullying you know, it's all wrong. And he said oh well yes – but of course there isn't enough for people to do, children to do in [local area]. Well I think that's an excuse. I wouldn't accept that as an excuse. It's a very fundamental thing [agreement], you know, about how you treat other people. And I bet a lot of these kids' parents are probably quite well-to-do, and like you said, they're not nasty people, but they haven't developed any sort of social conscience.' [FG13:14-15, higher SES, Aberdeenshire]

When talking about status, participants demonstrated an awareness of their standing in a perceived social hierarchy. Sheena and Marion present themselves as socially aware people in a climate of complacency. Generally, whilst around their peers, participants presented an image of themselves, an image which seemed especially important to preserve when discussing these sensitive topics. After looking at the manner in which participants from different groups present themselves, the last part of this section focuses on the comparisons people make with others.

The lower income groups appeared to be more consistent in the image they presented to the outside world. Many presented themselves as 'survivors' and 'fighters' against difficult odds. Participants in group two describe how they and others in their community made a decision to stand up and fight for themselves:

R2 [Jean]: 'Aye, they're no sitting... the ones that are getting broken into are no sitting and taking it, they're telling the police who's doing it.

R3 [Sheena]: Whereas years ago you wouldnae open your mouth.

R4 [Val]: No, 'cause you'd get leathered.

R3 [Sheena]: But now folk are standing up for themselves.

R4 [Val]: You've got to but...

R2 [Jean]: I mean it takes you years to build the house you've got, but just like one of them to come in one night and take everything that you own. I don't think people's going to sit back and do it anymore... let them take it.' [FG2:29, lower SES, Greater Glasgow]

A heartfelt response arises in group one, as Jane passionately describes the highs and lows she has encountered in her dealings with the local council:

R5 [Jane]: 'They've lied, they've made up stories, they've em...

R1 [Kay]: ...put in that paper saying you're getting money and you don't even know it [laughs].

R5 [Jane]: Aye, two thousand five hundred which we didnae know anything about it, we're still talking about it and we didn't get it. And they're, 'oh you're definitely getting it, oh you're definitely getting it', but we never got it. No, they tell lies, right and it's nothing to them, it's only us, we don't... I can sleep at night or they can sleep at night, but we cannae.

R3 [Doreen]: Just trying to butter us up so we don't make any more protests, things like that.

R5 [Jane]: Oh we'll just burst their bubble, we'll do it again because we'll no be bothered, and then they woke up. We'll be here the next time, and the next time, and maybe even the next time [laughs]. No I didn't give in very easily. I'm not a giver-upper. My bubble was burst a few times, and I lost my wind, and I went down and had nothing to say, which is very unusual for me, but it's true... I'm dying to be able – I would like to see this place rise above every one of them, and us to be better off than any other project in Scotland, never mind Glasgow. That's what I'd like to see, saying that it's a dream, but dreams do come true.

R3 [Doreen]: They know we're too strong the gether, so if they separate us all, they're hoping that we'll be weak.

R5 [Jane]: What they did this time is they made us stronger really, 'cause we all got together and we did stay together. Okay, we never got exactly what we wanted but we still made an effort and we still got something, but that's no just happened to us, 'cause we'll try elsewhere. And d'you know at the end of the day, you know that gut feeling you get, when you think everything's going to come right, and see the end of the day you can stand up high above them and say 'by the way, you tried to shut me out but I'm still here and I'm doing much better than you thought I was'. I'm dying to say that. I wished I could [laughter].' [FG1:27-28, lower SES, Greater Glasgow]

The lower income groups consisting of relatively young participants (approximately forty years of age or younger) tended to present a 'hardened' image of themselves. However, those with memories extending back further put their experience in context with earlier recollections of how harsh life could be. They did not perceive themselves to be deprived, as they compared their (relatively affluent) lifestyles with experiences of their (more deprived) youth. As a consequence, the idea that anyone could be classed as 'poor' in contemporary Britain was perceived as ridiculous. Participants seemed to be positioning themselves on a middle ground; they did not view themselves as deprived, yet they were not affluent either. A group of pensioners from a deprived inner-city area of Glasgow air their views on younger generations:

R3 [Margaret]: 'They don't realise.

R4 [Irene]: They take it for granted, don't they, the wee selfish things, they take everything for granted I think.

R2 [Ian]: Yes, it's like going to the cash machine, isn't it, you put the card in and the money keeps coming out, but you have to work to put it in [agreement and laughter].

R3 [Margaret]: It's like buying a pair of training shoes, I mean look at the price they pay for training shoes now, I mean, we never had that, we were lucky if we had a pair of sand shoes on our feet.

R4 [Irene]: And if they've no got a [brand] name to them they don't want them [laughs].'
[FG3:29-30, lower SES, Greater Glasgow]

A similar view is expressed from another group of pensioners living on a deprived Glasgow estate:

R6 [Robert]: 'If you're talking about poor people catching up, you stand at [local] roundabout there, and watch the taxis come up [agreement]. That's [local] folk – taxis.

R2 [Carol]: Aye I know, I know. You see at Kwiksave...

R6 [Robert]: And how about holidays, they're off on foreign holidays.

R2 [Carol]: That's what I want to...

R6 [Robert]: Years ago we were lucky if we got to Dunoon [a seaside town].

R2 [Carol]: They're really well dressed, some of the kids. That's what I mean, that's what I thought.

R6 [Robert]: And it's not really so much the dress, see some of the stuff they buy. Kids wandering about with trainers.

R2 [Carol]: They're about ninety-odd pounds.' [FG4:61, lower SES, Greater Glasgow]

The more affluent participants taking part in the study presented themselves in a number of different ways. A couple of groups contained participants who described themselves as 'soft' or 'soppy' because of their understanding views toward those they perceived as deprived. Geena, who earlier expressed her wish to help the boys from deprived areas working as valets for her company, described herself in this way [see p. 270]. Her account adds a different perspective to the group discussion, as previously the other participants had been quite unforgiving in their descriptions of people living in deprived areas nearby:

R2 [Geena]: '...I'm so bloody soft, I just feel sorry for them, I really do. They're from a rough part of Glasgow, they come through everyday and their boss just drops them off at half eight in the morning and picks them up again like eight at night. They're just hanging about if there's no cars to wash. I think they're probably on about £1.50 an hour... When I asked one of them to do my

own car, and I was going to give him cash in hand, he was over the moon... It's just an excuse to give them money...' [FG8:14, higher SES, Lothian Region]

Marion, a university lecturer taking part in group thirteen, speculates on how her left-of-centre beliefs may differ from the beliefs of others:

R3 [Marion]: 'I think one of the issues that's interesting is the impact of people's personality and beliefs on the way that they see the problem because, you know, I might say well I'm a bit sort of soft so I would say, you know, it's not people's fault if they are unemployed or alienated or whatever. But then somebody else who was maybe even more... down to earth, whatever, might say 'well that's too soppy, you know, these people have got to stand on their own feet'.'
[FG13:35, higher SES, Aberdeenshire]

Marion and Sheena go on to discuss the dynamics occurring in the group discussion. Constance has left the room by this time to attend a doctor's appointment. This gives the remaining participants the opportunity not only to discuss how the group went, but also to remark on how their views differed from Constance's:

R3 [Marion]: 'And I think there's a difficulty of getting people together on these issues [agreement] because I don't think anyone wants to see a major gap between rich and poor, especially when that means less adequate health care for vulnerable people. But then it's how do you get people to work together on that, because I've no doubt if I had an in-depth discussion with Constance, for example, I mean I like and respect Constance, but I know we would go off in completely opposite directions.

R1 [Sheena]: Yeah exactly, exactly. It's interesting though that she went along with more, went along with things more than I thought she would actually. But I think there are a whole lot of things that she hadn't thought about, maybe, I don't know.' [FG13:35-36, higher SES, Aberdeenshire]

These comments could apply to all participants, as the group setting may mask some of the differences in opinion which might arise in a discussion between two people. In group thirteen, Constance was in the minority, and consequently she possibly said less and communicated her views in a less forthright manner than she might otherwise have done in a different context. As participants were required to talk about quite sensitive and

controversial subjects, it is not surprising that such dynamics exist. Whilst participants in groups eight and thirteen sought to cover their backs, as it were, by portraying themselves as 'soft', other affluent groups were more open in their differences of opinion. Participants in group twelve openly acknowledged that they were from very different backgrounds. As a result, an open forum was established in which contrasting sections of the population seemed to be represented. In this group, no sense of a collective group image was established. Opposing experiences (and self images) were expressed, perhaps keeping participants 'in check' as they could not make unchallenged generalisations about sections of society:

R6 [Sam]: 'I think you should realise it exists [poverty] 'cause it definitely does. But I mean, I haven't had first-hand experience of any of the really rough, you know.

R4 [Rich]: Well I know it exists 'cause I come from it.

R6 [Sam]: Yeah you see I've never experienced it.

R4 [Rich]: So I was brought up in it so...' [FG12:18, higher SES, Greater Glasgow]

Group fourteen appear tolerant, caring and thoughtful when expressing themselves, yet their views – like many of the affluent groups – do not have the same momentum and energy behind them as those from the lower income groups. Niall attempts to speak for all the participants in the group when he contrasts his standard of living with those on low incomes:

R4 [Niall]: '...Not just with the physical manifestation of damp walls but the sheer kind of poverty and the stress of having no money all the time. I mean we all moan about money but we're actually fucking comfortable compared to a lot of these people.' [FG14:10, higher SES, Greater Glasgow]

The group most critical of those less fortunate than themselves consisted of participants who tended to present themselves as 'respectable citizens'. This 'respectability' was achieved, in part, by 'judging others at face value'. Cedrick, for example, is a retired

teacher who has no problem placing himself in a hierarchy of stress on the basis that he 'knows' how stressful other professions are, despite not having worked in them himself:

R6 [Cedrick]: 'Housewives, bricklayers and craftsmen of that kind don't find their work stressful at all, they enjoy it because they're doing something creative et cetera. But a teacher, of course, as you well know [laughter], and policemen, a salesman, and people of that ilk, they of course will find life stressful.' [FG11:4, higher SES, Greater Manchester]

Cedrick seems to construct arbitrary divisions to explain things. He comes up with a series of dualisms; the motivated versus the unmotivated, the responsible versus the irresponsible:

R6 [Cedrick]: 'Oh yes, and you know why, because the people who are unemployed are either unemployable or haven't tried very hard [amusement in background]. And in fact anyone usually who is capable of keeping themselves fit and has a good regime of exercise and things like that, will be employable. And no employer in their right mind would turn them down, or her down.' [FG11:4-5, higher SES, Greater Manchester]

The women in the group appear to use their involvement on school boards as a badge of their respectability, as well as a means of judging others:

R4 [Connie]: 'Yeah, well I mean you've got the single mother who doesn't need the father to support [her] 'cause she knows – if she falls pregnant with the lad, and they fall out, nobody is going to bat an eyelid if they don't have a shotgun wedding...

R5 [Alice]: Unfortunately, all they're doing is giving birth to a big doll, which is lovely at the time. But when that child grows up, 'cause actually – I'm on the Board of Governors at a school, and nearly all the children, I would say ninety-nine per cent of the children they exclude – come from one-parent families.

R3 [Elaine]: Well we were just saying that, I've just been at the school governors meeting this afternoon and that was the exact same thing.

R5 [Alice]: I just know, 'cause I have to chair the meeting, and I know every time I go, there's going to be no father, or no mother, on the scene.' [FG11:17-18, higher SES, Greater Manchester]

This section has looked so far at the extent to which participants think in terms of status, as well as the way in which they present themselves to their peer groups. By looking at the impact of social standing and status, the question of whether participants compare themselves with others has already been touched upon. However, the final part of this section attempts to scrutinize this area further. What evidence is there to suggest that participants, and possibly the wider population, compare themselves with others? The lower income groups in the study were forthright in their comparisons. Participants in one low income group actually compare amongst themselves the levels of state benefit they receive. Sheena, in particular, becomes quite confrontational with another member of the group, Bob:

R1 [Bob]: 'I'm on invalidity right, and my money's only gone up two pounds.

R3 [Sheena]: Bob, bet you get more a week to keep yourself than we do for us and our weans.

R1 [Bob]: That's what happens you know [mumbles].

R3 [Sheena]: So you're getting richer and we're getting poorer Bob.

I: Is that because the child benefit... that's not covering... [all children in a household]?

R2 [Jean]: You're only getting it... I think you're only getting it on your first wean, aren't you , the rise?

R3 [Sheena]: I don't know.

R2 [Jean]: I don't know, but I think...

R3 [Sheena]: I think it goes down again [laughs under breath].

R2 [Jean]: No, in your family allowance I'm talking about.

R4 [Val]: Mine doesnae go up at all.

R3 [Sheena]: I get thirty-five seventy and it goes up to thirty-six thirty or something like that.

R2 [Jean]: Not unless they're going to send you out a new book or something...

R4 [Val]: But Katie'll be the same as me, I get seventeen-ten, what does she get? That and all, but then ours is going up to twenty-seven.

R2 [Jean]: Aye. [FG2:16-17, lower SES, Greater Glasgow]

In a culture where, amongst the working population at least, it is often considered rude or intrusive to question somebody about their salary or to disclose details of their own, such a conversation seems surprising. However, for this group at least, it appears acceptable to compare the minutiae of benefit provision amongst themselves (perhaps because they do not see it as a true reflection of their 'worth'). Whilst a sense of anger and frustration about their situation comes across in this group (as in other low income groups in this study), participants also discuss how they feel better off than 'a lot' of other people, particularly in terms of childcare and related services:

R2 [Jean]: 'I'd say we are a lot better off than a lot of people with what we've got for our weans. 'Cause when the weans are off from the school holidays we run a... we've got a playscheme in here and all so that takes weans in five days, well it's only like half a day each day, but it's still – and on a Friday, the weans are getting a wee trip whereas a lot of families cannae do that.

R4 [Val]: And it only costs you a pound. D'you know what I mean, they do a lot of fundraising all through the year, by the time it comes your wean can go to Butlins for a pound. All he needs is a pound and a packed lunch and that's your wean away, d'you know what I mean.

R3 [Sheena]: And you know it's getting watched, there's plenty of staff to watch about.'
[FG2:32, lower SES, Greater Glasgow]

This exchange suggests that the women are not placing themselves at the very bottom of the social hierarchy. They do not perceive others to always be doing better than themselves, in certain ways at least. Yet for a lower income group to compare themselves in any way as better off was the exception rather than the rule. Even the groups less likely to perceive themselves as deprived, namely those consisting of participants around

pensionable age, still made comparisons in which they came out unfavourably. To illustrate, Mary compares herself with the unemployed residents in their community:

R5 [Mary]: 'I'm in a wee bought property that's just up the tenement close, and I'm paying to get the stairs done, the back garden cut. Other ones up the close [stairway], don't work, never worked – they don't pay for anything. And I'm penalised because I saved and tried to improve my own life. So you're penalised for things that's no your fault. So it doesnae give people coming up an incentive to save money. It just says you get something for nothing.' [FG4:49, lower SES, Greater Glasgow]

The lower income Greater Manchester group discuss a street in their community on which some of the participants reside. One end of the street is perceived as a pleasant place to live whilst the other end has degenerated rapidly. The participants openly compare their experiences:

R3 [Jake]: 'From this end, nobody likes it, okay. But where me and Danny live, we're right at the other end, right. There's no houses there except ours. We've got an open green, everything is nice, clean...

R4 [Danny]: We've got ducks and foxes.

R3 [Jake]: We've got foxes, no ducks, you shot the ducks [laughter].

I: I won't ask!

R3 [Jake]: And it ends up, you know, everybody knows their neighbours, we all know each other, we all get on great together.

I: Right, so your experience is very different.

R3 [Jake]: Yeah, yeah, but you come to this end – it's totally different.

R6 [Sonia]: It never used to be though Jake. When I first come here, it was this end what was very bad. That end, and this was dead good, dead clean and everything. Now it's opposite way, that's good end and this is the bad end now. It's turned around.

R3 [Jake]: Yeah but see, the neighbours there won't tolerate it.

R6 [Sonia]: Where?

R3 [Jake]: In my end now.' [FG9:31-32, lower SES, Greater Manchester]

A feeling of community spirit is apparent at Jake's end of the street, yet such an atmosphere is said to be absent from the other. A similar feeling emerges in group two, when childcare and related services are discussed by Sheena, Val and Jean. In both groups, participants are willing to make direct comparisons between themselves and others in the group in terms of their living environment (group nine), and how much benefit they receive (group two). Group ten look further afield in their comparisons, focusing their attention on the ways in which the residents of Bearsden (an affluent suburb of Glasgow) are better off, both generally, and in terms of their health. Yet as the discussion progresses, participants begin to make comparisons with their neighbours:

R4 [Norma]: 'I think it would be because... they're no living in damp houses that's overrun with rats and dampness.

R2 [Hilary]: And they're no stressed out 'cause they've got alarms in their houses and everything.

R4 [Norma]: And plus if they can afford to live there, they've got a better standard of living than what somebody has, say maybe in Drumchapel, Possil Park.

R2 [Hilary]: They're no living – there's nae fear in them. I'm no saying there's nae fear in them, [when] they're out, there might be, but they've all got alarms, I mean in my street they're all alarmed.

R3 [Alison]: And they wouldnae have gangs hanging about the corners...

R2 [Hilary]: So they're okay in their own houses, staying theirself whereas an old person in a tenement, they are getting battered, d'you know what I mean. That's you who stays down that way [referring to one of the participants], down that ? street, aye.' [FG10:28, lower SES, Greater Glasgow]

In response to the headline **Wealthy stay healthy but the poor get more poorly** [Fig. 16], Alison makes a powerful statement when comparing her situation to the 'rich':

I: 'And what about Wealthy stay healthy but the poor get more poorly [Fig. 16]?

R3 [Alison]: That is true, aye [agreement]. They've got the money to buy the best a food, their clothing, best of houses, whilst we are living in slums.' [FG10:31, lower SES, Greater Glasgow]

Whilst making comparisons, group three stumbles into sensitive territory. Margaret recalls a documentary filmed in America where 'poor' people justified mugging the 'rich'. As the discussion starts getting awkward, Betty interjects with a more 'acceptable' viewpoint:

R3 [Margaret]: 'I was watching a documentary, granted it was about America, you know, I suppose, I don't know whether it could happen here at all, but they were talking about actually mugging the rich people, and they thought they had a right to do that. Why should they have all the money and I've not got any money? You know, and I [sighs], to myself, I mean, I couldnae do that mind you, you know, but...

I: It crossed your mind?

R3 [Margaret]: No, no, but people thought that was a right to do that.

R1 [Betty]: I have no jealousies about people being rich, and I'd like to see the poor getting a wee bit richer, but, I don't grudge anybody their wealth, or anything like that you know.'
[FG3:44, lower SES, Greater Glasgow]

Participants from two low income groups claimed to be unaware of others, or to shut out others as a coping mechanism. Jane responds to the 'woman with pushchair' image [Fig. 9] with the suggestion that everyone is so consumed with their own affairs that they rarely notice the circumstances other people have to endure:

R5 [Jane]: 'I would say that one's [Fig. 9] more like to open your eyes up to see what's happening about you instead of looking at yourself. 'Cause you don't realise what's happening to other folk, you only know what's happened to yourself...in your own group, but you don't realise what's happening to other people, through coloured, or prejudiced or whatever.'
[FG1:7, lower SES, Greater Glasgow]

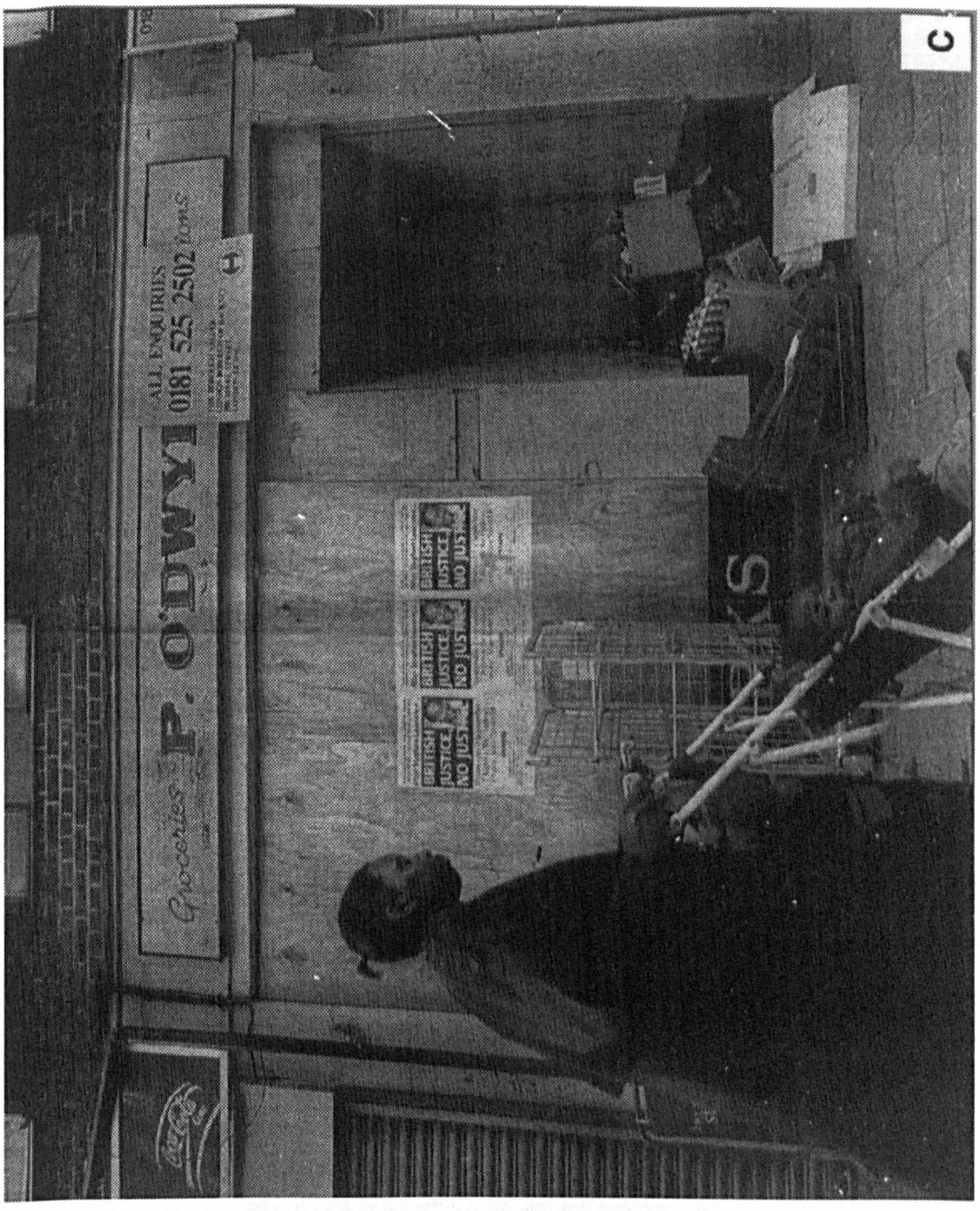


Figure 9 ' woman with pushchair '

However, as the discussion continues, it becomes clear that Jane is painfully aware of her status, readily making comparisons with others. A woman in another group, Sarah, adds a different slant to the nature of (non)comparisons. She explains how, in order to survive impoverished circumstances, it is necessary to shut out the outside world:

R6 [Sarah]: 'People don't want to know, they tend to kind of shut off. If you're living in poverty you tend to kind of shut off and say it's not happening, because nothing is done about it and you can't see a way out it. I mean, if that's the one family [referring to 'child with plate' image, Fig. 8], what must the mother of these kids be thinking? 'I cannae see a way out this, I cannae provide for my kids, my kids haven't got what other kids have got.' You're not wanting to sit and read about another family who's in poverty, because you're in exactly the same position as the other family.' [FG5:15, lower SES, Greater Glasgow]

One of the more deprived Glasgow groups discuss the complexities of making comparisons, both from the perspective of residents of an area and outsiders:

R5 [Joe]: 'You've just got to think that other people in parts of the city are just getting on with their life, don't sit and think about these things, don't sit and think, 'I wonder if [local area] is getting any better.' [laughter]

R3 [Ed]: It's no just about places like [local area], it's Easterhouse as well, every time someone talks about Easterhouse you get the Frankie Black thing. I mean that was in the 60s, this is the 1990s, we're nearly in the year 2000 and they're still going on about that.

R4 [Richard]: To be quite honest we don't sit thinking about 'I wonder how Easterhouse is getting on'. People are just trying to get on with their lives, basically.' [FG6:11, lower SES, Greater Glasgow]

Later the tone changes as the 'workers drinking/estate' image [Fig. 10] is discussed. The group is asked if they think people compare themselves with others:

R3 [Ed]: 'I would think so aye. Likes of this woman here would probably see these people with their money, well with their nice suits and their glasses of champagne and say 'Why have I no got that?' And that'll put them down as well, they'll think 'I must be an inferior type person', well she's probably had bad luck or something eh, and she's saying 'How can I no be like them? I want to be like them.

R1 [Andrea]: Yeah, their self confidence.' [FG6:32, lower SES, Greater Glasgow]

The group is then asked how these comparisons affect people, and they continue to refer to the 'workers drinking/estate' image [Fig. 10]:

R3 [Ed]: 'Oh it makes them feel bad, makes them feel bad if they don't have what they see on the TV or in the paper or whatever and there they have this, the woman [in Fig. 10], 'Why am I like that, is it because of me?' 'Or is it because society has basically fucked me up', em, I mean also this photograph could be implying that this is a single mother who's living off the backs of these two men. You know, they're working hard, paying their taxes so she can live her jolly wee lifestyle...a lot of people look down on that person and all that sort of thing, 'look at the state of her, why's she like that, it's her fault'. Whereas it might not be.

R5 [Joe]: People are made to feel it's their fault, scrounging, and it's like people in general don't have a sense of being exploited...

R2 [John]: I know, I know, don't know they're being exploited until they're told.

R5 [Joe]: They don't realise in a way that's what's been happening. Then of course the way, the set-up of society as it is, individuals feel it's their fault that they're no there, you know. That's how people try to win the lottery, the quick fix or quick ascension into nae worries and what not, so everybody's looking to escape from that.' [FG6:33-34, lower SES, Greater Glasgow]

The group move on to distinguish between the terms 'poverty' and 'deprivation'. As they do so, Joe no longer refers to 'they' or 'their' as he did previously. He refers emotively to 'we' and 'us', presumably referring to himself and the other group members:

I: 'So the distinction between poverty and deprivation, deprivation maybe meaning that you don't have access to the things that other people might have?

R5 [Joe]: No just that, no you're still at a certain level of resources that prevent you from living life to the – I mean how many of us even, thingmy's working [referring to other participant], but how many of us are just going to jump away to a restaurant you know?

[End of side B, tape 1]

R5 [Joe]: ...we're deprived psychologically, we're deprived intellectually, because we're inspirations – probably more than people who are submerged in poverty and you know, they are just trying to get from day-to-day. In a way we are – there's a lot of aspirations and so on, deprivation is... the only reason isnae out the goodness of our hearts, it just means that people might revolt if they left it, but they'll no starve, you'll no starve, and you'll, you know...' [FG6:45, lower SES, Greater Glasgow]

Initially it appeared that participants in group six did not compare themselves with others, at least that is what Joe, Ed, and Richard claimed. However, as the discussion continues, it becomes apparent that Joe in particular is making direct personal comparisons about his, and the group's fortunes, in relation to others. There was a similar reaction in two of the affluent groups, as participants claimed they 'forgot' deprived areas existed, or 'blocked out' deprivation from their minds. Rather than comparing herself to others, Sam explains that she 'tend[s] to block things out. I'd rather not know...I'd rather live in ignorance' [FG12:17, higher SES, Greater Glasgow]. Yet when she is confronted with other participants' recollections of impoverished circumstances, she rapidly changes her view.

The graduates in group eight veer between making quite involved comparisons with people living in the surrounding deprived areas, and then claiming to 'forget' that such people exist. I ask them how much they compare themselves to others, a question to which they quickly define their terms:

R4 [Catriona]: 'Yeah I think it goes on, I do it.

R3 [Philipa]: You see, I don't really compare myself to anybody in [local area]...

R4 [Catriona]: No, but like, from like this area to somewhere like Braehead, you think oh...

R3 [Philipa]: Yeah there's comparisons with ?? I would think. If somebody told you they lived in Braehead...

R4 [Catriona]: 'God they're dead rough', or you know.

R3 [Philipa]: Yeah.

R4 [Catriona]: Sometimes the way they dress as well.' [FG8:10, higher SES, Lothian Region]

Catriona goes on to make more detailed comparisons, drawing on her experience of working in a local supermarket. However, she qualifies her comments by saying that she *does not* compare herself to others:

R4 [Catriona]: 'But then I would also say, not comparing myself to people, but I work in Tesco's like part-time, and see when I get a trolley through, I don't mean to do it but I can tell by the food that they're buying what kind of, well I can guess, what kind of area they come from, and if they have a lot of money or if they are like, well-off or not well-off, d'you know, just from what they have. It's not even necessarily if they buy 'Value' goods or not, but it's just the types of things that they have in their trolley.' [FG8:11, higher SES, Lothian Region]

Despite comparing themselves so readily with others, and making such detailed observations as Catriona does, Philipa goes on to say that she forgets that deprived areas exist:

R3 [Philipa]: 'I think it wakes you up...you forget, well personally, I forget that areas like this exist [referring to images depicting deprivation], you know, if you're in a town like this, you know, with Edinburgh on one side, Glasgow on the other, you forget that there are these very poor areas where people are struggling. Even the poor areas here are not that bad, nothing compared to any of this. So I think you do forget sometimes that people are struggling.'
[FG8:14, higher SES Lothian Region]

These comments were made after Geena had described the valet boys employed in her workplace [see p. 270]. Perhaps a personal account of coming into contact with these young men encouraged this more empathetic view from Philipa. However, this leaves participants in the position of rationalising their views. If they are aware of people less fortunate than themselves and the poorer quality of their lives, where does it leave them? When the group is asked how people in deprived areas might feel, and more specifically, whether they think they also compare themselves with others, an interesting theory emerges:

R3 [Philipa]: 'I think they're happy with who they are, what they are. They don't try to be something they're not, they're happy if they live in Govan, and they come from Govan, they're quite proud of it, or they get on with it at least.' [FG8:20, higher SES, Lothian Region]

Philipa doesn't appear to know anyone from Govan or have any personal experience of the area. Yet she uses Govan to illustrate how she imagines people to behave in deprived circumstances. Govan is well known as an area of Glasgow which declined rapidly as the

shipbuilding industry it relied upon lost momentum. Speculation over whether the residents of deprived areas are 'happy' also occurs in group seven. The participants of this affluent Aberdeenshire group would not be drawn into any involved discussion on inequality and/or social comparisons. In a similar response to Philipa (group eight), participants agree that people living in deprived areas compare themselves to others before speculating on their outlook:

R4 [Debbie]: 'Oh I would think so yes.

R2 [Lindsay]: But then they may be just as happy... they probably do compare.'
[FG7:7, higher SES, Aberdeenshire]

When affluent groups in the study did reflect on their standing by making comparative observations, it was often in very general terms. This is in stark contrast to a number of the lower income groups who had compared benefit levels, their neighbours, and different ends of the same street, in the course of discussion. When affluent group thirteen, based in the North-east of Scotland, make comparisons they focus on how lucky they are:

R1 [Sheena]: '...And I think it is easy, I mean we sit here, we live here, we don't really have any major problems of um, food or all this sort of thing. We're not going hungry, we're...

R3 [Marion]: We can pay the bills.

R1 [Sheena]: We're in a beautiful countryside so we can get rid of the stress by going off for a walk or whatever. It's so difficult to think about this sort of situation when you're sitting comf – I don't think it's that people don't want to, it's because they're unaware of the problems.'
[FG13:15, higher SES, Aberdeenshire]

Group eleven, who seemed the least understanding of those on low incomes, were also the least likely to become involved in discussion on comparisons. Ironically, when a comparison was made, it was by Cedrick who describes past society as 'more caring and responsible', qualities that the group demonstrate little of throughout the discussion:

R6 [Cedrick]: 'Most of the facilities that you have now we didn't have, and that was before the war 'cause I'm seventy-five. Anyway, in those days, we had a society that was far more caring and far more responsible and how are you going to make that. Now either move to an area where, or a country where life is better and society is much more honest and kind and well regimented perhaps, or stick it out here.' [FG11:50, higher SES, Greater Manchester]

When discussing image management earlier in the section, Niall had been quoted [see p. 291] as saying 'we're actually fucking comfortable compared to a lot of these people' [FG11:10, higher SES, Greater Glasgow]. Other comments tended to be less emotive, couched in reflexive reasoning. The observations Sheetal makes are on the macro level, instead of drawing from personal experience:

R3 [Sheetal]: 'I wonder whether in the same sense that though we can see these images and go 'yeah that is a reality', how much of an actual reality, how much we can actually empathise with that. Whether that's the case in reverse, where these people look out and though they know there are rich people out there, and they know that this is the way they lead their lives, whether they actually can feel that as reality, and as part of the world they live in, or that's just something that's on the telly.' [FG14:8, higher SES, Greater Glasgow]

By the end of this chapter it can be concluded that a language of division permeated all groups in the study. However, lower income groups were particularly aware of their status. Feelings of embarrassment, shame, stigma and frustration were often communicated. Participants from the lower income groups were likely to present themselves as 'survivors' and 'fighters' against difficult odds, although this tendency was age-related. Those nearer pensionable age in the lower income groups were less likely to present themselves in this manner as they often did not perceive themselves to be deprived. The lower income groups were more likely to make direct comparisons with other participants within their respective groups and the community around them. In many senses, social norms and taboos were broken down when comparisons were being made, but there still remained 'acceptable limits' to how far participants would explore the implications of what is such a sensitive topic.

Higher income groups were, on the whole, far less emotive in their discussions on status. A number of the groups could only speak about social status in very distanced and vague terms, and were not particularly empathetic to those living in more deprived circumstances. The groups containing more understanding participants had a more multi-faceted, complex view of deprivation and the causes underlying it. Self image in the context of discussions regarding deprivation and inequality seemed to be determined by participants' attitudes to the less fortunate. A more disparate range of reactions emerged when compared with the 'survivors' and 'fighters' of the lower income groups. The higher income groups did not compare themselves to others in the same direct manner as some of the lower income groups. They spoke in more generalised, 'safe' terms, although groups consisting of younger participants were sometimes very candid in their discussion of social comparisons.

Chapter nine

Living in an unequal society: The cost to health and well-being and suggested solutions

9.1 Introduction

Chapters seven and eight have established the extent to which participants discuss inequality and the ways in which they do so. Evidence has also been presented to suggest that people compare themselves with others, and that this evokes feelings of embarrassment, shame, anger and frustration. The key question that can now be asked is, do participants relate accounts of inequality to their own health? Does the inequality that they experience have an impact on them personally? Chapters three to six analysed media coverage of the government's public health policy, and returning to this area, the latter half of chapter nine examines lay perceptions of the government and of the media.

9.2 The cost of 'keeping up with the Jones's': Do participants relate inequality to their own health?

'...it is assumed that stress and pressure is a fact of life – almost a 'natural' feature of life in modern urban and industrial environments.' (Cornwell 1984, p. 161)

In the 1980s, Cornwell suggested that stress and pressure had become almost a 'natural' feature of modern life, and by the late 1990s, it had arguably become cliché. To be suffering from stress or to be 'stressed out' is perceived to be a common ailment. Participants in this study often related stress to their experience of ill health, and depression was readily discussed. Mental health was linked with physical well-being. The majority of participants believed 'good health' or 'bad health' to be determined by a number of, often complex, factors. The attainment of good health or the misfortune of experiencing bad health was not a straightforward process explainable in simple terms. Within this multi-factorial model, participants from a number of groups made a link

between poverty and addictive behaviour, seeing the behaviour in question as a 'coping strategy'. Comments made in lower income groups, such as 'it's either a cigarette or a tablet' [FG9:43, lower SES, Greater Manchester] and 'people are always going to buy cakes, it's just the pills of life' [FG6:26, lower SES, Greater Glasgow] illustrate this.

The data presented in chapter seven have already demonstrated that participants are aware of health inequalities. Disparities in mortality rates were greeted with little surprise, particularly by the lower income groups. In fact a resigned acceptance was often apparent in contrast to the ambivalence of more affluent groups. Participants from low income groups also appeared very bothered by the idea that patients could 'queue skip' if they could afford private healthcare. The views of those from the higher income groups were more disparate. Yet overall, the existence of inequalities in health remained uncontested by the majority of groups, and discussion often attracted emotive responses, particularly from those in more deprived circumstances.

On the basis of the focus group discussions, can a further link be made to psycho-social processes, to social cohesion and health? The answer to this question is 'yes', although the challenge is to distinguish between participants relating ill-health to substandard living conditions on the one hand, and Wilkinson's theory employing psycho-social mechanisms on the other (Wilkinson 1996). On the basis of the themes emerging from the data, section 9.2 will address two areas. The first looks at the ways in which participants describe the *effects* of inequality, both physical and mental, with discussion of social cohesion featuring prominently. The second and concluding part of this section focuses on accounts of ill health that are linked directly to inequality by participants.

9.2.1 The effects of inequality

The perception that community life is breaking down emerged in a cross section of groups in the study. Participants mourned the loss of a sense of community, and related declining levels of social cohesion to health and well-being. Sian, as part of a group of professionals working for a theatre company, places importance on family and

community support. She refers to the end of a well-known series of advertisements featuring family life, which had run on television for twenty-five years. Their demise seems to be particularly symbolic:

I: 'And when you were talking about community in an area, how would that be a positive effect?

R2 [Sian]: Oh no I'm just talking from sort of emotional support, and em, I mean it's that whole notion of families and communities and having somebody to get together with, and to talk over things and this is completely off the wall – the fact that em, the Bisto gravy ad has been taken off after 25 years.

I: Oh, with the family.

R2 [Sian]: Because they reckon that it's not appropriate. People don't sit down and actually get together, and I think that has to have a negative effect.

R4 [Niall]: Taking that off? [laughing]

R2 [Sian]: No [laughter], not the Bisto ad, the fact that – people don't communicate.

R4 [Niall]: I mean I never, in all the time I was at home – I left home when I was 19, I never, ever had dinner off my lap in front of the television. It was not allowed, you sat round the table [agreement].

R2 [Sian]: Yeah, neither did I, it wasn't allowed.

R4 [Niall]: I sit round the table once a week now if I'm lucky. I mean I eat healthy, so it's not the food issue, but, when you've got a lot of things to do.

R2 [Sian]: Whereas in Europe you would never...

R4 [Niall]: In my family, the TV goes off, you sit down and you eat your dinner, and you had vegetables on your plate and –

R3 [Sheetal]: And you talk.

R2 [Sian]: And you talk.

R4 [Niall]: So it's kind of, the whole health thing goes beyond just, the issue of food. It's kind of like, you create an environment I suppose.' [FG14:11-12, higher SES, Greater Glasgow]

The group is then asked if everyone's mental health is affected by this social change, to which they all respond by strongly agreeing. Sheena, a participant in another affluent group, does not relate her views on social cohesion to society as a whole, referring instead to deprived communities only. At times she appears to romanticize the idea of 'community' and is somewhat patronising in her choice of words. However, she draws on her personal experience of the benefits of community generating activities in deprived areas:

R1 [Sheena]: 'I think because they're living on lower incomes and haven't much hope to the future, the smoking, the drugs, the alcohol are all means of escape, and they haven't got anything more worthwhile in their lives. Because as soon as you find good community groups growing up in some of these deprived places then they've got the reason for moving forward, and there are examples of that in Aberdeen where um, [names community leader] for instance, put on a sort of community drama art activities in some of the deprived areas of Aberdeen. And things are still going on from that foundation, they feel that they belong and there's something outside their own little lives to work for, and women, a lot of women have benefited very much from their sort of, input there.' [FG13:16, higher SES, Aberdeenshire]

Participants living in a deprived area of Greater Manchester readily relate the community breakdown they have witnessed to a number of ailments. Feelings of shame and embarrassment are linked directly to their ill health. Sleeplessness and a fear of break-ins have left them 'grumpy, depressed, and stressed out' [FG9:35, lower SES, Greater Manchester]. Cassie recounts the problems of carrying out seemingly straightforward tasks such as visiting the local shop:

R5 [Cassie]: 'It's the impact on your health is quite tremendous because you feel threatened. I'm going to a different shop at the minute because I won't – I'll clock these kids, I will. So I'm having to go to a different shop, and I don't want to because I want to support the shop that's already there but it's been very difficult. So, I'm at the point where I want to move.

R6 [Sonia]: Yeah, it does, yeah.

R5 [Cassie]: I really want to get out. So you get depressed, you get anxious.

R6 [Sonia]: Yeah but there's hundreds like you, feeling like you though, i[s]n't there Cassie. There's hundreds, people like this.

R5 [Cassie]: Oooh, gosh yes.' [FG9:23-24, lower SES, Greater Manchester]

Furthermore, it is significant that when discussing the ten-year difference in mortality rates between different areas of Glasgow, Sonia refers again to the tense social relations in the community:

R6 [Sonia]: 'Depends on the area.

R1 [Jerry]: The atmosphere and that.

R6 [Sonia]: Nasty neighbours and things like that. Bound to take time off your life. I think so [sounds of agreement].' [FG9:45, lower SES, Greater Manchester]

Participants based in a deprived inner city area of Glasgow discuss the ways in which health might be affected by the breakdown of communities. They make comparisons with communities past and present in an attempt to fathom the extent to which health has been influenced by this perceived social change. The practical ways in which people help each other is focused upon:

R2 [Ian]: 'So is that a reason why we're unhealthy, we don't bother now? Years ago mining communities, my parents were from a mining community, my granny... my grandfather was unwell, or she was unwell, sorry, she was unwell, the other ladies in the close would do the washing, one would make sure the dinner was made, one would be sure that my grandfather was okay or whatever.

R3 [Margaret]: That's right, exactly, we've lost all that now.

R6 [Elizabeth]: They've got a community like that over in Newton Mearns, the Jews.

R1 [Betty]: That's right.

R3 [Margaret]: So we really have lost that now, I don't know whether it's...

R2 [Ian]: The break-up of communities, so maybe we're losing our sense of community. Not necessarily made us more unhealthy, but the fact was that if someone was unemployed years ago, there was always...

R3 [Margaret]: There was always be, that's right, looked after them.

R2 [Ian]: You would look after the old dear up the stairs or whatever.

R3 [Margaret]: Exactly.' [FG3:24, lower SES, Greater Glasgow]

After recounting the moment when a number of mothers in her community had decided they could not 'take it any more', Val describes how the action taken on street gangs in her area subsequently improved her health:

I: 'And how do you think your health has improved if you've...?

R4 [Val]: 'Cause you're sleeping better, you're no getting woke up every night by a bloody fire engine zooming by your window and twenty or thirty weans at the corner shouting all night.' [FG2:30, lower SES, Greater Glasgow]

It is clear from these extracts that a lack of social cohesion is being linked to a decline in health (or a more socially cohesive environment to improved health), with participants drawing on their own experience of living in deprived areas. There are also a couple of occasions where the effects of inequality are described. Moving on from the links made between social cohesion and health, an unemployed man describes the health effects that inequalities arguably produce:

R2 [John]: 'The thing I've noticed as well through the football teams is that when, see the team I've got now are eighteen year-olds, when they were twelve year-olds, and we were playing in different areas of Glasgow, but when you're playing the likes of say it was my team from [local area] that were twelve year-olds, and we were played by a team from Newton Mearns [affluent area], you could see the difference in the build of the two teams...

R4 [Richard]: Aye, aye, the height and so on...?

R2 [John]: Aye you could see they'd broadened out and they were taller and ours, they looked no ill but...

R1 [Andrea]: A bit malnourished.

R2 [John]: ...they did, you could see a difference at that age group, if you go into the different areas likes of in a sporting committee.

I: And do you think that's because of better living?

R2 [John]: Uh-huh, aye.' [FG6:42, lower SES, Greater Glasgow]

It is suggested rather simplistically that John's observations might be due to 'better living'. However, when the group are shown newspaper headlines shortly afterwards, Ed prompts John to link his earlier comments to inequalities:

I: 'Right I'll show you my last lot of headlines very quickly because I know that we're running out of time. **Gap between rich and poor widens again** [Fig. 15], it's really a lot of what we've been doing. **Children at risk as health inequality between rich and poor increases** [Fig. 17] and **Wealthy stay healthy but the poor get more poorly** [Fig. 16].

R3 [Ed]: Well that really is the case, highlighted with playing with the football boys. I mean that - that, the 'children's at risk' headline, is that what you say about your football team?

R2 [John]: Aye.' [FG6:43, lower SES, Greater Glasgow]

A similar observation is made in one of the more affluent groups, where Sheena compares her experiences teaching in affluent and deprived schools in the Aberdeen area. Her account reflects statistics demonstrating the higher incidence of accidents in deprived households (Acheson 1998, p. 15, 52):

R1 [Sheena]: 'But it's a much better quality of life. If you've got a good quality of life you're likely to be healthy, unless you're unfortunate and have an accident or some genetic disease... I can remember years ago, but it doesn't really quite relate to this, I was teaching at [a] school once a week in the

> Spittal in Aberdeen, and that was before the new houses went up and it was really a very very poor area. And one group [laughs] came in one day and I said 'you had a good holiday?' Oh, and out of, I should think half the class, out of about twenty, had some – either had had an accident with a fire and gone to hospital, someone had a heart condition and so on. Whereas another school I was teaching at [laughs] was Airlie Hall, where, I mean, everybody had a nice Christmas holiday. But, you see accidents happen if you haven't... if you can't afford to get an electrician to fix your points [agreement]. And, you know, it's, the poverty thing really brings you down in every way.' [FG13:17-18, higher SES, Aberdeenshire]

There were a number of groups in which the link between inequalities and social cohesion did not arise. In fact, participants in two of the more affluent groups seemed to suggest that in deprived communities, ill health may be less of a concern:

R3 [Philipa]: 'I think that health's less of an issue in poor areas because you have got other things to be thinking about like where their next meal's going to be coming from. That's quite drastic obviously, but they've got more things, like they'll just ignore things that a more well-off family'll probably panic over and have the child at the doctors every two hours or something.' [FG8:27, higher SES, Lothian Region]

Philipa seems to be suggesting that 'health' is something that can be separated from everyday experience. However, the accounts offered in the lower income groups suggest that this is anything but the case. If anything, participants in deprived circumstances possess a heightened awareness of the health problems they face – or are more vocal at the very least – as a direct result of their environment. For example, in response to the 'workers drinking/estate' image [Fig. 10], with its extremes of poverty and wealth, a group of office workers reject the idea that the picture may also be conveying 'extremes of health':

R1 [Denise]: 'But I'm not sure what it's saying about health, you know, I mean they're probably none the healthier are they [referring to the men drinking champagne].

I: What as in they have money but they're not necessarily...

R1 [Denise]: Yeah I mean I don't think that's a picture of two extremes of health. I don't know if that's what it's supposed to be showing but it doesn't to me.

R2 [Lindsay]: It shows the lifestyle.' [FG7:4, higher SES, Aberdeenshire]

To illustrate the contrast in responses between affluent groups in the study, it is worth comparing this to one of the Greater Glasgow groups who responded to the same image with the following exchange:

R3 [Sheetal]: 'They've got a lot more health care ['workers drinking'].

R4 [Niall]: No, they'll survive it ['workers drinking'].

R2 [Sian]: They'll just go private.

R4 [Niall]: But they'll just get through it. I mean these two blokes [laughter] as it happens, whatever, if you're in that you get through it. It's kind of, for those people it's a phase ['workers drinking'], for those people it's a reality ['estate'], it stretches on.' [FG14:11, higher SES, Greater Glasgow]

In this case, 'lifestyle' is not a separate entity as defined by the participants in group seven. Sheetal, Niall, and Sian go from the assumption that the people featured in the contrasting images are pursuing similar lifestyle choices, drinking and drug-taking, for vastly differing reasons. For the 'workers drinking', it is to enhance their social lives, for the people on the 'estate', it is a coping mechanism and a means of escape. The views expressed in the affluent groups in this study illustrate the diversity of opinion concerning the links between poverty, inequality and health.

9.2.2 A missing link? Lay accounts of ill health directly attributed to inequitable circumstances

In what ways do participants directly relate the impact of living in an increasingly unequal society to their health? Answers to this question were more forthcoming from the lower income groups, possibly because they were so much more aware of status, and their (less powerful) position in relation to others. Three such groups discussed the pressures of competing materially and keeping up with aspirations which were, more

often than not, unattainable. Ian and Margaret believe that the pressure of competing materially can affect health directly:

R2 [Ian]: 'Again, that's a part of it, a lot of people spend their resources on that [consumer goods], to keep up with...

R3 [Margaret]: Exactly, and labelled clothing, to the Jones' or whatever...

R2 [Ian]: To the expense of not eating properly, not looking after themselves.'
[FG3:30, lower SES, Greater Glasgow]

The group is questioned further to see if they elaborate on the concept of 'keeping up with the Jones's':

I: 'And what about when spending money, and people spending it on things that, like say expensive training shoes that they don't necessarily need, but they may not have enough money to maybe have a decent – why do you think they do that?

R2 [Ian]: It makes them feel good.

R4 [Irene]: Want to keep up with everybody else.

R2 [Ian]: It's the label, it's the expensive label, it's not the colour, it's not... it's the label...

R3 [Margaret]: Or do you think it's pressure from other kids and things.

R6 [Elizabeth]: No, because my nephew gets bullied at school for that, if he's not got the proper stuff.

I: And why do you think it makes people feel good then, when they've got the label?

R1 [Betty]: The same as everybody else, aren't they.

R5 [Carole]: Keeping up with the Jones's.' [FG3:30-31, lower SES, Greater Glasgow]

This awareness of a lifestyle to be attained, a lifestyle that some are living whilst others are not, is put simply by Margaret at an earlier point in the discussion:

R3 [Margaret]: 'I think if you've got a nice outlook in life, I mean, if you come from, for talking's sake, Bearsden [an affluent area], and you open your door and everything's rosy, you'll feel rosy. But if you open your door and it's full of rubbish and what have you, it makes you feel depressed, you know.

R1 [Betty]: And that's also involved in housing as well, you know, giving folk housing and...

R3 [Margaret]: The kids somewhere to play.' [FG3:4, lower SES, Greater Glasgow]

The power of aspirations is discussed in group six, with Joe referring to the role of the media:

R5 [Joe]: '...Aye, that's right. People might be sitting watching the telly and realise somewhere along the line, well, they like to think that they're part of all that. But, they'll sit and they'll say 'Well I don't see how these people can do what they're doing, I've no got the money', and all that kind of thing. So people are made to aspire for it – that's another health thing you know, it's a kind of false thing as well you know, to aspire to be what you think is respectable.

R3 [Ed]: They try and aspire to that and they fail to get to whatever they think they should be. That knocks them away as well... 'It must be my fault 'cause I'm inferior that – that I've not reached that level'.' [FG6:32, lower SES, Greater Glasgow]

A comment from group nine seems to reiterate the sentiment, with Cassie stating:

R5 [Cassie]: 'And that depresses you. That impacts on your health, the fact you know that this is what you've got.' [FG9:40, lower SES, Greater Manchester]

The last couple of extracts in this section provide powerful examples of participants linking inequality to health. The first arises in group one, with Jane responding emotively to the headline **Wealthy stay healthy but the poor get more poorly** [Fig.16]:

R5 [Jane]: 'I think that statement means, the poor get poorer, or poorly, it's because we don't have – you're fighting to get your benefits. You get yourself into a state, you get depressed, stress sets in, because of the circumstances you're in. We know, or I know, in the back of your head, you're

saying, 'they've got money, they're getting this, they're getting that', so you get yourself in a state, you get more depressed.

I: So it's kind of a struggle to get what you think is...

R5 [Jane]: I mean I was taking, I still do on occasion, I was taking panic attacks. I mean really bad panic attacks, because I would say right, I've got a bill to pay, where am I getting that money fae. I'd get myself into a state, and I was taken to the hospital from the nursery, and they thought I was having a heart attack, and the doctor said to me then 'I've never saw an attack the way you've done today'. He says, 'but that's a panic attack, the worst I've ever seen'. And I was boaking, I was shaking, I couldnae breathe. I'd passed out beforehand, when I came to [regained consciousness] my whole body was going, I couldnae control it.' [FG1:48-49, lower SES, Greater Glasgow]

The other participants are asked if they can identify with Jane's experience. Doreen describes not only the effects of living on a low income, but the perceived awareness of an unfair - and therefore unequal situation - on a wider scale:

R3 [Doreen]: 'I think it's the system, because see when you try to better yourself, they slap you back into place.

R5 [Jane]: Och I know. You get two steps up and five steps back.

R3 [Doreen]: They put obstacles in your way. I mean they're saying you're entitled to Family Credit. Even when you get that Family Credit you're no entitled to free prescriptions, you're no entitled to free school meals, things like that.' [FG1:49, lower SES, Greater Glasgow]

Scott, a participant in group five, also describes the legacy of an unequal society in practical terms:

R4 [Scott]: 'From food, to being at risk to drugs, to being at risk to a hostile environment, just the whole lot. Health inequality – you've seen that picture at the start, overcrowding [Fig. 8, 'child with plate']. If you've got four kids living in one room with a television on, how does the one that wants to get educated do their homework in that type of environment? Something as simple as that. Anything you get, you need to fight for. But at the end of the day, pure diet – we spoke about that. I think we've covered most of it.

R6 [Sarah]: Cutbacks. It's cutbacks.

R4 [Scott]: Arts and sport, the first to be cut. The other thing, and I don't think it's only physical, it's also mental, right. At the end of the day it's very stressful living in cramped conditions. Your parents are more liable to be arguing all the time and stuff – I mean, I could go on about it all day, but it's stressful as well.' [FG5:29, lower SES, Greater Glasgow]

Jane had described previously how she had 'begged for help' [FG1:36, lower SES, Greater Glasgow, p. 225] only to feel unheard, excluded and ultimately depressed. Her and Scott's problem is not so much about having to deal with unrealistic aspirations, but a struggle for survival in which it has become a 'fight' to win basic resources in a seemingly indifferent climate. A feeling of exclusion away from the population at large, of unfairness and inequality and its impact on health is recounted powerfully by Scott:

R4 [Scott]: 'At the end of the day, I can tell you if you take it right down to health issues, that we're back to the stage in the seventies here where the women are getting this Prozac now instead of Valium, 'cause they don't have the psychological support that's required in a lot of depression cases and stuff like that. Now, the fact is, if it's not seen it's not there, and if it's not there it's not a statistic, and if it's not a statistic, then it's not a political embarrassment. And that's the problem.'
[FG5:8, lower SES, Greater Glasgow]

In summary, just over a third (five out of fourteen) of the groups in the study linked the breakdown of communities to deteriorating health. Participants living in deprived areas gave compelling first-hand accounts as witnesses to such social breakdown themselves. In addition, a couple of groups contained participants who described the *effects* of inequality in their accounts. There was a uniformity of opinion from the low income groups (five out of eight low income groups) who discussed the links between ill health and inequalities in society. The power of aspirations seemed especially potent, with the constant pressure to live up to an unobtainable ideal having resonance with participants. These conclusions went hand-in-hand with feeling unheard, excluded or ignored by wider society.

Two of the affluent groups did not make a link between poverty and ill health, *let alone* speculate on whether living in an unequal society might affect health. More than anything, the affluent groups in the study were characterised by the sheer diversity of opinion expressed.

9.3 Things can only get better? Lay perceptions of New Labour and of the media

This section examines lay perceptions of the government and of the media. Chapters three to six provided an in-depth analysis of the media coverage of New Labour's public health policy. It thus takes the study full circle by detailing participants' perceptions of the government, and then going on to look at lay views of the media. The materials and questions used in the focus groups were employed primarily to gain insight into lay perceptions of health inequalities and the possible role of psycho-social mechanisms. The use of newspaper images and headlines from the media coverage of the Green and White Papers and of the Acheson Inquiry in the focus groups was also intended to lead discussion into the realm of the media and of government. Arguably, a discussion of inequalities would not be complete without considering the influence of the government and of the media as both institutions are so inextricably linked with power, control, representation and accountability.

9.3.1 New Labour and the inequalities debate: a point well made?

'...the government's made us feel, as if we're a carpet for [them] to wipe their feet on, and to be brushed aside.' [Jane, group one].

By 1998, and with only a few months in office, the government placed health inequalities at the forefront of its public health policy with the publication of the English and Scottish Green Papers. The inequalities debate had entered the public domain after years of being sidelined. However, the transition from consultation process to policy saw a dilution of the government's intention to 'tackle' inequalities (particularly in the English White Paper) and a downshifting of the proposals accompanying this pledge. The left-of-centre

UK national broadsheets continued to give inequalities in health a high profile despite the government's change of priorities. Whilst the Scottish White Paper continued to emphasise inequalities in health as a central part of public health policy, the Scottish-based media tended to report on specific initiatives in the document rather than entering into the inequalities debate. Much of the debate was played out in broadsheet publications, with little being reported in the tabloids. As a result, it could be concluded that a vast proportion of the British public might have been unaware of the inequalities debate, or even that inequalities in health was ever a priority for the government. This is certainly borne out by the focus group data in the study, as this section will demonstrate.

The publication of consultative and policy documents highlighting (to varying degrees) the health divide appear to have had little or no impact on focus group participants. Individuals from only five groups out of fourteen (one deprived, four affluent) claimed to have heard of the Green or White Papers. In no cases did participants elaborate further or give details of the policy documents. Instead, an overriding cynicism about the political process was the most prominent topic of discussion. The strongest, and by far most emotive responses came from participants in more deprived areas. These groups all expressed disillusionment, feelings of rejection and a conviction that Labour were pursuing Conservative policies. The following excerpt illustrates this forcefully:

R5 [Jane]: 'I'm not talking about the whole, I'm talking about me personally, I feel rejected by the government, like I've been told, we don't need you, I mean, who cares about yous up there, right, we'll just deal with people that's in our category with the suits.

R2 [Katie]: If it helps them politically they'll *get all* the money that you want, but if it's not helping them, I mean they're no interested.' [FG1:23, lower SES, Greater Glasgow]

The view that all actions are politically motivated is confirmed by participants' experiences at a local level:

R5 [Jane]: '...These people have come in and said oh – they could do their job at the time, but they've got in now, they've got money in their pockets and they don't care, they don't care, and I can

guarantee you they don't care as long as they've got their big bucks at the end of the day. Funnily enough they all disappeared, when they were...

R1 [Kay]: They just mellowed this past wee bit then now because there's an election on May the 6th, and they've gave us money to carry on for a wee while [to keep the community centre open], but after May 6th...

R5 [Jane]: They don't care.

R1 [Kay]: That's it, they're no caring. As long as their seats are there that's them.

R5 [Jane]: Even Labour's forgotten where they came fae. They're supposed to be for the poor, for the working class. Oh please...I was brought up believing that Labour Party was there for the poor and for the working class, and they've just turned themselves round, they're no for the working class, they're for the people with power, money, the businesses.'
[FG1:24, lower SES, Greater Glasgow]

The lack of power and control these women experience is highlighted as they discuss politics on a national level:

R5 [Jane]: '...I just feel that, if they're not in, it's fine and they're all for you. See once they get in through that threshold, they change fae a Jekyll to Hyde. Do you know, they become this person that you think 'Christ, what happened to him, I thought he was for the people'. Do you know what I mean, all of a sudden, 'I'm in there, I've got money in my pocket, I don't need you'.

R2 [Katie]: They promise all sorts until they get in and then they just change their tune.

R5 [Jane]: And it's rubbish, it's absolute rubbish. And we don't get a say in anything that has got to do with our money. I mean, they spend thousands, billions of pounds. They don't ask us, they just do it, like a bloody Millennium Dome, who wants it? They never asked us, they told us, we're getting this. We're no getting it, Scotland'll never see it, it's down south.'
[FG1:25, lower SES, Greater Glasgow]

In her dealings with local councillors, Jane goes as far as to say that she feels 'frustrated, angry, [and] threatened' [FG1:26, lower SES, Greater Glasgow]. As the discussion

progresses, participants reveal the extent of their cynicism about the new Labour government (after voting for them in the 1997 election):

R5 [Jane]: 'The solution is just not to vote Labour again.

R1 [Kay]: But they say precisely the same thing though, they're nae doing anymore than the Tories were doing.

R5 [Jane]: All he's [Tony Blair] done is take out old Tory policies.

R1 [Kay]: I think he's got Maggie Thatcher working for him and we just don't know it.

R5 [Jane]: Probably sleeping with her! [laughter]' [FG1:30, lower SES, Greater Glasgow]

Referring specifically to government policy concerning lone parents, these women (the majority of whom are lone parents) discuss the impact recent changes have had upon them. Their conclusions serve to confirm the view that Tony Blair has done 'nothing':

R5 [Jane]: 'It's all false, false. But he [Tony Blair] arrives when everything's done, just as if to say, 'I was there'.

R1 [Kay]: Just carrying everything on. He's no changed anything because he's still shouting now about single parents and whatnot, the same as what the other ones [Conservatives] were all shouting about.

R5 [Jane]: He's no doing nothing about it.

R1 [Kay]: So he's no changing it and you know one of these big things he was saying before that he was going to change it, he was going to give the under eighteen's back their money, and he was going to do this, and he was going to do that, and he's not done a thing, he's not done any of it.

R5 [Jane]: All he's done is – if you don't go back, if you don't try to get back to work, if you're not seen as trying to get back to work, they cut your money.

R1 [Kay]: What he's wanting to do with single parents – and that's what most of all us are [in the group] – is throw your kids into any childminder that you like and get back to work, and we're not supposed to question who these childminders are...' [FG1:31, lower SES, Greater Glasgow]

The similar themes of political opportunism and cynicism emerge in another deprived Glasgow group. Scott (a Labour voter) describes how his local MP, the late Donald Dewar, was involved in the community when an election was forthcoming, but was absent for the rest of the time:

R4 [Scott]: 'Donald Dewar's done nothing here...it's a common saying here: he's the local MP, none of us have seen him since he was elected. The night he was elected, he was in the centre till midnight. Nobody's seen him since. Correct? But we will see him.

R3 [Grant]: Because there's elections.' [FG5:22, lower SES, Greater Glasgow]

Talking in terms of inequality, Scott continues:

R4 [Scott]: 'There's an imbalance which has been kept there, and it's been kept there by everybody – I mean, that guy's [referring to a younger participant] never known a Labour government, neither have you [referring to interviewer], but they've been waiting on this so-called 'social exclusion movement' as they're saying coming back. It's just no happening. I don't know why.'
[FG5:22, lower SES, Greater Glasgow]

Scott expresses the view that the centre and its users are actually worse off under Labour than the previous Conservative government. This is first alluded to, and then directly stated later in discussion:

R4: [Scott]: 'At the end of the day we voted Labour because we didn't want any less, you know what I mean? We didn't want more, but there hasn't been any more and there's certainly been a hell of a lot less over the last two years... [FG5:23, lower SES, Greater Glasgow] ...This place was a derelict building which we, the community renovated. We've had ten years, fifteen years, we've done better under the Tories than we've done in the last year under the Labour government, and that's me saying that.' [FG5:32, lower SES, Greater Glasgow]

The participants of group six waste no time in drawing unfavourable parallels between Labour and the Conservatives:

R3 [Ed]: 'Well, they're just carrying on with the policies eh, doing down people who are vulnerable, I mean the Tory government done it eh, the New Labour government is doing exactly the same things, they're just Tories with a different name.

R1 [Andrea]: There's also the thing that [people] have to come in and be interviewed for – to get their benefits. They're not offering people a choice.' [FG6:37, lower SES, Greater Glasgow]

It seems that all the things Labour would like people to think they stand for – equality of opportunity, access, a fair society – are the opposite of how many (low income) participants in this study perceive them. Ed, an SNP voter, states:

R3 [Ed]: 'I mean I think it's a case, even more so than the Tories, New Labour are actually saying we know better than you, you're all little children, we'll tell you what to do. Well, like Tony Blair's your father, we're all his children. He knows better than we do, whereas they don't, they don't live our lifestyles, they've never lived our lifestyles, and they couldn't possibly – and they couldn't possibly imagine what it is to be us.

R1 [Andrea]: They seem to be continuing the same way that the Tory government was.

R5 [Joe]: Laissez-faire, no bothered. It means that the government canny do anything about economics, so they just try and...They'll no interfere, they'll no interfere with business, so what's the government – what the hell are they for?...They canny make any economic decisions, they canny go in and accept... come up with daft new deals stuff, which is bribe and it's gonnae take people for a ride. So that's what they're for, it's laissez-faire policy.' [FG6:38-39, lower SE S, Greater Glasgow]

Political opportunism and electioneering surface later in the discussion, as Ed and Andrea (a Labour voter) discuss the Labour Party's behaviour before and after the 1997 general election:

R3 [Ed]: 'The night before the election was 'this is it, the new, it's all going to change, it's going, you know, work for the people and everything else, and then soon as it's over everything's back to normal.

R1 [Andrea]: And it's all back room deals with the Lib-Dems which is – nothing's changed.'
[FG6:47-48, lower SES, Greater Glasgow]

Participants in other lower income groups in the study made similar comments to the groups featured above. However, they tended to be less harsh in their criticism of the government, acknowledging that Labour had held office for a relatively short period of time. Furthermore, their comments tended to be less emotive. Bob, an unemployed Labour voter, suggests that the party are 'taking after the Tories'. However there seems to be a strong consensus amongst these participants that more time will be needed to effect change:

R2 [Jean]: 'I know we need to give them more time but they made that many promises that there's nothing really been done.

R1 [Bob]: I know, I know, don't forget that this is only their second year, am I right? Their second year? Don't forget, in some ways, the Tories went for eighteen year, look at us the now.

R2 [Jean]: Aye they've got a lot of things to catch up on.' [FG2:11, lower SES, Greater Glasgow]

An underlying sense of disappointment is apparent in a group of Labour voters from a deprived inner city area as they discuss the government:

R1 [Betty]: 'Well, I had hoped that the New Labour people would of bridged that gap, you know, but we're still waiting – maybe they've got ideas – but we're still waiting. They should have done because we had eleven years of... people who were not concerned about the poor.'
[FG3:42-43, lower SES, Greater Glasgow]

Tony Blair's privileged background is perceived as an obstacle by the participants of group three. The Prime Minister is seen as far removed from the traditional working-class roots of the Labour Party:

R1 [Betty]: 'Tony Blair'll never know the need to understand the poor because he's never been poor. I don't mean to say that every Labour man should've been a poor man, but he's come from the high...

R3 [Margaret]: No, no, he's from the wealthiest families.

R1 [Betty]: The high families, you know. And that's the only thing I have against Tony Blair, I don't think he understands. I think somebody like Gordon Brown [Chancellor of the Exchequer], or somebody who is more into living, working for their living as well.' [FG3:43, lower SES, Greater Glasgow]

Despite their doubts, Betty and Margaret, like the members of group two, concede that more time may be needed to rectify the situation:

R1 [Betty]: 'It's still very early, it's still very soon, Rome wasnae built in a day, and if they start to address the problem now, I mean, they're only what eleven, what twelve months in office or something?

R3 [Margaret]: I've lost a wee bit of faith in Tony Blair actually, but I just hope I'm wrong, you know, and I'll give him the benefit of the doubt this time.

R6 [Elizabeth]: Aye.' [FG3:58, lower SES, Greater Glasgow]

Brief comments from participants in groups ten and four suggest the government is perceived as not doing enough [FG10:35, lower SES, Greater Glasgow] and that 'they're still taking care of theirself' [FG4:56, lower SES, Greater Glasgow]. The remaining low income group in the study [nine] was unusual in that participants did not volunteer any views of the government (either positive or negative). However, this was one of the groups containing participants who strongly believed that it is up to themselves to effect any change, implying a lack of faith in government action [see section 9.5].

The more affluent groups (7,8,11,12,13,14) in the study also tended to be cynical about the government. However the energy and emotion conveyed in a number of the deprived groups when discussing politics is largely absent in these latter groups. In general terms, the higher income groups had less engagement with the topic, as the following excerpts will demonstrate. Niall, a theatre administrator and Labour voter, comments that it is

'depressing' that New Labour 'don't seem to be doing much to remedy' the Thatcher years [FG14:14, higher SES, Greater Glasgow]. Referring to a specific manifesto pledge, Niall continues:

R4 [Niall]: 'Well certainly bringing down waiting lists which is the one they keep getting wrong. Poor Frank Dobson and Labour's avoiding answering that question. I mean that's key, a key manifesto pledge from Labour, they would reduce waiting lists in the NHS, now.'
[FG14:20, higher SES, Greater Glasgow]

The Labour Party's ideological stance is questioned by Marion, a Labour voting university lecturer taking part in group thirteen:

R3 [Marion]: '...I think [the government] say all this stuff about, you know, we must include more people in society. And Tony Blair said this hasn't he, that it's one of the most important things just to make everyone feel they're a stakeholder in society. But I'm not convinced they really believe that because if they did they would invest more I think, into changing things. I think that this government is keen to be sort of, to be all things to all people, so they don't want to alienate rich people for example, you know by um – I mean like tax rates for example – we've still only got two tax rates... So I think a lot of what they're saying is not borne out by what they do, so it's sort of words not deeds.' [FG13:3, higher SES, Aberdeenshire]

Julian, a retired professor and Labour voter, reiterates this view when referring to the government's aim of tackling social exclusion later in the discussion:

R2 [Julian]: '...I don't actually feel too inclined to rise up and say, sort of, three cheers for Tony Blair. It is such a complex thing to say that you attack social exclusion. It's not a prescription for action, they're all sort of things that need to be done. And obviously some of them are being done, but it's not always as clear in the headlines precisely what is being done and what isn't...'
[FG13:15-16, higher SES, Aberdeenshire]

Despite Marion's distrust of the Labour government, she is willing to allow them more time, particularly when it comes to addressing inequalities. She also makes the observation that, as everyone would see the problems and issues involved differently, it would be difficult to come to a consensus on what needed to be done:

R3 [Marion]: 'We can't expect [the government] to just solve all the problems at a stroke. And it's probably going to take generations if we are going to pull back this gap. And, I think one of the things that makes it difficult is that people, everyone has their own perception ... of why things are as the way they are ... ' [FG13:35, higher SES, Aberdeenshire]

Two of the affluent groups adopt the popular discourse of politicians as 'liars'. Elaine, a Labour voting practice manager, states bluntly that the government are 'a bunch of liars' [FG11:46, higher SES, Greater Manchester]. Word for word, Catriona, a supermarket checkout assistant who did not reveal her political stance, also describes the Labour Party as 'a bunch of liars'. Participants from both of these groups position this as an admission of truth, a moment in which they are speaking very honestly ['if you want to know the truth', Alice, FG11:46, higher SES, Greater Manchester; 'to be perfectly honest with you', Catriona, FG8:21, higher SES, Lothian Region]. With a similarly scathing tone, Debbie, an accountant who did not vote at the last election, likens the interactions between politicians to the behaviour of 'a bunch of kids' [FG7:15, higher SES, Aberdeenshire]. Catriona (group eight) suggests that the Labour Party were 'probably trying' to aim for the 'middle to working class' because that is the 'majority of the population' as they were 'just trying to get extra votes' [FG8:21, higher SES, Lothian Region]. However, amongst the accusations of electioneering, Philipa (a graduate who 'can't remember' how she voted in 1997) questions whether the government can be blamed for all social ills, although she cannot suggest another cause:

R3 [Philipa]: 'I don't know if maybe it was a government thing or if it's just something that's going to happen anyway. Can it all be blamed on the government? I don't know if you can just, blame it on the government. I think you have to take in to account a lot of other things. I don't know what they are but, it might have happened anyway if the government had stayed the same. I'm no sticking up for them though [laughter].' [FG8:21, higher SES, Lothian Region]

Geena, who did not vote at the last election, then reinforces the notion that 'external' factors could influence events as opposed to the government:

R2 [Geena]: 'I think it's one of these things where they always say like, 'we'll bring them closer together', but no matter what happens some external factor is going to make it widen again, so it's not

actually the government that can do it, it would have to be the people that would want to do it as well. Obviously the richer people don't really want to give their money in the way of paying more taxes, they obviously want to stay out of it.' [FG8:21, higher SES, Lothian Region]

A similar line emerges in group twelve as Sandra, a Labour voting development assistant, ponders over the government's scope of influence:

R3 [Sandra]: 'What if it's caused by things outwith the government's control you know. A change to the service industry is caused, you know, a lot of unemployment for certain sectors. I mean air pollution's caused a lot by cars so that's just change in lifestyles. So I mean really, you can't blame the government for it all completely [agreement] em, but they do need to spend more money on tackling these things.' [FG12:56, higher SES, Greater Glasgow]

The only positive comment to be made in the entire sample about the government arises in the same group near the beginning of the discussion. Rich, a Labour voting taxi driver states:

R4 [Rich]: I think the government would love to help health-wise, but maybe they just can't afford to. Because if they put a ban on smoking they'll lose all the revenue from that.'
[FG12:3, higher SES, Greater Glasgow]

However, this comment is preceded by the suggestion from Sam (a Liberal Democrat voting meeting co-ordinator) that the influence of politics automatically causes distortion:

R6 [Sam]: I don't know 'cause it all is a lot to do with, when you bring politics into – everything seems to get more twisted.

By the group's conclusion Rich's tone has changed considerably:

R4 [Rich]: 'Well that's exactly what it is right, I mean, they're carrying on from where the last government left off, but only they're doing it in a wee bit of a better way.

R5 [Sadie]: Which is even worse.' [FG12:56, higher SES, Greater Glasgow]

Of the groups commenting on Frank Dobson's statement, '*This government recognises that poverty, poor housing, low wages, unemployment, air pollution, crime and disorder, can make people ill in both body and mind*' [Fig. 18], a clear socio-economic divide emerged. The statement appeared in a broadsheet newspaper next to an image of the then Secretary of State for Health, and was introduced last in the focus group running order. Participants were asked for their opinions on his statement, and if they were aware of the government's intention to reduce health inequalities. Participants from the lower income groups tended to react with exasperation and frustration when confronted with the government's pronouncements, whereas those from the more affluent groups were less emotive and expressed a wider range of views. Sheena, an unemployed Labour voter who now plans to support the Scottish National Party, says of Mr Dobson's statement, 'He recognises it, but they're no doing anything about it' [FG2:24, lower SES, Greater Glasgow]. Margaret, an unemployed Labour voter from another low income group comments, 'It's alright for him to make statements but what's he doing about it?' [FG3:58, lower SES, Greater Glasgow]. Mirroring these reactions, a charity officer and former Labour supporter states:

R4 [Scott]: 'What this statement doesn't say is what he's going to do about it. We're pissed off.

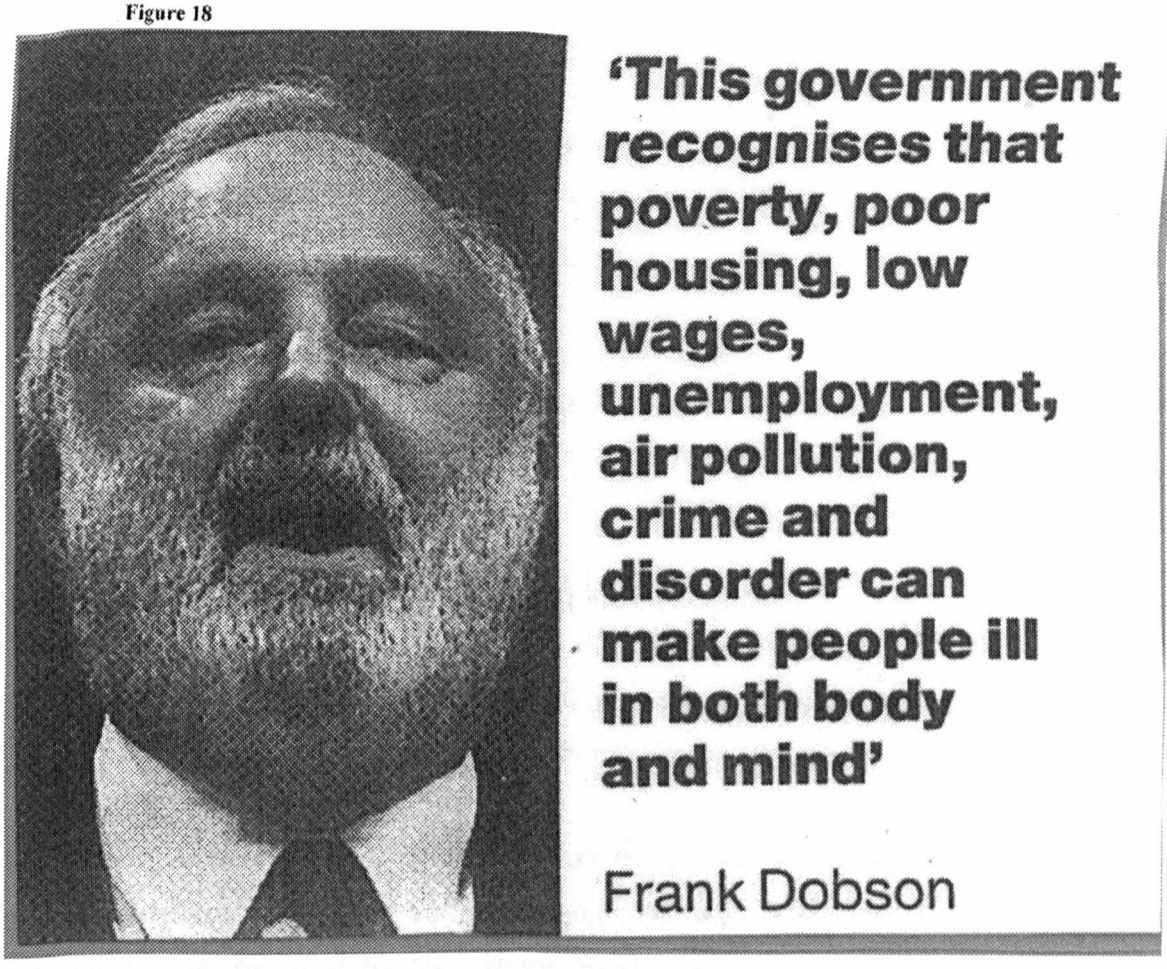
R6 [Sarah]: [Frank Dobson's] probably getting paid two hundred and fifty grand a year to sit and tell us what we're telling you.' [FG5:30, lower SES, Greater Glasgow]

Participants from low income group six, the majority of whom are SNP voters, react first with humour, then with cynicism to Frank Dobson's statement:

R2 [John]: 'Get away [laughter]. I mean that's every government, or politician. Everybody always recognises the problems but they never do anything about them.

R5 [Joe]: I mean that's just a stock thing and they put every ill in the world in there, you know, He's even mentioned round about – everything except insanity although he's touched on it you know...' [FG6:46, lower SES, Greater Glasgow]

Figure 18



The group then reveal an interesting slant to the statement by referring to anarchy and unrest amongst the masses. They begin to elaborate on various issues that Frank Dobson is listing[65]. A group of office workers, consisting of both Labour and Conservative voters,

---

[65] R5 [Joe]: 'He's made the one thing in there in all that crap, crime and disorder – disorder is a great one where they say, that was when people take to the street... he's put crime and disorder, 'cause that is, you know what I mean, it's like it's his stock answer, and disorder is always in there...

R1 [Andrea]: Yeah, you know, keep us down in case we rebel and have stupid marches and stuff like that.

R5 [Joe]: ...crime and disorder. You know, it's just, you could list, just put everything down there, poor wages, low wages, the works. Everything you could think... Crime – but he's put in disorder – he couldn't help referring to the old government, you know. So don't, nae strikes, nae miners. Don't go out in the street and get a bit rowdy, you know.

R1 [Andrea]: ...That's right, we're going to rebel.' [FG6:47, lower SES, Greater Glasgow]

make a similar observation about the government's perceived lack of action despite Frank Dobson's declarations: 'But he's not saying what they're doing about it, he just... [laughter]' [FG7:10, higher SES, Aberdeenshire]. However, other higher income groups depart from this pattern. Marion, a Labour voting university lecturer, adopts an altogether more positive stance:

R3 [Marion]: 'I suppose at least it's a step forward um, in that they are openly stating it, because I suspect under Margaret Thatcher's version of Conservatism, the message would be, if people are ill in body and mind then it's up to them to do something about it.'
[FG13:34, higher SES, Aberdeenshire]

In vaguer terms, Geena, a non-voter from group eight, states:

R2 [Geena]: 'I agree with this statement, but I didn't realise the government would be kind of inclined and looking at it that way, but I do agree with the statement.' [FG8:32, higher SES, Lothian Region]

So, despite an overall air of cynicism in all the groups, the lower income groups are distinguished by the energy and momentum of their responses. Many low-income participants feel betrayed by the Labour government, whereas there is often a non-committal tone and a utilisation of common discourses surrounding lay political debate in the higher income groups. Labour's (initial) intention was to clearly set out an agenda for addressing inequalities, yet it appears to be a point poorly made, or inadequately performed, according to the participants of this study, and this is felt particularly strongly in low income groups.

9.4 A question of recognition? The reporting of poverty, deprivation and inequality in the media.

Whilst the government's inequalities message failed to permeate (or convince when presented in the focus group sessions), many participants readily referred to issues surrounding poverty, deprivation and inequality they had seen reported in the media. All

but one group made direct reference to the media in the course of their respective discussions. Some participants – usually in lower-income groups – cited specific news reports as evidence of the existence of poverty and deprivation in contemporary Britain. Some participants simply made reference to media stories in general of deprived, run down areas.

Of the groups drawing on the media in their discussion of poverty and deprivation, two contained participants who simply commented that they had seen related reports. For example, prompted by the focus group images of poverty and deprivation, Scott comments 'You see this kind of stuff every day' [FG5:6, lower SES, Greater Glasgow]. When the group are asked about what stories might appear alongside such images, Lesley, another member of this group and a *Daily Record* and *Daily Mail* reader, comments resignedly 'In the newspapers? I dunno... Could be appearing next to somebody who's won the lottery' [FG5:6, lower SES, Greater Glasgow].

In one instance, unemployed participants (predominantly *Daily Record* readers) living in a deprived Glasgow area refer to an item in the news in order to highlight what they perceive to be a failure of government policy:

R2 [Jean]: 'There was a housing estate on the news, I never caught it all, it was the other night, it was somewhere in London and eh, they were talking about when Tony Blair first came in [became Prime Minister]. He went to the housing estate and says that this would change and that would change and that was the cameras going back to it the other night to ask them what's happened fae the first time he'd been there?

R4 [Val]: I think I seen something like that.

R3 [Sheena]: And it's still the same.

R2 [Jean]: And more or less, one of them says, nothing at all, it's still the same as what it was when he first came and visited us.' [FG2:25, lower SES, Greater Glasgow]

The current affairs programme *Panorama* is referred to in a couple of the groups. Rather than suggesting, as Jean did, that there has been no improvements, Geena, a local newspaper reader, cites a *Panorama* investigation as proof that change is occurring:

R2 [Geena]: 'But then the council seems to be doing quite a lot 'cause I watched, there was a programme on last night, *Panorama*. They were saying that they knocked down all these buildings because they were like, damp rot and everything. They had rebuilt them so the government's obviously putting lots of money into it.' [FG8:4, higher SES, Lothian Region]

Similar to Jean in group two, and contrasting with Geena, Jane (a lone parent from low income group one) cites a *Panorama* programme to confirm the existence of poverty. A debate ensues between participants (who are tabloid and local newspaper readers) as to whether the poverty (as depicted in the focus group images and the *Panorama* programme) still exists in contemporary society:

R5 [Jane]: 'Well I don't know if you've been watching your TV but in the eighties there was a thing on TV, *Panorama*. And it was a family from Priesthill and there was three children in the bedroom with a mattress on the floor, stinking of urine, and being fed like dogs, and that was on TV in the eighties.

R2 [Katie]: Aye that's the eighties, but this is in 1999.

R5 [Jane]: Aye, but I'm saying that's probably late eighties, nineties.

R2 [Katie]: I wouldn't, I'd have said earlier.

R5 [Jane]: That was the eighties and it wasnae early eighties, it was late eighties, do you know what I mean?

R2 [Kate]: Reminds me of when I used to stay down at [local] street.'
[FG1:12-13, lower SES, Greater Glasgow]

The conversation culminates with Jane claiming 'I could take you to a house right now', presumably in the impoverished state depicted in the *Panorama* programme [FG1:13, lower SES, Greater Glasgow]. Later in the discussion, Doreen (a lone parent) recalls a

documentary about a politician attempting to live on benefits as confirmation that government policy is divorced from reality:

R5 [Jane]: '...they had Margaret Thatcher in the eighties, the early eighties, trying to prove to us that you could live on – how much was it? God I can't – twenty-five pound or something – a week. You could live on that [exasperated sounds]. And my words to her would have been if I'd met her would have been well, 'why don't you try it and I'll take your money for a week'.

R3 [Doreen]: They did that, there was a documentary on, they got an MP...

R1 [Kay]: They had to live on income support's money, that's right, I remember seeing that.

R3 [Doreen]: Aye, and they gave the lassie his wages. And he managed to do it, but it was the cheapest of the cheap he was buying, stuff that was unhealthy and all the rest of it.

R5 [Jane]: Probably slept half the fortnight. But he couldnae do that for fifty-two weeks of the year, or for every year of his life, he couldnae.' [FG1:42, lower SES, Greater Glasgow]

The group of university cleaners, who normally read a combination of tabloid and local newspapers, take a similar approach, describing a low income family featured in a local newspaper, struggling to make ends meet:

R4 [Norma]: 'A family in the paper last night, where was it, Cranhill. He was disabled and he got a pension, but he also drove, and he got a small wage, and it broke down exactly what they spent his money on and how they never got anywhere, and they couldnae afford this and couldnae afford that. The youngest son had, what do you call it, autism. And I mean, reading their story, it was quite heartbreaking. I mean it's bad enough being skint, but if you've got problems like that, it just makes it worse doesn't it.

R5 [Jean]: Aye, there's a lot of poverty. It's in the [news] the past couple of weeks.

I: So this is in recent – what you've seen?

R3 [Alison]: Last night's [*Evening*] *Times* [local Glasgow evening newspaper] I think it was in. Aye, it was like a big double spread showing you inside their flat and that. The ages of their kids, and how they broke their money down between rent, council tax, and what type of food that they were buying. She'd go and buy so many groceries on a Monday with the family allowance and that

> would last them like Tuesday and Wednesday. She'd get his money on a Tuesday, that was like, they paid the rent, the council tax and the debt, and they tried to save what they'd left for like at the weekend. And they bought daily, you know, something for Thursday, something for Friday, something for Saturday. There was nae treats or anything for the kids, or, come a Sunday they'd nae money left, waiting on the family allowance on the Monday [agreement].
> [FG10:5-6, lower SES, Greater Glasgow]

The 'child with plate' image [Fig. 8][66] reminds Cassie, a community worker and *Guardian* and local newspaper reader living in a deprived area of Greater Manchester, of an item on the radio about poverty in Scotland:

> R5 [Cassie]: 'I don't – maybe this is saying [Fig. 8] that nothing has changed in that particular area in many years, and I do vaguely remember hearing an article on the radio about Scotland ... '
> [FG9:15, lower SES, Greater Manchester]

A smaller proportion of affluent groups in the study referred to stories of poverty and deprivation in the media. Geena (group eight), a local newspaper reader, cited a *Panorama* programme, but as evidence of government taking action rather than evidence of poverty. A further two affluent groups refer to the media in the same sense as the previous low income groups have – to confirm the existence of deprivation. A discussion takes place in group twelve, (whose participants read a mixture of tabloid, broadsheet, and local newspapers) about a *Scotland on Sunday* feature report:

> R5 [Sadie]: 'No, there was an article in *Scotland on Sunday* about somewhere in Edinburgh. I thought it was Glasgow but it was actually somewhere in Edinburgh but I can't remember what it was called.
>
> R4 [Rich]: Sighthill or something.
>
> R5 [Sadie]: I don't know. It was an article, and there was images similar to that [Fig. 7, 'estate'] but then you could choose a lot of housing estates and get similar images [agreement].
>
> I: Do you remember what the article was about?

R5 [Sadie]: Em, it was just basically, 'look how bad this area is' [laughs]. The article – it showed you like people of different ages, em like a young mum and dad who were heroin addicts but bringing up their kids.

R3 [Sandra]: I saw that as well. It was really, the pictures...

R5 [Sadie]: Did you? It was really – I couldn't remember the place either.

R3 [Sandra]: It was quite well known, the place.

R5 [Sadie]: There was a girl that used to live up there, that was brought up there, that did – I can't remember if it's photography or media studies – went back to cover the area she was from and it was pretty harrowing. The pictures were really kind a [makes sound].'
[FG12:10, higher SES, Greater Glasgow]

The *Scotland on Sunday* feature seems to have made a significant impact on Sandra and Sadie in particular. This group contained some participants who had experience of impoverished conditions either through childhood or professional experience, and this seems to be reflected in their reactions toward poverty and deprivation. The **Living in Glasgow takes fives years off your life** headline [Fig. 14] prompts Niall, a reader of a range of broadsheets, to recall another news report highlighting the city's unenviable levels of deprivation:

R4 [Niall]: '...every year there's another article where Glasgow is having the worst health, the worst health record in Europe I think.

R2 [Sian]: I think Northern Ireland's actually beating it [laughs].

R4 [Niall]: Whey! And you know, there was something recently, showing, it might have been diet or poverty, showing ten worst areas in Britain. I think six of them were in Glasgow. That's where social deprivation's the greatest, so that comes up constantly.'
[FG14:19, higher SES, Greater Glasgow]

[66] Figure 8 is an image of a Dickensian-looking child holding a plate surrounded by a group of children eating.

Whilst the more affluent groups had less to say concerning the reporting of poverty and deprivation in the media, they were often outspoken when discussing the media in general. The majority of comments centred around the media's perceived preoccupation with 'bad news'. Participants in group fourteen, who read a range of (predominantly left-of-centre) broadsheets as well as local newspapers, illustrate this with the following exchange:

R4 [Niall]: '[the media] ostensibly cover the negative aspects. It's a story for the press isn't it. If fifteen thousand women had been incorrectly screened or whatever, for cancer, it's a great story for the press. Yeah, it's a tragedy for the two thousand women, but it's a headline in a newspaper.

R1 [Brendan]: Particularly in Scotland, and Glasgow in particular, you know, over the last year has been sort of, all the heart disease and the way that's been phrased. They don't actually say, you know, Aberdeen's the healthiest city in Britain or anything like that. I think the press always focus on the negative aspects.' [FG14:2-3, higher SES, Greater Glasgow]

However, this negativity seems to be countered by an acknowledgement of the transient nature of media reporting:

R1 [Brendan]: '...it's a story one day and it's replaced by something else, an air crash the next day, d'you know what I mean.' [FG14:6, higher SES, Greater Glasgow]

Referring to television in particular, Connie, a *Daily Express* and *Sunday Mail* reader, states that there is 'All bad news on television anyway, there's never any good' [FG11:39, higher SES, Greater Glasgow]. Geena and Philipa, who read a selection of local newspapers, as well as the *Daily Record*, *Herald* and *Scotsman*, believe that newspapers have a preference for 'scandal', particularly the *Daily Record*. Interestingly, the discussion between participants in group eight draws a distinction between public health issues and deprivation, suggesting that they do not readily make a link between the two:

I: '...have you seen any of these type of images [depicting poverty and deprivation] in the newspapers?

R4 [Catriona]: No.

R3 [Philipa]: No. Not in the *Daily Record* anyway [laughter].

I: What sort of things do the *Daily Record* have in then?

R2 [Geena]: Scandal [laughter]. Like you will see things like that but it wouldn't be health and hygiene awareness. It would be someone's [referring to deprived images] kind of area.

R3 [Philipa]: Or it would be more about the run down areas in like Edinburgh or Glasgow or something, rather than to do with health-related problems. It would probably come in maybe a run down old council estate or something, that would be the story, I would think, more than health-related.' [FG8:4, higher SES, Lothian Region]

The media's supposed preoccupation with scandal is discussed by participants in group twelve. The participants list tabloids, broadsheets and local newspapers as reading material, however, a distinction is made between tabloid and broadsheet newspapers. Broadsheets can be trusted to give a more objective viewpoint:

R6 [Sam]: 'The difference between your average tabloid like the *Record* or the *Sun* or whatever, they'll put something totally blatant and probably half of it's untrue anyway. And then you get your newspapers like, you know, the *Herald* and *The Times* who are actually reporting on the news, and they're not giving such a biased view.

R4 [Rich]: You get a fairer view on the broadsheets than you would on the rags don't you, obviously.

R6 [Sam]: Yeah, definitely.

I: So what sort of view do you think the tabloids are portraying?

R6 [Sam]: They're just looking for scandal. They're looking for somebody to pick up their paper because of the headline that's on the front of it...They were more likely to put something more like, to shock you, whereas the broadsheets are more likely to put a fact, you know. Put it in a more subtle manner, and a more balanced manner because they're just reporting on the facts as opposed to trying to grab your attention.

R3 [Sandra]: I think that the tabloids, like, aim it towards more sort of the class thing and try and say it's more to do with poverty and working class, tends to be more of a slant on things than exercise...' [FG12:4, higher SES, Greater Glasgow]

This observation is in fact the opposite of what was found earlier in chapters three to six. My analysis showed that, in the periods studied, the tabloids focused more on lifestyle and health behaviours, along with the right-of-centre broadsheets, whereas the left-leaning broadsheets focused on the 'social issues' of poverty, deprivation and inequality. Despite broadsheet publications being deemed arbiters of truth, Sam is aware of the contradictions in what she is saying, as a *Record* reader herself. In a similar tone to Geena and Philipa in group eight, she states:

R6 [Sam]: '[laughs]...yeah, can't be anything more than two syllables just in case nobody gets it. Says me who reads the *Record*.

R3 [Sandra]: Exactly [laughter].

R6 [Sam]: Only 'cause it's easier to hold [laughter].

R5 [Sadie]: It's a definite problem. They should have small broadsheets [laughter].

R6 [Sam]: It's a wee bit of a contradiction in terms [laughter].' [FG12:5, higher SES, Greater Glasgow]

The mixed messages sometimes communicated in the media are highlighted later in group twelve's discussion, an aspect borne out in chapters three to six. This finding was particularly apparent in the left-of-centre broadsheets, where in some instances the text of a news report would highlight poverty, deprivation and inequality whilst the accompanying picture would depict health and lifestyle behaviours:

R5 [Sadie]: 'They contradict themselves though. I mean these things come out all the time but, on the article on the next page or somewhere else in the same newspaper, they can have one that is implicitly saying these kind of things are your own fault, that are blaming the individual for em, well a number of things. Like unemployment or ill-health...so it's total contradiction but it's a headline grabber. You go 'oh god that's terrible' then you forget *all* about it [laughing].' [FG12:41-42, higher SES, Greater Glasgow]

Marion's views (group thirteen) concerning tabloids and broadsheets echo more of the findings of the content analysis chapters. While she disects the different factions of the media, as a broadsheet buyer and reader of local newspapers, she resists the urge to label the tabloids as purveyors of lies and scandal:

R3 [Marion]: 'I think the media, from what I've seen, it sort of differs in terms of what you're reading, because I think the tabloid press, not that I read it of course [laughter], when I read over people's shoulders, they seem to see it much more as an individual problem like, you know, people should give up smoking, people are too fat, or they eat the wrong diet. And there seems to be more of a suggestion that it's within people's own gift to sort themselves out. Whereas if you read something like the *Guardian*, it's perhaps more of a suggestion that this is a, you know, a major social issue. It's not just a problem for individuals. And I suppose the two can overlap, and because obviously ultimately we are as individuals responsible for our health. But if, for example, your ill-health is brought on by doing a very stressful job, um, then, you know, what do you do about it...' [FG13:5-6, higher SES, Aberdeenshire]

Two lower income groups comment on the media in similar terms. Briefly describing tabloid publications, Scott, a *Herald* and *Sunday Mail* reader, comments that 'the front page is a big picture and not a lot of writing' [FG5:6, lower SES, Greater Glasgow]. Joe, a *Daily* and *Sunday Mail* reader from group six, describes the media as dwelling on negativity and sensationalism:

R5 [Joe]: 'It's no news when everything's going alright, you know. They can't go 'everything's fine' – need to wait until somebody gets killed or something like that, you know...but it's sensationalism, somebody's a killer, a 'beast' you know. He could be probably not guilty next week but he's a beast at the moment.' [FG6:13-14, lower SES, Greater Glasgow]

As Ed attempts to link the focus group images together later in the discussion, he and John make further observations about the media's negative qualities:

R3 [Ed]: 'The implication being that the children...near the burnt-out car ['estate', Fig. 7] are the products of single parents and so on. They grow up without the proper two-parent family and so on, whether that is proper eh, and this is what the outcome is.

R2 [John]: That'd be too elaborate for the newspapers.

R3 [Ed]: Oh, but that's the kind of thing they imply though. I mean I was brought up for a while in a single parent family and look at the state of me [laughs].' [FG6:25, lower SES, Greater Glasgow]

Although a number of the affluent groups – and a lesser proportion of deprived groups – swiftly dismissed the media with offhand criticisms, many of the same groups talked of the media's incredible power. Behind this uneasy alliance of dismissal yet deference, there often seemed to be the assumption that those in deprived circumstances would be more susceptible to the media's influence. Participants belonging to a resident's association in an affluent area of Greater Manchester strongly link the media to incidences of crime:

R3 [Elaine]: '...you know the media's there and it's all available, and it's you know the pressure to – you've got to have this because it's on the telly and I've seen it and I want it because it's blasted at you all the time. It's like subliminal messages isn't it. You see it so often you think, 'oh I'll try that'.

R2 [Lesley]: And don't you think as well with a lot of these television programmes, it gives people the idea of how to commit crime.

R4 [Connie]: I was just thinking the same thing.

R5 [Alice]: Yeah I mean last night we watched the Jack the Ripper thing, and my husband was saying, he said 'I bet we get another spate of those, somebody else will have watched this'.

R4 [Connie]: That's right, yes...A few weeks ago there was a film, it was an actual burglar, you know, showing how he did his crimes and it showed how he got into the front doors, you know, with a card. And I wondered how many more had learned from him [laughs] and were going to try it out.' [FG11:37-38, higher SES, Greater Manchester]

Marion, a university lecturer, suggests that television in turn creates aspirations y*et al*so 'reflect[s] back' the lives of a vast majority of the population:

R1 [Sheena]: 'But I think television has a terrific impact on perceptions. Everyone lives in a home, you know, like you see on some of the television shows, or everyone buys all these bits of equipment and so on.

R3 [Marion]: But on the other hand though, 'cause I was thinking that as you were saying, you would think that people would be looking at em, TV and thinking, 'ooh, you know, I'd like that, I'd like a video recorder' and whatever. But that's I think the popularity of some of these soap operas which seems to just reflect back the lives of people, don't they, that watch them...maybe it's just thinking well other people have my problems and these people are on TV.'
[FG13:21-22, higher SES, Aberdeenshire]

Although theatre administrator Niall makes similar comments about the media and aspirations, his observations seem to extend to all of society:

R4 [Niall]: 'You're just shown images of what you should be attaining all the time, and you push yourself to attain those things. And you want a certain lifestyle, and even if you've got money you can't live it because you've worked so hard to do it...' [FG14:13, higher SES, Greater Glasgow]

Whilst Marion (group thirteen) suggests that soap operas 'reflect back' the lives people have, participants living on a deprived Glasgow estate perceive things very differently:

R5 [Joe]: 'Powerful stuff. They're seeing people looking like themselves, appearing like themselves but always doing better, you know...

R3 [Ed]: They're like themselves but they forget they're actually actors and get one thousand pounds a week you know, so they're no actually like themselves at all.

R5 [Joe]: Who's writing it, who's writing it, nobody's that came here anyway.

R3 [Ed]: People who don't live it, write it.' [FG6:37, lower SES, Greater Glasgow]

Comments made by Joe earlier in the discussion sum-up what he and Ed are trying to articulate:

R5 [Joe]: 'Cause really it's aimed towards middle class, the whole thing is. We'll stick on *Coronation Street*, which is a middle class person's view of working class people about today. You *get al*bert Square [*Eastenders*] and they're all traders, they're all cockneys, they're all, they don't exist any more.

R1 [Andrea]: But they all can afford to drink every lunchtime, I want to know how they can?' [FG6:32, lower SES, Greater Glasgow]

Illustrating the gulf in perceptions on this issue, Debbie from affluent group seven gives her view from the opposite end of the spectrum:

R4 [Debbie]: 'I think, really, more affluent people throughout the country tend to take more notice of media, you know, and what people tell us we need now to lead a healthy life em, than those that are poorer.' [FG7:12, higher SES, Aberdeenshire]

Thirteen of the fourteen groups in the study referred directly to the media. Participants appeared to draw on previous knowledge of news stories to confirm their views and perceptions. Both higher and lower income groups recounted stories in the media to confirm the existence of poverty. Media stories were also cited to illustrate both government inaction (low income participants) and action (affluent participants). Higher income groups talked less about media stories per se, tending to concentrate discussion on the negative, transient nature of media reporting, and the mixed messages sometimes communicated. Groups from across the socio-economic spectrum talked about their varying perceptions of tabloid and broadsheet publications, and the power of the media to shape both aspirations and behaviour.

9.5 A way out? Resolution, solution and responsibility

'...you can't suddenly make everybody grow financially so you've got to tackle it from the root, you know. But, in an ideal world, what are you going to do?' [Denise, group seven]

At times, in the course of discussion on poverty, relative deprivation and inequality, the government and the media, participants revealed the ways (unprompted by interviewer)

in which they thought the situation could be improved. Discussion focused ultimately on the health effects of living in an unequal society, which perhaps contributed to the lack of emphasis placed on improvements to public services. There was limited discussion in three groups on improvements to hospitals and health services, housing, the police, and the judicial system. A small proportion highlighted the social ills of 'delinquent' (often lone) parents and children in the context of societal breakdown.

Discussion focused more on the following areas: investment, access, increases in benefits and taxes, and finally, change precipitated by communities themselves. The subject of education also featured highly. The ways in which groups suggested the use of health education varied dramatically and seemed to be dependent on socio-economic status. A number of affluent groups cited health education as a touchstone with the potential to cure all social ills, adhering to a behavioural model where changing lifestyles would solve the majority of health problems. However, the more left-wing affluent groups suggest education as a means of escape from deprived circumstances.

The lower income groups tended to look elsewhere for solutions. Just over a third of groups in the study cited investment and/or access (in various different guises) as the means by which to effect change. Scott, a charity officer, details what he thinks it takes to create jobs, thus alleviating poverty:

R4 [Scott]: 'At the end of the day, the banks, the banks who used to be partners – I honestly believe that the only people that will cure poverty are entrepreneurs and people who can create meaningful employment opportunity, which means six pound an hour or more.'
[FG5:13, lower SES, Greater Glasgow]

John, who is unemployed, envisages a situation where industry is encouraged to invest in people, thereby reducing unemployment as well as the physical and mental health problems associated with it:

R2 [John]: 'If you're on the brew [unemployed] right, you think you're worthless, now that's not something I think... there's a lot of people... I read about it, and I heard other people saying that

> they think they're worthless eh, and the government could actually encourage more industry to invest more in people, as well and get more jobs and so on, their worthlessness would eventually go away, and they'd be able to have the money to concentrate on their physical as well as mental health.' [FG6:3-4, lower SES, Greater Glasgow]

Whilst investment would involve monetary commitment from both public and private sectors, the subject of access was more complex. Scott (group five) makes a distinction between 'access' and 'money', although it could be argued from his following account that the two are inextricably linked:

> R4 [Scott]: '...And it's access. It's not about money, it's about access. You cannae – this guy [referring to another participant] cannae go to a football match. It's fucking nineteen quid to get in the door. Meanwhile Rangers [football club] are spending a hundred-odd million on football players! I mean, if they've got that type of money, why don't they reduce it for the unemployed to six pounds every fourth game and give them access? Or have a childrens seat or whatever. They're no doing that.' [FG5:23, lower SES, Greater Glasgow]

The participants suggesting or alluding to an increase in state benefits or higher taxes were confined in all but one case to the less affluent groups. John (group six) directly links his perception of the government's lack of financial support to the ill health experienced by those on low incomes:

> R2 [John]: '...They don't give them enough money to go and buy healthy foods right, they blame them because they're on the brew [unemployed] eh which is another way of not keeping healthy.' [FG6:3, lower SES, Greater Glasgow]

Whilst benefits were perceived as too low, the transition from dependence on benefits to gainful employment seemed especially problematic. Three of the lower income groups simply felt that work did not pay. Jane, a lone parent, reflects:

> R5 [Jane]: 'There are thousands of females, and males, that are single parents, that do want to go back to work, and the job they want to go for won't pay enough, they cannae pay the bills.' [FG1:34, lower SES, Greater Glasgow]

Beyond discussions of access, investment and benefits, it seemed that many participants from deprived areas were crying out to be heard, to have an input into decisions affecting their communities. However, sometimes there was a sense of resignation, or a belief that if you want something done, you have to do it yourself. Certainly, often the only tangible change that participants perceived had in their view occurred through the efforts of their community alone. Placed in the context of an incoming Labour administration and the ensuing hope for change, it is easy to understand the sense of isolation and hopelessness people feel. Ed, a participant living in a deprived Glasgow area, summarises this feeling, and concludes:

R3 [Ed]: 'I mean they aren't giving what you want, they're giving what they want. The developers put in what they think the people want, they don't actually ask the vast majority of people actually what they want. I mean they want easy access to cheap foods that you can get a variation on, eh, dairy types of foods and so on em, they want a pet shop but they're no getting it, they're no getting what they want.' [FG6:29, lower SES, Greater Glasgow]

Scott, from another deprived Glasgow area, describes a situation where 'outsiders' dictate the fate of those living in deprived areas. As part of his view of poverty as an industry, he states 'I don't know anybody that's in that industry earning under twenty thousand a year' [FG5:12, lower SES, Greater Glasgow]. Furthermore, he describes the middle classes as directly benefiting from the myriad of problems arising from deprived communities:

R4 [Scott]: '...what I'm saying is, for every pound that's flung at deprivation, bad health, you're lucky if ten pence of it is getting on to the ground level – at this level – because it's a rip-off all the way down... It's an economy, and it is keeping people in middle class areas...'
[FG5:12, lower SES, Greater Glasgow]

When asked how he would change the situation, Scott declares:

R4 [Scott]: I would have a local – I'd impose a policy which said basically that where there is resources going in that they should be included, the people at grass-root level, and that basically there are local priorities. Local priorities for employment, local priorities for investment, etc, etc.'
[FG5:12, lower SES, Greater Glasgow]

This was also the view expressed in group six. Whilst Scott wants to see a shift in the balance of power, participants in another lower income group seem to have bypassed the thought that there could be capacity for change on a wider level. Their's is a quiet resignation, rather than optimism, that they are on their own, and it is solely their responsibility:

R2 [Jean]: I think at the end of the day if you want to improve somewhere, it's up to yourself.

R4 [Val]: You've got to do it yourself. That's it.

I: And do you think that's happened around here?

R1 [Bob]: Aye [agreement].' [FG2:26, lower SES, Greater Glasgow]

It is suggested to them that the government must have a role, particularly as, at the time of this group in 1999, the Labour government (with its commitment to reducing inequalities) had been in office for approximately twenty-two months:

I: So the change you think, has come around is not really through political changes?

R3 [Sheena]: No [agreement]

R2 [Jean]: No it's through people's own...

R4 [Val]: Aye it's through the communities themselves.

R1 [Bob]: About here there's been a big improvement, about here.

R2 [Jean]: But there again I think it needs to be stronger and all, doesn't it...'
[FG2:29, lower SES, Greater Glasgow]

Danny, a participant living in a deprived area of Greater Manchester, explicitly dismisses the role of the 'authorities' in his experience of community life:

R4 [Danny]: 'The authorities really, in a sense, don't matter. It's down to the community itself.

R7 [Betty]: You mean the people.

R4 [Danny]: Now you remember this Jake, as well as I do. Years ago, the community used to police itself. If you stepped out a line, like you broke into somebody's house or something like that, they dealt with you...

R7 [Betty]: Yeah, they moved you out of town, they moved you out.

R4 [Danny]: No police, you didn't need the police, you got a good hiding.'
[FG9:20, lower SES, Greater Manchester]

Any change witnessed by lower income participants was perceived to be generated by themselves. Although investment and access were cited as the means to improve their situation, it was on the proviso that they were consulted about it. The affluent groups routinely referred to education as a solution, but in very different senses depending on their attitude to those on lower incomes. Health education was suggested by four of the six affluent groups in the study, whilst the remaining two (more empathetic) groups suggested education in the sense of gaining training and qualifications, as a route out of deprived circumstances. When education was discussed in the lower income groups, it was in terms of acquiring training and skills to gain employment. Their perception of having to do 'everything themselves' further emphasised their sense of being excluded. The transition from dependence on benefits to paid work was especially problematic, as the kind of jobs they would expect to get would not pay adequately. In short, it was 'not worth their while'. Lower income groups also suggested increases in taxes for high earners, lower taxes for those on low incomes, and severe penalties for tax evasion.

However, such suggestions masqueraded as distant dreams as participants in deprived circumstances described the grim reality of their lives. Any change instigated had been mobilised by themselves as part of small groups. Three of the lower income groups placed utmost importance on the processes of community input and participation. Whilst the feelings of empowerment generated as a consequence of being part of a community

can be perceived as positive, there are also negative connotations. The picture that emerges is one of excluded areas consisting of people who feel they have no-one to rely on but themselves. There is an overwhelming sense from the data presented in chapters seven to nine that participants living in deprived areas view themselves as cut-off from society as a whole, so used are they to fending for themselves.

Chapter Ten

Conclusion

This study has attempted to contribute to research on health inequalities by analysing the development and presentation of government public health policy, the subsequent media coverage, and lay perceptions of societal inequalities. The newly elected Labour government forced the issue of health inequalities back into the public domain as a key policy debate in 1997. Inequalities in health had been a highly contested issue, both politically and academically, throughout the previous two decades, and although some of the vehemence surrounding the debate had mellowed, key theoretical questions remained unanswered. One such question arose from the work of Richard Wilkinson who had put forward the theory that psycho-social mechanisms provide the pathway linking relative deprivation to ill health. It was suggested that fine gradations of material inequality were perceived by people, and were sufficiently important to impact not just on their psychological health, but on longer term and more life-threatening conditions. A growing body of work on psycho-social theories was emerging yet few studies had empirically addressed the issue leaving the area relatively underexplained.

10.1 Method and main findings

In order to address the presentation of inequalities in the press, content analysis of five key 'news events' was carried out. In order to begin to explore Wilkinson's questions about people's perceptions of and experiences of inequalities, fourteen focus groups were conducted. These two related but distinct strands of research addressed questions such as: How were health inequalities presented in the public domain? What levels of social injustice or inequality do people perceive to be health damaging and why, and with whom do they make comparisons?

Content analysis of the press coverage of key consultative, inquiry, and policy documents on health inequalities was carried out. The development of inequalities in health as an

issue once again on the public agenda was then documented and public awareness of these developments was gauged by using the media coverage in the focus group discussions. Focus group discussions were conducted with a cross section of the population in order to record lay perceptions, observe interactions between people and the dynamics within peer groups. These then provided the opportunity to examine how status and self image were 'managed' within the group context.

10.1.1 Findings from the content analysis

The content analysis of five key news 'events' over an eighteen month period illustrates the fluctuating fortunes of the inequalities debate in the UK national and Scottish print media. It also highlights how, in some sections of the press, namely the tabloids, the debate made no impact at all. Where tabloids did cover the government's Green Papers, the stories showed a strong lifestyle bias, but the overall response of the tabloid press was to ignore the issue entirely, potentially leaving a vast proportion of the UK population unaware of the government's intention to reduce inequalities. This study analysed the press coverage of the Scottish Green and White Papers, published in February 1998, the Acheson Report, published in November 1998, the Scottish White Paper, published in February 1999, and the English White Paper, published in July 1999. Such an approach, which allowed an analysis of the development of a particular public and policy debate over a considerable period of time, highlighted the crucial issue of political context and news timing.

10.1.1.1 February 1998

In February 1998 (when the English and Scottish Green Papers on public health were published) the initial excitement and novelty of a public airing of the inequalities debate was apparent, yet the tone of reporting largely reflected the traditional political stance of the different newspapers. In the UK national press, right-of-centre newspapers focused on proposals to improve and promote healthy behaviours, whereas left-of-centre publications focused their reporting on initiatives targeted at the deprived. Meanwhile in the Scottish

print media, the legacy of Scotland's 'appalling' health record lingered on. Reporting was more political in a way not seen in the UK national media at this time, perhaps reflecting Scotland's stronger socialist roots and long-standing affiliation with the Labour Party, as well as the sense of 'them' and 'us' traditionally felt in relation to the English.

10.1.1.2 November 1998

By November 1998, and the publication of the Acheson Inquiry recommendations, little had changed in terms of the trends emerging in the print media. Very little coverage appeared in the tabloids, yet again missing out a sizeable section of the population, perhaps leading to less public awareness of recommendations to increase benefits and to reinstate free school meals for all children and free milk for the under fives. The right-leaning broadsheets, in covering the Acheson Report and its recommendations, saw inequalities in health as an abstract problem, both too impractical and unrealistic to remedy. The left-of-centre broadsheets viewed any action to reduce inequalities as a moral imperative, and were sometimes very critical of the government despite the new administration very publicly putting inequalities at the centre of their public health policy.

10.1.1.3 February 1999

The effects of devolution were apparent when the Scottish Executive published its public health policy document (White Paper) nearly five months before England's equivalent in February 1999. This was in contrast to the situation in 1998, when the English and Scottish consultative documents were published in tandem. The Scottish White Paper re-emphasised the intention to reduce health inequalities in a broad cross-section of policies. However, the print media coverage was descriptive rather than analytical, and there was little mention of inequality. This was starkly different from the politicised coverage of the Scottish Green Paper by the Scottish-based media. For the White Paper, the Scottish press reported on specific government initiatives, and failed to highlight health inequalities as a consequence. As a result, the issue did not become a topic for wider debate and consideration in the Scottish press.

10.1.1.4 July 1999

The English White Paper was published in July 1999, four months after the focus groups for this study began. A subtle marginalisation of inequalities had taken place in the transition from Green to White paper (akin to the fate of the Black Report). Instead of being central to the White paper, inequalities were addressed in an 'Action Plan' separate from the main policy document. This Action Plan was only available from the Department of Health, ensuring a restricted circulation, unlike the English White Paper itself, which was widely accessible from Stationery Office shops around the country and electronically via the government website. Despite – or because of – the government's actions, a lively debate ensued amongst some of the UK national broadsheets over the downgrading of inequalities in health from the public health agenda. A strong satirical political dialogue was prominent, as these broadsheets actively engaged with the inequalities debate rather than merely relaying the government line. However, the absence of tabloid coverage again left a sizeable proportion of the newspaper-reading public untouched. Moreover, even for those newspapers reporting on the English White Paper, the story was overshadowed by the British Medical Association's annual conference.

This thesis has shown how media coverage varied between UK national and Scottish newspapers and how the nature of reporting related to the traditional political stance of the different newspapers. Right-of-centre newspapers often continued to frame the problem of health inequalities in terms of health behaviours whereas left-of-centre publications tended to highlight the consequences of poverty and inequality, although this pattern changed somewhat in the fifth sample period covering the English White Paper. The analysis also identifies common themes across the press coverage, such as growing criticisms about the lack of target setting and, by the time the White Papers were released, a growing cynicism directed at the new Labour government. The study highlights the crucial issue of political context and news timing, illustrating how the English White Paper was overshadowed by other health stories which formed the basis for attacks on the Labour government in general and the Health Minister in particular.

The findings of this study suggest that the reporting of inequalities in health is a cyclical issue, periodically in the limelight but apparently with no sustained, continuous coverage. These findings fit with Blaxter's observation that health inequalities are habitually rediscovered by the media (Blaxter 1997, p. 747) and of Wilkinson's description of 'repeat coverage' of health inequalities (Wilkinson 1996, p. 231).

In addition, the data collected for this study suggest that the views of the population on inequalities in health would be reinforced rather than challenged by the newspapers they read. If a *Times* reader felt that lifestyle was wholly responsible for ill health, their views would not be challenged, and similarly, if a *Guardian* reader favoured poverty as an explanation, their views would be confirmed. The data also suggest that a sizeable proportion of the UK newspaper readership would not glean anything of the inequalities debate from the press.

10.1.2 Findings from the focus groups

After examining how the inequalities debate was presented through these five key 'news events', the question remained as to how much public awareness was actually raised. All of the focus groups for this study were conducted after four of the key news events had passed, with only a few conducted prior to the fifth news event (the publication of the English White Paper). The findings suggest that the government's declaration that they were committed to tackling health inequalities had little impact. Few research participants were aware that the government had made such a commitment. In any case, lower income groups in particular felt disillusioned by Labour and often expressed feelings of rejection and cynicism. The knowledge of UK Prime Minister Tony Blair's privileged upbringing only served to increase negativity, although some low income participants were willing to give the government the benefit of the doubt as they had held office for a relatively short period of time. Higher income groups also expressed cynicism about the government, but there was less engagement with the topic, and a non-committal tone was apparent with the repetition of the age-old discourse of politicians as dishonest figures.

Whilst the inequalities debate in terms of these five key 'news events' appeared to have little impact on focus group participants, it did *not* mean that media reporting of poverty and deprivation went unnoticed. Lower income groups in particular referred to related media stories, suggesting that reports of poverty and deprivation are a staple of the media agenda, and that those less fortunate may feel in some way represented and validated by such coverage, or sometimes exposed and caricatured. Affluent groups had less to say about media stories of poverty and deprivation, tending to view them as a symptom of the media's preoccupation with 'bad news'. A theme running throughout the focus groups was the power of the media, including the fictional media such as soap opera, to shape aspirations, y*et al*so their ability to reflect back people's lives.

Blaxter writes that there is 'no evidence that inequality in health is an issue of great concern among the lay public in Western industrialised societies' (Blaxter 1997, p. 747). Confirmation of this view seems evident when considering the lack of impact the five key 'news events' had on focus group participants. Certainly, discussion of possible variations in mortality rates were prompted by the **Living in Glasgow takes five years off your life** headline [Fig. 14]. However, it was in the personal accounts of the lower income participants that inequalities as an 'issue' transformed into a subject attracting passionate views, and such strong emotions appeared to have far-reaching consequences for those expressing them. Rather than the 'transformation of public awareness' of the linkage of poverty to ill health that Wilkinson claims has occurred as a result of 'repeat coverage' by the media (Wilkinson 1996, p. 231), the data from this study suggest that lay views result more from a combination of awareness of wider media stories depicting poverty and inequality coupled with personal experience of deprived circumstances.

The focus group data collected in this study revealed that participants conceptualised inequality in terms of 'haves' and 'have-nots', and also in terms of a gradient or continuum. These models were often used interchangeably, suggesting that they were not mutually exclusive. Those from lower income groups, and some of the more affluent groups who had previously come into contact with poverty and deprivation, gave first-hand accounts of a widening economic divide. Some lower income participants felt that

they were deliberately being 'kept down'. Sometimes accounts were complex and contradictory as people talked in the second person or about others whilst expressing their feelings. A process of normalising or generalising problems occurred, and a passive acceptance of poverty sometimes outweighed any anger or injustice felt.

Those on low incomes were particularly aware of their status, and by implication possessed a heightened awareness of their position in the social hierarchy. Comparisons took many forms within groups, including talk about the unfair allocation of resources, pensioners comparing themselves with benefit claimants, the contrast between different ends of the same street, and local comparisons between affluent and deprived areas. Some attempted to shut themselves off from the outside world and get on with life, while some viewed themselves as 'fighters' or 'survivors'. This finding echoes, to a degree, Popay, Thomas *et al's* observation that repondents in their study could '(re)construct a positive identity despite living in what they and others perceive to be an 'improper' place' (Popay, Thomas *et al.* 2003, p. 55). Affluent groups displayed less energy and momentum and held more disparate views. Some self-consciously expressed politically correct views or saw themselves as 'soft' or 'soppy' for empathising with those on low incomes. Others were judgmental of those on low incomes for their 'failure' to get on, and positioned themselves, by contrast, as respectable citizens. A number of affluent groups spoke of the deprived in derogatory terms with little or no sense of collectivity or social responsibility.

Lower income participants in particular were in agreement that people compare themselves to each other and that such a process had a detrimental effect on self image. The views of more affluent groups were often contradictory, as after making comparisons, participants would claim that they usually 'forgot' that people lived in deprived circumstances. Such perceptions fitted in with lower income participants feeling hidden, disregarded and surplus to requirements. Generally, the powerful accounts emerging from the deprived groups contrasted with the more detached manner prevalent in the higher income groups. They were less inclined to get involved in discussion on

comparisons, and when comparisons were made they talked in a 'safer' way in that they were less direct and more general.

This study has demonstrated that people are aware inequalities exist, and that those 'at the bottom of the heap' converse in a way that suggests inequalities deeply affect them. This was shown most clearly when people talked about the effects of inequality, both individually and socially, on their health and well-being. Accounts of community breakdown were plentiful, including the demise of family life. People powerfully expressed their feelings of being 'marked', of feeling shame, anger, frustration, rejection, embarrassment, injustice and alienation. These emotional states, often recounted in the course of discussion on community breakdown, comparisons and status, were perceived to lead to sleeplessness, fear, anxiety, depression, stress, and feeling threatened. The notion that such tense social relations would take 'time off your life' was met with little surprise. In short, a lack of social cohesion was perceived to be directly related to a decline in health and well-being. These findings therefore lend only partial support to Cattell's conclusion that perceptions of inequality 'could be a source of social capital as well as demoralisation' (Cattell 2001, p. 1501). The more affluent groups spoke little of the negative effects of living in an unequal society, suggesting that those further up the social scale are less affected. Therefore, on the basis of material collected for this study, Wilkinson's assertions that people across the entire social spectrum are affected by a skewed income distribution remain questionable.

From these data two observations can be made. First, acknowledging inequalities and their effects did not always appear in any straightforward way to entail admitting 'inferior moral status' as Blaxter speculates, for these participants at least (Blaxter 1997, p. 754). The accounts given by those from deprived circumstances were punctuated with anger and frustration about the injustice of their situation, yet they did not appear to perceive themselves to be 'bad' people, although they may be aware of the image their situation might project to others. It seemed that they could verbalise their experiences, within the confines of a focus group discussion, without their social identity being compromised. Second, Blaxter describes how the findings of the Black Report were greeted with unease

and disbelief in a study conducted in the late eighties (Calnan 1987). Yet this study shows that in the late 1990s, a sizeable proportion of participants (at least when prompted) were not surprised in the slightest at the existence of large differences in mortality rates. This was clearly demonstrated by, for example, reactions to a headline stating that **Living in Glasgow takes five years off your life.** Lower income participants in particular responded to the headline matter-of-factly, and there were a number of comments suggesting that the figure of five years could be an under estimate. Such variations in findings between studies could be attributed to changes over time, but is most probably attributable to methodological differences in data collection. Larger scale surveys involving (semi-) structured interviews would elicit different responses when compared with a study employing focus groups such as this, which invoked another level of answer and another type of discourse. The trajectory of the group discussion itself suggests a progression toward further acknowledgement of inequalities impacting on health as the discussion evolved. However, in confirmation of Calnan (1987), a recent study by Popay, Bennett *et al.* (2003) reported that people in disadvantaged areas were 'reluctant to accept the existence of health inequalities (Popay, Bennet *et al.* 2003, p. 1).

Other significant findings concerning lay perceptions of inequalities emerged. Data from the *Health and Lifestyles* survey, collected in 1984-5, suggested that higher income groups appeared to think more in economic or environmental terms about the aetiology of ill health (Blaxter 1990). Few specifically mentioned poverty as a cause of ill health, and those who did were more affluent. Yet the data from this current study reveal the opposite. It was participants from lower income groups who were most likely to link poverty to ill-health. Conversely, higher income groups tended to attribute illness to lifestyle factors, unless they had some personal or professional contact with deprived communities or individuals. It was not that those from the lower income groups were unaware of 'good' or 'bad' lifestyle choices – indeed they seemed well versed in health education campaigns – they merely had a more sophisticated understanding as to why people continued certain lifestyle choices in the knowledge that they were health-damaging. Stress was seen to drive some behaviours. As one participant lamented 'it's either a cigarette or a pill'.

Lower income participants talked of how pressures to compete materially can affect health, for example by diverting resources so the children in the family got what they wanted. However, participants were prepared to divulge further on the psychological impact of living in a consumer society where incomes have polarised to an unprecedented degree. Pressure to 'keep up with the Jones' appeared strong, and the desire to have the 'right stuff' in order to fit in was particularly important for children (according to parents) to avoid being bullied. Keeping up with others symbolised attaining respectability, and failing to do so resulted in feelings of failure, inferiority and depression. Making comparisons with others who were better-off was, at times, interpreted as a reminder of personal failure, and of current poor circumstances, and was linked by some lower income participants to physical manifestations of psychological problems (such as panic attacks). It seemed that those from deprived areas craved for their voices to be heard, and in the absence of that happening they instigated change for themselves, to the best of their ability, with the resources available to them.

From the mid eighties Richard Wilkinson has formulated a theory based on the health effects of subjective experience, yet there have been only a few studies conducted on lay perceptions. This study contributes to this burgeoning area of research. It highlights one potential route which may impact on health by analysing lay accounts of inequalities in a focus group setting. It identifies the 'missing social economy of well-being' that society lacks. The numerous criticisms of Wilkinson's thesis deserve careful consideration, yet the psycho-social theory he has put forward offers a compelling contributory explanation for the pronounced gradient of ill health experienced in developed societies. Wilkinson has admitted that his theory needs refining and has increasingly favoured a multi-causal, multi-layered approach. Certainly, defining the terms 'social capital' and 'social cohesion' post *Unhealthy Societies* (Kawachi, Kennedy *et al.* 1999) demystifies a paradox inherent in this Ph.D. thesis. Whilst Wilkinson postulates that social cohesion is breaking down, the lower income groups in this study seemed to be particularly socially cohesive within themselves. Yet as Wilkinson points out, a street gang, by way of an example, can experience high levels of social capital but have a deleterious effect on the social cohesion in a given neighbourhood due to their anti-social behaviour. Transferring

this logic to the lower income groups who participated in this study, it would appear that they have built-up high levels of social capital amongst themselves in order to survive the breakdown of social cohesion they have witnessed in their communities and in wider society.

Therefore, returning to the original aims of this study:

- In respect of the relationship between societal (media) representations of health inequalities and lay perceptions of inequalities, this study has demonstrated that there was little convergence between lay perceptions and the five key news 'events' analysed. This is not to say that participants did not draw on wider media stories of poverty, inequality and deprivation from a range of sources (in addition to newspapers), spanning considerable lengths of time
- In respect of the extent to which people perceive societal inequalities, the answer is dependent on socio-economic status, with participants on lower incomes expressing greater awareness. These same participants often related the negative feelings generated by these comparisons to their mental, and sometimes physical, health. With regard to this conclusion, it is important to distinguish between lay perceptions of societal inequalities and health inequalities. A primary aim of this study, following Wilkinson's thesis, was to research the extent to which participants perceived societal inequalities generated by widening income differences, and if these fine gradations in material inequalities were perceived to impact on health. Perceptions of *health* inequalities were more salient in relation to newspaper coverage with the five key news 'events'.
- In respect of whether lay accounts confirm Wilkinson's thesis, the data presented here suggest partial confirmation in that those lower down the social spectrum were acutely aware of their social position. Therefore the macro (societal) theory that Wilkinson has advanced is echoed partially in lay accounts
- In respect of whether psycho-social mechanisms are represented in lay views, this was certainly more apparent in accounts from lower income participants. As detailed previously in this section, feelings of shame, anger, frustration, rejection,

embarrassment, injustice and alienation were related to sleeplessness, fear, anxiety, depression and stress. With respect to which health 'model' participants utilised, lower income participants tended to adopt a combination of psycho-social and material models, whereas higher income participants were more likely to adopt a combination of material and behavioural models of health.

10.2 Methodological reflection: strengths and limitations

10.2.1 Strengths

This thesis has shown the vital importance of social context, and its pivotal role not only in the experience of health and illness, but in quality of life itself. An examination of the presentation of health inequalities in the public domain was enabled by carrying out a detailed, multi-factorial analysis of the UK press. This study was longitudinal, 'live', and comparative with its focus on Scotland and England, charting current events at a particularly fascinating juncture in political history as the effects of devolution and a new stage in the parliamentary cycle became evident. A journey from consultation to policy has been charted and hard, rather than electronic, copies of all press coverage was collected.

The focus groups were conducted in a sensitive, considered manner, with the subsequent in-depth, thematic analysis focusing on the emotions and ambivalence expressed within groups, the language used, presentation of identity, and the dynamics between participants. Consequently, the strength of this thesis lies in its originality, as no other study has researched people's perceptions of societal inequalities as directly.

10.2.2 Limitations

As with any research, a number of limitations need to be considered in the evaluation of this work. Due to time constraints, and after preliminary data collection, television (and radio) news coverage could not be included in the content analysis of media coverage.

This would have allowed an evaluation of the media coverage of inequalities to be more comprehensive. However, analysis of the press does at least cover a considerable spectrum of political affiliations and therefore variations in the presentations of the health inequalities debate.

A consideration when examining the focus group sample recruited for this study is the omission of both the very affluent and the very deprived and isolated. With regard to the very deprived, the lower income groups interviewed tended to be motivated people banding together against the odds with their high levels of social capital. That possibly leaves an extremely disaffected and demoralised section of the population whose views remain untapped. In light of the alternative 'neo-materialist' explanations put forward by Lynch *et al* (Lynch, Davey Smith *et al.* 2000), the focus group data collected for this study illustrates people's accounts of their experience of poverty as well as relative deprivation. However, the lay perceptions gathered in this study do convey more than the experience of living in impoverished circumstances, exploring the impact of status, hierarchies, and personal comparisons. The focus on lay perceptions means that the wider debates on the validity and quality of the data Wilkinson uses (i.e. Judge 1995, West 1997, Platt 1998, Catalano 1998, Sinfield 1998, Wight 1998) remain ongoing.

Another potential limitation concerns the focus group sample itself. The sample was biased towards women and those with left-of-centre political beliefs and it underrepresented the views of those from ethnic minority communities and from other minority groups[67]. A spectrum of opinion is contained within the study, but there is potential for a lot more if these sampling biases could be rectified. Only by obtaining personal accounts from right across the social spectrum on a large scale will a comprehensive picture of the nature of social relations and cohesion emerge, thereby contributing to an explanation of mortality and morbidity gradients by social class. Particular attention also needs to be given to how views change over time, and in the case of this study, this was not only reflected by socio-economic status, but also in the average

[67] There were no 'out' lesbians or gay men in the groups, with their potentially differing experience of social exclusion and coherence.

age of focus group participants. A broad spectrum of accounts is also needed in order to assess the influence of cultural and subcultural factors (Forbes and Wainwright 2001) on social cohesion and the generation of inequalities in health. This study was located in the UK with a particular focus on the west of Scotland (although a number of groups were conducted elsewhere), and therefore the findings should be greeted with caution. As Elstad has already observed, the previous work on psycho-social mechanisms (along with the content of this study) does not by any means constitute a paradigm shift (Elstad 1998). Any further work in this area should perhaps be of a comparative nature, on both a national and international level. Subsequent studies may also benefit from the inclusion of individual interviews as well as focus groups, although group discussions seem particularly suited to a study of this nature, with their ability to shed light on social relations, status and hierarchies. Nevertheless, individual interviews (perhaps as a follow-up for those who have participated in focus group discussions) may tap into the opinions people may not be so comfortable in airing in front of their peers. Also interviews could be used to access some people who would not attend focus groups. Another interesting approach may be to actively recruit groups consisting of strangers on the basis that it might promote more uninhibited discussion (although it may also have the opposite effect, see Kitzinger and Farquhar, 1999).

10.3 Policy reflections

In terms of the policy debate, the Acheson Report could have reasonably been expected to be the foundation on which to develop policies to reduce inequalities in health. Yet subsequent commentary has concluded otherwise, with little progress made on researching which interventions actually reduce health inequalities. The promise of the late 1990s fuelled by a new Labour government coupled with the publication of the Acheson Report have failed to deliver any conclusive results. It seems, from the policy literature at least, that inequalities are still a very worrying problem that have yet to be adequately addressed.

The economic climate has changed dramatically over the last twenty years, and it would take strong political will to make the radical changes required to improve public services, increase benefits and redistribute income to even a modest degree (beyond the 'redistribution by stealth' strategy favoured by UK Chancellor of the Exchequer, Gordon Brown). For as long as the view persists that the government is 'impotent' in relation to wider economic forces, little will change. A fundamental shift in opinion would have to occur, reminiscent of 1960s thinking, whereby the government is held responsible, and publicly accountable, for the quality of social life in Britain through the careful management of economic trends. Changes of this nature can only be instigated with the weight of greater public and political awareness across-the-board of how sensitive health and well-being are to even modest changes in the economic climate, and how deep-rooted the consequences are for our social fabric. The picture painted in the thesis is clear: wide social divisions have emerged in society with groups no longer able to identify with one another. Those in disadvantaged circumstances feel that they are fending for themselves and that they are no longer a part of society. If social and economic divisions continue to widen, the consequences can only be detrimental both for health and for the future of society.

Bibliography

Acheson, D. (1998). Independent Inquiry into Inequalities in Health Report. London, Stationery Office.

Albee, G. (1998). "A Community Psychology Perspective (I)." Journal of Community and Applied Social Psychology **8**: 163-180.

Atkinson, A. B. (1999). "Income inequality in the UK." Health Economics **8**: 283-288.

Backett, K. (1992). "Taboos and excesses: lay health moralities in middle class families." Sociology of Health and Illness **14**(2): 255-274.

Barker, D. J. P., Ed. (1992). Fetal and Infant Origins of Adult Disease. London, British Medical Journal.

Bartley, M., B. Blane, *et al.* (1997). "Health and the life course: why safety nets matter." British Medical Journal **314**: 1194-6.

Bartley, M., D. Blane, *et al.* (1998). "Introduction: beyond the Black Report." Sociology of Health and Illness **20**(5): 563-577.

Bauman, Z. (1998). Globalization: The Human Consequences. Cambridge, Polity Press.

Benzeval, M. (1997). Health. Britain Divided: The growth of social exclusion in the 1980s and 1990s. A. Walker and C. Walker. London, Child Poverty Action Group: 153-169.

Benzeval, M., K. Judge, *et al.* (1995). Tackling inequalities in health - an agenda for action. London, King's Fund.

Birch, S. (1999). "The 39 steps: The mystery of health inequalities in the UK." Health Economics(8): 301-308.

Black, D. (1999). "A Black look at the independent inquiry into Inequalities in Health." Journal of the Royal College of Physicians of London **33**(2): 148-149.

Black, D., J. N. Morris, *et al.* (1988). Inequalities in Health: The Black Report; The Health Divide. London, Penguin.

Blane, D. (1985). "An assessment of the Black Report's explanations of health inequalities." Sociology of Health and Illness **7**(3): 423-445.

Blane, D. (1987). "The meaning of social class differences in health: people's experiences of risk factors." Radical Community Medicine: 31-37.

Blaxter, M. (1990). Health and Lifestyles. London, Tavistock.

Blaxter, M. (1997). "Whose fault is it? People's own conceptions of the reasons for health inequalities." Social Science & Medicine **44**(6): 747-756.

Blaxter, M. and E. Paterson (1982). Mothers and Daughters. London, Heinemann.

Blume, S. (2003). The Black Committee on Health Inequalities (1977-80): A personal view of its work. Poor Health: Social Inequality before and after the Black Report. V. Berridge and S. Blume. London, Frank Cass: pp. 107-122.

Brittan, S. and S. Webb (1990). Beyond the welfare state: An examination of basic incomes in a market economy. The David Hume Institute, Aberdeen, Aberdeen University Press.

Brunner, E. (1997). "Stress and the biology of inequality." British Medical Journal **314**: 1472-6.

Bunton, R., R. Burrows, *et al.* (1994). Interventions to Promote Health in Economically Deprived Areas: A Critical Review of the Literature, A Report to the Northern Regional Health Authority. Newcastle-Upon-Tyne, NHS Executive: Northern and Yorkshire.

Calnan, M. (1987). Health and Illness: The Lay Perspective. London, Tavistock.

Campbell, Wood, and Kelly (1999). Social Capital and Health. Health Education Authority.

Carr-Hill, R. (1987). "The Inequalities in Health Debate: A Critical Review of the Issues." Journal of Social Policy **16**(4): 509-542.

Carroll, D. and G. Davey Smith (1997). "Health and Socio-economic position: a commentary." Journal of Health Psychology **2**(3): 275-282.

Carstairs, V. and R. Morris (1991). Deprivation and health in Scotland. Aberdeen, Aberdeen University Press.

Catalano, R. (1998). "An Epidemiological Perspective." Journal of Community and Applied Social Psychology **8**: 163-180.

Cattell, V. (1995). Community, Equality and Health. Middlesex University. Social Policy Occasional Paper Series.

Cattell, V. and Evans, M. (1999). Neighbourhood images in East London. York, Joseph Rowntree.

Cattell, V. (2001). "Poor people, poor places and poor health: the mediating role of social networks and social capital." Social Science and Medicine **52** (10).

Cornwell, J. (1984). Hard-earned Lives: Accounts of Health and Illness from East London. London, Tavistock.

Cox, B. D., F. A. Huppert, *et al.*, Eds. (1993). The Health and Lifestyle Survey: Seven Years On. Aldershot, Dartmouth.

Cox, B. D. et. al. (1987). The Health and Lifestyle Survey: Preliminary Report. London, Health Promotion Research Trust.

Dahlgren, G. (1993). "Economic Analysis of Health Development." Newsletter on Health Care in Developing Countries: Health Economics **2**: 4-7.

Dahlgren, G. and M. Whitehead (1991). Policies and strategies to promote social equity in health. Stockholm, Institute of Futures Studies.

Dahlgren, G. and M. Whitehead (1992). Policies and Strategies to Promote Equity in Health. Copenhagen, World Health Organization.

Davey Smith, G., M. Bartley, *et al.* (1990). "The Black Report on socio-economic inequalities in health 10 years on." British Medical Journal **301**: 373-377.

Davey Smith, G., D. Dorling, *et al.* (2002). "Health inequalities in Britain: continuing increases up to the end of the 20th century." Journal of Epidemiology and Community Health **56**(434-435).

Davey Smith, G., S. Ebrahim, *et al.* (2001). "How policy informs the evidence." British Medical Journal **322**: 184-185.

Davidson, R., Hunt, K., Kitzinger, J. (2003). "'Radical blueprint for social change'? Media representations of New Labour's policies on public health." Sociology of Health and Illness (forthcoming).

Deacon, D. (1999). Researching communications: a practical guide to methods in media and cultural analysis. London, Arnold.

Deaton, A. (2002). "Policy implications of the gradient of health and wealth." Health Affairs **22**(2): 13-30.

Department of Health (1991). The Health of the Nation. London, Stationery Office.

Department of Health (1992). The Health of the Nation. London, Stationery Office.

Department of Health (1998). Our Healthier Nation: A Contract for Health. London, Stationery Office.

Department of Health (1999). Reducing Health Inequalities: An Action Report. London.

Department of Health (1999). Saving Lives: Our Healthier Nation. London, Stationery Office.

Department of Health (2001a). Tackling Health Inequalities: Consultation on a plan for delivery. London, Stationery Office.

Department of Health (2001b). From vision to reality. London, Stationery Office.

Desai, M. (1998). A basic income proposal. The state of the future. R. Skidelsky, W. Eltis, E. Davis, N. Gemmell and M. Desai. London, Social Market Foundation.

Duesenberry, J. S. (1949). Income, Saving, and the Theory of Consumer Behavior. Cambridge, MA., Harvard University Press.

Elstad, J. I. (1996). "How large are the differences - really? Self-reported long-standing illness among working class and middle class men." Sociology of Health and Illness **18**(4): 475-498.

Elstad, J. I. (1998). "The psycho-social perspective on social inequalities in health." Sociology of Health and Illness **20**(5): 598-618.

Epstein, H. (1998). Life and Death on the Social Ladder. New York Review. New York: 26-30.

Evans, R. (2002). Interpreting and addressing inequalities in health: From Black to Acheson to Blair to...? London, Office of Health Economics.

Farquhar, C. and R. Das (1999). Are focus groups suitable for 'sensitive' topics? Developing Focus Group Research: Politics, Theory and Practice. R. Barbour and J. Kitzinger. London, Sage.

Forbes, A. and S. P. Wainwright (2001). "On the methodological, theoretical and philosophical context of health inequalities research: a critique." Social Science and Medicine **53**(6): 801-816.

Fryer, D. (1998). "A Community Psychology Perspective (II)." Journal of Community and Applied Social Psychology **8**: 163-180.

Furnham, A. (1994). "Explaining health and illness: Lay perceptions on current and future health, the causes of illness, and the nature of recovery." Social Science and Medicine **39**(5): 715-725.

Gepkens, A. and L. Gunning-Schepers (1993). Interventions for Addressing Socio-economic Inequalities in Health, Institute of Social Medicine, University of Amsterdam.

Horton, R. (2002). "What the UK government is (not) doing about health inequalities." The Lancet **360**: 186.

Illsley, R. (1986). "Occupational Class, Selection and the Production of Inequalities in Health." The Quarterly Journal of Social Affairs **2**((2)): 151-165.

Jacobson, B., A. Smith, *et al.*, Eds. (1991). The Nation's Health: A strategy for the 1990s. London, King's Fund.

Judge, K. (1995). "Income distribution and life expectancy: a critical appraisal." British Medical Journal **311**: 1282-5.

Kaplan, G. A., E. Pamuk, *et al.* (1996). "Inequality in income and mortality in the United States: analysis of mortality and potential pathways." British Medical Journal **312**: 999-1003.

Kawachi, I. and B. P. Kennedy (1997). "Health and social cohesion: why care about income inequality?" British Medical Journal **314**: 1037-40.

Kawachi, I., B. P. Kennedy, *et al.* (1999). "Crime: social disorganization and relative deprivation." Social Science and Medicine **48**: 719-731.

Kennedy, B. P., I. Kawachi, *et al.* (1996). "Income distribution and mortality: cross sectional ecological study of the Robin Hood Index in the US." British Medical Journal **312**: 1004-7.

King's Fund (1998). Local Inequalities Targets. London, King's Fund.

Kitzinger, J. (1990). "Audience understandings of AIDS media messages: a discussion of methods." Sociology of Health and Illness **12**(3): 319-35.

Kitzinger, J. and R. Barbour (1999). Introduction. Developing Focus Group Research: Politics, Theory and Practice. R. Barbour and J. Kitzinger. London, Sage.

Kitzinger, J. and C. Farquhar (1999). The analytical potential of 'sensitive moments' in focus group discussion. Developing Focus Group Research: Politics, Theory and Practice. R. Barbour and J. Kitzinger. London, Sage: 156-172.

Leon, D., G. Walt, *et al.* (2001). "International perspectives on health inequalities and policy." British Medical Journal **322**: 591-594.

Lynch, J. W., G. Davey Smith, *et al.* (2000). "Income inequality and mortality: importance to health of individual income, psycho-social environment, or material conditions." British Medical Journal **320**: 1200-4.

Lynch, J. W. and G. A. Kaplan (1997). "Understanding how inequality in the distribution of income affects health." Journal of Health Psychology **2**(3): 297-314.

Lynch, J. W., G. A. Kaplan, *et al.* (1997). "Why do poor people behave poorly? Variation in adult health behaviours and psycho-social characteristics by stages of the socio-economic lifecourse." Social Science and Medicine **44**(6): 809-819.

Macintyre, S. (1994). "Socio Economic Variations in Scotland's Health - A Review." Health Bulletin(2.6).

Macintyre, S. (1997). "The Black Report and Beyond; What Are the Issues?" Social Science and Medicine 44(6): 723-746.

Macintyre, S. (2002). Before and after the Black Report: four fallacies. Poor Health: Social Inequality before and after the Black Report. V. Berridge and S. Blume. London, Frank Cass: 198-219.

Macintyre, S., I. Chalmers, *et al.* (2001). "Using evidence to inform health policy: case study." British Medical Journal 322: 222-225.

Macintyre, S. and M. Petticrew (2000). "Good intentions and received wisdom are not enough." Journal of Epidemiology and Community Health 54: 802-803.

Macintyre, S., MacIver, S. and Sooman, A. (1993). "Area Class and Health: Should we be focusing on Places or People". Journal of Social Policy 22(2): 213-234.

Mackenbach, J. P. and A. E. Kunst (1994). "International variations in the size of mortality differences associated with occupational status." International Journal of Epidemiology 23: 742-750.

MacPherson, S. W. (1999). The Stephen Lawrence Inquiry. London, Stationary Office.

Marmot, M. G. (2001). "From Black to Acheson: two decades of concern with inequalities in health. A celebration of the 90th birthday of Professor Jerry Morris." International Journal of Epidemiology 30: 1165-1171.

Marmot, M. G. and R. G. Wilkinson (2001). "Psycho-social and material pathways in the relation between income and health: a response to Lynch *et al.*" British Medical Journal 322: 1233-6.

Maynard, A. (1999). "Inequalities in Health: An introductory editorial." Health Economics(8): 281-282.

McCloone, P. (1994). Carstairs Scores for Scottish Postcode Sectors from the 1991 Census. Glasgow, Medical Research Council, Social and Public Health Sciences Unit.

Michell, L. (1999). Combining focus groups and interviews: telling how it is; telling how it feels. Developing Focus Group Research: Politics, Theory and Practice. R. K. Barbour, J. London, Sage.

Mitchell, R., D. Dorling, *et al.* (2000). Inequalities in life and death: What if Britain were more equal? Bristol, The Policy Press and the Joseph Rowntree Foundation.

Morris, J. N. (1990). "Inequalities in health: ten years and a little further on." Lancet 336: 491-493.

Morrow, G. (2002). "Children's experiences of 'community': Implications of social capital discourses." in Swann and Morgan (eds) Social Capital for Health: Insights from Qualitative Research. Health Development Agency.

Office of Population Censuses and Surveys (1986). Registrar General's Decennial Supplement on Occupational Mortality 1979-80, 1982-83. London, HMSO.

Pierret, J. (1993). "Constructing Discourses about Health and their Social Determinants" in Radley, A. (eds). Worlds of Illness: Biographical and Cultural Perspectives on Health and Disease. Routledge: London & New York.

Platt, S. (1998). "A Medical Sociology Perspective." Journal of Community and Applied Social Psychology 8: 163-180.

Popay, J., Bennet, S. et al. (2003) "Beyond 'beer, fags, eggs and chips'. Exploring Lay Understandings of Social Inequalities in Health." Sociology of Health and Illness 25(1).

Popay, J., Thomas, et al (2003). "A proper place to live: health inequalities, agency and the normative dimensions of space." Social Science and Medicine **57**(1):55-69.

Popay, J. and G. Williams (1996). "Public Health Research and Lay Knowledge." Social Science and Medicine **42**(5): 759-768.

Popay, J., G. Williams, *et al.* (1998). "Theorising inequalities in health: the place of lay knowledge." Sociology of Health and Illness **20**(5): 619-644.

Richards, H., Emslie, E. (2000). "The 'doctor' or the 'girl from the university'? Considering the influence of professional roles in qualitative interviewing." Family Practice **17**(1): 71-75.

Roberts, H. (1997). "Children, inequalities, and health." British Medical Journal **314**: 1122-5.

Scambler, G. and P. Higgs (1999). "Stratification, class and health: Class relations and health inequalities in high modernity." Sociology **33**(2): 275-296.

Scottish Executive (2001). Social Justice Annual Report Scotland 2001. Edinburgh, Scottish Executive, Social Inclusion Division: 116-120.

Scottish Office Department of Health (1992). Scotland's Health: A Challenge to us all. Edinburgh, Stationery Office.

Scottish Office Department of Health (1997). Scottish Health Survey 1995, TSO.

Scottish Office Department of Health (1998). Working Together for a Healthier Scotland: A Consultation Document. Edinburgh, The Stationery Office.

Scottish Office Department of Health (1999). Towards a Healthier Scotland. Edinburgh, Stationery Office.

Shaw, M., D. Dorling, *et al.* (1999). The widening gap: Health inequalities and policy in Britain. Bristol, Policy Press.

Sinfield, A. (1998). "A Social Policy Perspective." Journal of Community and Applied Social Psychology **8**: 163-180.

Sixsmith, J. and Boneham, M. (2002). "Men and masculinities: accounts of health and social capital." in Swann and Morgan (eds) Social Capital for Health: Insights from Qualitative Research. Health Development Agency.

Smail, D. (1998). "A Clinical Psychology Perspective." Journal of Community and Applied Social Psychology **8**: 163-180.

Strong, P. M. (1990). "Black on class and mortality: Theory, method and history." Journal of Public Health Medicine **12**: 168-180.

Townsend, P. and N. Davidson (1988). Introduction. Inequalities in Health: The Black Report; The Health Divide. London, Penguin.

Townsend, P., M. Whitehead, *et al.* (1988). Inequalities in health: the Black Report and the Health Divide. London, Penguin.

Vagero, D. (1995). "Health inequalities as policy issues - reflections on ethics, policy and public health." Sociology of Health and Illness **17**(1): 1-19.

Vagero, D. and R. Illsley (1995). "Explaining health inequalities: Beyond Black and Barker." European Sociological Review **11**(3): 219-241.

Walker, A. and C. Walker, Eds. (1997). Britain Divided: The growth of social exclusion in the 1980s and 1990s. London, Child Poverty Action Group.

Walters, V. (1993). "Stress, anxiety and depression: Women's accounts of their health problems." Social Science and Medicine **36**(4): 393-402.

Watt, G. (2001). "Policies to tackle social exclusion." British Medical Journal **323**: 175-176.

Watt, G. and R. Ecob (1992). "Mortality in Glasgow and Edinburgh: a paradigm of inequality in health." Journal of Epidemiology and Community Health **46**: 498-505.

Webley, P. (1998). "An Economic Psychology Perspective." Journal of Community and Applied Social Psychology **8**: 163-180.

West, P. (1997). "Review of 'Unhealthy Societies'." Sociology of Health and Illness **19**(5): 668-70.

Whitehead, M. (1995). Tackling inequalities: a review of policy initiatives. Tackling Inequalities in Health: An agenda for action. M. Benzeval, K. Judge and M. Whitehead. London, King's Fund.

Whitehead, M. (1998). "Diffusion of ideas on social inequalities in health: A European perspective." Millbank Quarterly **76**(3): 469-478.

Whitehead, M., B. Burstrom, *et al.* (1999). "Social policies and the pathways to inequalities in health: a comparative analysis of lone mothers in Britain and Sweden." Social Science and Medicine **50**: 255-270.

Whitehead, M. and G. Dahlgren (1991). "'What Can Be Done about Inequalities in Health?'" Lancet **338**: 1059-63.

Whitehead, M. and N. Davidson (1988). Introduction. Inequalities in Health: The Black Report; The Health Divide. London, Penguin.

Whitehead, M., F. Diderichsen, *et al.* (2001). Researching the impact of public policy on inequalities in health. Understanding Health Inequalities. H. Graham. Buckingham/Philadelphia, Open University Press.

Wight, D. (1998). "An Anthropological Perspective." Journal of Community and Applied Social Psychology **8**: 163-180.

Wilkinson, R. G. (1986a). "Occupational Class, Selection and Inequalities in Health: a Reply to Raymond Illsley." The Quarterly Journal of Social Affairs **2**((4)): 415-422.

Wilkinson, R. G. (1986b). Income and Mortality. Class and Health: Research and longitudinal data. R. G. Wilkinson. London, Tavistock: 88-114.

Wilkinson, R. G. (1989). "Class Mortality Differentials, Income Distribution and Trends in Poverty 1921-1981." Journal of Social Policy **18**(3): 307-335.

Wilkinson, R. G. (1990). "Income distribution and mortality: a 'natural' experiment." Sociology of Health and Illness **12**(4): 391-412.

Wilkinson, R. G. (1992a). "Income distribution and life expectancy." British Medical Journal **304**: 165-8.

Wilkinson, R. G. (1992b). "Glasgow, Edinburgh, and the health divide: Is it ever too late for prevention?" British Medical Journal **305**: 1239-1240.

Wilkinson, R. G. (1993a). Income and health. Health wealth and poverty. R. Ross and S. Iliffe. London, Medical World/Socialist Health Association: 6-11.

Wilkinson, R. G. (1993b). The impact of income inequality on life expectancy. Locating health: sociological and historical explanations. S. Platt, H. Thomas, S. Scott and G. Williams. Aldershot, Avebury: 7-28.

Wilkinson, R. G. (1994a). Health, redistribution and growth. Paying for inequality: the economic cost of social injustice. A. Glyn and D. Miliband. London, IPPR/Rivers Oram Press: 24-43.

Wilkinson, R. G. (1994b). Unfair shares: the effects of widening income differences on the welfare of the young. Illford, Essex, Barnados.

Wilkinson, R. G. (1994c). "Divided we fall: The poor pay the price of increased social inequality with their health." British Medical Journal **308**: 1113-1114.

Wilkinson, R. G. (1995a). "Commentary: A reply to Ken Judge: mistaken criticisms ignore overwhelming evidence." British Medical Journal **311**: 1285-7.

Wilkinson, R. G. (1995b). ""Variations" in health: The costs of government timidity." British Medical Journal **311**: 1177-1178.

Wilkinson, R. G. (1996). Unhealthy Societies: The Afflictions of Inequality. London, Routledge.

Wilkinson, R. G. (1997). "Health inequalities: relative or absolute material standards?" British Medical Journal **314**: 591-5.

Wilkinson, R. G. (1999b). "Two pathways, but how much do they diverge?" British Medical Journal **319**: 956-7.

Wilkinson, R. G., I. Kawachi, *et al.* (1998). "Mortality, the social environment, crime and violence." Sociology of Health and Illness **20**(5): 578-597.

Wilkinson, S. (1999). How useful are focus groups in feminist research? Developing Focus Group Research: Politics, Theory and Practice. R. Barbour and J. Kitzinger. London, Sage.

Williams, A. (1999). "Commentary on the Acheson Report." Health Economics(8): 297-299.

Williams, G. and Popay, J. (1994). "Lay knowledge and the privilcdge of experience" in Gabe et al. Challenging Medicine. Routledge: London & New York.

Williams, J. and M. Calnan (1996). "The 'limits' of medicalization?: Modern medicine and the lay populace in 'late' modernity." Social Science and Medicine **42**(12): 1609-1620.

Woodward, A. and I. Kawachi (2000). "Why reduce health inequalities?" Journal of Epidemiology and Community Health **54**(12): 923-929.

Appendix A
Methodology

A.1 Green Paper coding sheet

Green Paper Coding Sheet

Source:

Date:

Headline:

Journalist's Name:

Journalist's Specialism:

FORMAT

News report

Feature article

Editorial

Column

Review

Letter

Other

PAGE DESCRIPTION

Front

News

Health

Politics

Feature

Unknown

Other

No. OF IMAGES

A.1 (cont) Green Paper coding sheet

Green Paper Coding Sheet

TYPE OF IMAGES Description of image
Unveiling of Green Paper
Government Minister
'Healthy' image (describe)
'Unhealthy' image (describe)
Other

STORY TYPE
Details of contents of Green Paper (news-report style)
Health story (rather than specific Green Paper story)
Issue bound i.e. focusing on one aspect of Green Paper
Personal experience - lay person
Personal experience - professional

TONE
negative
positive
mixture of both

INACCURACIES
Any misreporting (if so, describe)?

A.1 (cont) Green Paper coding sheet

Green Paper Coding Sheet

CONTENTS

shared responsibility

Conservatives, mention of

'third' way

schools emphasis

both Green Papers, mention of

no health inequality targets, mention of

'holistic', inter-departmental approach of Government

'contracts' for health

what about more resources?

reductions of funding, NHS charging, mention of

job creation, mention of

Scottish Parliament, mention of

Glasgow vs Edinburgh

Nanny State: not to 'nag' or 'nanny'

'roots' of ill health

Scotland's 'apalling' health record

health inequalities worsening, mention of

war imagery (tackle, fight etc.)

hints to psycho-social factors

support for Labour

A.1 (cont) Green Paper coding sheet

Green Paper Coding Sheet

SOURCES

Medical/Research Interviewees

Research scientist

Medical practitioners - GPs, consultants

Public Health/Administration

Politicians (not D of H)

Jack Straw
Peter Lilley
Kenneth Clarke
John Maples
Virginia Bottomley
Calum MacDonald
Department of Health (any rep including Health Minister)

Tessa Jowell
Frank Dobson
Sam Galbraith

NHS executive/administrator/manager

Lay Person Interviewees

Funding/Research/Activist/Charity organisations

National Alliance Against Dental Health Inequalities
British Medical Association
British Dental Association
One Plus
National Children's Homes Action for Children Scotland
Instant Neighbour Trust
Safe and Sound
HEBS
Shelter
The Office For Public Health in Scotland
King's Fund

Political Parties

Scottish Conservatives
SNP
Scottish Liberal Democrats

A.1 (cont) Green Paper coding sheet

Green Paper Coding Sheet

Phrases/language used in articles from Green Papers

'tackle'
'root'
'inequalities'
partnerships/alliances
contract for health
government vs individual role
wider social and economic factors
social exclusion
'third way'
'individual victim blaming vs nanny state social engineering'
blame
'not about blame, but about opportunity and responsibility'
responsibility:
= individual
= mutual
= government
= local/health authority
= NHS
Action
Challenging
hard choices/not easy/no quick fix
'well-being, a sense of control over your life, and optimism for the future'
old(er) people
link between poverty and ill health
'new' public health etc.
'we' meaning us all, together
working together
'drive' i.e. against poor health
government departments working together
'framework'
National Lottery
'if everything is a priority, nothing will be a priority'
previous Green Paper: 'its vision for health was limited...'

'good health is more than the absence of disease'
'life circumstances'
'healthier lifestyles'
'attack'
Scottish Parliament, mention of
Scottish Health Survey, mention of
Black Report, mention of
'sense of belonging, hope, self-esteem and confidence'
Commitment
cohesive society

A.1 (cont) Green Paper coding sheet

Green Paper Coding Sheet

Phrases/words used from Green Paper Press Releases

'extending fit and healthy life'
tackling inequalities
Tackling
contract for health
'third way' for public health
improving all areas of life, not just health
'tough' and 'challenging'
3 key settings for action (children/adults/older people)
Schools – Internet Website *Wired*
Health Improvement Programmes
Health Action Zones
Healthy Living Centres
Addressing needs of local community
'drive against poor health'
'mutual responsibilities'
Mr Motivator & Ainsley Harriot

a 'self confident' Scot
improving whole quality of life - 'barriers to good health'
2 perspectives approach to tackling ill health
Acknowledgement of social circumstances causing poor health
priority spending in all areas
no 'quick fix'
New Deal - job as most important factor
Bearsden/Drumchapel comparison
'challenge' for individual - target problem areas
'nanny' or 'nag', instead 'empower' and 'encourage'
information and economic ability to choose for themselves
Challenge to tackle together
Health Impact Assessments
COSLA post
Health and Lifestyle targets
fluoridation of water
teenage pregnancies
excessive drinking
directors of public health to become ad hoc members of Local Authority committees
'choose life'
'a life less ordinary'

A.2 Invitation sheet

Media coverage of health: Invitation to participate in a discussion group

Can you help?

Health issues have been in the media a lot recently. What do **you** think are important health issues? What do you think generally about the coverage of health in the media?

We are currently doing research into media coverage of health and would like to hear your views.

This would involve meeting up with the researcher, Rosemary Davidson, for a group discussion at a time and place that's convenient for you. The discussion involves being shown some pictures from newspapers and headlines from news stories.

Perhaps you are aware of some health stories in the media, or maybe this is the first time you've thought about it. Either way, your opinion is valuable. People usually find the discussion interesting, and it is important that we talk to as wide a range of people as possible. This includes people who do not read newspapers or watch television, as well as people who actively take an interest in health stories. All views are equally important.

The discussion usually involves between 4 to 6 people, is one and a half hours in length and is tape-recorded. There is a cash payment of £10 per participant.

I will telephone in the next few days, or if you prefer, you could reach me at work on 0141 357 3949, or by writing to the address below. I look forward to speaking to you in the near future.

Yours sincerely

ROSEMARY DAVIDSON
MRC Social and Public Health Sciences Unit
University of Glasgow
4 Lilybank Gardens
Glasgow G12 8RZ
Email: rosey@msoc.mrc.gla.ac.uk

This project is funded by the Medical Research Council.

A.3 Focus group running order

fg running order

demographics

- can I get you to fill in these questionnaires

warm-up

- these are recent headlines taken from health stories in the news
- *what do you think* are the 'root causes' of ill-health, just write whatever springs to mind.
- *if you could* set four goals for a 'healthier Britain', what would they be?
- you can write your in the middle pages of the booklet, in the boxes
- what sort of things did people come up with? (ask randomly rather than going systematically round the group)
- what do the rest of you think of that (i.e. what X has said)?
- what do you think the newspaper was saying about the Govt's proposals?
- do you think the suggestions you have made are similar to what the govt. is actually doing to improve people's health

images I

- these are three images taken from newspapers in February 1998
- they all appear alongside news articles covering the same story
- what do you think the articles are about?
- what do you think these pictures are trying to convey?
- are there other pictures you would associate with this sort of story?

images II

- can I get you to split into two groups
- these are newspaper pictures taken from another story that appeared in October and November of last year
- can you make up a story using all these pictures? Try to reconstruct what might have been said in the actual news article.

(bring groups together)

- what stories did you come up with?
- what do you think of these images?

**how do participants define inequality? If inequality is perceived, what do participants mean by inequality?*

**do participants make reference to themselves/compare themselves to others?*

- how would you describe the area in which you live?
- how do you think your community is viewed by outsiders
- do you think that your views are represented in newspapers or on TV?
- do you think these representations change your views in any way?

images III

- these two sets of photos were also featured in news stories in October and November of last year to illustrate the same news story as the last set of photos I just showed you
- what do you think the journalist or editor is trying to convey with these pictures?
- can you incorporate them into your existing news stories?

**if participants perceive inequality, can they speculate on possible causes?*

**what action would they take to improve the inequalities they perceive?*

- do you think people compare themselves to others?

A.3 (cont) Focus group running order

- how might this affect people's health?
- why do you think people compare themselves to others?

headlines I

- these headlines are taken from January and February of 1998 (around the same time as the first set of photos that I showed you)
- have you seen any of these headlines before?
- what do you think the headlines are about?
- what exactly do you think is meant by the **'three nations'** of Scotland?
- what do you think is meant by the **'nanny state'**?
- what do you think is meant by the headline **'Living in Glasgow takes 5 years off your life'**?
- do you think there is any truth in these headlines?

headlines II

- these headlines are taken from October and November of 1998 (around the same time as the second set of photos I showed you)
- have you seen any of these headlines in the press?
- what do you think about this headline? (**Gap between rich and poor widens again**)
- what about this headline - do you think the better-off are healthier than the less well-off?
- if so, why is this the case?
- how would the 'poor' be more likely to experience ill-health?
- is there anything that could be done to reduce the gap?
- this headline describes health inequalities as widening - what exactly do you think they mean by 'health inequalities'?
- do you think there is any truth to these headlines?

- in the last exercise, I showed you the headline, **Living in Glasgow takes 5 years off your life** - but what about health differences *within* Glasgow?
- do you think that people living in deprived areas, such as Drumchapel, will die at an earlier age than those in more affluent areas, such as Bearsden?
- how much earlier - is it a matter of weeks? months? years?
- how many (weeks/months/years)?
(10 years for men, 7 years for women)
- why do you think there are such differences in life expectancy?
- what would you do to try and change this situation?
**do participants think there is, or are they aware of inequality in this country?*
**if so, how did they become aware of it?*
**what does inequality mean to participants?*
**how do participants feel inequalities are generated?*

images III

- this is a picture of Frank Dobson, Secretary of State for Health
- what do you think about his statement here?
- are you aware that the government has highlighted this area (health inequalities) in its health plans?

conclusion

- before we finish, can I get you to fill in the last page of the booklet

Appendix B
The English Green Paper: 'Our Healthier Nation'

The English Green Paper *Our Healthier Nation: A Contract for Health* (Department of Health 1998) sets long-term targets in four areas. By the year 2010, the government aims to:

- Reduce the death rate from heart disease and stroke and related illnesses amongst people under aged 65 years by 'at least a further third'
- Reduce accidents by 'at least a fifth'
- Reduce the death rate from cancer amongst people under 65 years by 'at least a further fifth'
- Reduce the death rate from suicide and undetermined injury by 'at least a further sixth' (Department of Health 1998, Summary, p. 6).[68]

It is calculated that over 90,000 lives will be saved (under the age of 65) if the government's four health targets are met. These targets will, according to the English Green Paper, be achieved by making a 'contract' between individuals, communities, health and local authorities, businesses, voluntary bodies and the government. Three settings are identified for facilitating action: healthy schools 'focusing on children', healthy workplaces 'focusing on adults' and healthy neighbourhoods 'focusing on older people' (Department of Health 1998, Summary, p. 6). To hold this framework together, the government's two key aims are stated as:

- 'To improve the health of the population as a whole by increasing the length of people's lives and the number of years people spend free from illness.
- To improve the health of the worst off in society and to narrow the health gap' (Department of Health 1998, Summary, p. 5).

The English Green Paper takes the view that past efforts to improve health have been 'too much about blame. Individuals were to blame for failing to listen to well-intentioned but misdirected health advice.' [3.1][69] The Conservatives' vision for health as expressed in the 1992 White Paper 'was limited, mainly because of its reluctance to acknowledge the social, economic and environmental causes of ill health.' [4.12] Arguments about health in the Conservative years rallied between two extremes "...individual victim blaming on

---

[68] See Summary section p. 6 and chapter 4 'Targets for Health' (paragraphs 4.1-4.54) of the English Green Paper for a full discussion of these targets.

[69] Numbers in brackets indicate paragraphs from the English Green Paper *Our Healthier Nation: A Contract for Health.*

the one hand and nanny state social engineering on the other." [Summary and 3.2]. The word 'blame' is mentioned 5 times in three adjoining paragraphs in the English Green Paper [3.1-3.3] as the government distances itself from the previous administration's approach.

Thus the English Green Paper acknowledges that ill health has complex causes, and groups these factors into 'fixed', 'social and economic', 'environment', 'lifestyle' and 'access to services' (See table B.1).

Table B.1. Factors affecting health (Department of Health 1998, p. 16).

Fixed	Social and Economic	Environment	Lifestyle	Access to Services
Genes	Poverty	Air Quality	Diet	Education
Sex	Unemployment	Housing	Physical activity	NHS
Ageing	Social exclusion	Water Quality	Smoking	Social Services
		Social environment	Alcohol	Transport
			Sexual behaviour	Leisure
			Drugs	

As part of its holistic approach to health, the government sets out an explicit 'Contract' for health in three areas, detailing the responsibilities of government and 'national players', 'local players' and communities, and individuals.

B.1 Role of Government

For the government to fulfil its role, the Green Paper details the appointment of a Minister for Public Health 'to ensure co-ordination of health policy across Government, not the in the Department of Health.' [3.11] Health impact assessments will be applied to relevant key policies so that the 'consequences of those policies for our health is considered.'[3.11] The government also proposes publicity campaigns to highlight public health issues [3.24]. A section, 'Tackling the Root Causes of Ill Health' [3.28-3.38], describes the New Deal programme, an initiative designed to get young people, the long

term unemployed and lone parents into the workforce. Social exclusion will be the subject of a 'long term, determined and coordinated Government effort', led by the Social Exclusion Unit [3.29]. Additional resources totalling £800 million will be channelled in to improving the housing stock [3.30] and an Integrated National Transport Policy will 'tackle congestion and pollution' [3.31]. Other initiatives include fluoridating the water supply [3.33], measures to combat crime [3.35] and reforms to education [3.36].

B.2 Role of local organisations

The English Green Paper states that Health Authorities will have 'an important local leadership role in identifying local health needs and translating *Our Healthier Nation's* twin aims, priorities, targets and contracts into action.' [3.41] The section 'Local Partnership' outlines the setting up of Health Action Zones which will 'provide a framework for the NHS, Local Authorities and other partners'. Health Action Zones will target health inequalities, their purpose being to 'bring together all those contributing to the health of the local population to develop and implement a locally agreed strategy for improving the health of local people' [3.51]. With £300 million pounds of lottery money, the government proposes to set up Healthy Living Centres across Britain. These Centres will be 'local flagships for health in the community, reaching out to people who have been excluded from opportunities for better health, and [be] powerful catalysts for change in their neighbourhoods.' [3.62]

B.3 Role of individuals

In terms of individual behaviours, the English Green Paper works from the premise that most of us know what is beneficial and detrimental to health [3.68]. However, individual responsibility is emphasised as part of 'the example we set to those around us' [3.69]. The English Green Paper cites the positive influence of 'stable and caring' families and the role parents can have in shaping the lifestyles of their children [3.69]. The impact personal behaviour can have on the health of others is also highlighted, with reference to the detrimental effects of passive smoking [3.70].

Appendix C
The Scottish Green Paper: 'Working Together for a Healthier Scotland'

The Scottish Office Department of Health published its public health consultation document entitled 'Working Together for a Healthier Scotland' (Scottish Office Department of Health 1998) on the same day as its English counterpart, Thursday 5th February 1998. The same philosophy guiding English policy applies to the Scottish Green Paper. The document argues for a 'fresh approach...a public health strategy which addresses the root causes of our health problems' [3][70]. The 'root causes' are described as poverty, unemployment and the environment [1]. The Scottish Parliament, it is believed, will facilitate the 'cohesive approach to health improvement we have hitherto lacked' [4].

The Scottish Green Paper describes a 'twin health challenge' for individuals to improve their own lives and institutions to protect health through policies [Foreword & 95]:

- 'We can all act to improve our own lives, avoiding illness as we would accidents.
- Public and private bodies – Government, local authorities, agencies, companies – can protect health through their policies, plans and actions.'

Although the English and Scottish Green Papers are similar in both having two overriding goals, their respective aims are different[71]. However, this is due more to a difference in emphasis than a difference in approach. Both stress the importance of different sections of society taking responsibility for health, and both also indicate the desire to improve quality of life and reduce inequalities in health. However, whilst the English Green Paper explicitly distances itself from the previous Conservative government's health policy, the Scottish Green Paper states in a more neutral tone that 'Brave attempts to tackle ill-health have often foundered on the rocks of real lives, poor prospects and counter-pressures' [Foreword].

---

[70] Numbers in brackets indicate paragraphs from the Scottish Green Paper *Working Together for a Healthier Scotland.*

[71] Rather than framing their twin aims in terms of institutions and individuals, the aims of the English Green Paper are to improve population health overall and to narrow the 'health gap' (Department of Health 1998, Summary, p. 5). See also earlier in chapter, p. 3.

The Scottish Green Paper describes 'Action at 3 Levels': 'life circumstances', 'lifestyle topics' and 'health topics'. To make an impact on public health involves improving 'life circumstances' and encouraging 'healthy lifestyles'. 'Life circumstances' include a worthwhile job, a decent home, a good education and a clean environment' [Summary, p. vii]. 'Healthy lifestyles' will be maintained by 'not smoking, by eating for health, taking greater physical exercise, and avoiding alcohol and drug misuse [Summary, p. viii & 81]. The Scottish Green Paper does not explicitly set out targets for improving health in the same manner as the English Green Paper. Instead, 'priority health topics' are identified [Summary and 46]:

- Coronary heart disease and stroke
- Cancer[72]
- Mental health
- Sexual health, including teenage pregnancies and HIV/AIDS
- Dental and oral health
- Accidents and safety

Progress in each of the 'priority health topic' areas will be achieved, the Scottish Green Paper states, by forming 'strong partnerships between health professionals and other local bodies within a national framework' [Summary and 95]. Schools, workplaces, communities and the Health Service will be targeted as locations for policy implementation, as these are the 'places where people are' [Summary and 92].

The Scottish Green Paper, like its English counterpart, proposes Health Impact Assessments to 'consider the consequences of all major policies'. As part of the new partnerships to be forged, both central and local government as well as other agencies will be involved in carrying out these assessments [103]. Another element of both the English and Scottish vision is the proposed Healthy Living Centres. The Scottish Green Paper describes these as 'of particular value in deprived communities...with great potential to improve health' [118], although less space is devoted to the initiative (one paragraph) than in the English Green Paper (6 paragraphs). The Scottish document goes on to propose an expert working group chaired by the Scottish Office Minister for Health

[72] Coronary heart disease, stroke and cancer are also termed 'Scotland's Big Three' in an attempt to 'place them firmly on the agenda' [7].

which will 'draw up a strategic framework for strengthening and regenerating communities, particularly disadvantaged communities' [108]. Broad programmes of area regeneration are proposed in places 'where Scotland's health is poorest' [113-117].

As part of the drive to 'tackle lifestyles that cause illness', the Scottish Green Paper seeks views on smoking [121], excessive drinking [122], drug misuse [123-128], diet [129-130], physical activity [132-137], and water fluoridation [139-142]. Views are also sought on how to reduce teenage pregnancies, improve mental health and end domestic violence [143-146], as well as on accident prevention [150], and infectious diseases [151-153].

Highlighting the role of local authorities, the Scottish Green Paper describes how Directors of Public Health can assess the health impact of local policies [154]. A Scottish Office funded public health post in the Convention of Scottish Local Authorities (COSLA) is proposed 'to develop good practice and to help co-ordinate healthy local authority policies' [157]. Also, the Health Education Board for Scotland (HEBS), the Scottish Consultative Council on the Curriculum and COSLA are to 'set up a small specialist unit to help develop health promoting schools throughout Scotland'[180].

The Scottish Green Paper notes that a separate White Paper, *Designed to Care: Renewing the NHS in Scotland* (Scottish Office Department of Health 1997), requires public health organisations to be 'responsible for securing health improvement in their area' [Summary]. To complement this development, the Scottish Green Paper seeks views on how the overall contribution of the Health Service can be maximised [158-175]. To enable the communication of health information, the Health Education Board for Scotland (HEBS) will have a 'key responsibility for high-profile health education initiatives in priority health and lifestyle topics' [177]. Suggestions are sought on how to use the 'explosion' in information technology to 'harness' health improvement [182].

Appendix D
The Scottish White Paper: 'Towards a Healthier Scotland'

Towards a Healthier Scotland sets targets in a broad range of areas. Under the banner of 'Headline Targets' [Annex A, p. 56], the Scottish White Paper proposes to reduce premature mortality from CHD by 50% (the forthcoming English White Paper sets the targets for reducing premature mortality from CHD *and* stroke by 'at least' two fifths (Department of Health 1999, para's 6.12-6.24)) and to reduce premature mortality from cancer by 20% (the English White Paper sets the same target (Department of Health 1999, para's 5.11-5.31)). Both targets are to be achieved by the year 2010 for persons under the age of 75. The remaining 'Headline Targets' are set in the areas of smoking (reduce smoking among 12-15 year olds from 14% to 11% and reduce proportion of women smoking during pregnancy from 29% to 20%); alcohol misuse (reduce incidence of men and women exceeding weekly limits from 33% to 29 % and 13% to 11% respectively); teenage pregnancy (reduce rate among 13-15 year old by 20%) and dental health (69% of 5 year old children to have no experience of dental health disease).

To complement the above targets, six 'Second Rank Targets' are listed in Annex A of the Scottish White Paper (Scottish Office Department of Health 1999, p. 57). These targets span the areas of diet, smoking, alcohol misuse, physical activity, cerebrovascular disease and dental health. In contrast, the forthcoming English White Paper favours a more focused approach, setting targets in four areas only (see Chapter 6, *Saving Lives: Our Healthier Nation*).

The many factors influencing health are recognised in paragraph ten of *Towards a Healthier Scotland*, echoing the stance of the previous Scottish Green Paper document (Scottish Office Department of Health 1998):

'Life circumstances, as reflected in a worthwhile job, decent housing, good education and a clean and pleasant environment, make for physical and mental well-being: the converse is also true. Lifestyles – as

reflected in smoking and drinking patterns, diet and exercise – have a powerful effect on health but these factors are linked strongly to social class and underlying life circumstances.' [10][73]

In accordance with this belief, chapter two of the Scottish White Paper describes '3 Action Levels for Better Health' in which all the 'Headline' and 'Second Rank' targets previously fall: life circumstances, lifestyles and health topics [11]. From the consultation process stimulated by the Scottish Green Paper, the Scottish White Paper concludes:

'...our drive towards better health should focus on 3 linked action levels. Emphasis was placed on developing a coherent, co-ordinated and inter-sectoral strategy to attack the roots of ill-health, rather than just focusing on specific diseases or individual behaviours.' [11]

Child health is to be added to the White Paper's list of priority health topics due to emphasis placed on the 'lifelong impact of ill-health and health-damaging lifestyles in childhood' [13] throughout the consultation period.

D.1 First action level: 'life circumstances'

Chapter three of the Scottish White Paper outlines the initiatives related to the first of the three action levels, life circumstances. The new proposals fall into one of seven areas: Social inclusion, Families with children, Housing, Community Care, Employment and Training, Environment, and Crime. Under the first heading, 'Social Inclusion' [18-21], the government proposes 'Social Inclusion Partnerships' funded with £48m over three years 'to promote inclusion and prevent exclusion in both urban and rural areas.' [19] The 'New Deal for Communities' programme will receive £12.9m over 3 years 'to help deprived communities articulate their needs better, and to make their public services more integrated and responsive' [19].

Under 'Families with Children' [22-25], the Scottish White Paper outlines the expansion of Family Centres (supporting families with children aged three and under) [23], and part-time pre-school education [23]. A wider age range of children (0-14) will be better

[73] numbers in brackets indicate paragraphs from 'Towards a Healthier Scotland'.

off with an increase in Child Benefit [24], and a Childcare Tax Credit (part of the Working Families Tax Credit) will provide 'a further £25m to £30m per annum towards childcare for lower income families' [24].

With regard to education [25], 60 New Community Schools 'will offer children and their families integrated education, social work, family support and health education and promotion services.' Class sizes with be reduced in Primary 1-3 to 30 or under by August 2001 [25]. Early Intervention Programmes are proposed to help improve the 'reading, writing and numeracy skills of young children' [25]. An extra £25m is earmarked to fund 'specific alternatives to exclusion of children from school' [25].

Under the third heading - 'Housing' [26] - the Scottish White Paper details action already taken including a 'New Housing Partnerships' initiative [26] 'to promote community ownership of public sector housing and achieve major improvements in housing conditions.' A 'Warm Deal Initiative' will improve the insulation of low-income family homes [26]. Legislation is being developed to deal more effectively with 'neighbour nuisance and anti-social behaviour', which can cause 'health-threatening stress to other people' [26]. The 'Community Care Action Plan (under the fourth heading, 'Community Care' [27]) sets out a strategy 'for improved delivery of services for older people, and people with physical and learning disabilities and mental ill-health living in the community' [27].

Under the fifth heading, 'Employment and Training' [28-30], the Scottish White Paper states that 'Work is the best route out of poverty and into a healthier life'. Therefore, the government's Welfare to Work Initiatives (including the New Deal) are 'designed to give more effective help to more people than ever before to get and keep a job' [28]. A Scottish 'New Futures Fund' has been set up to reach out to 'our most disadvantaged young people' [29]. While for those in work but still living in poverty, a National Minimum Wage will be introduced (£3.60 per hour from April 1999) [30].

The Scottish White Paper states that 'A clean environment is a prerequisite for health' (under the sixth heading of 'Environment' [31-33]). To help achieve this aim, there is a

National Air Quality Strategy [31]. The government is 'urging' water authorities to accelerate their investment in clean water and efficient sewerage services [31]. A Scottish Integrated Transport White Paper, *Travel choices for Scotland*, aims to deliver 'integrated and effective transport policy' [32] and the Rural Transport Funding Package aims to improve transport links in rural areas [32]. This broad-ranging approach to health policy is also reflected in the last of the seven areas, 'Crime' [34]. The Scottish White Paper acknowledges that crime can affect health in a number of ways and bases its policy on the social causes of crime, protecting the public, and 'ensuring that all those involved in the criminal justice system are treated fairly and humanely' [34].

D.2 Second action level: 'lifestyles'

The second action level 'lifestyles', is addressed in chapter four of *Towards a Healthier Scotland*. Under the heading, 'Reduction in the use of Tobacco' [36-38], the 'Headline Targets' for smoking are set out. The Scottish White Paper then goes on to detail laws to ban tobacco advertising, 'enhanced' health promotion campaigns (targeting young people, pregnant women and low income smokers), and specialist smoking cessation clinics offering an 'initial supply' of free Nicotine Replacement Therapy [38].

Under the heading 'Eating Better' [39-41], the government states that it will increase funding of Diet Action Plan[74] initiatives to over £2m over the next 3 years. The government will also appoint a national dietary co-ordinator to 'give impetus to implementation of the Plan' ['Action' below para. 41]. Finally the Food Standards Agency 'will improve access by people to information about nutrition and food safety' ['Action' below para. 41]. Under 'Physical Activity' [42-43], the setting-up of a Task Force to develop a National Physical Activity Strategy for Scotland is detailed. The strategy will 'bring together key agencies in sport and leisure, education, health, fitness, exercise and play, in joint action to help people of all ages and walks of life to enjoy the benefits of physical activity' ['Action' below para. 42]. The 'Alcohol Misuse' [44-45] section includes the government's 'Headline Targets' for reducing alcohol misuse [see

[74] *Eating for Health: A Diet Action Plan for Scotland*, the Scottish White Paper states, was published in 1996. The document 'provides the framework for the action needed over a ten-year period to improve Scotland's diet' [40].

beginning of section 5.2] and describes the improvement of services over the next three years with £2.5m funding ['Action' below para. 45]. In the last section, 'Drug Misuse' [46-48], the Scottish White Paper describes an 'enhanced strategic framework' to be published which will 'co-ordinate and focus drug misuse measures in Scotland'. In addition, from April 1999, new prevention and treatment services will be funded to 'help discourage drug misuse, offer effective treatment and cut drug-linked crime' ['Action' below para. 48].

D.3 Third action level: 'health topics'

The 'health topics' comprising the third action level of the government's strategy are outlined in Chapter five of *Towards a Healthier Scotland.* The 'topics' are 'The Health of Children' [49-52], 'Dental and Oral Health' [53-56], 'Coronary Heart Disease' [62-63], 'Cancer Prevention and Screening' [64-66], 'Mental Health' 67-72], and 'Accidents and Safety' [73-74]. Four demonstration projects, the core of the third action level strategy, are to be created, with the titles 'Starting Well', 'Healthy Respect', 'The Heart of Scotland' and 'The Cancer Challenge' (the Scottish White Paper gives more detailed descriptions of the demonstration projects in chapter seven, pp. 48-51).

The first demonstration project described, 'Starting Well' (fulfilling the more child-oriented focus of the Scottish White Paper in 'The Health of Children' section, paragraphs 49-52) will 'develop and disseminate best practice in supporting children's health from pre-conception through to school entry.' ['Action' below para's 52] Dental and oral health comes within this remit, including the responsibility of health boards to gauge public support for water fluoridation [53-56].

In a section entitled 'Sexual Health' the demonstration project 'Healthy Respect' is described [57-61]. The project 'will develop best practice in the promotion of sexual health and the prevention of unwanted teenage pregnancies' ['Action' under para. 61]. Funding will also be provided to increase availability of the voluntary sector's expertise in more schools to 'promote a more informed and responsible approach to sexual matters on the part of young people' ['Action' under para. 61].

Coronary heart disease [62-63] will be addressed with demonstration project 'The Heart of Scotland'. The project will develop an 'inter-sectoral community-based approach to the prevention of heart disease' ['Action' under para. 63]. As part of the government's strategy concerning cancer prevention and screening [64-66], demonstration project 'The Cancer Challenge' will implement a pilot colorectal screening programme. The Health Education Board for Scotland (HEBS) will intensify its national media campaign, 'promoting awareness' of the factors which contribute to make coronary heart disease and cancer 'Scotland's main killing diseases' ['Action' under para. 66].

Despite the lack of any target for 'Mental Health' [67-72], the Scottish White Paper states that it 'will be a leading priority for the NHS in Scotland'. The commitment is made to 'promote mental health in both parents and children.' HEBS will work in conjunction with the Health and Safety Executive (and others) to 'safeguard and promote mental health'. Finally, existing social inclusion initiatives are detailed to 'help improve mental well-being and so enhance mental health.' ['Action' under para. 72]. The final health topic, 'Accidents and Safety' [73-74], includes proposals to develop a national criteria for data collection, encouragement of Health boards to participate in inter-agency accident prevention work, and a 'new target for reducing road accident casualties' to be achieved by 2010 ['Action' under para. 74].

Chapter six, 'Putting the Jigsaw Together' details the 'Role of Government' [75-77], the 'Role of the NHS' [78-88] and a 'Review of Public Health Function' [89]. 'The Role of Local Government' is then described [90-94] and 'Health Information for the Public' [95-97]. Also in the English White Paper [Health, 1999 #105], Health Impact Assessments [98] and Healthy Living Centres [99-100] are featured. There are also sections on 'Health Promoting Schools' [101], 'Protecting and Promoting Health at Work [102-105], 'Communicable Diseases' [106-108] and 'Food Safety' [109-110].

Appendix E
The English White Paper: 'Saving Lives: Our Healthier Nation'

The English White Paper *Saving Lives: Our Healthier Nation* sets four key targets for the year 2010 (Department of Health 1999, Executive Summary):

- **'CANCER:** to reduce the death rate in people under 75 **by at least a fifth**
- **CORONARY HEART DISEASE and STROKE:** to reduce the death rate in people under 75 **by at least two fifths**
- **ACCIDENTS:** to reduce the death rate **by at least a fifth** and serious injury **by at least a tenth**
- **MENTAL ILLNESS:** to reduce the death rate from suicide and undetermined injury **by at least a fifth.'**

If these targets are achieved, up to 300,000 'untimely and unnecessary deaths' will be prevented. To meet these targets, the government is investing a further £21 billion into the NHS 'to help secure a healthier population', tackling smoking and integrating government and local government, emphasising health improvement as a key role for the NHS, and pressing for 'high standards for all, not just the privileged few' (Department of Health 1999, p. ix).

The White Paper goes on to reject past (Conservative) arguments surrounding the causes of ill health. The previous government's public health policy was based around the premise that the majority of ill health experienced by individuals is caused by lifestyles and health behaviours. Instead, 'social, economic and environmental factors tending towards poor health are potent' and people 'can make individual decisions about their and their families health which can make a difference'. For this to be achieved the White Paper describes a 'new balance' in which people, communities and government work together in 'partnerships' to improve health. Healthy Citizens programmes [3.27] (comprising of *NHS Direct*, *Health Skills* and *Expert Patients* detailed below) are to be created to help decision-making. The programmes will comprise of *NHS Direct* [3.30] (a nurse-led telephone helpline and Internet service providing information and advice on health), *Health Skills* programmes [3.36] (for people to help themselves and others, including training in the use of defibrillators), and *Expert Patients* programmes [3.36] (to help people manage their own illnesses).

Health improvement, the White Paper describes, will be integrated for the 'first time ever' into the local delivery of health care. This means 'reorienting' the NHS so that health authorities have a new role in improving the health of local people and primary care groups and trusts have new responsibilities for public health. Local authorities will work 'in partnership' with the NHS with health action zones (to break down barriers in providing services) and Healthy Living Centres (set-up to provide help for better health).

To monitor standards, a new Health Development Agency [11.5] is proposed to assess and raise quality. The Agency will increase education and training for health, with specific measures for nurses, midwives, health visitors and school nurses [11.13]. A review of public health information is proposed [11.29]. Public health observatories will be established in each NHS region [11.30], disease registers will be set-up [11.33], as well as the promotion of research [11.36]. A new Public Health Development Fund also will be established [11.39].

The White Paper includes a section on 'Communicating risk', which details the information, education and training available to the public via initiatives such as *Healthy Citizens*, *NHS Direct* and *Health Skills* (sub-divided into first aid, parents, later life, young people and training in the use of defibrillators). A chapter on each of the four targets follows (Chapter five on cancer, Chapter six on coronary heart disease and stroke, Chapter seven on accidents, and Chapter eight on mental health), and how the 'integrated action' of government, local authorities and individuals can bring about improvement. The White Paper then moves on to 'wider action' in chapter nine, looking at sexual health [9.2], drugs [9.8], alcohol [9.21], the 'genetics revolution' [9.24], and 'improving health for black and minority ethnic groups' [9.29]. Chapter ten describes how to 'make it work' via 'progress and partnerships' including reorienting and empowering Health Services [10.3], new primary care organisations [10.7], local partnerships [10.12] including Health Improvement Programmes [10.18] Health Action Zones [10.23] and Healthy Living Centres [10.24]. Chapter eleven continues the 'Making it work' theme with 'Standards and success, including Education and Training for Health [11.8] and Research [11.35].