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Working-class discourses of politics, policy and health: “I don't smoke; I don't drink. The only thing wrong with me is my health”

Abstract: It is known that population health is socially and politically determined. A gap, however, between the evidence and policy (where behavioural approaches dominate) is evident. This study used semi-structured interviews in two deindustrialised areas in Scotland to explore understandings of the causes of (ill)health in local communities. Using Raphael's Discourses of Social Health Determinants, we found that participants typically had highly integrated explanations of health, including vivid articulation of links between politics, policies, deindustrialisation, damage to community fabric, and impacts on health. This understanding contrasts with that identified by research elsewhere. We posit explanations for our findings, and discuss their implications.

Key words: Policy Gaps, Health Determinants, Neoliberalism, Health Inequalities, Working Class Discourses

Introduction

There is research consensus that health is socially and politically determined (e.g. Black, 1980; Marmot et al., 2008). Based largely on epidemiological data, this consensus is supported by qualitative research exploring pathways linking social phenomena at different levels (e.g., Roberts, 2009, Peacock et al, 2014). Across many countries, however, a gap is evident between this consensus and policy ostensibly designed to reduce health inequalities. Here, behaviourally

orientated emphases dominate. Social, and particularly political, emphases are few and subject to 'lifestyle drift' in implementation.

But how do social and political determinants *connect* to health outcomes in real lives? Recently, Peacock and colleagues (2014) highlighted the importance of understanding the processes involved. Here, we report findings from a qualitative study of two different Scottish working-class communities which explores how health outcomes emerge from the experience of macro-level determinants impacting in their lives in recent decades.

To contextualise the study we discuss two threads within the health inequalities literature: first we consider research exploring discourses on health's social determinants; second, we explore work that considers these determinants in relation to the specific challenge of 'excess mortality' in Scotland. These literatures point to the need to connect the political dynamic of neoliberalism (as ideology and institutional policy and practices) with health outcomes, and emphasise the need for qualitative investigation in places where health has been compromised.

Causes and Pathways: Discourses of the Social Determinants of Health and Neoliberalism

A growing body of research has examined discourses of health determination within policy networks. Raphael (2011) identified a hierarchy of seven such discourses. These "differ greatly in their explication ... and in their implications for action" (Raphael, 2011, p. 221). At discourse level 1, the social determinants of health are simply a means of identifying and treating at-risk individuals. At level 2, the need for health services to focus on modifiable risk factors is recognised. That life circumstances actively shape health is recognised at level 3. At level 4, life circumstances are seen to be patterned by group membership (e.g., by class or gender). This is more sophisticated than preceding levels, but rests with mitigating impacts of health-compromising circumstances. Level 5 sees that the social determinants and their distribution are the results of policy decisions, and

modifiable by policy action. The final levels view policy decisions as shaped by economic and political structures (level 6), and influenced by those benefitting from decisions causing inequalities (level 7). Here, the perspective connects with Coburn (2000, 2004) who has argued for a critical appreciation of the wider dynamics of neoliberalism as a political project. In this formulation, other 'causes'—lifestyles, cultural practices, psychosocial mechanisms, even income inequality—require explanation reflecting such an appreciation.

To inform such explanation, we need to briefly say something about the dynamics of neoliberalism. Neoliberalism came to prominence from the early 1970s as a political project committed to returning the division of the proceeds of wealth creation between classes to a pattern more characteristic of the previous century (Harvey, 2011). It has proved 'a tenacious animal', flexible across time and place – thus giving rise to 'actually existing neoliberalisms' (Boyle et al, 2008, p.322). In general, these neoliberalisms embrace inequality, refuting the concept of social justice, or equating justice with market deregulation and 'individual responsibility'. They reject ideas of solidarity—at times the idea of 'society' itself—and actively undermine social institutions based on such ideas (trade unions, social security, and public provision of services).

Hay and Farrell (2011), dealing with 'Thatcherism' (relevant in our context) as a particular form of neoliberalism, present an account – also arguably relevant more widely, and in Britain beyond Thatcher – of political and economic forces 'cascading' into and through inter-connected policy domains. Relatedly, Clarke (2007, p.974), characterising neo-liberalism as 'a potent term for denoting widespread change – economic, geographical, political and social', highlights the 'anti-social' tendencies evident in both its *raison d'être* and its *modus operandi*. These tendencies, he argues involve the 'subordination of the social' (p.975) including the subjugation of social welfare to global economic and labour market policies.

These are underlying dynamics of neo-liberalism that need to prefigure an understanding of the social determinants of health. The associations between those dynamics and health inequalities are clear, well known, and causal. They have been witnessed around the world in a variety of countries in a consistent and well-characterized pattern (Beckfield and Krieger 2009). Yet, Raphael highlights how researchers and practitioners have been “reluctant to identify the public policy implications of the SDH [social determinants of health] concept”, particularly where implications have conflicted “with current governmental approaches that reflect welfare state retrenchment” (Raphael, 2011, p.222). This has produced undue emphasis on ‘lifestyle choices’ and behaviour change to the detriment of “the political and ideological sources of the inequitable distribution of SDH” (Raphael, 2011, p.222; Raphael et al., 2014). Yet, as Leggett argues in his cogent unpicking of ‘nudge’ approaches (where citizens are prompted to make ‘the right’ choices across policy domains in terms of their individual behaviours), behaviour change policies must be understood within their political context.

Raphael’s findings chime with the UK context. Notwithstanding the research consensus around health as socially and politically created, and some echoing of this in policy *rhetoric*, Smith and colleagues (2009) found that health policy has focused increasingly on behaviours. Two examples of policy analysis are worth highlighting. First, Stevens’ (2011) rich ethnography of policymakers’ action and talk in sifting health inequalities research so that it might be digested by politicians finds practices not only of simplification but of ideologically informed selection. Thus ‘social inequality’ was “ ‘silently silenced’ in favour of promoting policies which were ‘totemically’ tough” (p.237). Second, Smith’s (2013) discursive institutional study drawing on policy makers and researchers reflections on the journeys of health inequalities relevant research into policy finds that, with the exception of a particular Early Years intervention, research evidence about the structural determinants of health inequalities makes largely ‘partial’, ‘recontextualised’ and ‘fragmented’ inroads to the development of policy solutions. Similarly, Katikireddi and colleagues (2014) highlight

that when wider determinants appear in policy, they are subject to 'lifestyle drift' in implementation. More recently, Mackenzie and colleagues (forthcoming) examined how individuals working in policy, planning and practice capacities in Scotland conceptualise the impact of different health inequalities interventions. Participants generally recognised how social disadvantage functioned in determining health, but were less likely to focus on politics and power.

If the social determinants discourse of those in policy and practice is limited, what of the discourses of people whose lives are often problematized by policy? How do they experience the social determination of health?

MacIntyre and colleagues (2005) indicated that people from disadvantaged social groups were less likely than their affluent counterparts to recognise social and structural determinants of health. Popay and colleagues (2003a, 2003b), however, found that such respondents presented a contradictory picture – denying the role of social background in determining health in interviews, while recognising it in self-completion surveys. One proffered explanation for the difference was unwillingness in interviews to take on the role of the 'disadvantaged' (thus stigmatised) participant. Subsequent research by Davidson and colleagues (2006, 2008), using focus groups, found that people from disadvantaged backgrounds demonstrated "lay awareness of social hierarchies and the impact of socio-economic factors on health". They also found evidence of the perceived importance of psycho social mechanisms of shame and social comparison (Davidson et al, 2006, p.2180). They concluded that people in more favourable circumstances, however, were found more likely to attribute health inequalities to lifestyle choices.

Most recently, Peacock and colleagues (2014), in a study of women in Salford (England), also found evidence for the role of psycho-social mechanisms in generating health. But, unexpectedly, participants had internalised 'anti-social' (as per Clarke, 2007) neoliberal discourses leading to the

construction of 'individuated' and 'responsibilised' selves, and the fostering of divisive 'othering'. Such discourses resulted from the erosion of protective material and discursive resources, leaving participants more vulnerable to isolating ideological precepts. Consequently, Peacock et al, with Coburn (2000, 2004), argue for perspectives on health informed by an appreciation of the wider dynamic of neoliberalism as experienced within the 'inner worlds of individuals' (Peacock, et al., 2014, p.175).

Scotland – excess mortality and a synthesis of the Social Determinants of Health

Turning to the second literature, we argue that Scotland provides an interesting context to consider health determinants and mechanisms. Despite having comparatively good health until around 1950, Scotland has improved more slowly and now has the worst mortality outcomes, and the widest health inequalities, in Western Europe (McCartney et al., 2012). Mortality outcomes are worse than would be predicted based on deprivation – with 'excess mortality' (EM) (after accounting for age, sex and deprivation) when compared to the rest of Britain increasing substantially between 1981 and 2001 (McCartney et al, 2011). Scotland's largest city, Glasgow, has been found since the 1970s to have developed a premature mortality rate 30% higher than the equally deprived cities of Liverpool and Manchester (Walsh et al., 2010). This period saw Scottish mortality diverge rapidly from that of Western Europe more generally, with premature mortality rates in deprived areas increasing (Norman et al., 2011), and particular causes of death, (drug- and alcohol-related deaths, suicide and violence), becoming more common (Whyte and Ajetunmobi, 2012).

There have been many hypotheses proposed for Scottish EM, ranging across the spectrum of Raphael's identified discourses. McCartney and colleagues (2011) proposed a 'synthesis' which sought to understand the interaction between likely contributory causes. It proposed that a trigger for divergence was Scotland's particular experience of the post-1979 Conservative Government's UK-wide neoliberal 'political attack' on social democracy. This was an attack to which Scotland was particularly vulnerable, given its social, economic and political-cultural characteristics. Of all the

hypotheses, the “political attack hypothesis” (Collins and McCartney, 2011) seemed to highlight the most likely ‘trigger’ for the widening divergence (McCartney et al., 2012 p.466).

The “political attack hypothesis” reflects a view widely current amongst commentators and in Scottish society which has largely been ignored by researchers (Collins and McCartney, 2011). As yet, it has not been tested against the lived experience of communities likely to have been most adversely affected.

Bringing together these two literatures, this study aims to explore how people in two different, adversely impacted communities in Scotland talk about health: How have macro determinants of health been experienced? Through what pathways have they impacted? Are there variations in discursive understanding at a community level depending on different local experiences of the political dynamic of neo-liberalism?

Neoliberal Austerity and Health in Ayrshire: A Qualitative Study

Our project focused on two towns in West Central Scotland adversely affected across two periods of government-imposed austerity (legitimated by neo-liberal precepts), the 1980s and the period since the launch in 2010 of the UK Conservative-Liberal Democratic coalition’s austerity programme. We sought to ascertain, through semi-structured interviews, how the local experiences of austerity and other macro determinants had shaped lived experiences of health in two different but similarly deprived areas.

We purposefully selected areas in the same locality (Ayrshire), comparable in health and deprivation profiles but with different historic industrial profiles, thus, perhaps, leading to different local experiences of neoliberalism (beginning during the Thatcher years) including austerity, deindustrialisation, unemployment and ‘welfare reform’. Kilmarnock was, in the post-war period, a

private sector manufacturing town with a range of major employers, including BMK (carpets) and Johnny Walker (whisky bottling). The town suffered from the sharp deindustrialisation and unemployment arising from macro-economic policy after 1979. Cumnock, a smaller town, was dominated by the nationalised deep coal mining industry shut down by UK Conservative administrations in the years following the miners' strike of 1984-85. Mining communities experienced the full coercive power of the state during their attempt, as they saw it, to save their industry and their communities. Our assumption was that the more overt process of 'political attack' in Cumnock, where the process of 'subordinating the social' might have been more palpable, would lead to differences in the experience of the political dynamic of neoliberalism and in perceptions of its health-shaping role.

We attempted to recruit participants employed in the later 1970s in the typical industries of the towns who had since struggled to find stable employment. We contacted community organisations to identify participants. This was largely successful in Cumnock, but not in Kilmarnock, and recruitment there was ultimately secured through a community 'Facebook' page. This led to a more 'socially engaged' sample in Cumnock, and a more 'social media-engaged' sample in Kilmarnock. This difference was problematic for some of our intended purposes, but illuminating in others – as will be explained below. To broaden participation, initial participants were asked to help recruit partners and younger family members. This proved more fruitful in Kilmarnock than in Cumnock. Informed consent was obtained from all participants; in total, 20 people were interviewed. Participants have been categorised into two generations. Generation 1 participants were employed in the late 1970s and 1980s, generation 2 came to adulthood later (and, in Cumnock, were more difficult to recruit).

Table 1 below summarises participant details.

Table 1 - Generation and age profiles of participants by location

Location	Generation (1 or 2) and Gender (M/F)		Total participants
	G1	G2	G1/G2
Kilmarnock	5(F)	5(F); 2(M)	12
Cumnock	4(M); 3(F)	1(F)	8

Interviews were conducted in community venues or in participants' homes. Participants' received a shopping voucher worth £20. Most interviews were one-to-one, but for some, partners were also present because of participant preference or practicalities. Interviews were recorded and transcribed in full.

Data were analysed against themes derived from the social determinants and health inequalities literatures, including Raphael's framework. Three researchers read each transcript. Themes were discussed and discrepancies resolved. Interview data are reported using pseudonyms.

Findings

We report our findings in relation to three key themes derived from the literature. First, we describe how material circumstances are perceived to impact on health and discuss discourses of power and politics as determinants of health. Second, we set out participants' views on psycho-social mechanisms in creating/destroying health and show how these are connected in participants' discourses with the material and the political. Third, we tackle views on lifestyles, discuss the concept of 'othering' invoked in other studies and present findings indicating that, whilst some participants do distinguish themselves from a stigmatised 'other' group, most discuss witnessing the processes of 'othering'. Where relevant we draw out differences between responses in the two areas to reflect on how far the differences in the specific exposure to the political dynamic of neoliberalism led to different understandings of the processes through which health is determined.

1. Material drivers of ill health - politics writ large

Participants' discourse demonstrates strong alignment with Raphael's highest level discourses (levels 6 and 7). For both periods of austerity, in both places and reported by younger and older participants, material circumstances were described as having direct health effects. Regarding current austerity, material deficits were also *demonstrated* – in Cumnock, interviews with John and Cathy were held simultaneously in their only heated room; Nancy in Kilmarnock opened her cupboard showing it was almost bare:

'the only things my mum told me when I got married was ... "always make sure there was tins of meat in the cupboard, so if you run short you've got something to fall back on", which I always did... right up until recently ...[but now] you cannae afford to eat healthy'.

The 'good times' (prior to the 1980s) were by and large past. Although not presented romantically, they were signified in Cumnock by the pride of doing a hard job well and of knowing relative stability. In Kilmarnock they were represented by 'abundant' employment; as Claire said, *'if you didnae like a job one day, you could walk intae a job the next day'*.

Since the 1980s, participants had witnessed hardship. Dan said that in Cumnock in the early 1980s, there was recognition that *'the wolves were coming to the door'*. More recently, food banks and unaffordable heating were a common signifiers of health compromising poverty. Janice in Kilmarnock said, *'there's people in this street that have gotta choose between ... eating or getting a wee bit heat'*.

So, there was no shortage of discourse about how life circumstances shape health (Raphael's level 3 discourse), but what determines such circumstances? Although with different levels of sophistication, almost all participants told of austerity and labour markets shaped to benefit the affluent. 'Neoliberal political attack' was rendered almost viscerally in some accounts; Marion said, *'I think they're trying to kill folk aff'*.

Here we present two sustained accounts from Cumnock, where such analysis was most developed.

In box 1, Alex, an ex-miner, speaks of the Thatcher government's attack on the miners and of the roots of current austerity. He is well aware of what Clarke and Newman refers to as 'the alchemy of austerity' (2012), where the discrepancies between the actual causes and enacted solutions of economic crisis are 'magicked' into an uneasy but powerful neo-liberal narrative.

Box 1: Alex

Alex: It was planned. We got a sense in probably '81 or '82 prior to the miners' strike of what was coming, and there was a sorta lightning reaction and the pits all walked out But Thatcher backed down at that time because she wasn't ready, ... looking back you can see the preparation got made. And they backed the union into a corner ... But it was all planned, they wanted to take the mining union ... and communities on.

Interviewer: **What was people's kinda sense of the reasoning for that?**

Alex: Well... at that time I thought it was to diminish the power of the unions and fragment communities ...

Interviewer: **And the cause of current austerity?**

Alex: You saw the sudden influx of banks going bust, liquid assets going, dispersing all over the place. And, I think it was probably the Blair government that encouraged it. They'd built up the financial services to such a strength that it outweighed manufacturing, it outweighed any other service in the UK. But they were the kings and everybody else was the minions. ... financial services I would say were the main cause of what has happened, the greed. And what gets up our noses is that we still see bankers bonuses being paid, we still see the very rich getting tax breaks and we're looking at people living in our community getting hit w' sixteen pound a week [benefit reductions]... there's no a God, at this moment in time.

The second account comes from John, again an ex-miner, and in poor health. He recounts how, after the 1984-85 strike, he took on very low-paid security work preventing other local people taking coal scraps from National Coal Board land to heat their homes. He tells (box 2) how he was literally valued lower than a security dog and how he felt in relation to his community and about himself.

Box 2: John

I was ... going and standing on top o' a coal bing to stop neighbours of mine heating their hoose. ... So there, I went full circle ... I'm even against my ain neighbours, noo. And just before the minimum wage came in, ... it came in to roughly, was it four pound or something? It was quite high, it wasn't too bad when it come in – and the week before it come in, my highest wage, and I was a supervisor, noo, in security – a supervisor – my highest wage was two pound an hoor, (small laugh). And the bad thing about it, –but I didn't know at the time, like ... I was up on top of the coal bing – it's a cold place, sat on top o' a coal bing, I can assure you – and one of the bosses fae the coal company came up in his Land Rover and he stopped beside me. ... He said, "many coal thieves on?" I says, "no, it's kinda quiet." And the rain was steadily hammering down at the side ae my face, and he says, "do you know something?" he says, "it's bloody terrible," he says. The [security] dogs is making mair money than what you are'.

[And discussing current experiences] Nearly every day I'm picking this paper up, I'm reading about the life expectancy wae me and [compared to] maybe staying doon in London ...They're absolutely kicking you every way they can, like. And if you're in a poor area, you'll always be in a poor area. Naebody's gonna try and help you oot it, but if you're in an affluent area, to hell wae the rest.... They'd like to have an exclusion zone roon some of these places ... I've heated their bums wae coal ... we've served wur cause. If they could dae away wae you noo, they would dae away wae you, because you're a drain on society. They want me, noo, to work til I'm sixty-seven. I've no chance of working to I'm sixty-seven. I'll no' see sixty-seven.

In Kilmarnock, with its different economic base and experience of austerity, the analysis of the causes of poor life circumstances was less that of a targeted attack on a particular group of workers (although they recognised this to have been true in neighbouring mining communities); instead the focus was on policy shaped by minority economic interests.

Alison provided a sketch of the failure of inward investment policies in Scotland:

'The government brought a lot of firms up into Scotland, I think, with lots of promises – 'you won't have to pay this, you won't have to pay that', you know? And then, when everything went belly-up, all the firms pulled out because they were either American-based or European-based, and the promises ran out and they went, "oh well, that's it, we're going."'

The sense that decline was politically driven, rather than an inevitable trajectory, is stated by Rose:

'she [Thatcher] allowed a' the work to go abroad. And oor factories in Kilmarnock... we had a great town, and it just finished. Factory after factory, well-known brands... employers went. They all went wi' a feeling o' sorrow but it didnae help the workers'.

For Sharon, corporations used 'globalisation' to find a less confident workforce:

'People were starting to speak oot a wee bit more and say 'no, that's no' right.'" ... People realised their ability to say "I might work here but I'm a person and I've got rights." And again, the big employers I think thought "well, we can make carpets cheaper wherever," so...'

Meanwhile, Louise recognises that disempowerment of workers through unemployment was government policy.

'The policies of the government and the way they... well, I don't know the technical terms for these things, so bear with me. What I can say is I remember George King [pseudonym] who was oor boss in Jaegers [clothing company], this is where it started coming in that we were told to, like as a company, as a group of people, of workers, we were told that we would... it was for pay rises, like, take it or leave it, and he would quite literally roar at us that, "if you don't want tae then there are hundreds o' folk oot there". That's when it came into play that you don't have a leg to stand on and fae then on I

would be inclined to say it's got worse... the government has given the employer the right to hire like and sack... it was a Thatcher thing'.

Ideas about governments serving powerful elites and taking action damaging to the poor were shared across the study participants with only two partial exceptions. Claire from Kilmarnock describes how in the 1980s she, a young, working-class woman, was oblivious to local hardship because personally unaffected. She grew to recognise the impacts of austerity, but, at the time, she *'had blinkers on. I wasnae aware'*. Anne, working in a professional role, appreciated that investment decisions were often 'unsentimental', but this was less 'understandable' when it affected her own family. These somewhat more individualistic perspectives were absent from other responses.

Psycho-social mechanisms – individual stress and the protective 'skin' of community.

We know from the literature that potentially overlapping psycho-social mechanisms through which health is created include: depression resulting from loss of role and control; mental stress from the efforts of coping; and the impacts of social comparison (both stigmatisation and low self-esteem). All occur at individual and community levels.

Within our sample, turning first to individual health, interviewees spoke of mental ill-health and low self-esteem resulting from unemployment. Rose talks of her father who *'felt absolutely worthless [after] being made redundant'*; and after Janice's husband became unemployed *'he became really depressed and he was on sleeping tablets for a long time'*. Mary, wife of a miner, speaks of gendered roles and of how men lost their identity when the pits closed:

'A man no' working was a bad thing in those days, it was the men that kept the women and their families afloat. **Interviewer: Although a lot of women here would've worked as well?** Mary: that's right, but the men got depressed because that was their job tae [provide] for their family.'

For Louise, unemployment in Kilmarnock brought a new vocabulary: *'it brought a lot of depression, ... an everyday used word, which I'd never really kinda heard of before'*. In these accounts mental health problems are linked to political and policy decisions via unemployment and loss of job role..

For the younger generation lacking opportunities, self-esteem is hard to sustain. Alex describes his son's job-seeking:

'I've watched my son who is now twenty-two... I've watched him over a period of time having to go onto websites, having to apply for jobs, no' getting any word back, no' even getting notified whether he's getting an interview, or whether he's successful, or unsuccessful. You just watch the ... sorta esteem just drain out them.'

When discussing heavy manual labour in dangerous settings, work was simultaneously seen as health giving and damaging. John says that, when he was a miner, he was *'fit as a butcher's dog – I'd muscles on top o' muscles'*, whilst Tommy comments, *'they say hard work never killed naebody. I say different, because the heavy lifting in the pit done it tae me.'* Having said this, Tommy's next statement may seem paradoxical:

'That's the cause o' it [his ill-health], aye – the lack o' work. See if I'd been working? I'd never have any bother because you were that used tae working and it kept you fit. So if you're no' working, what are you daein?. Your system's shutting doon. And that's what's wrong wi' all these men round about here. Their systems are shutting down'.

However, this paradox is clarified by Rose, suggesting that work is health-protecting, masking or inhibiting illness. Symptoms are unmasked by redundancy:

'I don't know whether it was people kind o' lost hope, in a way. No' lost hope but... "Oh, God, this is an awful life". And where they carried on regardless before, all of a sudden began tae feel their aches and pains'.

Similar psycho-social processes were identified at community level. Prior to 1980s, both communities seem to have provided the kind of 'skin' described by Walkerdine (2010), preventing fragmentation and maintaining identity. As Marion, a middle-aged woman from Cumnock describes, community provided psychological and material support:

'everybody kinda looked out for each other. If somebody was short [of money], like the neighbours next door, there was a, still a long running joke, the floating fiver [£5 note] because this fiver, you dinnae ken who it belonged to it, it just went between the two hooes ... There was mair a kinda sense o' community. ...There's no' the same kinda feeling noo, doors are shut '.

This type of discourse of community, distinguishing between a better 'then' and a bleaker 'now' is well recognised and rightly critiqued in the literature when it diminishes problematic aspects of 'traditional' working-class communities (Walkerdine and Jimenez, 2012). Nonetheless, our participants rooted the post-1979 disruption to employment in deliberate government efforts to break community cohesion. The attack on the miners' and the deep divisions it hewed was viewed in Cumnock as signalling loss; John said:

'A' that [community] fell away. That was the past. There were nae mair solidarity. Noo, it was us and them.'"

The strike was later given as a cause for mental ill health by his doctor:

'... the doctor said, "you'll probably need tae go and see a psychiatrist," he says, "the pit strike has broken you. A lot of miners go through the same thing"'.

In Kilmarnock, employment and austerity was less targeted and more cumulative, but the 2012 closure and subsequent demolition of the Johnnie Walker whisky bottling plant (present in the town since the mid-19th Century) had a deep symbolic impact, as Nancy describes:

'that's a hard hit to the town ... I think it's done something to the morale in the town. Ken, just no' having it there because that was our kinda claim to fame. it's drastically affected it [the community], just even the actually, physicality of the building coming doon affected ... you know, you'd hear people on the bus, ...you'd hear them a' talk "oh look", ... just actually seeing the building away was just devastating for some people ... the town's just in a kinda low ebb altogether'.

In summary, psycho-social mechanisms were powerfully present in accounts of how health is damaged but were always connected back to fundamental generative causes, bound up with the dynamic of neo-liberalism as a political force.

Health behaviours and practices

The causal pathway to poor health and health inequalities least supported by research, but, nonetheless, the focus of much policy and practice, involves certain cultural practices and individual behaviours. Below, we describe how our participants talk about lifestyles; we end by discussing 'othering'.

We were careful to avoid stigmatising individuals. We asked about behaviours saying that we all do stuff we know is unhealthy. Responses were mixed: some didn't exercise, and ate, drank or smoked

'more than they should'; some did the opposite. All were aware of the negative connotations (and physical impacts) of certain behaviours and generally laughed about 'trying to be good'.

A few spoke of behaviours and negatively valued cultural practices (such as 'poor' parenting or work ethic) as responsible for poor health. Anne said:

'its parenting and their work ethic. It's something that's put into you, you know, we were never allowed to be off sick from school. ... there was a discipline that I certainly use at home'.

Claire also blames poor parenting for problems across generations:

'It's how you're brought up and it's how in turn you bring your children up, and that is the bottom line in my mind ... they've went oot and they've maybe had babies at 15, 16 –... They've nae life experience or working, hence the reason why there's a multitude o' young yins a' say" if ye get pregnant, you can get a hoose"'. .

Somewhat in contradiction, however, she says that '*the poor are only poor because the government have made them poor*'. This concurs with the work of Peacock and colleagues (2014), where moralistic assessments of individual 'failings' were seldom rendered unproblematically.

However, more commonly, stories about lifestyle behaviours and health asserted prior causes. Two ex-miners exemplify this. First, Dan speaks of his brothers:

'Brian, was only what? two year [unemployed] [when] his wife left him. All those [unemployed miners] did was drink and gamble. They'd nae work, nothing else to dae in the morning, got up, go to the pub, come back hame, go to the pub. It ruined ma brother's life. His wife left James's wife left him and a lot of guys in this area, a' their wives, ... all the women were seeing was a drunk man coming in. ... An awfy lot of men seemed to just go off the rails'.

Second, Alex provides a broader account of how unemployment links to problematic behaviours:

'about a year later you started to see things dwindling. You seen the disjointed community because what was happening, the younger people werenae having places to go and work, and probably about two, three year after the Barony [local deep coalmine] shut ... the textile industry was going belly-up at the same time. So where, where people maybe got redundancy fae the deep mining, their wives were still working in the factories. It was like a double-whammy for us because it was only probably two years at the very maist when the textile industry went belly-up and a lot of people started losing their job in the factories. The factories started slimmin doon, cutting workforces. The ability for young people to get into work was becoming limited. We started to see probably drugs in our community for the first time. And probably the excessive drinking was starting to take a hold as well ...

later in the interview he says: if you're working and in a steady environment you have a much more controlled life. ... Where you don't have that central plan where you're working you tend to do chaotic things and probably self-harm although you don't even know it yourself. And do things that affect your health, maybe no' at that particular time but in the longer time it affects your health'.

Already implicit in the talk of Anne and Claire above is ‘othering’ – separating out a group of people whose behaviours or circumstances or outcomes can be attributed to their own (lack of) agency and ‘resilience’. Othering has been widely theorised (Johnson et al., 2004; Thomson and Kumar, 2011) as protecting the identities of the ‘us’ at the expense of ‘them’. Here Claire makes classic distinctions between deserving and undeserving based on ‘working’ the benefits system; in this context ‘welfare reform’ is a legitimate means of penalising fraud:

‘what’s happened, as the years have went on, the government have made it too easy for them? Now, I’m on benefits but I worked aw ma days, right? But what I feel is, these folk, they know how tae work the system. And the government have made it so easy for them, giving them this, giving them that and aw the rest ae it – day in, day oot.’

Anne’s narrative is different: asked about whether ‘we’re all in it together’ (David Cameron’s refrain about spreading the burden of austerity), she distances herself from those who are faring badly:

‘No. I don’t think we’re in it together. ... I don’t think I’m a snob but at the same time I’ve got my own family to protect, and I’ve got my own work ethic, my own ambition, and I don’t think I—I don’t think I’ve got the time, or probably not the notion, to be in something wi’ people that don’t have that, and don’t want to do that either. It’s not just the fact there’s no opportunity they won’t take up the opportunity that’s offered to them’

This reflects what we see from other studies and much media. In our study, however, a number of participants expressed an understanding of ‘othering’ as a fragmenting device deployed in communities but also by government (rhetorically and through specific policies) and other powerful interests. John, an ex-miner, articulates that his community *is* the stigmatised other:

‘We’re going way back to the Victorian times here, like. ...They think if you’re in poverty, it’s through your own making, and if you’re in bad health, like myself, it’s through my own making. I’ve probably drunk all my days and, I’ve took drugs and I’ve partied to the early hours of the morning and it’s all self-inflicted. That’s how a lot of people will look at it, and the way the government’s at it just now, anybody that’s on benefits – there’s got to be some reason why they’re on benefits’.

Sharon, a younger woman from Kilmarnock reflected on how tough times created fragmented discourses leading to internal divisions:

‘That’s when your kinda layabout thing came into it, “oh, he’s never worked a day in his life,”. There wasnae much thought given tae maybe he’s, cannae work because there’s nae work... I think there was a kinda separation, looking back on it, where people became, “no, he’s such-and-such, and he’s lazy, ... so I think there was more a divide ...I think people became more envious o’ what other people had’.

That 'othering' is not only analysed but actively critiqued by some of our participants is best conveyed by Marion from Cumnock. Below she describes the use of the phenomenon:

'They are using the media, ... tae bombard folk wi' this image and the good old 'divide and conquer'. 'Cause you can see the divide and conquer all around you. You just need tae fire on Jeremy [Jeremy Kyle – the reality TV programme that specialises in televising turbulent lives] at half nine every morning... I think that's Tory sponsored TV to be quite honest wi' you. ... it's like stigmatising full groups at a time. It comes in waves. I mean, the immigrants'll be due a shot ... it's a' their fault. It's like they're trying to deliberately create this, "everybody that's on incapacity's a scrounger"'.

In summary, discourses around lifestyles indicate knowledge of the association between behaviours or cultural practices and health; and a minority see these as 'fundamental' causes. For the majority, however, lifestyle and poor health were aspects of longer causal pathways emerging from politics. Likewise, whilst, some participants' discourse involved 'othering', many others presented both a thoughtful understanding, and some a clear critical assessment, of the process.

Discussion

Our study aimed to understand how health outcomes emerge from macro-level processes impacting on particular communities where they are experienced by both groups and individuals. The study has strengths and weaknesses. It generated rich data, sourced across different places and generations, and from both women and men. It is one of the few studies focused on Scottish 'excess mortality' which has used a qualitative approach, and it is the only one we know seeking directly to understand determinants and mechanisms by exploring the lived experience of working-class communities. The data, however, arise from a relatively small sample that is uneven in parts and from which we did not actively seek views as to policy solutions (though these are implicit in responses). That the sampling method was different in each location is partly a weakness, but also has utility.

To elaborate, our hypothesis was that with a similar sampling strategy in each community we would find different lived experiences – with Cumnock's more visceral experience of the active destruction

of mining anticipated to generate a stronger discourse around the role of politics in determining health. Our strategy in Cumnock generated a 'socially engaged' sample; but our modified method in Kilmarnock produced a more 'social media-engaged' group. Our expectation was that differences between the samples would render the responses incomparable. But, instead, the data were highly comparable, mutually aware, and the differences were interpretable as reflecting the same fundamental process of politically driven change impacting in two distinct contexts. Thus, the modification to our sampling revealed the extent to which, both across different industrial communities, and between more and less 'socially engaged' samples, there was a highly developed perspective on the generative processes of health and health inequalities which was almost always anchored around fundamental causes, and more specifically, anchored to the political dynamic of neoliberalism. This perspective placed participants in the upper reaches of Raphael's typology of discourses – not just beyond individual behaviours and group cultures, or beyond 'material circumstances', but also, with Coburn (2004), 'beyond the income inequality hypothesis'. Participants, moreover, in line with Coburn's thinking, generally demonstrated a shared perspective on the role of intermediate causes or intervening mechanisms – as connected to the more fundamental causes highlighted above.

There are notable contrasts between our findings and other findings on 'lay' perspectives on health generation discussed earlier. Firstly, like the research of Davidson and colleagues (2006, 2008) ours found compelling evidence of lay awareness of wider social inequalities in determining health and health inequalities. This is in contrast to the work of MacIntyre et al (2005). However, while the evidence reported by Davidson and colleagues would place their disadvantaged respondents around the mid-range of Raphael's continuum of discourses, our respondents much more clearly position themselves at the top end of the continuum. One explanation for the discrepancy echoes observations by Popay et al (2003a) and Davidson et al (2006, 2008) that different methods and 'framings' have different meanings for research participants that can lead to conflicting findings. In this light it is probable that our study both through its focus on place and particularly through its

foregrounding of experiences of macro level factors, gave participants ‘permission’ to voice their understanding of the fundamental causes of the social determinants of health and the pathways through which they operate. A second, contrast is with more recent findings from northern England (Peacock et al., 2014; Schildrick and MacDonald, 2014). In the latter studies, researchers found more consistent evidence of ‘othering’ and, in one context, evidence of the ‘internalisation’ of the kinds of ‘anti-social’ aspects of neo-liberal discourse which delegitimated reliance on others (Peacock et al., 2014). These findings pointed to the success of ideological strategies which divert attention from the fundamental causes of social ills.

In our research, we found less evidence for the success of these strategies. This may reflect the somewhat different ideological terrain in contemporary Scotland as compared to other parts of the UK – which was in evidence in the debates around the 2014 Independence Referendum. And all of this might be understood, we argue, as the legacy of the cultural response to ‘Thatcherism’ in Scotland –also highlighted in the ‘political attack hypothesis’ (Collins and McCartney, 2011). A negative response to ‘Thatcherism’ was evident in many parts of the UK. However, in Scotland, the refraction of that through the prism of national identity, to generate ideas of a ‘democratic deficit’, seems, in our sample, to have provided a greater (though by no means impervious) resilience against the invasion of ‘the inner worlds of individuals’ by neoliberal ideological constructs. However, what is less clear is the role, if any, that continuing resilience to neo-liberal discourses plays in making communities less vulnerable to the health-damaging impacts of such economic, political and social forces. Does ‘disaffected consent’ to the reality of austerity (Gilbert cited in Clarke and Newman , 2012: 315) or accepting the mantle of the ‘responsibilised’ self (Peacock, 2014) lead to worse health outcomes than resistance to such discourses, either at an individual or community level? This requires further investigation.

The aforementioned ideological difference between Scotland and many other parts of the UK should not be exaggerated, but it seems nonetheless real. Its implications might be considered as akin to

those deduced by Lamont (2001) in her comparison of working-class men in the US and France, with the latter proving more resilient to neoliberal ideological constructs due to their more sophisticated understanding of class. The difference is also, we believe, in conjunction with Scotland's health outcomes, an aspect of what makes the Scottish context important for wider research purposes. The circumstances of contemporary Scotland seem to provide, at least to these communities but, we suspect, to others too, both a powerful reason to speak about health, and broadly available discursive means for expressing in integrated and intelligent ways the experiences of the pertinent, generative processes.

As they speak, we argue, our participants are able not only to make *themselves* understood, but also to help us to understand rather more about the determination of health and its inequalities – and, perhaps in particular, about intervening mechanisms. They too, like Coburn and Peacock and her colleagues, take us 'beyond the income inequality hypothesis' to engage with the political dynamic of neoliberalism. And, we argue, their contributions might play a role in helping to 'close the gap' between the prevailing research consensus and the domain of policy and practice; firstly, because the convergence in fundamental thinking between their contributions and the research consensus around social and political *causes* problematizes the prevailing policy and practice approach to health education; secondly, because our participants' contributions seem articulate in relation to the continuing debate as to the nature the *mechanisms* at work in connecting causal determinants to health outcomes. The continuing disagreement on the latter aspect of health determination is surely an impediment to bringing the domain of policy and practice closer to the substantive truths established by research, and it is one which the well-funded advocates of neoliberalism do not fail to highlight (Snowdon, 2014).

Conclusion and Future Research

Raphael's (2011) recommendation for 'closing the gap' involves "educating the public" to raise understanding towards the upper levels of his continuum of discourses. We do not demur.

Ultimately, however, the conclusion from the research conducted with our participants – few of whom would claim to be 'highly educated' and many of whom have lived through terribly difficult times and continue to do so – is that within these communities a significant proportion of people *are already there*. And not only do many policy makers and practitioners have something to learn from them, so too does a significant section of the research community – ourselves included.

Finally, our findings indicate a number of routes future research might take. Here we mention only two. First, the difference between our own and other research findings suggests the need for further comparative research in working-class communities in different/diverging political and policy contexts, not least to explore how far political resilience to neoliberal ideological constructs at individual and community level might affect health outcomes. Second, our findings suggest that investigating the role of community voices in generating politically and structurally aware resilience is warranted, as is exploring further their contribution towards creating conditions for public health policy and practice acting on fundamental causes of health inequalities. In this respect we advocate developing health education towards including communities *as educators of policy-makers*.

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