



THE COALFIELDS RESEARCH PROGRAMME:

DISCUSSION PAPER NO. 7

HEALTH ISSUES IN THE COAL DISTRICTS

HUW BEYNON, EMMA HOLLYWOOD

AND RAY HUDSON

Cardiff University is the public name of the University of Wales, Cardiff, a constituent institution of the University of Wales

Prifysgol Caerdydd yw enw cyhoeddus Prifysgol Cymru, Caerdydd, un o sefydliadau cyfansoddol Prifysgol Cymru.

Acknowledgement

This Research Programme is currently funded by the ESRC (Project Number R000236776- Social exclusion or flexible adaptation coal districts in a period of economic transformation) and the Joseph Rowntree Foundation (Project Number 150233 – Rural Areas Learning from the Coalfields? Economic Regeneration, Social Exclusion and Integration)

1999

1. Introduction

The aim of this paper is to examine the issue of health in the four districts of Cynon Valley, Easington, Mansfield and St. Helensⁱ. Health is not traditionally seen as part of the regeneration process, however, in the course of the research it became clear that levels of poor health were a major concern to those involved in the regeneration of the coalfields. Consequently, this paper will address the issue of poor health in the districts and examine the attempts to improve the situation.

In order to fully examine the issue of health this paper is divided into two main sections. Section one examines the levels of ill-health and prevalent illness of health of those living in the districts both before and after closure. The second section examines the practicalities of improving health by focusing on some of the difficulties in improving health and then proceeds by looking at the relationship between regeneration and health and the role of funding and partnership working in health.

2. A picture of health in the coal districts?

Mining communities have long had an historical association with ill health, and it will be argued here that it is one that continues even after the pits have closed. This section aims to outline some of the health issues affecting the coal districts; a first section focuses on the relationship between miners with ill-health; a second section examines the present state of health in the districts and discusses the effect of pit closures on the health of mining communities, in particular the impact of unemployment on ill-health.

The health of individuals living in particular areas is very much linked to the economic health of an area. It is well known that in areas of low unemployment and high wages levels of health are much better than in more deprived areas. In terms of geography, the health of individuals in Britain tends to be worse in the north than in the south, and in urban areas compared to rural areas. Health is also known to be affected by social class, occupation, housing, education, ethnicity and unemployment. Nationally death rates are higher in social classes IV and V as are incidences of sickness and ill health (Black Report). A large body of work exists on the link between socio-economic group and ill health (see for example the Black Report) however the link between health and place has received less attention. Other factors found to have an influence on health include housing tenure, number of rooms, central heating, access to a car and unemployment. In general the unemployed tend to have much poorer health than those in work, and those areas of the country with high levels of unemployment have worse health records than areas of low unemployment (Black Report, 1992).

One aim of this section is to describe how coal districts fit into this pattern. As will be shown, it is difficult to determine exactly 'where' coal districts fit into an overall geography of health in Britain as different indicators place the districts at different levels in any national 'league table of health'. Although it might be difficult to precisely 'place' the coal districts in relation to the rest of the country in terms of health, this paper will aim to show that ill health is certainly an issue in the coalfields

and that the legacy of the mining industry presents particular issues in relation to health.

2.1 Miners and ill health

The association of the mining industry with particular diseases is well documented. For example it is well known that miners suffer disproportionately from illnesses such as Silicosis and pneumoconiosis. Despite this, it is only recently that the government has accepted the link; a Department of Trade and Industry Press Release (23rd January 1998) confirmed that

British Coal's conduct of its mining operations has resulted in many miners suffering from lung disease having their conditions made worse by coal mining dust. The Government has accepted this, following the judgement given today in eight lead cases brought by former employees of British Coal, claiming compensation for various respiratory diseases

Health has always been an issue in the coalfields and accidents and ill-health have long been associated with the mining industry:

Coal dust at the face should also be mentioned, for although it does not immediately affect the work of the experienced collier, it has devastating effects along with stone dust on the long-term health and fitness of miners...The incidence of ill-health and death from pneumoconiosis is of terrible proportions. (Dennis et al, 1956)

Hart (1975, 184) outlines the poor health in the Welsh Valleys:

There has probably been a greater burden of ill-health and premature death in the South Wales Valleys than anywhere else in England and Wales.

John Pilger (1992,10) gives a particularly graphic description of the kinds of health problems afflicting miners (in 1974):

He made a sound, which would reach a terrible crescendo later, in the pithead baths. It was a heaving from deep in the throat, followed by a stuttering wheeze and, finally, a hacking that went on for a minute or for a night, until the black phlegm was brought up. It is called the 'dust' or pneumoconiosis.

The OPCS (ONS) survey of occupational health gives a useful indication of the diseases affecting miners and their state of health in relation to the rest of the working population. Using a number of measures such as SMR (standard mortality rate) and PMR (proportional mortality rate) it outlines the particular diseases affecting miners in the period 1981-1989. The main causes of death among miners is outlined below in Table 1. The study found that when compared to other occupations miners had much higher incidences of pneumoconiosis (see Table 1) and miners were also found to have excess mortality from chronic and unspecified myocarditis. The PMR illustrates the number of miners dying from a particular disease compared to the rest of the population. Other major causes of death were from accidents, also high a incidence of tuberculosis

Table 1: Main causes of death amongst coal miners

Disease	Other Coal miner PMR	Face trained coalminer
Pneumoconiosis	770	3771
Silicosis	179	695
Pulmonary Fibrosis	143	Not listed
Chronic bronchitis and Emphysema	142	156
Acute bronchitis	161	246

Study of mortality from the ONS LS also identified high mortality among coalminers, the category 'miners and quarrymen' were found to have an SMR of 117 when broken down by broad age groups. Table 2 shows that miners had a higher risk of dying at all age groups than the rest of the population (where SMR for the rest of the population=100). This category also had a greater risk of dying from respiratory disease, for example, deaths from bronchitis, emphysema and asthma were significantly higher than expected at ages 65-74 (SMR 234).

Table 2: SMR 1981-89 by age at death

	20-64	65-74	75+
Other coal miners	116	131	117
Face trained coal miners	103	136	110

It is clear that mining has a strong association with certain forms of ill-health. It might be argued that with the decline of the mining industry there would an improvement in the overall health of the population but even with closure the legacy of ill health from mining lingers on creating a number of problems for former workers as David Guy, President of the Durham NUM, states;

The biggest amount of work load at present, has been the surfacing of our members, who were either unemployed, or suffering from some incapacity whereby they can't work. Dealing with DSS claims and that can range from industrial injury benefit, mobility allowances, attendance allowances, housing benefit, income support, family income supplement for them that are working but are on poor earnings. We were recently successful, last year in Newcastle, winning a major claim against British Coal for the occupation disease vibration 'white finger', which has generated thousands of claims both through the DSS and against British Coal. That's an on going situation, British Coal have appealed to the High Court, which is due to be heard in June or July of this year, and then we're hoping to get something finalised on that. We've had a major success on the chronic bronchitis and emphysema claims what we've had. And again it looks very much as if, er, the DTI, who are now

responsible for these claims, are gonna negotiate a scheme whereby people will get compensation without too much undue hassle, so in other words we were gonna to go to court...It's beneficial to them, it's beneficial to us, because, er, it would just clog the system up, the legal system, if all of our claims went in. There's a estimated 30,000 nationally, and out of that I would think that we would a quite substantial minority, that is between 8 - 12,000 cases, in this region. We still continue to represent people, it's a disease which can develop many years after you have left the mining industry. So, we get regular claimers phoning, which we deal with the DSS, and British Coal.

What comes out very strongly from the interviews is that the decline of the mining industry far from improving health, has had an adverse effect on health, in particular for those that worked in the industry for a long time. It may be that with time these disease will cease to be of significance in the coalfields.

Most of them are on invalidity, because a lot of them have aches and pains in their knees, backs and things. People in their 50s/60s, you can't work down the colliery for 30/40 years and be healthy at 50 onwards. (East Durham Community College.

There is a recognition that although the mining industry contributed to certain diseases the decline of the industry has had an equally adverse effect on health which, the director of public health for Cynon Valley sees as part of a process of declining health in Wales (which will be discussed in more detail in the next section):

You can't deny really that people who work underground, people who work in the coking industries, in coking plants, iron and steel, you know they were exposed not only to fumes and gases but also a cocktail of various chemicals, well coal what chemicals it does not contain rather! You can say that when you burn coal well you just don't know, you can get any type of chemical or gas produced from that. So people that worked there in the mines were exposed to all those and we will have to agree that that is certainly a factor which initiated the illness. And this was promoted by the disappearance of the mines and lack of jobs, absence of employment, deprivation and the houses also got older and the dimensions were not to standard, living conditions also deteriorated. So all those things deteriorated over time. (Dr. Arun Mukerjee, Bro Taff Health)

2.2 Health in the districts after closure

This section examines issues of health in the four districtsⁱⁱ in the period after closure. Although there is an established association between mining and ill-health evidence from the interviews and other material suggests that ill health continues to be a problem for both ex-miners and mining communities which seems to be linked to the job losses and increasing poverty in these communities.

A wide body of literature exists on the health effects of job loss. A number of recent studies have focused specifically on the health effects of pit closures (Rowlands and Huws, 1995, Avery et al 1998). The study carried out by Rowlands and Huw (1995) compared the 'psychological health' of miners at two collieries in 1992, one threatened with closure (Grimethorpe in S. Yorks) and one stable (Selby in N. Yorks). They found that redundancy does have a negative effect on psychological health with increases in alcohol consumption and higher usage of general practitioners, compared to the control group. Avery et al's (1998) study of Nottinghamshire miners after the 1992 closures found that such workers were physically and psychologically disadvantaged compared to other workers. Both studies also found that those remaining in the mining industry also displayed high levels of 'stress' due to feelings

of job insecurity.

There is evidence that throughout the coalfields closure has had an adverse affect on health. Critcher et al (1993,16) describe the effect of closure on the 'mental health' mining communities in Yorkshire:

The most immediate effects were those of personal trauma and stress. Miners told us with bitterness and sadness about colleagues who collapsed under the strain. In the most extreme cases, Valium has been prescribed.

The breakdown of social structures has also has its impact on health (160):

Miners and their wives were experiencing unprecedented levels and forms of stress at precisely the time when other around them were least able to offer help and comfort. A women who worked at the pit canteen described to us how miners had sustained her through her husband's serious illness and the death of her father. She feared the loss of such moral support as much as her loss of earnings.

The four districts are very similar in that they are all still affected by high levels of ill health. Particular diseases can be associated with the districts, in particular respiratory disease, heart disease, cancers and mental health. It is difficult to ascertain whether these diseases are particular to the areas or part of a national pattern. Indeed in many of the interviews the respondents discuss the health of the areas as being 'among the worst' but not as distinct to coalfield areas. For example a number discuss the increases in smoking among women but back it up with 'of course this is part of a national trend'. Although it is difficult to associate particular diseases to the coalfields it was nonetheless clear from many of the respondents that ill-health is a major problem throughout the districts. In Durham, David Guy outlines the situation in his area, of which Easington is a part:

"We've got kids now, suffering from Rickets, we've got TB, back in this region! We thought we'd eradicated that. Closed all the TB hospitals down, wasn't necessary. All of that's coming 'ere. So that's, I mean, they're indications. Mother Nature tells you herself, what the problems are. Because these diseases and ill health, manifest themselves where there's been a lowering in the standard of the quality of life. And that's what's happening in this region...If you look at the children, and look at the type of diseases, which are now prevalent in children, which weren't there 10/15/20 year ago, and ask yourself really, why? If we, as a country, are more wealthy than was ever been, then, growth has go on and wealth has bee, more wealth has been created. We've got better health care, why is it that the National Health Service is in crisis?"

Furthermore, a study of health in the North of England carried out by Townsend et al (1988) identifies Easington district as having particularly poor health. Easington has the greatest proportion of its population living in wards defined as experiencing bad health. It also has the highest incidences of permanent sickness and highest low birth weight, as they state (90):

Where Easington stands out is in its constantly poor health, on all three of our chosen criteria and across an almost continuous band of wards. The four villages of Wheatley hill, Thornley, Shotton and Wingate epitomise this unenviable condition in an extreme form.

RCT has lower life expectancies that Wales and E&W. Within Wales RCT ranks third in circulatory disease as cause of death; fifth for cancer; and second for

respiratory disease (Community care: Proposed social care plan RCT). Increasing health differentials seem to be a particular problem in Wales:

We've looked at changes in mortality and over the last ten years across all of Wales, and we have identified that some areas, particularly the high pockets of deprivation where the mortality rates have actually, where the differential in the mortality rates between wealthy and poor areas has actually increased over the last ten years. (Public Health, Bro Taff).

One distinction that comes out between the districts is that circulatory diseases and respiratory disease seem to be more of an issue in St Helens than any of the other districts. For example the deaths from coronary heart disease are quoted as being 40% higher than national (English) average (St Helens MBC submission to the taskforce and Government Office submission).

Very high incidence of heart disease, almost the worst in the country, respiratory diseases, lung cancer, mental health, those are our four priorities. Respiratory diseases is appalling. [shows tables and graphs on health figures] I'll show you some figures on...and it has really shocked me, the trends. Because with most things, although you have got high incidence, the rates are going down, but with respiratory disease in women in particular they are going up.(Dr. Diana Forrest, director of public health St Helens)

However, it is difficult to ascertain whether this is directly linked to the mining industry as both respiratory and coronary disease are common throughout the NW. Blackspots in the NW map on to former industrial areas and not just coal districts (see North West Health Authority health report 1997).

2.3 Long-term sickness

Incidences of illness between the four districts are difficult to compare because of both a lack of comparable statistics and the problems of associating particular diseases to place. One way of getting round this problem it to look at long-term sickness. One indicator, in particular, that has been used to examine the incidence of ill-health in coalfields is the levels of LLTI from the census of population. The inclusion of a question on Limiting Long-term Illness (LLTI) for the first time in the 1991 census brought about the possibility of a comprehensive survey of the incidence of ill health and morbidity in Britain. The census question asks 'does the person have any long term illness, health problem or handicap which limits his/her daily activities or the work he/she can do? Include problems due to old age'. From this data, a number of useful studies have emerged. In particular analyses of variations in LLTI have illustrated that there is a distinct North-South divide (excluding London), with Wales having the highest levels (Senior, 1998, Curtis, 1995).

Subsequent analysis of this data strongly indicated that the coalfield areas had among the highest rates of long term sickness, particularly in S.Wales and the North East [see Table 3]. Table 3 illustrates that levels of LLTI in the four districts is higher than nationally, particularly in Easington and the Cynon Valley (ward level data show that this difference is even greater at the more local level, see appendix). An extensive study carried out on LLTI by Senior (1998) identified the significance of the coalfields, the S.Wales coalfield in particular, in accounting for the highest rates of LLTI. Using age standardised LLTI Senior (1998) identified a strong association between coalfield communities and high LLTI (see Table 4). Ward level analysis also

showed the high prevalence of declining coalfield areas in the rankings (see Table 5). This analysis shows that there is an association between LLTI and former coalfields, but only with certain coalfields. Although all four districts have than average incidences of LLTI, Cynon Valley and Easington come out as most significant.

When interpreting these measures using LLTI rates it should be remember on the census form illness is self-defined and thus is not a reflection of accurate medical diagnosis. Indeed, Senior (1998) and Rees (????) have suggested that one interpretation of the high levels of LLTI in Wales could be explained by cultural factors (!). Furthermore, Beatty and Fothergill (1995, 1997) have argued that much of the reported ‘illness’ in the coalfields is actually masking ‘hidden unemployment’ (they use permanent sickness in their analyses). However, the levels of sickness suggested from the interviews and grey literature suggest that there is a very significant level of ill health. As such, there is much controversy surrounding the interpretation of these figures.

Table 3 Incidence of LLTI

	% of persons with limiting long term illness in h/hs
Easington	21.55
Cynon Valley	21.26
St Helens	15.82
Mansfield	15.72
England and Wales	13.1

1991 Census

Table 4

National Rank	County/region	Age standardised male LLTI ratio
1	Mid Glamorgan	173.34
4	Durham	140.95
8	Merseyside	128.66
19	Nottinghamshire	109.21

Source: Adapted from Senior (1998)

Table 5

Rank	District	Male LLTI
1	Rhondda	207.68
3	Easington	192.84
6	Cynon Valley	182.28
36	St Helens	137.27
41	Mansfield	137.44

Source: Adapted from Senior (1998)

Although rates of LLTI taken from the census strongly suggest that the coalfields have some of the highest levels of ill health in the country other measures of health do not single out the coalfields so strongly. For example when levels of mortality are examined, the highest levels are in urban industrial areas and not the coalfields. Areas with the highest mortality rates in 1992 (SMRs) are Oldham (131), Salford (131), Greenock (120) and Manchester (118) (Dorling, 1997). But at the smaller district scale the some of the coal districts do come out, see table 6 below.

Table 6

	SMR (1995)
Easington	119
St Helens	99
Mansfield	109
Cynon valley	119

Source: Regional Trends 1997

The statistical measures of health outlined indicate an ambiguous picture of health in the coalfields. LLTI rates suggest that the coalfields have amongst the highest levels of sickness in the country but in terms of mortality the coalfields do not rank among the highest. This may suggest that ill health is more an issue in the coalfields than indices of mortality. It has also been suggested that because LLTI is self-defined there may be an over-reporting of ill health in the coalfields. However, evidence from interviews with health practitioners and others in the four coal districts suggests strongly that ill-health is very much an issue and that focusing on levels of mortality may obscure the problem:

Mortality data are of little use in predicting the long-term effects of the rise in unemployment and the increased social disadvantage, which has affected the coalfield areas over the last five to ten years. (Annual report of director of public health, North Nottinghamshire, 1997:10)

Although there is much debate surround the issue of levels of LLTI in the coalfields there was a strong indication from the respondents that much of it was genuine. In explaining these patterns it may be useful to draw on the arguments of a recent publication (Greg and Wadsworth, 1998) that argues that the notion of 'long term sickness' is better understood as a continuum from the very ill to those who are able to work, with a number of situations in-between. All of the health practitioners and others interviewed stated that there were high levels of LLTI in their areas. When discussing this issue they reflected in their interpretation an ambiguity in relation to this issue. A particular issue was the confusion between ill-health and ability to work;

I am sure that there are people at the moment who would define themselves as long term sick, who would no longer define themselves long term sick if the could find work, because it is something like 40% out here. I don't believe in practice there is 40% of people who couldn't work. But just because you have long term illness doesn't mean if you suddenly get a job that you are no longer sick doesn't it? I think they seem to miss that point. Sickness doesn't mean you can't work, it means you are sick'. (Gerard Tomkins)

Many of those interviewed highlighted the issue of high levels of LLTI in terms of health risks associated with mining which adds to the confusion of the interpretation of the figures:

"What you'll find in this district, is there are 14,000 people who aren't working due to ill health, long term sickness. Working down the pits, for many yrs, cannot work, arthritis, chest problems, knee and back problems and they can't work. Many are genuine, some doctors are sympathetic to families that they have known for all their lives and have signed them off on long term sickness. It's difficult to prove that someone hasn't got a bad back," (Ken Greenfield EDDA).

Others, such as a NUM worker in Easington, felt that the focus on benefit fraud through LLTI shifted the focus away from the real issue between ill health and work in former mining communities:

Why is it that er, more and more people are claiming incapacity benefit, ill health benefits, disability living allowances. Why have we got all this increase? Why is people's health deteriorating at a time when we've got better medical care and better health products...There will be some people in the Government who'll see it, er, there's er, what's happening here is that there are people who are 'swinging the lead', they're not gen-u-ine claimants. That's their answer to it. That isn't the answer to it! That isn't the answer to it! If society is so bad now where we've got people who will resort to that type of thing, in order to mack (make) ends meet, that isn't the problem, it's what causes people to do that, is the problem, and that's what should be tackling. Erm, there'll never be benefit fraud! What you have to do is give people an alternative to benefit fraud, and improve the health of those people who are gen-u-inely ill and in receipt of benefits. And that way you will remove the crisis off the health service, because the demand will not be so great. The quality of life in the communities will improve, the health care will improve with it, the feeling of well-being will improve with it, you'll get LESS finalism, LESS people relying on drugs, LESS graffiti, you'll need to spend LESS money on building prisons and LESS money on the police force. It's a natural thing for this to happen. But they're gonna have to tackle the core problem and the core problem is, that these communities have been neglected. (Dave Guy, Durham NUM)

2.4 Ill-Health and Poverty

The ill health in the four districts is seen as linked to a number of factors that have come about as a consequence of the decline in the mining industry, increases in levels of poverty and deprivation being seen as the most significant. The link between poverty and ill health has been well documented (see in particular ‘The Black Report’). The link between poverty and ill health was well recognised by the respondents:

The areas where there is deprivation is areas where there is smoking and high indices for lung cancer and also heart disease. So it is all very much linked to the other...Well as I say if you look at the areas with high unemployment it maps with heart disease, it maps with stroke, it maps with lung cancer. Those are the main ones that it is closely aligned to. Which is what you would expect. We do have a, if you talk to the local people and the local vicars and people like that, they say that they have an abnormally large number of young deaths from things like heart disease. People you know in their 40s/50s dying of heart disease. (St Helens Public Health).

And, unemployment in my opinion causes poor health, it causes poverty, it causes poor health in young people. We’ve seen meningitis in this region. Raging away! We’re keeping a lid on it, but it’s travelling in this region, like nowhere else. It’s spreading among children. (Dave Guy, NUM Durham)

The levels of ill health in the coalfields are seen as related to increases in deprivation through a number of interrelated factors including increases in unemployment, crime, isolation, lack of education and poor housing.

Although ill health in general was an issue in the four districts the incidence of mental health problems and increases in substance misuse seemed to be of particular concern. Ill-health is not necessarily manifested as particular diseases but can be in the form of stress and depression. There is strong evidence that unemployment can lead to mental health problems as the Black Report (1992, 263) states:

‘It is now also beyond question that unemployment *causes* a deterioration in mental health and there is increasing evidence that the same is true for mental health’.

In the case of this research mental health deterioration was linked to the decline of the mining industry and the associated increases in unemployment and poverty:

But the things that don’t come out in the mortality statistics is the mental health stuff, cos. I would say there is a high level of stress, real stress not worried executives, high pressure crap! It’s that long standing grind. There is a lot of reactive depression, One of the things that came out of the presentation [CFTF] was the high level of prescribing of anti-depressives anti-depressants. We are the highest by some way[Northern and Yorkshire]’ (Gerard Tomkins)

It is much more difficult to measure [mental health] isn’t it because the statistics that we are expected to report on are numbers of suicides. So young males and you are talking about relatively small number so you can’t sort of statistically say this is significant but there is certainly an increase in the number of suicides of young males. Mental health...I mean surveys...I mean if you look at how do you collect data on mental health again you are talking about those that actually arrive at some sort of situation where they are receiving treatment in secondary care or hospitals. So data on those are available but we wouldn’t really expect that to be an indicator on the mental health of the community. I think much more appropriate is how many people are expressing a need to seek counselling and those sort of informal systems or are

reflecting a loss of support structures around them, a sort of decreasing social well being... There is much more unreported, things that come through citizens advice bureaux and those organisations in terms of the stress of...eventually the redundancy repayments die out and people are getting into a lot of debt. (North Nottinghamshire Public Health).

In addition increases in the rates of suicides was stated in the four districts, indeed many other studies have confirmed an association between unemployment and (attempted) suicide:

we had a period in Seaham, where the suicide rate of former miners was running at 3 times the national average. And the church, in Seaham, were really concerned about it, to such an extent that the, erm, Parish Priest from St Johns actually did a publication in his weekly, or monthly, church periodical, and erm, there was a lot of criticism about, but all the Parish Priest was saying drawing his parishioners to this serious problem what he was facing as a Parish Priest. Now people were committing suicide. (Dave Guy NUM Durham).

North Nottinghamshire health authority reported an increase in the number of male suicides which they attribute in part to the poor support networks and lack of contact with services among males.

Increases in drug use seems to a big worry, a view expressed by a number of agencies including the police, social services, housing and health:

Well of course in the valleys there are pockets where, the pockets of population particularly among the youngsters where there is a drug problem and drugs associated diseases like hepatitis b, hepatitis c particularly. Although that is not necessarily the overall picture but there are identified areas where it is a problem.

Alcohol misuse seems to be a bigger problem in some of the districts, St Helens in particular, and seems to be further compounded by underlying cultural acceptance of alcohol misuse.

I think much of their problems are related to their lifestyle. I mean it is accidents is the main killer of young people and the effects of drugs and alcohol hitting increasing numbers younger who have liver problems as a result of alcohol. Alcohol is much more of a problem than drugs is. And there is a real, around Liverpool and Knowsley and St Helens, the men and their drinking is part of their lifestyle and it is manly to drink loads. I actually can't see how you make deep inroad into that cultural thing. It is such a deeply entrenched cultural way of living. (St Helens Public Health).

3 Problems in improving health

Improving the 'health' of the four districts presents a numbers of problems and issues. It has already been established in this paper that there is a high incidence of ill-health in the four districts and that this is partly related to the decline of the mining industry and high levels of unemployment and poverty. This section aims to examine issues in improving health care. The first section focuses on some of the difficulties in improving health care in the four districts; the second section addresses how improving health is being tackled by focusing on the role of health in regeneration, funding for health and partnerships in health.

3.1

In addition to the health problems facing the four districts outlined in section 2 of this paper, there are a further set of issues that make improving health difficult. These will be outlined in this section.

In all four districts the dispersed nature of mining communities was seen as problematic in providing adequate health care for the population. The physical isolation of many ex-mining villages means that many have to travel long distances for health care. The economies of scale in medical provision also mean that it is not economically viable to set up health centres in all villages. This issue of access to health care is not so acute in St Helens (although it still is an issue) than in Easington, Mansfield and Cynon Valley. For example Easington district lacks a hospital which is problematic for those living there and also means that the district attracts less money, as a health officer outlines:

I suppose historically funding for health services flowed to where the hospitals were so if there wasn't a local hospital then the actual spend on health care for that area would be less. And that is the situation we inherited in Easington 5 years ago, and for one reason and another, largely financial there hasn't been a change in that. But we recognise it as something we need to do something about'. (Gerard Tomkins, Durham Health).

In addition, isolation of mining communities exacerbates many of the health problems with people having to undertake long journeys to access health care-this point was highlighted in the Taskforce Report. In Easington, the Cynon Valley and Mansfield the issue centres more strongly around isolated communities and a lack of transport.

In North Nottinghamshire you have some quite rural populations that are relatively difficult to access as well, or the people living there have difficulty in accessing other facilities, so the rurality of North Nottinghamshire is quite an issue too. (North Nottinghamshire Public Health)

A further problem facing the coal districts is the decline in the level of health infrastructure. Previously, when the pits were open various forms of medical care were provided by the Union or CISWO for miners and their families. When the pits closed these supports were cut back or removed meaning that many were left without access to necessary medical care:

So in many ways [they were] well looked after by coal industry as it used to be by the mining communities. You know the infrastructure that was there from CISWO is just one example of the structures that they had around them. So the impact of all of that being decimated is bound to have a great impact on the health of the community and those individuals within it.(Public Health North Nottinghamshire)

This issue is also outlined in the taskforce report:

Before pits closed, mines offered a range of health and social services for miners and their families, including screening programmes focused on specific health problems such as pneumoconiosis that are related with coal mining. (DETR,1998)

In relation to this, in many of the interviews there is an indication that the decline in the mining industry has led to a decline in the capacity of those communities to 'care', in relation to the care of the elderly in particular:

there has been an impact potentially on the ability of communities to care for older people. And some of our thoughts are around why we get increased hospital admissions that are around the capacity of communities to care. Which is reduced, practically, because more women who are traditional carers going out to work and b) because the philosophy of communities perhaps not being so predisposed to care for people within them. So those would be the sort of key groups really that we have targeted in terms of looking at health needs and health promotion. (Public Health, North Nottinghamshire)

The taskforce report also states that general health problems can be attributed to the weakening of traditional family support systems.

An additional problem which affects all four of the districts is attracting GPs to the areas. Nationally, there is a shortage of GPs because it is seen as an increasingly unattractive specialism to go into. This problem is even more acute in the less attractive areas such as inner cities and former coalfield areas. The problem for the four districts seems to centre around the perceived attractiveness of the areas, as a doctor in St Helens states:

Well I mean it...you have to be a certain kind of person want to go into a deprived area don't you. And there aren't a lot of those kind of people around. Most people would like to go into a nice affluent area which is a nice place for their kids to go to school and you know all the other things that go with middle class sort of lifestyle. Kirby is not one of those and nor is St Helens really. It is not a very exciting place to be. (St Helens, Public Health).

In North Nottinghamshire it has become such a problem that they have to market the area for potential GPs in a similar way for attracting inward investors:

Certainly we have had difficulties in the more disadvantaged parts of the area where it is perceived that there is higher demands, higher numbers of out of hours calls, I mean to an extent that is true we can actually show that. So we are at the moment embarking on a come and work in north Nottinghamshire and be a GP in our community sort of marketing campaign. Though it is quite difficult to say would you rather work in North Nottinghamshire or would you rather work on the south coast where you could have a boat and those sort of lifestyle things that most GPs can eventually afford. (North Nottinghamshire. Public Health).

It is not only a question of attractiveness of the areas but also the level of investment that GPs are required to do when coming to a particular area that also act as a disincentive:

'Would you want to live here?', I don't! It's not like hospital Doctors where they come and they go and they can happily move on, they make a substantial, they make a lifetime commitment. When a young doctor wants to join a practice he or she has to buy into a partnership as you would as a lawyer or and architect they need to borrow money to buy in to the good will and so on of the practice so that's one thing; secondly, the premises they have to buy them. And virtually every medical practice in this area has substantial negative equity. You might be talking about a quarter of a million to build a premises and the day they are open they are worth £150,000. So there is substantial negative equity and all these things are positive disincentives to come in to Easington. Look at the schools and drug problems, and crime and quality of housing, transport, all those things, I mean just as I am bothered where my kids go to school and wouldn't want my kids to go to school around here because of it and so do Doctors. It's inevitable that they will look more favourably on areas like Durham and Darlington and places like that'. (Gerard Tomkins, Durham Health).

This is partly being overcome in North Nottinghamshire by offering GPs contracts rather than partnerships, and nationally the move to Primary Care groups may help overcome this issue (see 'our healthier nation').

3.2

This final section examines some of the strategies and problems in improving health care in the four districts.

Issues of regeneration have tended to centre round job creation and attracting inward investment. All too often health (and, as outlined in the last paper, housing) is not seen as a relevant part of the regeneration formula. This is in spite of the fact that the association between health and unemployment/poverty have long been recognised. Yet, it is only recently that this link has been recognised by the government. The previous government refused to acknowledge the link between unemployment and ill health despite the evidence put forward by the Black Report. However, the present government's White Paper ('Our Healthier Nation') is significant as for the first time it directly relates poverty with health, as it states (p.9):

‘the poorest in our society are hit harder than the well off by of the major causes of death. Poor people are ill more often and die sooner. The life expectancy of those higher up the social scale (in professional and managerial jobs) has improved more than those in lower down (manual and unskilled jobs). This inequality has widened since the early 1980s’.

and that (p.12):

‘government recognises that the social causes of ill health and the inequalities which stem from them must be acknowledged and acted on. Connected require joined-up solutions. This means tackling inequality which stems from poverty, poor housing, pollution, low educational standards, joblessness and low pay. Tackling inequalities is the best means of tackling health inequalities in particular.’

This change in attitude to health by the government was seen as a positive step by the health workers in the districts and also signalled a change in the way they should work, as a doctor from St Helens states:

Up until the new government and the white paper all the health service was responsible for statutory was balancing books, they weren't actually responsible for health or improving health. Now they are, we have actually got to improve health now....now we have actually have to improve health and also the underlying causes of ill health are also the responsibility of the local authority. (St Helens, Public Health).

The findings of 'our healthier nation' seem to reflect a feeling that has long been felt by those involved in health in the coalfields. From the interviews it was made evident that there was a clear link between health and wider issues of regeneration and those involved in health were keen to emphasise the need to link the health of the population with other areas ranging from incidences of crime to economic regeneration:

‘We are trying to make a specific link between our health forums and any regeneration that is going on in the villages so that it is seen as part of the wider agenda all of the time’. (Gerard Tomkins, Durham Health)

It is not just in the field of economic development where improving health is ignored,

it is also seen as a problem within health authorities themselves.

getting the message across that economic regeneration is not just about inward investment and new jobs, social health and economic regeneration are inextricably linked and trying to get that message across. And I think it has been as difficult getting it across in a health authority where the focus is on how do we reduce waiting lists. I have often found that people are more ready to listen outside the health authority than they have been sometimes inside it. But as I say that is changing for the good. (North Nottinghamshire Public Health)

Improving health is also seen as part of improving the structure of the communities:

Yes, we focus particularly on families, recognising that if you have an input and an impact in particularly pre-school time then you can actually help to develop parenting and family support skills that you can help to reduce inequalities in health but that early intervention. Evidence also that that very much links with educational attainment and things like language development and increasing interest from the police and community service people and the links that that has with early...trying to prevent youth, disaffection is the term, and youth crime ultimately along the line. So a general interest for everybody in family support and parenting being the name of the game now. (North Nottinghamshire Public Health).

In addition to the policies outlined in 'Our Healthier Nation', the 'coalfield taskforce' made a number of recommendations to the government in relation to health. It highlighted the high levels of ill-health in mining communities and the declining levels of health care, it advocated the implementation of 'one-stop shops' to provide health care and screening, community based services for those suffering from mining related illnesses and injuries, the provision of sheltered accommodation for the elderly and for the coalfields to benefit from Health Action Zones (HAZs). However, in the government's response to the report it is apparent that much less money is being directed to health in comparison to economic and housing regeneration. The response stated that HAZs are to be created in South Yorkshire and Northumberland. This only represents small contribution to a large problem and may contribute to a further isolation of health issues in the regeneration of the coalfields.

Many of those involved in health in the four districts felt that they tended to be sidelined in regeneration agendas. A conference of representatives from the four districts freely stated that health has tended to be tagged on to projects/partnerships. For example it was only in the last 12 months that health was included in the East Durham Taskforce.

In some cases it was felt that health was sidelined in regeneration packages because emphasising the poor health of the districts would portray a negative image to potential inward investors. A doctor from North Nottinghamshire highlights this dilemma and her frustration of it:

the emphasis was very much on getting jobs into an area and then talking about social disadvantage, health needs, poorer health, poorer environment, that is very much seen as negative marketing. Which in a sense it was, I mean if you want to attract people here you don't want to go around saying how awful it is. But at the same time unless people coming from that angle recognise that they need to work in partnership for investment in social health for the community they ain't going to get anywhere. (Public Health, North Nottinghamshire)

3.3 Funding

The funding crisis in the NHS is well documented and health authorities throughout Britain would no doubt complain of a lack of funding. However, in addition to overall cut-backs, the four district also felt that they lost out in other sources of funding. Expenditure per head on health in the coal districts tends to be very low. EU money is not available for health projects and health tends to be seen as peripheral in SRB bids. The response to the coalfield taskforce made much of the potential of Health Action Zones but in the districts (excluding Wales) most felt they were ineligible to access this source of funding. For example in North Nottinghamshire the issue centred around the dispersed nature of the problem:

there are significant variations within the patch and they get diluted by the averaging out, so I think that is one of the issues in attracting more funding. Certainly our bid for a Health Action Zone, regional office does recognise that we have done a lot of networking, good partnership work and good infrastructure for doing all sort of concepts that health action zones are all about. ...Looking at the indices for South Yorkshire and they appear considerably worse than ours...so ours tends to get diluted out a bit. (Public Health North Nottinghamshire)

and similarly in Easington:

There are two specific things in the guidance which were why we didn't apply for health action zone status. One was around this thing that there would normally need to be whole health authority size, we're not whole health authority, we don't want to do a whole health authority thing, because the problems of Easington are totally different from say upper Teesdale. It seems to us ludicrous that there is a case for a health action zone for the whole of county Durham. (Gerard Tomkins)

Although there are number of health projects in operation in the four districts there is an indication that they can only go so far in improving health and that what is needed is a more holistic approach that provides sustainable economic regeneration, as a doctor from St Helens states when discussing this issue:

but they do feel like a bit of a drop in a bucket in comparison with the actual problems. What needs to happen is economic regeneration really. (Public Health, St Helens)

There is also a feeling that despite the current government's commitment to improving health that what actually is needed is more funding:

so we had all these data on inequalities and say we had to do something about it. Its great. What they haven't done so far is put more money into the areas where the health is worst. That's what they really ought to be doing. They are actually taking money out of Liverpool still, its health is terrible and they are still taking money out. (St Helens, Public Health).

3.4 Partnerships

It seems that for health authorities partnership working has long been part of their working process. It may be that health tends to form natural partnerships with agencies such as social services and education. Contrary to much of the rhetoric in the interviews and the grey literature partnership working is not entirely new, as quote from Hatherley (1975) illustrates when discussing health in the Welsh valleys:

We might find some common purpose in examining the sorts of roles played by various agencies, who, when combined and in concert together can lead to healthy communities. (Hatherley, 1975: 202).

And more recently:

You know it's the name of the game to show that you are working in partnership with these other agencies, that's what health authorities are about. So we have been saying that for sometime. (Public Health, North Nottinghamshire)

Public health in both North Nottinghamshire and St Helens and Knowsley worked with a wide range of people including economic development. One stop shops have been set up in St Helens in conjunction with the local authorities. In addition they are putting together a bid for 'healthy living centres' from lottery money. Partnerships appear to be a central part of the strategy in St Helens, indeed the focus of the most recent annual report on public health focuses on partnerships and outlines partnerships for everything from 'partnership to develop strategy' to 'partnerships to reduce accidents'. Health partnerships did not appear to be as well developed in Easington, and in Bro Taff there was little indication of partnership working although it was being developed

Partnership in health were also problematic. In North Nottinghamshire a lack of involvement of local GPs was discussed and was linked to their heavy commitments and perhaps a lack of ability to look beyond their own practise. Working with the county council was also problematic as there was a feeling that they were less concerned with health issues than the district council although was partly explained by the recent reorganisations within the council in Nottinghamshire. Partnerships were seen as operating effectively in St Helens, but it was stated that there was friction at two levels. Firstly there was the difficulties of getting St Helens and Knowsley MBCs to work together and secondly and perhaps most significantly, there was the tension between St Helens and Knowsley and the Merseyside health authority. For example... HAZ bid caused concern for the local authorities in St Helens and Knowsley as it was on a Merseyside level and they felt they were being swallowed up by Liverpool.

In general, the health authorities seemed to have a number of 'natural' partnership with agencies like social services and education, where partnership working was more difficult was with economic development agencies which was further complicated by the two tier structure of councils. There was also a variation to this with partnerships in health being more effective and developed in St Helens and Mansfield compared to Easington. The health authority in Wales did not seem to have as well developed a partnership structure which can in part be related to the recent structural changes in both the health authority and local councils.

4 Discussion/conclusions

The aim of this paper has been to examine the issue of health in the four districts focusing on the changing health of miners and mining communities before and after closure and problems improving health in the districts.

It was outlined that miners and mining work has had a long association with ill health and despite improvements in health and safety through the years miners continue to suffer disproportionately from certain diseases, even after leaving the mining industry. This is in part reflected in the high incidences of long-term illness in former mining areas. It was outlined that far from the closure of the mines leading to an improvement in health it has led to a continuation of the problem. This is particularly linked to the resultant increases in unemployment, deprivation and poverty that are known to have a strong link with ill health. In addition to a general level of poor health, it was also outlined that increases in incidences of mental health have also occurred.

The high levels of sickness in the districts highlight the complexity and the need for caution when interpreting levels of sickness in the coalfields. Beatty and Fothergill (various dates) suggested that high levels of sickness in the coalfields were masking what they termed 'hidden unemployment' in the coalfields. However, the indication from interviews in the four districts suggests that there are high levels of sickness in the districts and thus hidden unemployment is only a partial explanation.

The paper also outlined how improving health-care in the districts was difficult for a variety of reasons. The dispersed and isolated nature of mining communities made providing universal health provision difficult. The decline of health support provided by the unions and CISWO left a gap in the health infrastructure that the NHS was unable to fill. It was also outlined that in addition to these problems the coal districts were finding it difficult to attract GPs thus contributing further to the problem of health provision in these areas.

In relation to wider issues of regeneration it was outlined that it was only very recently that health has been recognised and included within the regeneration agenda. It was also outlined that there is a strong sense of frustration among health practitioners that they are limited in their abilities to improve health unless there is a significant improvement in the economies of these areas. The limitations of Health Action Zones and the response to the taskforce report were also outlined. There were, some positive elements, particularly in relation to the changing attitude to health at the level of government. However, these needed to be backed up by an increase in funding.

Finally, it was illustrated that the partnership approach seemed to be effective and widely used in the field of health, although the links with the economic side of regeneration were weaker.

References

- Avery, J., Betts, D.S., Whittington, A., Heron, T.B., Wilson, S.H., Reeves, J.P. (1998) The mental health and physical health of miners following the 1992 national pit closure programme: A cross sectional survey using General Health Questionnaire GHQ-12 and Short Form SF-36, *Public Health*, 112, pp169-173
- Beatty, C. and Fothergill, S. (1996) *Registered and Hidden Unemployment in the UK Coalfields*, Sheffield Hallam University, Sheffield

- Beatty, C., Fothergill, S. (1996) Labour market adjustment in areas of chronic industrial decline: the case of the UK coalfields, *Regional Studies*, 30, pp. 637-650
- Black Report (1992) *Inequalities in Health* (revised edition), Penguin, London
- Critcher, C., Dicks, B., Waddington, D. (1993) Portrait of despair, *New Statesman and Society*, October 23rd, pp. 16-17
- Curtis, S. (1995) Geographical perspectives on poverty, health and health poverty in different parts of the UK, in Philo, C. (ed.) *Off the map: A social geography of poverty in the UK*, pp. 153-174, CPAG, London
- Dennis, N. et. al. (1956) *Coal is Our Life: An Analysis of a Yorkshire Mining Community*, Tavistock, London
- Department of Trade and Industry, Press Release (23 January, 1998)
- DETR, D. (1998) *Making the difference: A new start for England's coalfield communities*, London
- Dorling, D. (1997) *Death in Britain: How local mortality rates have changed 1950s 1990s*, Joseph Rowntree Foundation, York
- Ferris, J. (1993) *The British Coal Housing Sales in Nottinghamshire 1985-1989*, School of Social Studies, University of Nottingham: Nottinghamshire County Council
- Greg, P., Wadsworth, J (1997) *Unemployment and non-employment: Unpacking economic inactivity*, Employment Policy Institute
- Hart, J. (1975) A forgotten war, in Ballard, P., and Jones, E. *The Valleys Call*, pp. 185-198, Ron Jones Publications, Ferndale
- Hatherley, W. (1975) Social Welfare, in Ballard, P., and Jones, E. *The Valleys Call*, pp. 202-204, Ron Jones Publications, Ferndale
- North Nottinghamshire Health Authority (1997) *Annual report of the director of public health*
- North Nottinghamshire TEC (1998) *North Nottinghamshire in Focus 1997-2002*, Edwinstowe
- North West Health Authority Health (1997) *Annual Report 1997*
- OPCS (1995) *Occupational Health: Decennial supplement*, HMSO, London
- Pilger, J. (1992) Heartlands to wastelands, *New Statesman and Society*, October 23rd, pp. 10-11

Rhondda Cynon Taff County Borough Council (1998) *Community care: Proposed social care plan*

Rhondda Cynon Taff County Borough Council (undated) *Housing strategy and operational plan 1998/99*

Rees,G., Thomas, M (1991) From coalminers to entrepreneurs? A case study in the sociology of re-industrialisation, in Cross, M Payne, G (eds.) *Work and the Enterprise Culture*, pp. 57-78, Falmer Press, Brighton

Rowlands and Huw (1995) Psychological effects of colliery closures, *International Journal of Social Psychiatry*, 41, 1, 21-5

Senior, M. (1998) Area variations in self-perceived limiting long-term illness in Britain, 1991: Is the Welsh experience exceptional, *Regional Studies*, 32, 3, pp. 265-280

Townsend, P. (1988) *Health and deprivation: Inequality in the north*, Croom Helm. London

ⁱ Health Authorities in the four districts: Health Authorities introduce another set of boundaries for these districts [could stick in some maps here for the four district]. Cynon Valley comes under the Bro Taff Health authority which also includes Rhondda, Taff Ely, Vale of Glamorgan and Cardiff. Mansfield is included in the North Nottinghamshire health authority which includes Bassetlaw, Newark and Sherwood, and Ashfield. St Helens is included with the Knowsley in the St Helens and Knowsley health authority. Easington comes under the Durham Health Authority..

ⁱⁱ It should be noted that it is difficult to compare the health of different areas because of difficulties in arriving at an acceptable measure of what 'health' constitutes. A number of different ways can be used to 'measure' the health of a population the most commonly used are mortality rates, morbidity rates, sickness rates and restricted activity rates. Each of these measures poses problems for measuring health for example mortality (the most often used) will tend to exclude the importance of chronic disease, measures of well being and quality of life.