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School of Humanities, Department of History

Unhealthy City? Public Health in Interwar Glasgow, 1919-1939

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of Doctor of Philosophy

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Abstract

This thesis examines the 'healthy-hungry thirties' debate from a Scottish perspective by analysing public health in Glasgow between 1919 and 1939. The extent to which British health improved or deteriorated in the period between the two World Wars is a point of contention among historians. Traditionally, 'optimist' historians such as Stevenson, Aldcroft and Winter have argued that mortality and morbidity rates improved, while 'pessimists' like Mitchell and Webster argue that the economic recession impacted adversely upon health. More recently however, writers like Jenkinson and Thompson have emphasised the importance of considering this debate from a regional perspective and on the intricacies and complexities of public health statistics according to different social criteria. Eschewing the optimist-pessimist visions of the Depression that dominate the literature, this study focuses upon highlighting divergences in experience according to variables such as location, social class, employment position, age, marital status and gender. It explores the role of individual agency and emphasises the multiplicity of social, economic and cultural exchanges which fashioned health experiences.

By analysing both qualitative and quantitative material from sources including medical journals, parliamentary papers, newspaper articles, contemporary literature, autobiographies and oral testimonies, this research suggests that a multi-dimensional, comparative approach to explaining public health during the interwar years is most appropriate. Statistics can be interpreted to support either historical stance and a closer analysis reveals diverging health experiences according to a number of variables. By evaluating public health records and the popular perceptions of interwar Glaswegians, it is shown that Glasgow was an 'unhealthy city' as historians propose. However, this research argues that health experiences were complex, were characterised by diversity, and are better explained in terms

of inequalities between and within individual groups of the population, rather than conclusive improvements or deteriorations in health.

Abbreviations

ARDHS	Annual Report of the Department of Health for Scotland
ARSBH	Annual Report of the Scottish Board of Health
BMJ	British Medical Journal
DHS	Department of Health for Scotland
GGNHSBA	Greater Glasgow NHS Board Archive
GH	Glasgow Herald
GMJ	Glasgow Medical Journal
GP	Govan Press
GRMWH	Glasgow Royal Maternity and Women's Hospital
GUSC	Glasgow University Special Collections
MLG	Ministry of Labour Gazette
MOH	Medical Officer of Health
MMR	Maternal Mortality Rate
MRC	Medical Research Council
NAS	National Archives of Scotland
PH	Public Health
RMITSC	Report on the Medical Inspection and Treatment of School Children
RMOHG	Report of the Medical Officer of Health for Glasgow
RSICD	Report by the Sanitary Inspector of the Central Division
RSIED	Report by the Sanitary Inspector of the Eastern Division
RSIND	Report by the Sanitary Inspector of the Northern Division
RSISWD	Report by the Sanitary Inspector of the South Western Division
RSISED	Report by the Sanitary Inspector of the South Eastern Division

RUAB	Report of the Unemployment Assistance Board
SBH	Scottish Board of Health
SBMJ	Supplement to the British Medical Journal
SI	Sanitary Inspector
SOHCA	Scottish Oral History Centre Archive
SRMRC	Medical Research Council Special Report Series
UAB	Unemployment Assistance Board

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Chapter 1 Introduction

It is a central plank of the pessimists' argument regarding the 1930s that the health and welfare of substantial sections of the population were not only bad, but also worse than they need have been and, in some cases actually deteriorating. The optimists, on the other hand, claim there was a general improvement, partly deriving from natural forces but also helped by policies adopted by central and local government.¹

The extent to which public health in Britain improved or deteriorated in the period between the two World Wars is a point of contention among historians. The era, 1919-1939, was one of economic recession and popular perceptions of the period are overwhelmingly characterised by images of unemployment, poverty and poor health.² However, historical interpretations are contradictory and historians are 'deeply divided upon the true extent of deprivation and ill health' during the twenties and thirties.³ The opening quote by Andrew Thorpe neatly summarises the 'healthy-hungry' debate on health in the interwar years. This thesis engages with this historical debate through a detailed analysis of public health in Glasgow during the interwar recession. This chapter provides an overview of the literature, introduces key aspects of the historiography which have fuelled this debate, and sets out the methodology employed by this research.

¹ A. Thorpe, *Britain in the 1930s: The Deceptive Decade* (Oxford: Blackwell, 1992), p. 110.

² B. Harris, 'Unemployment and the Dole in Interwar Britain', in P. Johnson, ed., *Twentieth Century Britain: Economic, Social and Cultural Change* (London: Longman, 1998), p. 203; A. Crowther, *Social Policy in Britain 1914-1939* (Basingstoke: Macmillan Education, 1988), p. 1.

³ K. Laybourn, *Britain on the Breadline: A Social and Political History of Britain Between the Wars* (Gloucester: Alan Sutton, 1990), p. 43.

Optimists and Pessimists

The dichotomy in opinion within the literature has resulted in what has been described as 'optimist' and 'pessimist' interpretations of the interwar period. Broadly, 'optimist' historians such as Stevenson and Winter argue that the period was one of progress, demonstrated by falling rates of mortality and morbidity and improvements in nutrition.⁴ For Winter, for example, 'the most important feature' of infant death rates, which are conventionally used to gauge the health of populations overall, was 'the persistence of the trend towards better infant health for the nation as a whole despite the economic crisis of the early years of the [thirties].'⁵ Acknowledging that pockets of ill health and deprivation continued to exist, these historians maintain that the population was physically healthier and better fed in the interwar years than they had ever been before. Stevenson asserts that the 'situation as far as the health of the nation was concerned was one of great improvement, combined with concern that improvement was not as great or as equitably distributed as it might have been.'⁶

On the other hand writers including Brenner, Webster, Jenkinson and Mitchell, are critical of interpretations which suggest that a relatively undisturbed advance in public health is an accurate representation of these years.⁷ Writing in the same year as Winter, Brenner examined mortality rates

⁴ J. Stevenson and C. Cook, *The Slump* (London: Jonathan Cape, 1977); J. Stevenson, *Social Conditions in Britain between the Wars* (Middlesex: Penguin, 1977); J. Stevenson, *British Society 1914-1945* (London: Penguin, 1984); J.M. Winter, 'Infant Mortality, Maternal Mortality, and Public Health in Britain in the 1930s', *The Journal of European Economic History*, 8 (1979), 439-62; D.H. Aldcroft, *The Interwar Economy: Britain, 1919-1939* (London: 1979), p. 375.

⁵ Winter, 'Infant Mortality', p. 443.

⁶ Stevenson, *Social Conditions*, p. 171.

⁷ C. Webster, 'Healthy or Hungry Thirties', *History Workshop Journal*, 13 (1982), 110-29; C. Webster, 'Health, Welfare and Unemployment', *Past and Present*, 109 (1985), 204-29; M. Mitchell, 'The Effects of Unemployment on the Social Condition of Women and Children in the 1930s', *History Workshop Journal*, 19 (1985), 105-27; A. Hardy, *Health and Medicine in Britain since 1860* (Hampshire: Palgrave Macmillan, 2001); H. Jones, *Health and Society in Twentieth Century Britain* (London: Longman, 1994); M.H. Brenner, 'Mortality and the National Economy: A Review, and the Experience of England and Wales 1936-1976',

for England and Wales for 1936-1976. He argued that the effects of unemployment were clear, and that they could lag by a period of between one to fifteen years depending on 'the time span and the specific cause of death under analysis.'⁸ Writing specifically about the interwar period, other historians have highlighted marked stagnations in the rate of improvement, the inferior diets of those without work and the rise in infant mortality rates which corresponded with the deepening of the economic crisis in 1930-1931 – a trend at least suggestive of a relationship between the recession and poor health.⁹ Few disagree that overall improvements were made. However, in his well known article 'Healthy or Hungry Thirties', Webster argues that statistical averages are unhelpful because less flattering trends are obscured by advances occurring elsewhere.¹⁰ For Webster, the '30s emerge as a drag in the downward trend in infant mortality', that 'the basic explanation for excess morbidity lies firmly in the sphere of economic disadvantage' and that if maternal mortality was 'taken as the yard-stick of prevailing levels of health, it is difficult to support an optimistic conclusion from averages which rose during the interwar period to reach a peak in the mid '30s.'¹¹ Mitchell also highlights that neonatal mortality failed to improve, that poor health in regions

Lancet, 2 (1979), 568-73; J. Jenkinson, *Scotland's Health 1919-1948* (Oxford: Peter Lang, 2002).

⁸ Brenner, 'Mortality and the National Economy', p. 571; Brenner's interpretation has been challenged by Gravelle et al. (H.S.E. Gravelle, G. Hutchinson and J. Stern, 'Mortality and Unemployment: A Critique of Brenner's Time-Series Analysis', *Lancet*, 318 (1981), 675-79). However, Brenner has defended his position in reply M.H. Brenner and J.F. Forbes, 'Unemployment and Health', *Lancet*, 318 (1981), 874-75; Also see M.H. Brenner, 'Fetal, Infant and Maternal Mortality during Periods of Economic Instability', *International Journal of Health Services*, 3 (1973), 145-59.

⁹ G.D.H. Cole and M.I. Cole, *The Condition of Britain* (London: Gollancz, 1937), pp. 99-100; W. Hannington, *The Problem of the Distressed Areas* (London: Gollancz, 1937); A. Hutt, *The Condition of the Working Class in Britain* (Kent: Stanhope Press LTD, 1933), p. 116; Webster, 'Healthy or Hungry Thirties', 110-29; Mitchell, 'The Effects of Unemployment', p. 110; Harris, 'Unemployment and the Dole', p. 214; C. Cockburn, *The Devils Decade* (London: Sidgwick and Johnston, 1973), p. 27; A. Hughes, 'The Economic and Social Effects of Recession and Depression on Greenock between the Wars', *International Journal of Maritime History*, 17 (2006), 281-306; I. Gazeley, *Poverty in Britain, 1900-1965* (Hampshire: Palgrave Macmillan, 2003), p. 97; Jones, *Health and Society*, p. 72; J. Burnett, *Idle Hands: The Experience of Unemployment, 1790-1990* (London: Routledge, 1994), p. 253; Laybourn, *Britain on the Breadline*, p. 55.

¹⁰ Webster, 'Healthy or Hungry Thirties', 110-29; Also see F. Condrau and M. Worboys, 'Epidemics and Infections in Nineteenth Century Britain', *Social History of Medicine*, 20 (1), (2007), p. 156; Laybourn, *Britain on the Breadline*, p. 43.

¹¹ Webster, 'Healthy or Hungry Thirties', pp. 115, 123, 124.

affected by unemployment intensified, and that 'the national demographic picture thus postulates the possible connection between economic conditions and sheer survival for sections of the population in Britain.'¹² Therefore by using a number of public health indices and by drawing upon the health experiences of different groups, historians of the interwar period have debated the extent to which the era was one of progress in public health standards.

Within this debate, however, historians recognise that marked variations existed. Glynn and Oxborrow state that the 'interwar years present a paradox in British history' and that it was an era with 'two faces' – economic growth on the one hand and 'abnormally high unemployment' on the other.¹³ Consequently, in their book *Interwar Britain* they set out to 'give weight to both aspects' and not 'to arbitrate between them.'¹⁴ Hardy similarly states that 'the paradox of interwar Britain lies precisely in the steady modernisation and expansion of standards of living and expectations of life and health for many people on the one hand, and the miseries of the Depression in the old industrial areas on the other.'¹⁵ Throughout the historiography there is often a suggestion that the greater levels of illness north of the border was somewhat connected to its industrial decline. The dependence of the Scottish economy on the old staple industries meant that the recession struck hard. By the mid 1930s Scotland was experiencing poverty levels that were double the rate of those in England.¹⁶ The particularly unfavourable health position of Scotland was also 'almost never alluded to by Ministry officials in London.'¹⁷ For Smith this is 'important because health was much worse in

¹² Mitchell, 'Unemployment', pp. 107-09.

¹³ S. Glynn and J. Oxborrow, *Interwar Britain: A Social and Economic History* (London: George Allen and Unwin, 1976), p. 13.

¹⁴ *Ibid.*, p. 13.

¹⁵ Hardy, *Health and Medicine*, p. 109; Also see Constantine, *Unemployment*, p. 78.

¹⁶ I. Levitt, *Poverty and Welfare in Scotland 1890-1948* (Edinburgh: Edinburgh University Press, 1988), p. 200.

¹⁷ Webster, 'Healthy or Hungry Thirties', p. 116; S. Constantine, *Social Conditions in Britain, 1919-1939* (London: Methuen, 1983), p. 41; R. Smith, "Please Never Let it Happen Again":

Scotland: infant mortality was a third higher.’¹⁸ As a result, one might expect the contributions of Scottish historians to be more ‘pessimistic’ in tone. However, like the historiography written from a British perspective, the literature which exists on interwar Scotland is divided. Where historians such as Hughes, Finlay and Jenkinson have written in relatively negative terms, others including Knox and Devine have been more positive.¹⁹ In Scotland, health indices like infant mortality rates (IMR) were also better in 1939 than they had been in 1919, and Knox concludes that ‘the material experience of unemployment was contradictory, although poverty increased, Scotland, perhaps as a result of a fall in prices, experienced better nutritional and health standards which saw infant mortality rates fall quite sharply from a very high level.’²⁰ On the other hand, Jenkinson directly ‘challenges Winter’s optimistic view’ previously discussed.²¹ She claims that ‘the study of Scottish patterns in health statistics suggests that government and other welfare agencies dealt inadequately with the problems of ill health among mothers and infants, school children and the [sic] tuberculosis’, and that the divergence of the infant death rate between Scotland and England from 1918 ‘is perhaps why, as Charles Webster has noted, for those portraying an optimistic view of infant health trends in the interwar years, little attention was paid to Scottish figures at the time, or indeed since.’²² For Jenkinson, the ‘drain’ of chronic cases of illness on the health insurance system also ‘provides an indication of how far sustained economic depression undermined the general health of the population’ even if this is ‘by no means clear-cut.’²³ Clearly opinions on the Scottish experience are also divided. For Smout, in interwar Scotland ‘it all depended on who you were, where you

Lessons on Unemployment from the 1930s’, *British Medical Journal* (BMJ), 291 (1985), p. 1192.

¹⁸ Smith, “Please Never Let it Happen Again”, p. 1192.

¹⁹ W.W. Knox, *Industrial Nation: Work, Culture and Society in Scotland, 1800-Present* (Edinburgh: Edinburgh University Press, 1999); T.M. Devine, *Scottish Nation 1700-2000* (London: Penguin Press, 1999); R. Finlay, *Modern Scotland: 1914-2000* (London: Profile, 2004), p. 92; C. Harvie, *No Gods and Precious Few Heroes: Twentieth Century Scotland* (Edinburgh: Edinburgh University Press, 1998); Jenkinson, *Scotland’s Health*.

²⁰ Knox, *Industrial Nation*, p. 191.

²¹ Jenkinson, *Scotland’s Health*, p. 184.

²² *Ibid.*, pp. 31, 184.

²³ *Ibid.*, p. 334.

lived, and whether the shadow of unemployment fell on your life or passed you by.’²⁴

There is in fact little in depth literature on the health experience of the Great Depression north of the border, and out with the publication of *Scotland's Health 1919-1939* (2002) by Jenkinson, Scottish historians such as Devine, Finlay, Smout, Levitt and Knox, in broad social and economic histories of the country have merely touched on this theme.²⁵ Some have focused on particular aspects of Scotland's health story. Cage and McFarlane, for example, have attempted to establish the relationship between Scotland's poor housing and infant and tuberculosis mortality over a period which encompasses the Depression.²⁶ Nonetheless, Jenkinson is one of the few historians who have extensively considered interwar public health from a Scottish perspective. Her key goal was to explore Scotland's health services, 'to discover how far Scotland was successful in establishing and maintaining a health administration that was distinct from the Ministry of Health' and the extent to which the Scottish health administration 'responded to health issues in a manner which took into account the unique history and health concerns of the Scottish people.'²⁷ This thesis is distinctive (and hopefully complementary) in that it focuses upon the trends and characteristics of health in Glasgow – and is less of a top down analysis of the health policies and services implemented which is provided by Jenkinson. Writers such as Hardy argue that this approach is useful as 'the local perspective extends our understanding of the way disease affected the lives

²⁴ T.C. Smout, *A Century of the Scottish People* (London: Collins, 1986), p. 117.

²⁵ Devine, *Scottish Nation*; Finlay, *Modern Scotland*; Smout, *Century*; Levitt, *Poverty*; Knox, *Industrial Nation*.

²⁶ R.A. Cage, 'Infant Mortality Rates and Housing: Twentieth Century Glasgow', in A. Cooke, I. Donnachie, A. MacSween and C.A. Whatley, eds., *Modern Scottish History 1707 to the Present: Volume 4: Readings 1850 to the Present* (East Linton: Tuckwell Press, 1998), pp. 123-37; N. McFarlane, 'Hospitals, Housing and Tuberculosis in Glasgow, 1911-1951', *Social History of Medicine*, 2 (1989), 59-85.

²⁷ Jenkinson, *Scotland's Health*, p. 17.

of ordinary people, and complements the understanding of historical disease processes presented by existing studies based on national data.²⁸

Indeed, the more recent publications by Jacqueline Jenkinson *Scotland's Health* and Steven Thompson's *Unemployment, Poverty and Health in Interwar South Wales* (2006) have revived this historical topic, but with a regional dimension, *and* with specific reference to health. Here, Thompson's work is also significant. Similar to Glasgow, interwar south Wales has been traditionally associated with high levels of unemployment, poverty and ill health. Consequently, Thompson claims that authors have 'posited what might be termed a "pessimistic" interpretation' of the period.²⁹ However, the fresh, critical analysis provided by Thompson is important. It indicates the complexities of the era even within this notably depressed region and the historiographical trap of overemphasising the effects of the recession and unemployment upon health.³⁰ Thompson found that while evidence of the impact of the Depression was apparent, improvements also occurred, and that experiences varied across the population according to factors such as region, class and gender.³¹ This thesis also draws on Thompson's observation of the importance of considering the specific socio-economic, demographic and cultural features of individual regions, and engages with his emphasis on the 'interdependence of biological phenomena and their social, economic and cultural setting.'³² Following the methodologies and lead of Thompson this thesis takes a regional focus and examines public health in interwar Glasgow.³³ It uses the city as a case study to disentangle and engage with some of the key features of the

²⁸ A. Hardy, *The Epidemic Streets: Infectious Disease and the Rise of Preventative Medicine, 1856-1900* (Oxford: Clarendon Press, 1993), p. 8.

²⁹ Thompson, *Unemployment*, p. 1.

³⁰ *Ibid.*, pp. 246, 248-49.

³¹ *Ibid.*, p. 243.

³² *Ibid.*, pp. 2, 4, 243-49; Also see S. Thompson, 'Unemployment, Poverty and Women's Health', in P. Michael and C. Webster, eds., *Health and Society in Twentieth Century Wales* (Cardiff: University of Wales Press, 2006), p. 99.

³³ *Ibid.*, pp. 11, 78.

historiography and aims to provide a more nuanced understanding of what was going on in terms of public health during the interwar years.

Elements of the Debate

A survey of the literature on public health between the wars reveals a number of broad themes which have informed this debate. These include the mapping and interpretation of statistical trends, housing and the interwar building campaigns, the health experiences of women and children, and the role of unemployment in determining ill health and mortality. Historians have analysed a host of public health records to evaluate the extent to which health improved. In fact, this question has been complicated by the various interpretations which can be read from the extensive collection of accessible data, from the diverse range of experiences across the population, and by the underlining of specific features of mortality and morbidity trends while minimising the authority of others. For example, annual reports published by national and local authority health departments have ensured that detailed statistics on population, births and deaths, disease rates, public health programmes and welfare services are available to historians. This is not to mention the medical literature published by doctors in journals and the myriad of local investigations which were conducted by interested contemporaries. The growing field and understanding of nutrition and 'vitamins', of which Scottish characters like Boyd Orr and E.P. Cathcart were central, has also meant that detailed surveys of the foodstuffs consumed by the population were also compiled.³⁴ As such, the first chapter in this thesis which deals exclusively with health is largely statistical. It considers this material where it relates to Glasgow, maps the public health profile of the

³⁴ J. Boyd Orr, *Food, Health and Income: Report on a Survey of Adequacy of Diet in Relation to Income* (London: Macmillan, 1937); E.P. Cathcart, 'Food and Nutrition', *BMJ*, 27th February 1937, p. 435.

city, and reviews how far the various readings which can be obtained from this data informs the optimist-pessimist debate (Chapter 3). For the most part, detailed surveys of morbidity in Britain were not carried out before the Second World War.³⁵ In Scotland, statistics on sickness are available following the launch of the Morbidity Statistics Scheme in 1930, although they are not analysed in depth here.³⁶ This data has been examined thoroughly by Jenkinson.³⁷ Moreover, only incapacity among the insured workforce was recorded, whilst there is also the possibility that sickness benefit could be financially more attractive and obtainable than unemployment relief, undermining the use of these figures for measuring sickness per se.³⁸ There is also little existing evidence regarding 'good health' and the majority of records available to historians are evidence of sickness and death.³⁹ Modern definitions of 'health' assert that this is a 'state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity.'⁴⁰ Although the nature of health was debated throughout the interwar period it was not material that the Scottish health authorities collated.⁴¹ Consequently, mortality rather than morbidity data is emphasised throughout this project (see below).

Glasgow, like the nation in general, experienced a downward trend in its mortality rates. However, as has been indicated, a key element of the historiographical debate is the extent to which progress stagnated. A number of researchers emphasise a decline in the *rate* of improvement, if not actual

³⁵ C. Power, O. Manor and J. Fox, *Health and Class: The Early Years* (London: Chapman and Hall, 1991), p. 7; S. Cherry, *Medical Services and the Hospitals in Britain, 1860-1939* (Cambridge: Cambridge University Press, 1996), p. 12.

³⁶ *DHS: Health and Industrial Efficiency: Scottish Experiments in Social Medicine*, HMSO 1943, preface; 'Sickness in the Insured', *Medical Officer*, 13th April 1935, p. 143.

³⁷ Jenkinson, *Scotland's Health*, pp. 333-91.

³⁸ For a detailed explanation see Jenkinson, *Scotland's Health*, pp. 333-91; N. Whiteside, 'Counting the Cost: Sickness and Disability among Working People in an Era of Industrial Recession, 1920-1939', *The Economic History Review*, 40 (1987), 228-46.

³⁹ Constantine, *Social Conditions*, p. 33; Also recognised in *Department of Health for Scotland: Summary of Report of Committee on Scottish Health Services*, HMSO 1937, p. 46.

⁴⁰ A. Bowling, *Measuring Disease: A Review of Disease Specific Quality of Life Measurement Scales* (Buckingham: Open University Press, 2001), p. 6.

⁴¹ 'Women's Topics: Happiness, Health Values', *GH*, 3rd November 1926, p. 8.

deteriorations, from health indices like infant mortality rates.⁴² Hardy also points out that public health services were undermined as ‘the prospects for reforming and improving the delivery of health care and environmental reform were clouded throughout the interwar years by economic depression and financial stringency.’⁴³ Certainly, the rate of improvement in IMR was considerably faster in England than in Scotland and Harvie argues that ‘this was largely due to Scotland’s industrial depression and poor housing’.⁴⁴ ‘Optimist’ Stevenson also acknowledges that ‘the most that was conceded was that in the depressed areas unemployment was retarding the rate of improvement enjoyed by the more prosperous parts of the country.’⁴⁵ This is significant, as on many levels there is agreement between historians and their views cannot be neatly pigeonholed into ‘optimist’ and ‘pessimist’ categories.

All recognise that experiences were not universal, that improvements were often unequal, and that health standards varied according to a number of social, economic and cultural variables. Both often agree on the groups of the population where achievements were made and where they fell short, and it is the *extent* to which improvements or deteriorations occurred which is contested. For example there is widespread recognition of the significant disparities which existed according to class.⁴⁶ Class inequalities had always existed, and in the context of interwar public health the debate has focused upon the extent to which this gap widened or narrowed. According to Burnett, ‘a fair judgement on the statistical evidence would be that the unemployed, in common with the poor generally, shared unequally in the

⁴² Jones, *Health and Society*, p. 76; K. Nicholas, *The Social Effects of Unemployment on Teesside, 1919-39* (Manchester: Manchester University Press, 1986), pp. 84, 103; Hardy, *Health and Medicine*, pp. 78, 95, 96; Mitchell, ‘The Effects of Unemployment’, p. 107.

⁴³ Hardy, *Health and Medicine*, pp. 8, 95, 96.

⁴⁴ Harvie, *No Gods*, p. 68.

⁴⁵ Stevenson, *British Society*, p. 285.

⁴⁶ Constantine, *Social Conditions*, p. 37; J. Stewart, ‘Sickness and Health’, in L. Abrams and C.G. Brown, eds., *A History of Everyday Life in Scotland* (Edinburgh: Edinburgh University Press, 2010), p. 232; J. Gardiner, *The Thirties: An Intimate History, Britain’s Forgotten Decade* (London: Harper Press, 2010), p. 210; Cherry, *Medical Services and the Hospitals in Britain*, p. 14.

improvements in health standards which the British people experienced between the wars.⁴⁷ Whilst this is endorsed by writers like Webster and Jones, others including Winter, Levine and Wilkinson reject claims that this was the case.⁴⁸ Marked variations according to geographic region have also been highlighted. The frequent mention of high rates of unemployment and ill health in Glasgow is testament to this point. Discussing health in Middlesbrough, Doyle also suggests that unemployment and poverty 'left death rates, especially infant mortality, stubbornly high in the poorest areas.'⁴⁹ According to Winter, 'what is remarkable' is that the pressure on working class budgets and diets 'did not result in a deterioration of infant and maternal health in those areas most deeply affected by industrial decline.'⁵⁰ However, population studies reveal important regional demographic factors which could also influence mortality patterns. Modifications in death rates have been explained by population changes including later marriage, and alterations in the age composition of regions due to changing birth rates and emigration.⁵¹ For example, Thompson has stressed the importance of considering the age structure of communities to account for regional variations in health, since districts with an older populace, such as areas in south Wales where unemployment was high and the young migrated in search for work, tended to record greater levels of ill health.⁵² Consequently, this thesis considers the demographic features specific to Glasgow which

⁴⁷ Burnett, *Idle Hands*, p. 254.

⁴⁸ Webster, 'Healthy or Hungry Thirties', p. 116; Jones, *Health and Society*, pp. 75-6; Winter, 'Infant Mortality', p. 451; D. Levine, *Reproducing Families: The Political Economy of English Population History* (Cambridge: Cambridge University Press, 1987), p. 203; R.G. Wilkinson, 'Class Mortality Differentials: Income Distribution and Trends in Poverty', *Journal of Social Policy*, 18 (3), (1989), p. 307.

⁴⁹ B. Doyle, 'Power and Accountability in the Voluntary Hospitals of Middlesbrough 1900-1948', in A. Borsay and P. Shapely, eds., *Medicine, Charity and Mutual Aid: The Consumption of Health and Welfare in Britain, c. 1550-1950* (Aldershot: Ashgate, 1988), p. 212.

⁵⁰ Winter, 'Infant Mortality', p. 460.

⁵¹ Harvie, *No Gods*, p. 68; See Habakkuk cited in T. McKeown and R.G. Brown, 'Medical Evidence Related to English Population Changes in the Eighteenth Century', *Population Studies*, 2 (1955), p. 134; Hughes, 'The Economic and Social Effects of Recession and Depression', p. 297; E.A. Wrigley, *Population and History* (London: World University Library, 1969), p. 11.

⁵² Thompson, *Unemployment*, pp. 182, 186.

influenced its mortality trends as well as the wider social and economic context of the interwar years (Chapter 3).

A contributing factor to alterations in the spatial arrangement of the population was the housing policies of the interwar period. The success of these house building campaigns is also a key feature of the historiography which has helped inform historians' views on the extent to which the period was one of improvement. Nearly four million homes were provided throughout Britain between 1919 and 1939, and for writers like Stevenson these provided healthier environments more conducive to health.⁵³ For others like Thorpe, the efforts made to improve housing were, numerically, simply inadequate.⁵⁴ Constantine also notes that in industrial regions including southern Scotland many houses were 'decaying fast.'⁵⁵ The intensity of slum housing, overcrowding and insanitary conditions which prevailed in Scotland, and of the challenges this presented for public health, is widely recognised by historians.⁵⁶ As Macdonald notes, 'on the eve of a war that would claim millions of lives, poor housing in Scotland was claiming the health of the nation.'⁵⁷ Nevertheless, again, the Scottish view is contradictory. While Knox argues that 'the patchy but visible improvements in health standards was influenced by the progress being made in housing construction'⁵⁸ for Smout improvements were 'only in relative terms.'⁵⁹ Indeed, McFarlane has specifically argued that overcrowding exacerbated the incidence of tuberculosis in Glasgow, not unemployment.⁶⁰ Others have

⁵³ Stevenson, *British Society*, p. 221.

⁵⁴ Thorpe, *Britain in the 1930s*, p. 100; Constantine, *Social Conditions*, pp. 28, 31; McFarlane, 'Hospitals, Housing and Tuberculosis in Glasgow', p. 80; I. Maver, *Glasgow* (Edinburgh: Edinburgh University Press, 2000), p. 262.

⁵⁵ Constantine, *Social Conditions*, p. 31.

⁵⁶ Hardy, *Health and Medicine*, p. 89; L. Johnman and H. Murphy, 'Introduction', *International Journal of Maritime History*, 17 (2006), p. 237; Thorpe, *Britain in the 1930s*, p. 100; Cage, 'Infant Mortality Rates and Housing', pp. 123-37.

⁵⁷ C.M.M. MacDonald, *Whaur Extremes Meet: Scotland's Twentieth Century* (Edinburgh: John Donald, 2009), pp. 123, 124.

⁵⁸ Knox, *Industrial Nation*, p. 192.

⁵⁹ Smout, *Century*, pp. 34-5.

⁶⁰ McFarlane, 'Hospitals, Housing and Tuberculosis in Glasgow', pp. 60, 74.

pointed to the damaging effects of the high rents of new housing upon family budgets, the social exclusion, continued overcrowding, and the lack of local shops, employment opportunities, medical provisions and other services which often accompanied these new housing schemes, so that relocating to new, local authority accommodation could actually be disadvantageous to health.⁶¹ However, again, historians point out that the interwar housing legislation affected some more than others. For the most part, those higher up the socio-economic scale, including the middle classes and skilled working class, are deemed to be the main beneficiaries of housing developments. Crowther states for example that the 'new council estates tended to be occupied by skilled and white-collar workers, leaving behind the poor, especially those with large families, in overcrowded and insanitary slums.'⁶² Laybourn similarly argues that 'there is much to suggest that improvements in the quantity and quality of the housing stock did not greatly improve the lot of the unemployed and the poor.'⁶³ This thesis engages with these issues in chapter four through an in-depth analysis of housing, rehousing and health in interwar Glasgow.

Structural surroundings contributed significantly to health standards. However, historians have emphasised a range of factors in explaining mortality patterns including the role of the environment, nutrition and the practice of birth control.⁶⁴ The relationship between biological and socio-

⁶¹ Harvie, *No Gods*, pp. 71-2; Hutt, *Condition of the Working Class*, p. 11; J. McKee, *Glasgow: Working Class Housing between the Wars 1919-1939* (Unpublished M. Litt Thesis: University of Strathclyde, 1976-1977); J. Butt, 'Working Class Housing in Glasgow, 1900-1939', in I. MacDougall, ed., *Essays in Scottish Labour History: A Tribute to W.H. Marwick* (Edinburgh: John Donald Publishers LTD, 1978); M. Horsey, *Tenements and Towers: Glasgow: Working Class Housing 1890-1990* (Crown Copyright, 1990); S. Damer, *From Moorepark to 'Wine Alley': The Rise and Fall of a Glasgow Housing Scheme* (Edinburgh: Edinburgh University Press, 1989); Hughes, 'The Economic and Social Effects of Recession and Depression', p. 301; Nicholas, *Social Effects of Unemployment*, pp. 77, 88; Laybourn, *Britain on the Breadline*, p. 84; Constantine, *Social Conditions*, p. 29.

⁶² Crowther, *Social Policy*, p. 56; Thorpe, *Britain in the 1930s*, p. 118.

⁶³ Laybourn, *Britain on the Breadline*, p. 83.

⁶⁴ See E.A. Wrigley, 'The Prospects for Population History', *Journal of Interdisciplinary History: The New History: The 1980s and Beyond*, 12 (1981), 207-26; S.H. Preston, 'Population Studies of Mortality', *Population Studies*, 50 (1996), 525-36; T. McKeown and

economic determinants is important. For example, reductions in family size could affect living standards where limiting the number of mouths to be fed meant that more could be spent on food.⁶⁵ In the literature on interwar public health the interaction between social and biological factors is frequently discussed in relation to women. Historians have considered their role as child bearers, their position as domestic 'manager' within the home, their cultural responsibility of caring for family members and the impact that the social effects of the recession could have upon their health. For the most part, historians of the interwar period have argued that 'women' were one section of the population where standards of health could worsen. This is evidenced by the personal sacrifices they made within the home to protect the wellbeing of their families and by the high maternal death rate of the era. Winter is one of the few writers who contest this point. In his paper 'Infant Mortality, Maternal Mortality, and Public Health in Britain in the 1930s' he argues that the economic vicissitudes of the period did not 'affect adversely the life expectation of the infant and maternal population' and 'it would be wrong to perpetuate the view that among the costs of the Depression of the early 1930s in Britain was deterioration in the health of women in childbirth and of their infants.'⁶⁶ On the other hand, when also examining infant and maternal mortality data, Mitchell has contended that 'a strong statistical relationship has emerged between chronic deprivation and the condition, if not the very survival, of many women and children in the 1930s.'⁶⁷ Indeed, Winter acknowledges that the effects of the recession among women were perhaps felt a generation later, manifested in a higher number of still births in

R.G. Brown, 'Medical Evidence Related to English Population Changes in the Eighteenth Century', *Population Studies*, 2 (1955), 119-41; S. Cherry, 'The Hospitals and Population Growth: The Voluntary General Hospitals in the English Provinces in the Eighteenth and Nineteenth Centuries Part 2', *Population Studies*, 34 (1980), 251-65; J.M. Winter, 'The Decline of Mortality in Britain 1870-1950', in *Population and Society in Britain 1850-1980*, p. 109; Papers from the *International Conference on Better Health for Women and Children through Family Planning* held in Nairobi, Kenya, October 5-9 (1987) – J.L. Bobadilla, 'The Effects of Family Formation Patterns on Perinatal Health', National Institute of Public Health, p. 1; J. Hobcraft, 'Does Family Planning Save Children's Lives?', London School of Economics and Political Science, p. 48; J. Bongaarts, 'Does Family Planning Reduce Infant Mortality Rates', The Population Council, pp. 1, 11-12.

⁶⁵ Stevenson, *British Society*, p. 118; Devine, *Scottish Nation*, p. 530.

⁶⁶ Winter, 'Infant Mortality', p. 440.

⁶⁷ Mitchell, 'The Effects of Unemployment', p. 112.

later life among the children of mothers likely to have been affected by the socio-economic consequences of the recession. Consequently, chapter five evaluates the health of Glasgow's women and identifies where and how far their experience lends weight to these interpretations.

The sacrifices women made to secure the health of their families, and the unequal allocation of resources in the home which favoured male wage earners, is often cited as a cause of the widely recognised high levels of illness among women. The literature suggests distinctive health experiences according to gender.⁶⁸ However, in the interwar period it was often argued that poor health within the family was also due to the neglect or ignorance of wives and mothers. Medical professionals, health officials and the state stressed the importance of domestic education for mothers as a means of eradicating this shortcoming. However, Lewis claims that 'problems arising from poverty and insanitary living conditions were as pressing as any individual inadequacies,' and this has been similarly proposed by Crowther.⁶⁹ Some writers view the responsibility given to women as a form of oppression and state control.⁷⁰ For example, discussing the care of family members with mental and physical disabilities, Sanders and Carver argue that 'rather than insist that society as a whole shoulder its responsibilities for these people through the state, the health professionals pressure the families – and that

⁶⁸ Constantine, *Unemployment*, pp. 31, 34; Mitchell, 'The Effects of Unemployment', p. 111; S. Glynn and A. Booth, 'Introduction', in S. Glynn and A. Booth, eds., *The Road to Full Employment* (London: Allen and Unwin, 1987), p. 22; Whiteside, 'Counting the Cost', pp. 242, 244; Webster, 'Healthy or Hungry Thirties', p. 125; Gazeley, *Poverty*, p. 128; Crowther, *Social Policy*, p. 71; Burnett, *Idle Hands*, p. 254; Constantine, *Social Conditions*, p. 40; Stevenson, *Social Conditions in Britain*, p. 228; Jones, *Health and Society*, p. 73; R. Johnston and A. Mclvor, 'Dangerous Work, Hard Men and Broken Bodies: Masculinity in the Clydeside Heavy Industries, c. 1930-1970', *Labour History Review*, 69 (2004), p. 138; Mowat, *Britain between the Wars*, p. 487; S. Rowbotham, *Hidden from History* (1973), p. 145, cited in Winter, 'Infant Mortality', p. 439; Thompson, 'Unemployment, Poverty and Women's Health', p. 101.

⁶⁹ J. Lewis, *The Politics of Motherhood: Child and Maternal Welfare in England, 1900-1939* (London: Croom Helm, 1980), p. 61; Crowther, *Social Policy*, p. 70.

⁷⁰ D. Sanders and R. Carver, *The Struggle for Health: Medicine and the Politics of Underdevelopment* (Hampshire: Macmillan, 1985), p. 126.

usually means the *women* – to shoulder “their responsibilities”.⁷¹ Feminists have argued that the insistence that women were accountable for the health of their families was an effort to reinforce their role within the home.⁷² Oakley also views ante-natal care as a form of social control and a means of managing women during pregnancy – a predominantly male ‘attempt to control the behaviour of women’s bodies.’⁷³

The extension of state medicine into women’s lives was considerably augmented during the interwar period due to the increasing influence of local authority ante-natal clinics. Miles has argued that domestic advisors in the modern era, similar to those introduced in the twenties and thirties, increased the oppressive and intrusive nature of medicine in the lives of women. She states that domestic aids ‘backed by the prestige of “scientific medicine” and designed to promote “good health”’ represented the extension of ‘medical control... in the private domain of the home’ – a phenomenon, as we will see, some women of Glasgow attempted to resist.⁷⁴ Nonetheless, it will be shown that for health experiences within the home and family, the attendance of women at ante-natal and child welfare services, the cleanliness of the household, feeding and the management of scarce resources, arduous housework, family size, childbirth and standards of child care were centred within the private sphere and could significantly influence the physical wellbeing of its inhabitants.⁷⁵ However, experiences were diverse. Historians have noted marked variations according to the employment status of the household, that married women were particularly affected by their cultural role and responsibilities within the home, while other historians point

⁷¹ *Ibid.*, p. 126.

⁷² E. Wilson, *Women and the Welfare State* (London: Tavistock Publications, 1977), p. 7.

⁷³ A. Oakley, *The Captured Womb: A History of the Medical Care of Pregnant Women* (Oxford: Basil Blackwell, 1984), pp. 2, 77, 252, 254-5, 265.

⁷⁴ A. Miles, *Women, Health and Medicine* (Buckingham: Open University Press, 1993), p. 201.

⁷⁵ Johnston and McIvor, ‘Dangerous Work’, pp. 137-38; J. Bourke, *Working Class Culture in Britain 1890-1960: Gender, Class and Ethnicity* (London: Routledge, 1996), p. 95; Finlay, *Modern Scotland*, pp. 86, 132; J. Thomas and A.S. Williams, ‘Women and Abortion in 1930s Britain: A Survey and its Data’, *Social History of Medicine*, 11 (2), 1998, p. 288.

out that the death rates for children born to unmarried parents was significantly higher than those born in wed-lock.⁷⁶ This will also be examined in chapter five where the health of 'women' and their cultural responsibility for securing the wellbeing of their families will be explored.

However, the role of males in shaping health outcomes is also important and is a facet notably neglected by the historiography. Thompson is one of the few writers who acknowledge that men, for example, could also endure the unequal allocation of resources in the home in an attempt to preserve the health of their children.⁷⁷ On the other hand, contemporary notions of masculinity were central to a host of negative health experiences, including 'emasculatation', deteriorations in mental health when faced with unemployment, and the existence of domestic violence within the home.⁷⁸ Indeed, regarding men's role within the 'private' sphere, historians have tended to focus their attention on the effects of unemployed husbands on the health of their wives. The experiences of men are more regularly bound up with discussions on the impact of unemployment upon standards of health. It has been noted that historians agree that experiences were unequal. Perhaps the most obvious observation is that experiences varied between the employed and unemployed. The deteriorating physical condition of the long-term unemployed was at least witnessed, even if a conclusive relationship was difficult to establish medically.⁷⁹ A host of writers maintain that for the long-term unemployed physical form waned, so much so that they were less likely to be considered for work and less able to accept new work

⁷⁶ Thomas and Williams, 'Women and Abortion', pp. 288-9; A. Hughes, 'Representations and Counter-Representations of Domestic Violence on Clydeside between the Two World Wars', *Labour History Review*, 69 (2004), 169-84; Cage, 'Infant Mortality Rates and Housing', p. 128.

⁷⁷ Thompson, *Unemployment*, p. 85.

⁷⁸ Johnston and Mclvor, 'Dangerous Work', 135-52; G. Hutchison and M. O'Neill, *The Springburn Experience: An Oral History of Work in a Railway Community from 1840-Present* (Edinburgh: Polygon, 1989), pp. 56-67; Hughes, 'Representations and Counter-Representations'.

⁷⁹ Burnett, *Idle Hands*, p. 254.

when employment opportunities arose.⁸⁰ There is also broad agreement that unemployment affected mental health. Writers including Whiteside point out that the stress caused by unemployment could aggravate physical complaints.⁸¹ However, establishing the direct impact of unemployment upon health is complex. Historians have deliberated the question of causality – the extent to which unemployment caused sickness or ill health led to unemployment. Writers like Whiteside note that the least healthy were ‘at one and the same time the most likely candidates for redundancy and particularly vulnerable to the illness emanating from the stress and poverty associated with unemployment’, but that unemployment could reveal ill health as much as it could cause it.⁸² Chapter six grapples with some of these issues, considers those affected by unemployment in Glasgow in isolation, and aims to determine how far unemployment shaped public health experiences.

What this survey of the literature has shown is the awareness of historians that there was no universal experience. Standards of health varied throughout the population according to factors like class, geographic region, gender, marital status and employment position. In the context of industrial depression, the historiography on the interwar period has tended to emphasise the socio-economic influences which affected health. However, others attempting to establish the primary determinants of mortality and the persistence of health inequalities have highlighted both materialist and behaviourist factors, terms which discern the effects of socio-economic circumstances and health-related behaviours.⁸³ Kunitz comments that in the

⁸⁰ Nicholas, *Social Effects of Unemployment*, p. 33; Constantine, *Unemployment*, p. 23; R. Graves and A. Hodge, *The Long Week-End: A Social History of Great Britain 1918-1939* (New York: W.W. Norton and Company INC, 1963), p. 257.

⁸¹ Whiteside, ‘Counting the Cost’, p. 228.

⁸² Whiteside, ‘Counting the Cost’, pp. 240, 245; Stevenson, *British Society*, p. 267; Nicholas, *Social Effects of Unemployment*, p. 33; Constantine, *Unemployment*, p. 23; Bourke, *Working Class Culture*, p. 110; Finlay, *Modern Scotland*, p. 132.

⁸³ Power, Manor and Fox, *Health and Class*, p. 22; M. Anderson, ‘British Population History, 1911-1991’, in M. Anderson, ed., *British Population History: From the Black Death to the*

course of research on the key causes of mortality, ‘the debate was, in essence, between those who attributed most importance to socio-economic factors in disease and those who attributed most importance to “lifestyle” factors.’⁸⁴ In discussing the influence of these two variables Kunitz refers to the former as ‘determinists’ and the latter ‘voluntarists’.⁸⁵ In an era of economic decline, mass unemployment and heightened poverty, ‘determinist’ influences are an obvious starting point for any researcher of interwar Britain. However, voluntary lifestyle choices like smoking and drinking also had important consequences for individual and public health. Contrastingly, attempts were also made to improve physical wellbeing.⁸⁶ Welshman notes that the idea that physical education and exercise could constitute a form of preventative medicine was ‘an important aspect of policy in the late 1920s and early 1930s’, so much so that the national government implemented the Physical Training and Recreation Act (1937) to encourage sport, fitness and recreation by establishing new facilities throughout the country.⁸⁷ According to Navarro, in a time of economic crisis the state emphasises the ‘individual’s responsibility for care’ in order to cut costs on medical provisions and aid capitalist development, not to secure maximum health standards – a view similarly expressed by Doyal, Sanders and Carver.⁸⁸

Nevertheless, actively determined behaviours and lifestyle choices had important consequences for health. These health-related behaviours have been acknowledged in the literature but have not been examined in

Present Day (Cambridge: Cambridge University Press, 1996), p. 379; Brenner, ‘Personal Stability and Economic Security’, p. 2.

⁸⁴ S. Kunitz, ‘Explanations and Ideologies of Mortality Patterns’, *Population and Development Review*, 13 (1987), p. 390.

⁸⁵ *Ibid.*, p. 390.

⁸⁶ Hardy, *Health and Medicine*, p. 83.

⁸⁷ J. Welshman, ‘Physical Education and the School Medical Service in England and Wales, 1907-1939’, *Social History of Medicine*, 9 (1), 1996, p. 38; Jones, *Health and Society*, p. 70.

⁸⁸ V. Navarro, *Class Struggle, the State and Medicine: An Historical and Contemporary Analysis of the Medical Sector in Great Britain* (London: Martin Robertson, 1978), pp. 139, 140; L. Doyal, *The Political Economy of Health* (London: Pluto Press, 1979), pp. 23, 44; Sanders and Carver, *The Struggle for Health*, pp. 174-75; R. Baggott, *Health and Health Care in Britain 3rd Edition* (Hampshire: Palgrave Macmillan, 2004), p. 68.

depth with reference to health. Historians writing on the interwar period have commented on the 'healthy' aspects of the time like the national 'Keep Fit' craze, hiking opportunities and increased participation in sporting activities including football and cycling.⁸⁹ This image is at odds with popular perceptions of the Great Depression as a time of ill health, physical weakness and malnutrition. The recent publication *Managing the Body: Beauty, Health and Fitness in Britain, 1880-1939* (2010) by Zweiniger-Bargielowska has highlighted growing concerns over obesity in interwar Britain and developing pressures to slim. Poorer lifestyle choices due, ironically, to improving living standards have also been recognised, including the rise in sugary diets and consequent tooth decay, "diseases of affluence", 'Fish and Chip' shops and ice-cream parlours, the increase in smoking, masculine practices such as the consumption of large amounts of alcohol (perhaps particularly relevant at a time when masculinity was threatened by unemployment), risk taking in the workplace among both sexes, gang warfare and heightened poverty due to gambling.⁹⁰ All of these could be important but self-inflicted influences on health which were not directly related to wider economic conditions. Webster observes that 'changes in social and dietary habits, including the greater use of convenience foods, and the growth of cigarette smoking, were not always advantageous to health' and Brown also notes that in Scotland at least, 'Scottish Office files indicate that the moral panic over gambling, drink and "rough culture"... reached a peak during the slump years of 1932-33.'⁹¹ Consequently, the lifestyles and

⁸⁹ S. Jones, *Sport, Politics and the Working Class: Organised Labour and Sport in Interwar Britain* (Manchester: Manchester University Press, 1988); Jones, *Health and Society*, p. 70; Harvie, *No Gods*, p. 119.

⁹⁰ Thorpe, *Britain in the 1930s*, p. 114; Constantine, *Social Conditions*, p. 15; Harvie, *No Gods*, p. 73; Smout, *Century*, p. 124; Nicholas, *Social Effects of Unemployment*, p. 63; Finlay, *Modern Scotland*, p. 131; M. Abendstern, C. Hallett and L. Wade, 'Flouting the Law: Women and the Hazards of Cleaning Moving Machinery in the Cotton Industry, 1930-1970', *Oral History*, 33 (2) (2005), p. 70; R. Johnston and A. McIvor, 'Dust to Dust: Oral Testimonies of Asbestos-Related Disease on Clydeside, 1930 to the Present', *Oral History*, 29 (2001), p. 54; Johnston and McIvor, 'Dangerous Work', p. 136; C.G. Brown, 'Popular Culture and the Continuing Struggle for Rational Recreation', in T.M. Devine and R. Finlay eds., *Scotland in the Twentieth Century* (Edinburgh: Edinburgh University Press, 1996), p. 220; A. Davies, 'Street Gangs, Crime and Policing in Glasgow during the 1930s: The Case of the Beehive Boys', *Social History*, 23 (3), (1998), 251-67.

⁹¹ Webster, 'Healthy or Hungry Thirties', p. 125; Brown, 'Popular Culture', p. 223.

agency of Glaswegians in shaping their own health experiences is examined in depth in chapter seven.

The importance of individual agency has been arguably overshadowed by skewed debates on the extent to which unemployment had an adverse affect on physical wellbeing. Thompson supports the view that 'by closely examining the everyday realities of people's lives it is possible to obtain a better understanding of the specific ways in which social variables determined standards of health.'⁹² For example, it is claimed that lifestyle choices may also help to explain health inequalities according to class and gender.⁹³ It is necessary to examine biological and cultural interactions where, as Porter and Wear argue, physiological events are influenced not only by biological variables like death and disease, but 'these themselves operate in a complex dialectic with cultural choices.'⁹⁴ This is additionally important since, as Thompson points out, studies which have considered this relationship have so far focused upon the early modern period and the nineteenth century and neglected the twentieth.⁹⁵ Hence, it seems that a multilayered interpretation of interwar public health is required where the reality of the period was more complex than conventional one-dimensional interpretations can suggest. This is the approach adopted throughout this thesis.

Sources and Methodology

This study combines both quantitative and qualitative source material in order to provide a more nuanced view of health experiences in Glasgow. The

⁹² Thompson, *Unemployment*, p. 6.

⁹³ R. Mitchison, *British Population Change since 1860* (Basingstoke: Macmillan, 1977), p. 41.

⁹⁴ R. Porter and A. Wear, 'Introduction', in R. Porter and A. Wear, eds., *Problems and Methods in the History of Medicine* (Kent: Croom Helm, 1987), p. 4.

⁹⁵ Thompson, *Unemployment*, p. 4.

quantitative aspect of this research, for the most part, focuses upon mortality patterns, and thus what could be described as 'physical health'. However, this research has attempted to broaden the primary sources typically associated with studies of public health. Consequently, statistical data is supplemented and coalesced with qualitative evidence such as subjective observations provided by the Medical Officer of Health and the *Reports of the Unemployment Assistance Board*, newspaper articles, letters to editors, and minutes and correspondence by various contemporaries held at the *National Archives of Scotland*. In order to gain insight into what the public were being told about health, and lay understandings and perceptions, the *Glasgow Herald*, *Govan Press*, *Scotsman* and *Times* newspapers were systematically researched. The *Glasgow Herald* was chosen due to a middle class readership while the *Govan Press* was published for a working class area. The *Scotsman* and *Times* were chosen due to their availability online, and were more easily searchable and accessible. As most of these were issued daily it was impossible to read all publications. Therefore, the papers for every second day in the years 1920, 1922, 1926, 1933, 1935-36, 1938 were chosen in terms of their importance, and their ability to 'provide a perspective across the interwar period'.⁹⁶ This is in line with the approach adopted by Jones and Rahman.⁹⁷ Published personal testimonies and autobiographies such as *No Mean Fighter*, Glasser's *Growing up in the Gorbals*, and contemporary factual and fictional literature including Edwin Muir's *Scottish Journey*, Alexander McArthur and H. Kinsley Long's *No Mean City*, and George Blake's *Shipbuilders* are consulted, as well as existing unpublished oral history sound files and transcripts from the *Scottish Oral History Centre Archive* (SOHCA), the *Strathkelvin Local Studies Project Oral Archive*, Glasgow Museum's *M74 Oral History Project* and *2000 Glasgow Lives*

⁹⁶ 1920 the beginning of the period when conditions were still relatively favourable; 1922 the low point of the slump in this decade; 1926 the year of the General Strike; 1933 incorporating the lowest point of the Depression in this decade; 1935-36 a period of some improvement and the important national housing survey on overcrowding (see chapter 4); and 1938 a period again of improvement and relative prosperity, and approaching the end of the period (1939 was not chosen due to shifting priorities and the dominance of articles regarding the impending war).

⁹⁷ E. Jones and S. Rahman, 'Framing Mental Illness, 1923-1939: The Maudsley Hospital and its Patients', *Social History of Medicine*, 21 (1), (2008), 107-25.

Collection, and Thompson's *Edwardians: Family Life and Work Experience before 1918*.⁹⁸ Consideration of such source material is crucial to understanding the influence of health cultures and agency which is impossible from stringent statistical analysis.⁹⁹ Beier has called for an 'expansion of scholarly approaches to the histories of public health and medicine to include "lay" as well as "professional" sources and perspectives' – an appeal, it is hoped, that this thesis will help to address.¹⁰⁰ This practice provides a more nuanced view of interwar health trends, an understanding of the 'human' dimension behind the statistics, whilst locating mortality patterns more broadly.

Quantitative Analysis

The plentiful supply of statistics provided by official publications including the *Annual Reports of the Medical Officer of Health, City of Glasgow* (published by Medical Officer of Health (MOH) A.K. Chalmers from 1919-25, and A.S.M. Macgregor up until 1939), the *Annual Reports of the Scottish Board of Health* and (after 1929) the *Department of Health for Scotland* are used to analyse mortality patterns, particularly using the computer software package Microsoft Excel. Averages calculated by myself – annual unemployment rates from monthly recordings or IMR according to region for example – were consistently rounded to one decimal place to ensure that small deteriorations or improvements were captured.¹⁰¹ The decision to emphasise mortality figures also stems from the many methodological problems implicit to any analysis of morbidity, sickness or 'good' health. For example, postmodern analyses have highlighted the difficulty of evaluating morbidity data due to

⁹⁸ The Edwardian's project was consulted for transgressions into the interwar period.

⁹⁹ D. Morris, 'Postmodern Illness', in T. Heller, R. Muston, M. Sidell and C. Lloyd, eds., *Working for Health* (London: Sage Publications, 2001), p. 41.

¹⁰⁰ L.M. McCray Beier, *For Their Own Good: The Transformation of English Working Class Health Culture, 1880-1970* (Columbus: Ohio State University Press, 2008), p. 3.

¹⁰¹ Thompson, *Unemployment*, p. 96.

the 'social construction' of disease and illness. According to Nietzsche, there can be no medical 'facts' and illness can only be an interpretation of reality.¹⁰² Morris similarly argues:

From a postmodern perspective, doctors and medical researchers are never wholly objective, despite even heroic efforts to achieve verifiable results, much as the patients are never wholly subjective, despite evidence that we know the world as filtered through our individual egos.¹⁰³

Borowy and Gruner claim that the interwar period is a useful time span for the historical study of health because 'many people at the time were interested in health, there was growing scholarship in that field, and the collection and processing of statistical data became a growing part of scientific and public life.'¹⁰⁴ However, they also acknowledge that:

Relying on other people's observations means already using their interpretation of reality. Health is neither an objective reality, nor a cultural construction, but a synthesis of both. But in practical study, it is often very difficult to separate "objective" reality from its constructions by physicians, patients, public health officers, politicians which we as historians use. Reality does not exist on paper in a book, but historical analysis does... Keeping this bias in mind, the question of health and its role in the society at large necessitates an integration of two basic approaches: On the one hand attempting to define as accurately as possible the reality of health, the "real" facts, and, on the other hand, their political, social and ideological uses.¹⁰⁵

¹⁰² B.S. Turner, *Medical Power and Social Knowledge 2nd Edition* (London: Sage, 1995), p. 207.

¹⁰³ Morris, 'Postmodern Illness', p. 39.

¹⁰⁴ I. Borowy and W.D. Gruner, 'Introduction', in I. Borowy and W.D. Gruner, eds., *Facing Illness in Troubled Times: Health in Europe in the Interwar Years, 1918-1939* (Frankfurt am Main: Peter Lang, 2005), p. 8.

¹⁰⁵ *Ibid.*, pp. 8-9.

Nonetheless, it can be argued that utilising mortality data removes some of the ambiguity, where as Thompson notes, 'death is definite and irrefutable.'¹⁰⁶ Furthermore, it is widely agreed that infant mortality in particular is a useful indicator of the overall health and socio-economic conditions of a community.¹⁰⁷ Indeed, according to Power, Manor and Fox, mortality patterns often follow a similar trend to morbidity anyway.¹⁰⁸

Similar issues also lie behind the decision not to examine mental health extensively as part of this thesis. The general consensus during the interwar period was that unemployment increased the likelihood of psychological illness and that the probability of this increased the longer an individual was out of work (see chapter 6). However, time and methodological constraints, such as the subjective nature of psychological analysis even today, and the methods of psychiatric testing during the interwar period, make extensive analysis of mental health problematic, and one would be faced with a host of additional methodological considerations that are out with the remit of this study. Nonetheless, mental health cannot be neglected entirely. Both historians and psychologists acknowledge that the stresses and anxieties associated with unemployment could also aggravate physical sickness. Therefore, in this thesis, mental health studies are considered where significant, particularly in relation to the unemployed.¹⁰⁹

There are undoubtedly a host of difficulties associated with the use of official mortality statistics. Webster in particular condemns the bias of the interwar government in their interpretation and presentation of the evidence cited in their reports, stating:

¹⁰⁶ Thompson, *Unemployment*, p. 9.

¹⁰⁷ H. Graham, *Women, Health and the Family* (London: Harvester Wheatsheaf, 1984), p. 49; C.H. Lee, 'Regional Inequalities in Infant Mortality in Britain 1881-1971: Patterns and Hypotheses', *Population Studies*, 45 (1991), 55-66; Gazeley, *Poverty*, p. 116.

¹⁰⁸ Power, Manor and Fox, *Health and Class*, p. 2.

¹⁰⁹ However, the issue of mental health during the recession deserves due research attention.

Every major political and administrative influence operated to coerce the Ministry of Health and Board of Health and Board of Education into adopting the most optimistic interpretation of the available evidence, and there was little incentive for the Ministry to take initiatives which might not reinforce this impression.¹¹⁰

Smith similarly writes that ‘the historical evidence shows clearly that the government tended to play down or even ignore much of the evidence associating poor health with unemployment.’¹¹¹ Contrastingly, it is also useful to consider whether local authorities could have exaggerated the social problems of the period in order to gain more financial assistance from central government – a phenomenon which the *DHS* were seemingly guilty of in their reporting of the unemployment situation in the country. For example, in at least one instance, they emphasised the figure of unemployment for males in Glasgow which was notably higher than the rate for the city as a whole.¹¹² It is unclear why the *DHS* would essentially accentuate these figures when reporting regional variations. However, support for Levitt’s contention that certain members of government bodies ‘felt that Scotland required a different response than the British state seemed willing to provide’ is to some extent implied.¹¹³ Mitchell quotes the appropriate observation of one interwar contemporary that ‘facts and figures produced by public officials concerning the unemployment and the conditions of distressed areas must be taken with a grain of salt, for they do no more than interpret the mind of the party in power’.¹¹⁴

¹¹⁰ Webster, ‘Healthy or Hungry Thirties’, p. 123.

¹¹¹ Smith, “Please Never Let it Happen Again”, p. 1192.

¹¹² *Third Annual Report for the Department of Health for Scotland (ARDHS) 1931*, HMSO 1932 (4080), p. 141; *ARDHS 1933*, p. 114.

¹¹³ Levitt, *Poverty*, p. 6.

¹¹⁴ S. Hastings speaking at a public meeting on ‘Unemployment and the Housewife’, Essex Hall, London, 10/11/1936, organised by the Committee Against Malnutrition. Report filed with the Hannington Papers in the Marx Memorial Library, cited in Mitchell, ‘The Effects of Unemployment’, p. 112.

In fact, it could be argued that historians using the health data also utilised by interwar authorities may have simply reproduced the government's perspective, re-presenting the data which defended their case for the maintenance of public health. Whiteside notes that 'perhaps one of the weaknesses in the pessimists' analysis has been to present their case in optimists' terms.'¹¹⁵ Whiteside has alternatively analysed the statistics collated by the national health insurance scheme and found that they rose steadily during the interwar years. This seems to be related to some extent to increasing levels of unemployment – a pattern contrary to that commonly depicted by mortality and other health statistics.¹¹⁶ However, whilst acknowledging the shortcomings of official mortality statistics their use should not be entirely dismissed. As noted above, writers such as Mitchell and Thompson have broken down the same data utilised by interwar government officials to show that they can be reinterpreted to demonstrate significant deteriorations in health among particular sections of the population.

By disentangling the diverse range of health experiences, this study agrees with Mitchell's assertion that 'without differentiating between socio-economic groups, is to perpetuate the contemporary official presentation of the evidence influenced, as it was, by the particular political, economic and cultural ideology of the time.'¹¹⁷ For example, it has been noted that health statistics for Scotland were rarely acknowledged in official commentaries. Thus, this research responds to the need to also consider what was not highlighted in government reports, and the possibility that the Ministry of Health had good political reasons for not drawing attention to these health records. Furthermore, official figures are only one source utilised. As mentioned, they will be combined and verified with unofficial evidence, such as that produced in medical texts including the *Glasgow Medical Journal* (GMJ) and the *Lancet*, and less traditional qualitative source material which

¹¹⁵ Whiteside, 'Counting the Cost', p. 230.

¹¹⁶ *Ibid.*, pp. 230, 245.

¹¹⁷ Mitchell, 'The Effects of Unemployment', p. 119.

will be recognised as a legitimate historical source, as endorsed by Digby.¹¹⁸ Goubert has also written that researchers 'must investigate private archives' which he considers to be the diaries of doctors and surgeons for example, their medical notebooks, memoirs and journals etc., and in Glasgow there exists similar texts such as *Gorbals Doctor* by George Gladstone Robertson M.D.¹¹⁹ Loux adds that 'quantitative analysis will only yield hypotheses, leading once again to qualitative research' and that historical enquiry should oscillate constantly between these two kinds of sources.¹²⁰ In short, this research will answer Imhof's plea to 'look beyond the decimal points.'¹²¹

Qualitative Analysis

Porter states that in the past, historians of medicine have tended to overemphasise the role of doctors and medical professionals at the expense of the experiences of patients.¹²² This thesis is not a history of medicine or health policy and politics, but it does take a similar approach to that appealed for by Porter and follows the lead of historians like Thompson.¹²³ By adopting this method it is possible to analyse a number of non-medical sources which offer an alternative discourse to that found in official government and health reports. For example, Burnett notes that in terms of

¹¹⁸ A. Digby, 'Quantitative and Qualitative Perspectives on the Asylum', in R. Porter and A. Wear, eds., *Problems and Methods in the History of Medicine*, pp. 171, 172.

¹¹⁹ J.P. Goubert, 'Twenty Years On: Problems of Historical Methodology in the History of Health', in R. Porter and A. Wear, eds., *Problems and Methods in the History of Medicine*, p. 47; George Gladstone Robertson, *Gorbals Doctor* (London: Jarrolds, 1970).

¹²⁰ F. Loux, 'Popular Culture and Knowledge of the Body: Infancy and the Medical Anthropologist', in R. Porter and A. Wear, eds., *Problems and Methods in the History of Medicine*, p. 89.

¹²¹ A.E. Imhof, 'Methodological Problems in Modern Urban History Writing: Graphic Representations of Urban Mortality', in R. Porter and A. Wear, eds., *Problems and Methods in the History of Medicine*, p. 126.

¹²² R. Porter, 'Historiography', in S. Lock, J.M. Last and G. Dunea, eds., *The Oxford Illustrated Companion to Medicine* (Oxford: Oxford University Press, 2001), p. 333; R. Porter, 'The Patients View: Doing Medical History from Below', *Theory and Society*, 14 (1985), 175-98.

¹²³ Thompson, *Unemployment*.

unemployment, experiences ‘followed no universal or simple pattern: on the contrary, autobiographies demonstrate a wide variety of reactions – of success and failure to adapt, acceptance and anger, frustration and creative activity – which defy any single model’ – an argument maintained throughout this thesis.¹²⁴ Moreover, required data is often unrecorded in contemporary material and the history of Scotland’s working class for example, cannot always be found in the archives.¹²⁵ Where they are, their lives and experiences are mostly seen and judged through the eyes of middle class medics and social investigators. Marginalised groups such as the working class and women were less likely to record their experiences and interviews are often the only means of gaining access to their information.¹²⁶ These issues are problematic for a study investigating health in relation to factors such as class and gender.

Accordingly, this research also examines a number of existing oral history projects which cover interwar Glasgow. The use of oral testimony is being increasingly adopted in historical studies on health and medicine.¹²⁷ Paul Thompson advocates its use for ‘reinterpreting and filling gaps and weaknesses in the documents.’¹²⁸ Indeed, according to Davidson, research

¹²⁴ Burnett, *Idle Hands*, p. 264.

¹²⁵ S. Reynolds, ‘Foreword’, in Ian MacDougall, eds., *‘Oh ye had to be careful!’: Personal Recollections by Roslin Gunpowder Mill Factory Workers* (East Linton: Tuckwell Press, 2000), p. x.

¹²⁶ J. Mason, *Qualitative Researching* (London: Sage, 2006), p. 66.

¹²⁷ Beier, *For Their Own Good*; Abendstern, Hallett and Wade, ‘Flouting the Law’, 69-78; Johnston and Mclvor, ‘Dust to Dust’, 48-61; L. Marks, ‘They’re Magicians’: Midwives, Doctors and Hospitals: Women’s Experiences of Childbirth in East London and Woolwich in the Interwar Years’, *Oral History*, 23 (1995), 46-53; P. King and R. O’Brien, ‘You didn’t get much help in them days, you just had to get on with it’: Parenting in Hertfordshire in the 1920s and 1930s, *Oral History*, 23 (1995), p. 54; J. Walmsley, ‘Life History Interviews with People with Learning Disabilities’, *Oral History*, 23 (1995), 71-7; R. Fido and M. Potts, ‘Its not true what was written down!: Experiences of Life in a Mental Handicap Institution’, *Oral History*, 17 (1989), 31-4; R. Wilkinson, ‘A Personal Experience of Polio’, *Oral History*, 33 (2005), 82-4; D. Mitchell and A.M. Rafferty, “‘I don’t think they ever really wanted to know anything about us’”: Oral History Interviews with Learning Disability Nurses’, *Oral History*, 33 (2005), 77-87; R. Johnston and A. Mclvor, ‘Narratives of the Urban Workplace: Oral Testimonies and the Reconstruction of Men’s Work in the Heavy Industries in Glasgow’, in R. Rodger and J. Herbert, eds., *Testimonies of the City: Identity, Community and Change in a Contemporary Urban World* (Aldershot: Ashgate, 2007), p. 30.

¹²⁸ P. Thompson, *Voice of the Past* (Oxford: Oxford University Press, 2000), p. 125.

on the transmission of sexually transmitted diseases in twentieth century Britain and on the contact-tracing of these infections had been neglected, largely due to the lack of archival evidence and the closure of official files which contain this highly sensitive personal information.¹²⁹ Similarly, given the reluctance of health authorities to associate unemployment with ill health, oral histories prove useful for understanding what people believed the impact of unemployment to be on physical and mental wellbeing. On the other hand, writers such as Abendstern, Hallett and Wade assert that personal testimonies 'both challenged and consolidated the documentary evidence whilst the latter has heightened the credibility of the former' during their enquiry into occupational health in the cotton industry.¹³⁰ The use of existing oral history projects, however, can be problematic.¹³¹ The most obvious issue is that it is not possible to address interviewees with questions directly related to individual research, and often the researcher is dependent on digressions into their area of interest. Furthermore, depending on the size of the available oral history projects and archives and the research topics investigated, it is not always possible to systematically sample the experiences of the population according to characteristics such as region and class, an approach recently employed by Szreter and Fisher.¹³² For this research on public health in interwar Glasgow, the life experiences of 74 Glaswegians (49 females and 25 males) born between 1897 and 1929 have been included, simply because their testimonies covered health in the interwar period. Nonetheless, they come from a range of backgrounds and geographical regions and provide rich and diverse stories about life in the city.¹³³

¹²⁹ R. Davidson, 'Searching for Mary, Glasgow: Contact Tracing for Sexually Transmitted Diseases in Twentieth Century Scotland', *Social History of Medicine*, 9 (2), 1996, p. 196.

¹³⁰ Abendstern, Hallett and Wade, 'Flouting the Law', p. 72.

¹³¹ See for example J. Bornat, 'A Second Take: Revisiting Interviews with a Different Purpose', *Oral History*, 31 (1), (2003), 47-53.

¹³² S. Szreter and K. Fisher, *Sex Before the Sexual Revolution: Intimate Life in England 1918-1963* (Cambridge: Cambridge University Press, 2010), pp. 388-93.

¹³³ For example, SOHCA/038/001 (1912) was the daughter of a Corporation worker and notably well off, as was Joyce Booth (1912) the daughter of a piano teacher and student of the Glasgow School of Art, and John Brown (1901), managing director of what was perhaps Glasgow's most famous shipyard. On the other hand, a number of interviewees could be

It seems that historians emphasising the personal realities of the period tend to adopt a less 'optimistic' stance. For example, Gray's *The Worst of Times* was written in reaction to historians who portray the interwar years as a period of affluence. This he claims is an 'insult to millions whose experience of living at that time ran quite counter to this rosy analysis' and that for many 'these years brought malnutrition, shabbiness, dirt, industrial strife, the indignities of the Means Test and the threat of the workhouse' – a view similarly advanced by MacDougall in relation to Scotland.¹³⁴ It has also been argued that the major strength of oral history is the insight gained into everyday lives.¹³⁵ This is vital for a study which aims to reconstruct the social experience of health. Herbert and Rodger argue that oral sources 'can aid a deeper and richer understanding of the *experience* of urban life', that they 'can provide descriptions of particular social settings, which help to reconstruct a picture of daily life in the city from the respondent's perspective' and that 'in challenging traditional histories, oral testimonies draw our attention to the complexity of urban life.'¹³⁶

There are, however, obvious methodological challenges regarding the use of oral history. For instance, as Condrau points out, 'one of the pitfalls of taking into account the patient's view in medical history is that the patients whose stories we know were usually long-term survivors.'¹³⁷ While this does not invalidate the usefulness of oral histories as a source, it does 'shape the

defined under the spectrum 'working class', such as engineer James Phillips (1917), son of a cooper Robin Hodge (1926), while others such as Katy Lang (1913) and William Young (1902) came from obviously poor families (for example William's father was regularly unemployed and the interviewee himself spent time in a poor house).

¹³⁴ N. Gray, *The Worst of Times: An Oral History of the Great Depression in Britain* (Hampshire: Wildwood House Limited, 1985), pp. 4, 7; I. MacDougall, *Voices from the Hunger Marches Volume I: Personal Recollections by Scottish Hunger Marchers of the 1920s and 1930s* (Edinburgh: Polygon, 1990), p. 1.

¹³⁵ L. Abrams and C.G. Brown, eds., *A History of Everyday Life in Scotland* (Edinburgh: Edinburgh University Press, 2010); Thompson, *Voice of the Past*, p. 231; E. Roberts, *A Woman's Place: An Oral History of Working Class Women 1890-1940* (Oxford: Basil Blackwell, 1984), p. 3.

¹³⁶ J. Herbert and R. Rodger, 'Frameworks', in Rodger and Herbert, eds., *Testimonies of the City*, pp. 3, 7.

¹³⁷ Condrau, 'Urban Tuberculosis Patients and Sanatorium Treatment in the early Twentieth Century', p. 205.

historical context in which they need to be understood.’¹³⁸ Also, all interviews involve an interaction between interviewer and interviewee and will never be completely objective.¹³⁹ However, Legard, Keegan and Ward argue that this dynamic does ‘not discount the possibility that knowledge of the social world beyond the interaction can be obtained.’¹⁴⁰ Moreover, Reynolds and Bryman recognise that ‘the chief problem with the oral history interview is the possibility of bias introduced by memory lapses or distortions.’¹⁴¹ This issue has been examined in depth by Alistair Thomson who has noted that memories can be essentially ‘polluted’ – a phenomenon which he has termed the ‘cultural-circuit’. Thomson found that people could confuse their own memories with those which, for example, had been created by the media or even witnessed in films.¹⁴² Summerfield explains that:

The ‘cultural circuit’ suggests that personal accounts are in their own ways fictive or constructed, as are public accounts, because they are woven from available ways of understanding which suit the individual in relation to his or her own sense of self, and his or her audience’s expectations at the time of telling.¹⁴³

Significantly, during one interview consulted as part of this research, the interviewee refers to the interwar recession as the ‘hungry thirties’.¹⁴⁴ This provoked suspicion that this statement and ‘memory’ may have been affected by the stereotype of the Great Depression – a term heard, for instance, in one sound exhibition featured permanently in the popular *People’s Palace*

¹³⁸ *Ibid.*, p. 205.

¹³⁹ Mason, *Qualitative Researching*, p. 62.

¹⁴⁰ R. Legard, J. Keegan and K. Ward, ‘In-depth Interviews’, in J. Ritchie and J. Lewis, eds., *Qualitative Research Practice: A Guide for Social Science Students and Researchers* (London: Sage, 2006), p. 141.

¹⁴¹ Bryman, *Social Research Methods*, p. 321; Reynolds, ‘Foreword’, in MacDougal, eds., ‘*Oh ye had to be careful!*’, p. x.

¹⁴² A. Thomson, *Anzac Memories: Living with the Legend* (Oxford: Oxford University Press Australia, 1994), cited in P. Summerfield, *Reconstructing Women’s Wartime Lives: Discourse and Subjectivity in Oral Histories of the Second World War* (Manchester: Manchester University Press, 1998), pp. 18, 29.

¹⁴³ Summerfield, *Reconstructing Women’s Wartime Lives*, p. 29.

¹⁴⁴ *Strathkelvin Local Studies Project Oral Archive*, TO117, Mrs B interviewed by S. Powell, T. Peadle and C. McDaid, 24th July 1986.

social history museum in Glasgow.¹⁴⁵ Evidence of the ‘cultural circuit’ is also implied from other projects on the social history of health in Scotland. For example, when Diack investigated an outbreak of typhoid in Aberdeen in 1964, interviewees recurrently recalled myths surrounding the outbreak as though they were fact. Powerful images which were later offered as memories of the time had been created by the media. For instance, Aberdeen’s Medical Officer of Health was remembered to have said that Aberdeen was a ‘beleaguered city’ when there is no evidence to support that he had made this claim. Yet, as Diack notes, ‘it is a statement for which he is remembered and often blamed.’¹⁴⁶ Diack concludes that rather than a city under siege from typhoid, Aberdeen was:

In fact a city under siege from the media, a media who are misrepresenting or embellishing the words of the Medical Officer of Health to create a picture far worse than it actually was. This picture, however, has been the one that has survived in the folk memory of the city and one that most of the interviews have described.¹⁴⁷

Nevertheless, it can be maintained that this still constitutes legitimate historical evidence – as argued by historians such as Portelli.¹⁴⁸ Whilst the information recalled was incorrect, this is what the people believed to be true at the time and since. Thus the memory recalled can often be the lived experience of the time and thus continues to aid our understanding of the past. In his introduction to *Oral History, Health and Welfare* Paul Thompson asserts ‘that such popular “ideas and images of health” are particularly amenable to exploration by oral history’ and that ‘in this way oral history has

¹⁴⁵ *Peoples Palace*, Audio feature accompanying ‘single-end’ display, 23rd August 2010; The scripted voice over (not snippets from oral history interviews) refers to the period under review as ‘the hungry thirties as they were known’; Also see Rountree, *Govan Childhood*, p. 58.

¹⁴⁶ L. Diack, ‘Myths of a Beleaguered City: Aberdeen and the Typhoid Outbreak of 1964 Explored Through Oral History’, *Oral History*, 29 (2001), p. 66.

¹⁴⁷ Diack, ‘Myths of a Beleaguered City’, pp. 66-7.

¹⁴⁸ A. Portelli, *They Say in Harlan County: An Oral History* (New York: Oxford University Press, 2010); R. Perks and A. Thompson, *The Oral History Reader* (New York: Routledge, 1997).

a special contribution to make to the history of medicine.¹⁴⁹ Likewise, Ferguson notes that the responses of retired Scottish nurses regarding the changes which occurred in practice after the implementation of the NHS 'may be a view distorted by time, age and flaws of memory but it nevertheless represents a popular perception.'¹⁵⁰ Furthermore, Roberts and Thompson point to the detail recalled and have used oral evidence to provide insights into the complex and often contradictory nature of experience – precisely what this research aims to address.¹⁵¹ Many have adopted the view that oral histories, rather than providing direct access to the past, are social constructions. Summerfield has claimed that:

Historians who base their work on accounts of 'lived experience', claiming that such accounts give access to a social reality apart from the controlling forces of the social relations in which their subjects are implicated, falsely separate discourse and experience: experience cannot exist outside discourse, agency cannot exist independently of language.¹⁵²

However, as mentioned above, this similarly applies to written contemporary evidence and does not discount the use of oral history as a source. It is also well known that in order to gain accurate and legitimate historical evidence from oral history interviews, they must 'be treated carefully, using the normal conventions of cross-verification and corroboration.'¹⁵³ Roberts maintains that 'there are omissions, distortions and ambiguities in all primary historical sources, whether they be written or oral.'¹⁵⁴ Herbert and Rodgers note that justification of the use of oral history tends to be 'more as part of the historiography of the subject rather than as a belief that it is necessary any

¹⁴⁹ Cited in Diack, 'Myths of a Beleaguered City', p. 71; Herbert and Rodger, 'Frameworks', p. 2.

¹⁵⁰ R. Ferguson, 'Whose Nurse? The Doctor, the District and the NHS', in C. Nottingham, eds., *The NHS in Scotland: The Legacy of the Past and the Prospect of the Future* (Aldershot: Ashgate, 2000), p. 32.

¹⁵¹ Thompson, *Voice of the Past*, p. 129; E. Roberts, *Women and Families: An Oral History Reader 1940-1970* (Oxford: Blackwell, 1995), p. 1.

¹⁵² Summerfield, *Reconstructing Women's Wartime Lives*, pp. 10, 15.

¹⁵³ Johnston and McIvor, 'Dust to Dust', p. 60.

¹⁵⁴ Roberts, *Women and Families*, p. 3.

longer to mount a defence of its use as a means to explore historical change.¹⁵⁵ In her own research, Marks found that ‘such testimony also provides an important counter to the more dry and unemotional statistics that appear on childbirth’ at least.¹⁵⁶ The interviews consulted as part of this research often revealed the realities not mentioned in official statistics and archive material, supplemented and indeed challenged this data, enhanced understanding of lay perceptions and the actual experience of these years, and offered an additional, human dimension to statistical analyses.

Structure of the Thesis

By combining qualitative and quantitative source material, this study endorses the approach of Thompson, in that it will analyse health in a ‘more holistic way and takes into consideration the “multiplicity of interactions” which influenced mortality patterns.¹⁵⁷ This study also aims to address the lack of literature on interwar public health from a Scottish perspective, by examining in some detail health in Glasgow in the period 1919-1939. Glasgow is a useful geographic region to engage with this debate for a number of reasons. An industrial city, it deals with many of the issues inherent to this debate including industrial collapse, rising poverty and mass unemployment. Historians writing on the interwar period acknowledge the persistently and considerably higher levels of unemployment, poverty, poor housing and ill health north of the border, and in Glasgow and Clydeside compared to other Scottish cities.¹⁵⁸ May has written that the social

¹⁵⁵ Herbert and Rodger, ‘Frameworks’, p. 15.

¹⁵⁶ Marks, ‘They’re Magicians’, p. 47.

¹⁵⁷ Thompson, *Unemployment*, p. 3.

¹⁵⁸ Webster, ‘Health, Welfare and Unemployment’, p. 206; Laybourn, *Britain on the Breadline*, p. 87; Stevenson, *British Society*, p. 216; S. Constantine, *Unemployment in Britain between the Wars* (Essex: Longman, 1980), p. 18; Glynn and Oxborrow, *Interwar Britain*, p. 37; Mitchell, ‘The Effects of Unemployment’, p. 107; Hardy, *Health and Medicine*, p. 95; Webster, ‘Healthy or Hungry Thirties’, pp. 116, 124; Burnett, *Idle Hands*, p. 201; Jones, *Health and Society*, p. 75; Harris, ‘Unemployment and the Dole in Interwar Britain’, pp. 126,

problems associated with the decline of the heavy industries 'were exacerbated by the fact that they were highly concentrated in certain parts of the country, especially the north of England, Clydeside and South Wales.'¹⁵⁹ However, there is often the tendency to associate the severity of the recession with the city's poor health record with no follow up research to clarify whether this was the case. The city was also notoriously overcrowded, which allows us to consider the impact of housing upon health and the effectiveness of the interwar rebuilding campaigns. Furthermore, this project is significant as up until now, no monograph of this nature has focused entirely on public health in a British, urban, industrial city during this period of economic decline. Not only is the urban environment a contributing milieu to public health trends, Pinol and Rodger note that 'as the proportion of urban dwellers has increased, so the urban dimension has proved a legitimate unit of analysis through which to understand the spectrum of human experience and to explore the cumulative memory of past generations.'¹⁶⁰ Using Glasgow as a case study, this research will critically engage with some of the key features of the historiography on interwar public health and will 'unravel and reassess' the diverse range of experience across the population as called for by Mitchell.¹⁶¹ The elements of the debate outlined in this chapter shape the thesis into its constituent chapters.

510; Aldcroft, *The Interwar Economy*, pp. 381, 383; Stevenson, *Social Conditions*, p. 16; I. Levitt, 'Scottish Poverty: The Historical Background', in G. Brown and R. Cook, eds., *Scotland The Real Divide: Poverty and Deprivation in Scotland* (Edinburgh: Mainstream Publishing, 1983), p. 70; Mitchison, *British Population Change*, p. 48.

¹⁵⁹ T. May, *An Economic and Social History of Britain 1760-1970* (New York: Longman, 1988), p. 328.

¹⁶⁰ S. Sheard and H. Powell, 'Body and City: Medical and Urban Histories of Public Health', in S. Sheard and H. Power, eds., *Body and City: Histories of Urban Public Health* (Aldershot: Ashgate, 2000), p. 15; J. Pinol and R. Rodger, 'Historical Urban Studies: General Editors Preface', in Sheard and Power, eds., *Body and City*, p. xv.

¹⁶¹ Mitchell, 'Effects of Unemployment', p. 120.

Before examining the city's public health experience chapter two provides the necessary background on Glasgow in the period between the wars. This provides a contextual introduction to living conditions in the city, establishes the industrial nature and environment of Glasgow, and the impact of the economic depression. Hereafter, by mapping the broad health trends of Glasgow as an entity, and analysing the extent and characteristics of ill health in the city, chapter three engages with the validity of the 'optimist' and 'pessimist' debate, and introduces the notion that public health experiences are better understood in terms of inequalities according to a number of social factors. This view is advanced throughout the subsequent chapters. Chapter four evaluates the relationship between housing and physical condition, the success of the interwar building campaigns for public health, and challenges the simple construction that better housing resulted in better health. Chapter five examines health in relation to women, the home and the family by considering sex-specific mortality trends, the gendered cultural norms *within* the home that affected health, and the impact of this with regards to familial wellbeing. Chapter six explores the diverging health trends between those in and out of work, looking at the mortality patterns of 'distressed' localities across the city, the health experiences of the unemployed per se, whilst covering the relationship between unemployment, physical and mental health. Chapter seven contributes to the historiography by moving away from the traditional emphasis on socio-economic conditions, and underlines the role of the individual and cultural factors implicit to health trends. Lastly, the conclusion draws the various strands of the thesis together and highlights the key findings of my research.

This thesis attempts to provide a more nuanced view of interwar public health. It will be argued that attempts to evaluate the extent to which health standards improved or deteriorated, to use Szreter's words, are a 'quick and

approximate explanation' for a 'complex phenomenon.'¹⁶² Eschewing the 'optimist' and 'pessimist' visions of the interwar years that dominate the literature, this study focuses upon highlighting divergences in experience according to variables such as location/community, social class and occupational skill, employment position, age, marital status and gender, and emphasises the multiplicity of social, economic and cultural exchanges which fashioned health trends in the city. This research argues that health experiences were characterised by diversity, and are better explained in terms of *inequalities* according to a number of variables, rather than significant improvements or deteriorations in health. It is suggested that by emphasising and exploring the wide variety of experiences which existed a more detailed picture of interwar public health can emerge.

¹⁶² Phrases he has used when discussing the historical decline in fertility rates and the 'professional model' (see S. Szreter, *Fertility, Class and Gender in Britain, 1860-1940* (Cambridge: Cambridge University Press, 1996), p. 65).

Chapter 2 The City – Interwar Glasgow

Thompson has argued that historians need to narrow their focus and consider the specific nature of individual areas of Britain when attempting to explain health trends.¹⁶³ Thus, before considering health experiences, this chapter aims to provide a social geography of Glasgow by mapping important social, economic and environmental factors significant in the context of public health. This is important as many of the characteristics highlighted in the chapter relate closely to the city's pattern of health. It will be shown here, and in subsequent chapters, that in spite of the conventional interpretation of Glasgow as an urban space characterised by poverty, unemployment and ill health, the reality was much more complex, where experiences were diverse and varied according to a number of social variables.

Geography and Environment

During the interwar period, Glasgow was a large, densely populated industrial city, central to what was commonly referred to as the 'industrial belt of Scotland'.¹⁶⁴ In 1919 the population of the city was 1,114,656, the boundaries of which extended 19,183 acres with an average density of 58 persons per acre.¹⁶⁵ By 1939, the city's population had increased to 1,128,473, its acreage 39,725, with a density of 28 persons per acre.¹⁶⁶ At the beginning of the period especially, Glasgow was clearly more congested than regions of a similar industrial character where the person per acre

¹⁶³ Thompson, *Unemployment*, pp. 243-9.

¹⁶⁴ B.M. Osborne, *The Social Survey: The Glasgow and North Lanarkshire New Towns Survey* (April, 1948), p. 3.

¹⁶⁵ *Report of the Medical Officer of Health, City of Glasgow (RMOHG) 1920*, p. 19.

¹⁶⁶ *RMOHG 1939*, p. 1.

figures for Manchester, for example, were only 38 per acre in 1919 and 27 in 1939.¹⁶⁷ The housing situation in Glasgow was also considerably worse compared to Liverpool and Manchester throughout the period (see chapter 4). The city and its surrounding industrial areas, frequently referred to as 'Clydeside', dominated the Scottish economy and employed around 50 per cent of Scotland's working population.¹⁶⁸ Glasgow itself was commonly perceived as a 'rough', 'working class city' with a 'radical' tradition due to its industrial character, one article in the *British Medical Journal* (BMJ) commenting on the 'working classes, who form the majority of the population, and on whose skill and physical endurance the prosperity of Glasgow is based.'¹⁶⁹

¹⁶⁷ Report of the Medical Officer of Health for Manchester, 1919 and 1939, held at John Rylands Library, Manchester.

¹⁶⁸ R. Johnston and A. McIvor, 'Marginalising the Body at Work? Employers' Occupational Health Strategies and Occupational Medicine in Scotland c. 1930–1974', *Social History of Medicine*, 21 (2008), p. 128; D.N. Paton and L. Findlay, 'Child Life Investigations: Poverty, Nutrition and Growth: Studies of Child Life in Cities and Rural Districts of Scotland', *Special Report of the Medical Research Council* (SRMRC), 101 (1926), p. 13.

¹⁶⁹ 'Glasgow Today', *BMJ*, 11th February 1922, p. 244; *ARSBH 1928*, p. 161; *2000 Glasgow Lives*, David Easson (1923).

Table 2.1: Number and percentage of workers employed in various occupations

Occupation	Number and percentage of total occupied					
	Both sexes		Males		Females	
	1921	1931	1921	1931	1921	1931
Metals (Not precious)	101,540 (20.4)	66,793 (12.9)	99,200 (28.4)	65,335 (18.5)	2,340 (1.6)	1,458 (0.9)
Transport and Communications	54,598 (11.0)	57,860 (11.2)	50,236 (14.4)	53,241 (15.0)	4,362 (2.9)	4,619 (2.8)
Commercial Occupations (Clerks excluded)	53,934 (10.8)	70,291 (13.6)	30,379 (8.7)	41,607 (11.8)	23,555 (15.8)	28,684 (17.5)
Clerks etc., (Not Civil Service or Local Authority)	39,360 (7.9)	47,713 (9.2) ¹⁷⁰	17,821 (5.1)	22,888 (6.5)	21,539 (14.5)	24,825 (15.1)
Personal Service Occupations	35,969 (7.2)	50,124 (9.7)	7,809 (2.2)	11,427 (3.2)	28,160 (18.9)	38,697 (23.6)
Makers of Textile Goods and Articles of Dress	26,590 (5.3)	23,154 (4.5)	6,985 (2.0)	6,286 (1.8)	19,605 (13.2)	16,868 (10.3)
Wood and Furniture	23,271 (4.7)	16,993 (3.3)	21,353 (6.1)	16,256 (4.6)	1,918 (1.3)	737 (0.4)
Professional Occupations (Clerks excluded)	17,850 (3.6)	19,799 (3.8)	8,321 (2.4)	9,502 (2.7)	9,529 (6.4)	10,297 (6.3)
Makers of Food, Drink and Tobacco	15,418 (3.1)	11,620 (2.2)	7,159 (2.1)	6,243 (1.8)	8,259 (5.5)	5,377 (3.3)
Other Undefined Workers	15,219 (3.1)	58,780 (11.4) ¹⁷¹	13,711 (3.9)	52,986 (15.0)	1,508 (1.0)	5,794 (3.5)
Workers in Stone etc., Builders	13,899 (2.8)	12,596 (2.4)	13,886 (4.0)	12,587 (3.6)	13 (0.0)	9 (0.0)
Warehousemen, Packers etc.,	13,857 (2.8)	15,407 (3.0)	8,349 (2.4)	9,028 (2.6)	5,508 (3.7)	6,379 (3.9)
Workers in Textiles	13,650 (2.7)	11,077 (2.1)	3,009 (0.9)	1,944 (0.5)	10,641 (7.1)	9,133 (5.6)
Papermakers, Printers etc	11,311 (2.3)	4,543 (0.9) ¹⁷²	5,379 (1.5)	1,120 (0.3)	5,932 (4.0)	3,423 (2.1)
Printers and Photographers (1931 only)	*	6,368 (1.2)	*	4,526 (1.3)	*	1,842 (1.1)
Workers in Mixed or Undefined Materials	9,024 (1.8)	3,487 (0.7)	8,744 (2.5)	3,293 (0.9)	280 (0.2)	194 (0.1)
Employed in Public Administration and Defence	9,100 (1.8)	4,162 (0.8) ¹⁷³	7,941 (2.3)	4,053 (1.1)	1,159 (0.8)	109 (0.1)
Mining and Quarrying Operations	6,379 (1.3)	4,410 (0.8)	6,334 (1.8)	4,397 (1.2)	45 (0.0)	13 (0.0)
Painters and Decorators	5,653 (1.1)	7,784 (1.5)	5,564 (1.6)	6,134 (1.7)	89 (0.1)	1,650 (1.0)
Electrical Apparatus Makers, Electricians etc.,	5,614 (1.1)	5,424 (1.0)	5,472 (1.6)	5,325 (1.5)	142 (0.1)	99 (0.1)
Stationary Engine Drivers etc.,	5,078 (1.0)	4,476 (0.9)	5,069 (1.5)	4,465 (1.3)	9 (0.0)	11 (0.0)
Workers in Gas, Water, and Electricity Undertakings (1921 only)	3,327 (0.7)	*	3,306 (0.9)	*	21 (0.0)	*
Workers in Chemicals, Paints and Oils (1921 only)	3,279 (0.7)	*	2,569 (0.7)	*	710 (0.5)	*
Makers of Bricks, Pottery and Glass (1921 only)	3,116 (0.6)	*	2,314 (0.7)	*	802 (0.5)	*
Workers in Leather and Leather Goods, Tanners etc.,	2,377 (0.5)	2,196 (0.4)	1,631 (0.5)	1,346 (0.4)	746 (0.5)	850 (0.5)
Agricultural Occupations	2,337 (0.5)	2,504 (0.5)	1,888 (0.5)	2,196 (0.6)	449 (0.3)	308 (0.2)
Workers in Other Materials (1931 only)	*	2,500 (0.5)	*	1,348 (0.4)	*	1,152 (0.7)
Employed in Entertainment and Sport	2,180 (0.4)	2,939 (0.6)	1,611 (0.5)	2,502 (0.7)	569 (0.4)	437 (0.3)
All other occupations	3,757 (0.8)	4,646 (0.9)	2,720 (0.8)	3,722 (1.0)	1,037 (0.7)	924 (0.6)

SOURCE: Census Report, City of Glasgow 1921 and 1931.

¹⁷⁰ Now including Civil Service and Local Authority.

¹⁷¹ Said to be usually unskilled in 1931.

¹⁷² Now Paper and Cardboard Workers, Bookbinders.

¹⁷³ Excluding Clerks.

During these years, the commercial sector expanded whilst the traditional industries contracted. The total number employed in this area rose from 10.8 per cent to 13.6 per cent between 1921 and 1931 (Table 2.1). Nonetheless, census data reveals that the majority of the population were employed in what would be considered 'working class' occupations, and that at the beginning of the period especially, a considerable percentage were employed in heavy industry.

The dirty nature of the city was commonly referred to with reference to health. In a letter to the *Glasgow Herald* (GH), one man complained that 'some of Glasgow's principal streets are seldom ever clean. How can Glasgow people expect to avoid smallpox, influenza, and other periodical epidemics when they are so apathetic towards the cleanliness of the city?'¹⁷⁴ Many also pointed to the effects of Glasgow's smoky, polluted atmosphere, and that this aggravated and correlated with death rates from respiratory disease.¹⁷⁵ The majority of atmospheric pollution from smoke in Glasgow, around 70 per cent, was found to be caused by domestic fireplaces rather than industry, although the industrial nature of the city also played a role (see below).¹⁷⁶ It was claimed that 'children's lungs were filled with dust, and the light of the sun, which was more and more coming to be regarded as a source of health, was cut off by smoke.'¹⁷⁷ Indeed, Macgregor later highlighted the impact that air pollution had on the Glaswegian population during a three day period in 1929, when heavy fogs concomitant with frost and an influenza outbreak caused death rates to soar to 50.3 per 1,000

¹⁷⁴ 'Letter to the Editor: City Cleaning', *GH*, 28th May 1920, p. 7.

¹⁷⁵ A.K. Chalmers, *The Health of Glasgow 1818-1925: An Outline* (Glasgow: Glasgow Corporation, 1930), pp. 92-3; 'Socialist Buchanan', *GH*, 10th March 1926, p. 12; 'Glasgow Today', *BMJ*, 11th February 1922, p. 244; 'Letter to the Editor', *GH*, 30th March 1920, p. 5; 'Scottish Sanitary Congress', *BMJ*, 14th October 1933, p. 706; 'Death Rates and Atmospheric Pollution', *BMJ*, 19th October 1935, p. 757; 'Impure Atmosphere: Principal Cause of Death', *Scotsman*, 5th October 1933, p. 10; 'Smoke Fogs and Health', *Scotsman*, 9th October 1935, p. 10; *Glasgow City Archives* (GCA), DHE 1/1/3, Scottish Branch of the Society of Medical Officers of Health: Memorandum to the Committee on Scottish Health Services, p. 2.

¹⁷⁶ P.P. *Annual Report of the Department of Health for Scotland 1935* (ARDHS), HMSO 1936 (5123), p. 490.

¹⁷⁷ 'Child Welfare: Problems of Bad Housing and Impure Air', *GH*, 19th March 1926, p. 7.

compared to the annual rate of 15.3.¹⁷⁸ While some medics pointed to the 'seaside' advantages of Glasgow due to its position in relation to the Clyde, it is clear that regardless of class, age, gender or any other social criteria, the population sacrificed certain aspects of its health due to atmospheric pollution, the industrial nature of the city, and the high densities, overcrowding and manual labour that this entailed.¹⁷⁹ The health effects of Glasgow's contaminated environment were commonly acknowledged in qualitative literature, in autobiographies and from lay perceptions, and there are indications that the public understood its harmful properties to health.¹⁸⁰

However, other urban areas of a similar industrial character recorded higher levels of air pollution. An article published in the *BMJ* for example, recorded that 'Glasgow, like other cities in this country, has at times a smoky atmosphere... The deposit over a period of five years is quoted as 326 tons per square mile per annum; this is less than in Liverpool, Birmingham, and London, but more than in Salford.'¹⁸¹ Macgregor also pointed out that 'Glasgow was not by any means the worst offender', and other big cities like Birmingham recorded higher levels of 'solid matter falling from the air.'¹⁸² In the early 1920s, Liverpool recorded 584.19 and Newcastle-on-Tyne 585.10 tons per square mile per annum of solids compared to only 326.17 in Glasgow.¹⁸³ Thus the extent to which this was responsible for Glasgow's

¹⁷⁸ Cited in Stewart, 'Health and Sickness', p. 245.

¹⁷⁹ Paton and Findlay, 'Poverty, Nutrition and Growth', p. 13; Muir, *Scottish Journey*, p. 108; *Scotsman*, 2nd October 1920, p. 7.

¹⁸⁰ 'Air Pollution: A Glasgow Inquiry', *GH*, 1st Oct 1920, p. 9; 'Air Purification in Glasgow', *GH*, 8th January 1921, p. 5; 'Fresh Air and Health', *GH*, 22nd December 1938, p. 6; Muir, *Scottish Journey*, pp. 107-08, 117, 125, 168; Rountree, *Govan*, p. 22; 'Air Pollution: The Glasgow Inquiry: Additional Powers Needed: The Effect on Health', *GH*, 1st October 1920, p. 9; 'Air Purification in Glasgow', *GH*, 8th January 1921, p. 5; 'Public Health Section', *Scotsman*, 29th July 1922, p. 11; J. Bowie, *Penny Buff: A Clydeside School in the Thirties* (London: Constable, 1975), p. 25; Although, according to the early MOH Chalmers, 'the actual harm that a smoke-laden atmosphere does to the health of the community is not publically realised, else there would be a greater outcry for remedial measures to be taken to cope with it' (Chalmers, *Health of Glasgow*, p. 448).

¹⁸¹ 'A Century of Health Progress in Glasgow', *BMJ*, 23rd August 1930, p. 293.

¹⁸² A.S.M. Macgregor, *Public Health, 1905-1946* (Edinburgh: E. and S. Livingston, 1967), p. 79.

¹⁸³ Chalmers, *Health of Glasgow*, p. 457.

poor respiratory health record has to be kept in perspective. The enquiry of the Committee on Scottish Health Services in the early 1930s also recorded that there was a 30 per cent reduction of total solids in the atmosphere over the previous decade. Ironically, this health enhancing improvement was attributed to the industrial depression and the ‘falling away of industry,’ where places previously subject to monitoring by health officials became ‘out of existence.’¹⁸⁴ The contraction of industry had profound social consequences for the Glaswegian population and is an important backdrop of this study on interwar public health.

Unemployment and Recession

Glasgow – like most of the industrial western world – experienced a sharp economic recession during the interwar years, and the city is commonly cited as a place where its effects were particularly severe (see chapter 1). The depressed conditions of the era contrast sharply with Glasgow’s prior industrial success when at the turn of the twentieth century the city ‘was one of the leading industrial centres of the world’.¹⁸⁵ Glasgow’s economy which was based and dependent on the heavy industries of iron, steel, engineering and shipbuilding, had been in a ‘commanding position in the national and international economy’, evidenced by the record 756,973 tons of shipping which the Clydeside yards launched in 1913.¹⁸⁶ However, this prosperity gave way to a deep economic depression following the collapse of the economy in 1920.¹⁸⁷ The interdependent nature of the Scottish economy, its continued dependence on the old staple industries, its failure to diversify, and

¹⁸⁴ NAS, 02024, HH76-1-00057, p. 33 (or p. 62 NAS); As was similarly the case in south Wales (Thompson, *Unemployment*, p. 147).

¹⁸⁵ M. Pacione, *Glasgow: The Socio-Spatial Development of the City* (Chichester: John Wiley and Sons, 1995), p. 130.

¹⁸⁶ *Ibid.*, p. 130; Osborne, *The Social Survey*, p. 3.

¹⁸⁷ Johnman and Murphy, ‘Introduction’, p. 231.

the lack of development in the new light industries meant that the effects of the recession were widespread.¹⁸⁸ These issues have been examined in depth by a number of Scottish historians and it is not necessary to repeat their findings here.¹⁸⁹ However, in the context of public health, the social effects of the interwar depression are significant.

The most obvious consequence was unemployment and the rate in Scotland consistently exceeded UK averages.¹⁹⁰ The figures published by the *Ministry of Labour* reveal that at the height of the Depression in 1932 the average rate of Scottish unemployment was 27.7 per cent compared to 21.9 per cent for Great Britain as a whole.¹⁹¹ However, the fact that Glasgow was central to the 'industrial belt of Scotland' indicates the severity of industrial failure for the region.

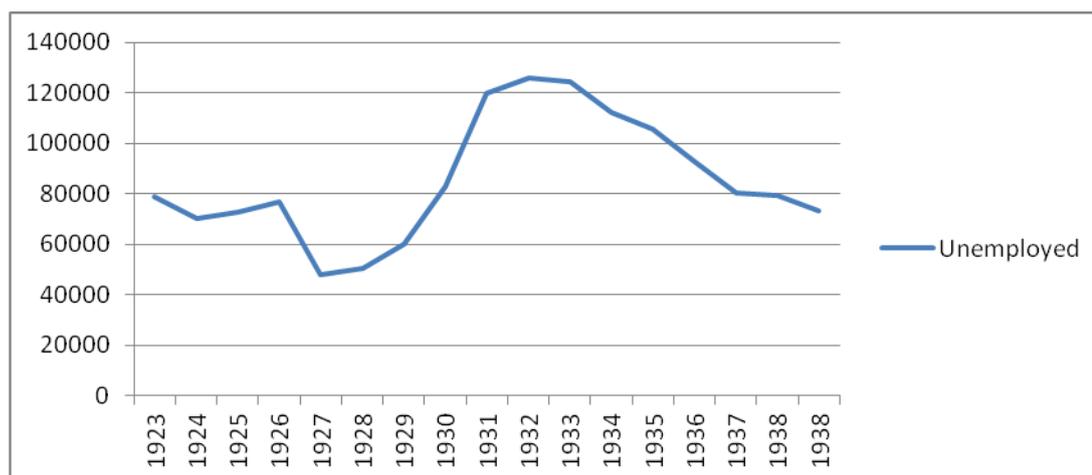
¹⁸⁸ P.L. Payne, 'The Economy', in T.M. Devine and R. Finlay, eds., *Scotland in the 20th Century* (Edinburgh: Edinburgh University Press, 1996), p. 20; MacDonald, *Whaur Extremes Meet*, p. 24.

¹⁸⁹ Knox, *Industrial Nation*; Maver, *Glasgow*; Payne, 'The Economy', p. 20; I. Slaven, *The Development of the West of Scotland: 1750-1960* (London: Routledge and Kegan Paul, 1975), p. 206.

¹⁹⁰ Macdonald, *Whaur Extremes Meet*, p. 29.

¹⁹¹ P.P. *Ministry of Labour Report for the year 1933*, HMSO 1934 (4543), p. 6; P.P. *Ministry of Labour Report for the year 1938*, HMSO 1939 (6016), p. 95; Finlay, *Modern Scotland*, p. 83.

Figure 2.1: Average unemployed in Glasgow, 1923-39



SOURCE: *Local Unemployment Index, 1923-39*.¹⁹²

In the summer of 1921 unemployment began to noticeably rise.¹⁹³ Slaven notes that even then ‘the worst was still to come. In the 1930s cyclical depression threw great numbers out of work and heaped these on top of the already large numbers unemployed through sectoral decline’ (Figure 2.1).¹⁹⁴ Unemployment in Glasgow consistently exceeded Scottish rates (Table 2.2).

Table 2.2: Average percentage of unemployed insured workers in Scotland and Glasgow 1930-1933

Year	Scotland	Glasgow
1930	18.5	26.1 ¹⁹⁵
1931	26.6	30.3
1932	27.7	30.7
1933	26.1	30.5

SOURCE: ARDHS 1933, p. 114; *Local Unemployment Index 1930-1933*.

¹⁹² These figures were only published for Glasgow from 1923.

¹⁹³ Maver, *Glasgow*, p. 204.

¹⁹⁴ Slaven, *Development*, p. 184.

¹⁹⁵ Calculated from figures published in February and December only.

The figures published in the *Local Unemployment Index* suggest that the worst year of unemployment for Glasgow was 1932 when the average rate for those workers insured under the National Insurance Scheme was 30.7 per cent (Table 2.2). However, these figures are problematic. On the one hand they can overstate the percentage of unemployment since the insured industries were more heavily hit by the trade depression than those occupations not covered by the Unemployment Insurance Act.¹⁹⁶ On the other hand, the figures can underreport the true number out of work where official figures published only refer to the insured population, meaning those unemployed but uninsured were unrecorded.

Furthermore, this data fails to illustrate the wider impact of unemployment in that it neglects the many wives and children affected by unemployment when the typically male breadwinner was out of work. Indeed, the *DHS* indicated that 32.3, 39.0, 38.9 and 37.9 per cent of Glasgow males were unemployed in December 1930, 1931, 1932 and 1933 respectively – figures significantly higher than the average unemployment rate for the *total* insured population.¹⁹⁷ Hutt estimated that when including those not recorded at employment exchanges, the ‘Glasgow workless and their families account for half the population of that city’, a proportion certainly suggested by the percentages of unemployment cited above.¹⁹⁸ While Hutt may be accused of exaggeration due to his political stance, the overall number of persons affected by unemployment was undoubtedly higher than official statistics record.¹⁹⁹ The severity of industrial decline for Glasgow is apparent. In 1932 the Scottish authorities reported that ‘the great mass of unemployment was in the Clydeside area and in Lanarkshire, approximately

¹⁹⁶ Gazeley, *Poverty*, p. 103.

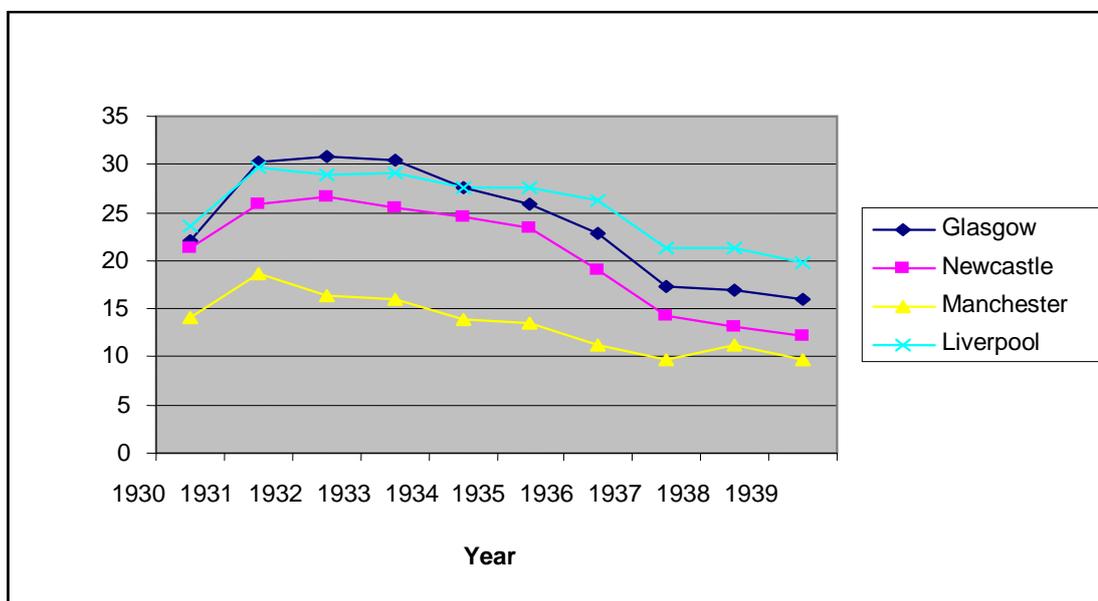
¹⁹⁷ *ARDHS 1931*, p. 141; *ARDHS 1933*, p. 114.

¹⁹⁸ Hutt, *Condition*, pp. 97-8.

¹⁹⁹ Burnett, *Idle Hands*, p. 205.

one third of the unemployed in Scotland being in the area of the Glasgow employment exchanges.²⁰⁰

Figure 2.2: Unemployment in industrial regions: Average registered at employment exchanges as a percentage of the insured population²⁰¹



SOURCE: *Local Unemployment Index* (HMSO 1930-1939).

Conditions in Glasgow were worse than other Scottish towns like Aberdeen and Dundee which had a 'greater variety of industry,' and Glasgow's regional officer of the *Unemployment Assistance Board* (UAB) was of the opinion that 'probably in no city in the United Kingdom is the density of unemployment so great as it is in Glasgow.'²⁰² Compared to regions of a similar industrial character, unemployment in the city was notably high (Figure 2.2).²⁰³ Other areas did endure greater levels of unemployment and distress than Glasgow. For mining communities such as Motherwell and Wishaw in Scotland, and areas of south Wales, the economic depression struck hard. For example

²⁰⁰ *ARDHS 1932*, p. 133; Slaven, *Development*, p. 199.

²⁰¹ The *SBH* wrote that 'from the point of view of industry, size and climate, Glasgow is comparable with Liverpool and Manchester' (*ARSBH 1928*, p. 161).

²⁰² P.P. *Report of the Unemployment Assistance Board for the year ended 31st December 1936* (RUAB), HMSO 1937 (5526), p. 121.

²⁰³ Except after 1935 when unemployment fell to a rate lower than Liverpool.

unemployment reached respective rates of 53 and 49 per cent in Wishaw and Motherwell.²⁰⁴ Nonetheless, the acute industrial distress in the city, and the sheer number of people affected, meant that the social effects of the economic recession were widespread.

Did unemployment result in poverty? Those in need of financial assistance increased almost consistently alongside unemployment and Slaven claims that the 'extent of deprivation is underwritten by the applications for poor relief' (Figure 2.3).²⁰⁵ As more and more workers slowly exhausted their entitlement to unemployment insurance payments they resorted to the relief offered by their parish councils.²⁰⁶ Regularly, this was only considered when all other options and savings were exhausted.²⁰⁷ Crowther reminds us that Poor Law figures recorded destitution and not poverty.²⁰⁸ Hence, those applying for relief were considered desperate and as the authorities acknowledged, it was 'acute distress [that] had compelled many to overcome their reluctance to accept parochial relief' and submit to the stigma which this entailed.²⁰⁹ Poor Law figures provide a more exact idea of the effects of the recession since, unlike unemployment benefits, there was no restriction on the length of time the relief could be provided.²¹⁰

²⁰⁴ R. Duncan, *Steelopolis: The Making of Motherwell 1750-1939* (Motherwell: Motherwell District Council, 1991), p. 165.

²⁰⁵ Slaven, *Development*, p. 199.

²⁰⁶ *ARSBH 1920*, pp. 199-200.

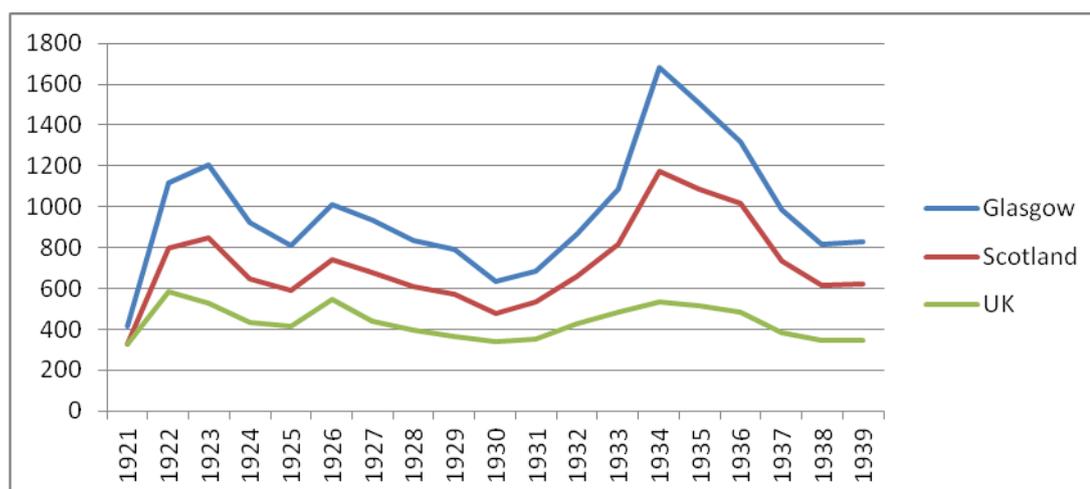
²⁰⁷ *ARSBH 1922*, p. 111.

²⁰⁸ Crowther, *Social Policy*, p. 50.

²⁰⁹ *ARSBH 1922*, p. 111.

²¹⁰ Finlay, *Modern Scotland*, pp. 83-4.

Figure 2.3: Average number of persons in receipt of Poor Law relief in Glasgow, Scotland and the UK per 10,000 of the population, 1921-1939



SOURCE: Ministry of Labour Gazette (MLG) 1921-1939.²¹¹

The graph demonstrates that destitution was higher in Glasgow compared to Scotland and the UK as a whole (Figure 2.3), and the city was home to 40 per cent of the Scottish ordinary poor and 56 per cent of the able-bodied poor at a time when Glasgow accounted for only around 23 per cent of Scotland's total population.²¹² By 1937, still one in ten depended upon financial relief 'as an applicant, or applicant's dependent – and that in a time of admitted prosperity.'²¹³

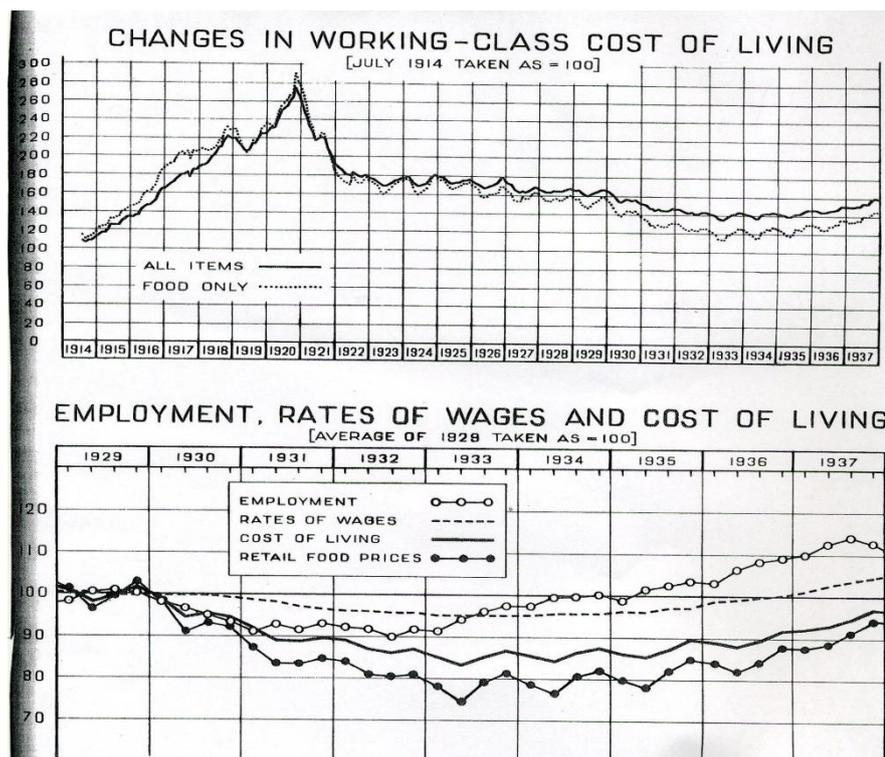
To balance this argument, many have argued that reductions in the cost of living which occurred over the period, combined with state benefits and relief, brought financial gains to a considerable proportion of the population (Figure 2.4).

²¹¹ The 'Scotland' figures were based on the four cities Aberdeen, Dundee, Glasgow and Edinburgh. The 'UK' figures were based on areas with populations over 10,000 including 47 regions in total (MLG, October 1930, pp. 361, 389). Data is only available in this format from 1921.

²¹² NAS, DD10/171, Letter by Sgt. S.L. McKenzie on behalf of the Corporation of Glasgow to the Secretary of State; ARDHS 1935, p. 140.

²¹³ RUAB 1937, pp. 160-1.

Figure 2.4: Changes in the cost of living for the working class between 1914-1937



SOURCE: MLG 1937 (Appendix).

For example, Constantine argues that 'in spite of the poverty to which the Depression condemned so many working class families between the wars, they found themselves because of unemployment insurance with a standard of living at least a little better than that of most *employed* unskilled labourers before the war.'²¹⁴ Certainly, contemporaries often claimed that many of the unemployed stopped their quest for work because state assistance was financially sufficient, and the authorities continually deliberated the possibility that there was an economic incentive for being out of work.²¹⁵ However, Burnett has also found that 'despite a good deal of hearsay accusation of 'malingering', numerous official investigations regularly undermined this claim.'²¹⁶ In 1922 for example a *SBH* investigation concluded that 'the great

²¹⁴ Constantine, *Unemployment*, p. 30.

²¹⁵ A. McArthur and H. Kingsley Long, *No Mean City* (London: Neville Spearman, 1976), p. 95; Paton and Findlay, 'Poverty, Nutrition and Growth', p. 162.

²¹⁶ Burnett, *Idle Hands*, pp. 203-4.

majority of the unemployed genuinely desire to return to work,' and in 1920 it had been claimed that 'unemployment and underemployment in the form of short time in works is bringing about a decided depression in the standard of living of many working class families in Glasgow and the West of Scotland.'²¹⁷ However, this was not universal, and the extent to which this was the case varied according to occupational skill and the financial status that this entailed.

Occupation and Income

The *DHS* reported that 'until the autumn of 1931 a common scale of allowance for the able-bodied unemployed in industrial areas' was 23s. to 26s. per week for a man and wife, an extra 2s. per week for dependent children under 16 years of age, and 7s. 6d. for each adult living in the household.²¹⁸ Wages published for the shipbuilding industry (information which admittedly has its shortcomings) tentatively suggest that these workers were not wealthier when unemployed (Table 2.3). Although spending power could increase with a corresponding fall in prices (Figure 2.4), the upper limit of 34s. which would have been received by an unemployed labourer with four dependants was notably less than the 41s. earned when employed in the shipbuilding industry, suggesting that in relative terms at least, a reduction in living standards occurred during unemployment.

²¹⁷ *ARSBH 1923*, p. 200; Also see *ARSBH 1925*, p. 278; 'Trade Depression', *GH*, 18th December 1920, p. 8.

²¹⁸ *ARDHS 1932*, pp. 138-9; *GCA*, TD 207/2 Corporation of Glasgow Public Assistance Department: Statistics for year ending 31st May 1932, p. 14.

Table 2.3: Weekly wage rates in the Glasgow shipbuilding industry, 1926-1936²¹⁹

Shipbuilding and Repairs							
	Shipwrights				Ship Joiners		Labourers
	New work		Repair work		New work	Repair work	
	S	D	S	D			
1926	56	6	58	9	59	61	37 6
1928	56	6	58	9	59	61	38 4 ½
1930	60		62	3	60	62	41
1933	60		62	3	60	62 0	41
1936	62		64	3	62	64	43

SOURCE: *Labour Statistics of the United Kingdom*.

However, writers like Whiteside point out that ‘based on industrial agreements, these take no account of the many firms who paid less than the recognised rate, nor of reductions in earnings due to short time working in times of slack trade’, and that ‘workers in Britain could not be divided into two virtually exclusive groups – those in full-time work and those with none.’²²⁰

Investigations into industrial conditions in Scotland reported that short-time was widespread; shipbuilding, engineering, iron founding, rubber, building, printing, chemicals, leather, textiles, tailoring and the distributive trades being the most affected.²²¹ As Constantine notes, unemployment could be ‘indirectly as well as directly a cause of poverty’ and Nicholas claims that ‘the financial advantages of having a job to a labourer with a family could be negligible during the thirties, even if he worked a full week.’²²² A survey of 50 slum houses in Glasgow recorded an average weekly wage of 35s.²²³ A *SBH* survey of the wages of *unskilled labourers* in Glasgow also found that

²¹⁹ Note that wages could be enhanced by working over time or by piece work, or reduced by short time or the failure of employers to uphold the agreed rates.

²²⁰ Whiteside, ‘The Social Consequences of Interwar Unemployment’, p. 21; Whiteside, ‘Counting the Cost’, p. 240; Stevenson, *British Society*, pp. 120-21.

²²¹ NAS, HH31/36/15, Memorandum by Mr. Highton on the Inquiry into Industrial Unemployment and Distress in Scotland, 1st October 1921, pp. 4, 8.

²²² Constantine, *Unemployment*, pp. 20, 26; Nicholas, *Social Effects of Unemployment*, pp. 51-3.

²²³ NAS, DD6/306, Report on Housing and Other Conditions in 50 Slum Houses in Glasgow, December 1936 by Miss H Galbraith, p. 2 (Draft copy of the report in this file). Described as being poorest working class, not average.

there were 'considerable numbers earning less than 40s per week', and that there was 'a distinct possibility that the unemployed man with four or more children may in some instances be better off than his neighbour who is working to maintain his family'.²²⁴ Detailed figures published in the *GH* in 1933 justifying intended reductions in financial assistance, set the figure of Parish Relief for a man with four children at 47s per week, and contended that this 'should not exceed, in any case, the wages of labourers employed in the area.'²²⁵ It was also realised that 'the man in employment often has to meet out of his wages travelling expenses, and may be subject to loss of income on account of bad weather or of short intervals between jobs.'²²⁶ Therefore unemployment benefit could provide consistent economic security for low wage earners being relatively similar to their previous earnings, and it is likely that this was financially acceptable for some families.²²⁷ Thus, the interpretation that some were financially better off when out of work could rightly apply, but only to lower paid unskilled workers and not the unemployed per se.²²⁸

For skilled industrial workers however, the experience was somewhat different. A number of historians agree that the effects of unemployment depended upon a number of social factors including family size, employment status and occupational skill.²²⁹ Firstly, it is widely acknowledged that unemployed skilled workers accepted work of lower status and pay, such as labouring jobs, and so even when in work, could be significantly worse off

²²⁴ *ARSBH 1925*, p. 274.

²²⁵ 'Corporation of Glasgow: Relief Scale for Poor: The Case for Reduction', *GH*, 6th June 1933, p. 7.

²²⁶ *ARDHS 1932*, p. 139.

²²⁷ *ARSBH 1925*, p. 276; One 1923 *SBH* survey claimed that short time work only amounted to some 0.7 per cent of the insured workforce (*ARSBH 1923*, p. 187). However, the sheer number of references to short time employment casts doubt on this figure. For example, see Paton and Findlay, 'Poverty, Nutrition and Growth', p. 17.

²²⁸ Thompson also notes that workers were often worse off when on short time than when 'permanently unemployed' (Thompson, *Unemployment*, pp. 6-7); Glynn and Booth, 'Introduction', p. 19.

²²⁹ Burnett, *Idle Hands*, p. 246; Stevenson, *British Society*, p. 119; Nicholas, *Social Effects of Unemployment*, pp. 47-8; Glynn and Booth, 'Introduction', p. 19; Thorpe, *Britain in the 1930s*, pp. 92-3.

than before. When unemployed, the Director of Public Assistance for Glasgow affirmed that:

It is no duty of the corporation to ensure that a person in receipt of public assistance should be in as good economic circumstances when in receipt of public assistance as they were when they were in work; their duty consists solely in seeing that destitution is relieved.²³⁰

However, it can be argued that in relative terms, the social effects of the recession were particularly detrimental for skilled workers due to their initially higher standard of living.²³¹ Numerically, unemployment was higher and more prolonged among the unskilled.²³² Nevertheless, a considerable proportion of the skilled workforce was also out of work, and in 1938 this group made up around 20 per cent of the unemployed.²³³ Indeed, a study by Paton and Findlay noted that in Glasgow, the skilled class 'forms a considerable proportion, as the shipbuilding, engineering, and other trades require a large number of such men.'²³⁴ Officials observed that 'the clerk and the artisan class when unemployed suffer relatively a greater reduction in their normal standard of living than the unskilled classes.'²³⁵ According to the *SBH*, this was intensified by there being 'always a greater reluctance amongst these classes to apply for poor relief... to "avoid the taint of pauperism," until compelled by sheer necessity to resort to poor law.'²³⁶ Many also attempted to preserve self respect by outwardly displaying the

²³⁰ *GCA*, Printed Minutes, Corporation of Glasgow, 27th June 1932.

²³¹ *ARSBH 1923*, p. 201.

²³² *RUAB 1935*, p. 271; *RUAB 1938*, p. 168; One detailed study carried out in slum areas of Glasgow in the early 1920s estimated that while there were an equal proportion of skilled and unskilled men considered for the purpose of the investigation, 27 per cent of skilled and 36 per cent of unskilled fathers were unemployed (Paton and Findlay, 'Poverty, Nutrition and Growth', p. 17).

²³³ By 1938, the *UAB* claimed that 'no less than 81 per cent of the young men interviewed had to be classified as unskilled', although this was associated to some extent with the taking up of 'blind alley' employment after leaving school (*RUAB 1938*, p. 168); The unequal distribution of unemployment according to occupational skill is consistent with the historiography. For example, see Constantine, *Unemployment*, p. 25.

²³⁴ Paton and Findlay, 'Poverty, Nutrition and Growth', p. 17.

²³⁵ *ARSBH 1923*, p. 201.

²³⁶ *Ibid.*, p. 194.

material living standards that they had exhibited when in work.²³⁷ In the early 1920s, the wages of artisan workers were roughly £3-4 per week (60-80s). Alexander Robbie also recalled that ‘the “upper” working class had a family income of about £4 per week. They were the foreman class and similar’, and that when a family earned £5 per week they qualified as lower middle class.²³⁸ However, one Glasgow study revealed that when affected by long term unemployment and short-time work, this fell to £2 2s (42s).²³⁹ Thus the social effects of the recession were not universal, where the impact upon living standards varied throughout different sections of the population.

It is clear that for those used to earning an adequate regular wage, redundancy could be devastating and only those on the very lowest incomes would have benefited to any real extent. It has been indicated that during the worst of the thirties, one third of the population was unemployed in Glasgow and in some instances, probably as much as half of the population were living at the very low level provided by state assistance. Evidence drawn from oral testimonies, autobiographies, and contemporary qualitative literature and lay observations, confirms this ‘pessimistic’ interpretation. Hundreds of general statements made by Glasgow’s medical officials, Sanitary Inspectors (SI’s) and social researchers detail the financial hardships of the unemployed.²⁴⁰ For example, the *Glasgow Royal Maternity Hospital* described ‘poverty that was to be deplored,’ and that because of unemployment ‘amongst our patients there are many genuine cases of poverty and distress.’²⁴¹ Writers such as Stevenson rightly point out that extreme poverty had always existed. However, in Glasgow, the sheer

²³⁷ *Ibid.*, p. 201.

²³⁸ A. Robbie, *A Privileged Boyhood* (Glasgow: Harper Collins, 1996), p. 21.

²³⁹ A.M.T. Tully, ‘A Study of the Diets and Economic Conditions of Artisan Families in Glasgow in May 1923’, *GMJ*, 1 (1924), pp. 12-3; Also see Paton and Findlay, ‘Poverty, Nutrition and Growth’, p. 284.

²⁴⁰ *RUAB 1936*, pp. 121-22; *RUAB 1937*, p. 165; *ARSBH 1921*, p. 200; Hughes, ‘Effects of Recession and Depression’, pp. 286-89; Hutt, *Condition*, pp. 108-9

²⁴¹ *Greater Glasgow NHS Board Archive* (GGNHSBA), HB45/3/7, *Annual Report of the Glasgow Royal Maternity and Women’s Hospital 1926* (GRMWH), pp. 28-9; GGNHSBA, HB45/3/8, *GRMWH 1927*, p. 27.

number of people who in the interwar period became unemployed, and the length of unemployment experienced for many, meant that significantly more were reduced to living at a very low level of subsistence.

Nonetheless, experiences were unequal, and the industrial make up of particular districts in Glasgow meant that this was more pronounced in certain parts of the city. Levitt found for example that 'the Poor Law disabled roll alone accounted for around 40 per cent of the population in areas such as Bridgeton, the Gorbals and Cowcaddens.'²⁴² Specific regions were affected by unemployment more so than others due to their industrial nature. Areas dependent on and consequently devastated by the collapse of a dominant local trade were particularly affected.²⁴³ Finlay points out that in certain areas the 'entire community [was] devastated by unemployment and all your friends and family would likewise be on the dole.'²⁴⁴ It seems that this was the case in the working class, industrial region of Govan, in that the district is regularly singled out as one of particularly high unemployment within the generally depressed city of Glasgow.²⁴⁵ Slaven notes that Govan's shipyards were almost inactive in 1932, as were the locomotive sheds of Springburn.²⁴⁶ This evidence endorses Finlay's assertion that 'statistics and averages can convey only a limited picture of the reality of mass unemployment. The truth of the matter was that there were few places in Scotland which had an average rate of unemployment.'²⁴⁷

²⁴² Levitt, 'Scottish Poverty', p. 69.

²⁴³ *RUAB 1935*, p. 271; Slaven, *Development*, p. 199.

²⁴⁴ Finlay, *Modern Scotland*, p. 84.

²⁴⁵ 'Govan's Black Year', *GP*, 6th January 1922, p. 2; 'Round and About in Govan', *GP*, 5th August 1938, p. 3.

²⁴⁶ Slaven, *Development*, p. 199; *RMOHG 1929*, pp. 84-5.

²⁴⁷ Finlay, *Modern Scotland*, p. 84.

Clearly, many were affected by the economic vicissitudes of the period. However Glynn and Booth acknowledge that folk memory may overlook the economic and industrial advances which were made and instead emphasise the unemployment which was an 'unfortunate but unavoidable part.'²⁴⁸ For many writers, the period was one of improving living standards for the majority of the population, and this is endorsed by Scottish historians like Devine and Smout.²⁴⁹ Prosperity and a good standard of living continued to exist for many. Record numbers attended the cinema, and the 'dancing' was a popular and weekly past time (some attended several times a week), for thousands of middle and working class Glaswegians, including the unemployed. Increasing numbers also indulged in luxury goods such as sweets and cigarettes, indicating that the era was not solely one of destitution (see chapter 7). Knox also argues that while the real earnings of Scottish workers did not improve substantially, 'due to the general fall in prices they were no worse off than normally.'²⁵⁰ Evidence of continuing affluence in Glasgow includes the emergence of a 'new generation of Glasgow entrepreneurs' including drapery tycoon Hugh Fraser and the inclusion of the city in the nationwide spread of chain stores – such as the opening of Marks and Spencer in 1937.²⁵¹ Likewise, in 1934 the Copland and Lye's store was considerably extended to include two restaurants and an in store orchestra in order to attract new customers – the wealth of which, and Glasgow's Sauchihall Street in general, is commonly

²⁴⁸ Glynn and Booth, 'Introduction', p. 18.

²⁴⁹ Thorpe, *Britain in the 1930s*, p. 91; Constantine, *Unemployment*, pp. 1-2; B.W.E. Alford, *Depression and Recovery? British Economic Growth 1918-1939* (London: Macmillan, 1972); Stevenson and Cook, *The Slump*; Constantine, *Social Conditions*, pp. 13-4, 19; C.L. Mowat, *Britain between the Wars 1918-1940* (London: Methuen and Co. Ltd., 1968), pp. 205, 490-2; L.C.B. Seaman, *Life in Britain between the Wars* (London: B.T. Batsford Ltd., 1970), p. 47; J. Davis, *A History of Britain, 1885-1939* (Basingstoke: MacMillan Press Ltd., 1999), p. 214; Stevenson, *British Society*, p. 116; Burnett, *Idle Hands*, p. 201; Crowther, *Social Policy*, p. 23; Bourke, *Working Class Culture*, p. 5; Devine, *Scottish Nation*, pp. 348, 528; Smout, *Century*, pp. 116-17; T.C. Smout, 'Scotland 1850-1950', in F.M.L. Thompson ed., *The Cambridge Social History of Britain 1750-1950* (Cambridge: Cambridge University Press, 1990), p. 227; Glynn and Oxborrow, *Interwar Britain*, p. 38.

²⁵⁰ Knox, *Industrial Nation*, p. 195.

²⁵¹ Maver, *Glasgow*, p. 210.

remembered in oral testimonies.²⁵² Maver notes that ‘for many in the city the multiplicity of shopping outlets represented starkly contrasting lifestyles,’ reinforcing the contention that interwar experiences in Glasgow were characterised by diversity.²⁵³

Certainly, many of the Glaswegian middle class continued to enjoy affluence despite the Depression and were able to satisfy their demand for domestic servants due to the shortage of employment opportunities available to women. Delap found that ‘many interwar employers struggled to afford servants, as rising rents, wages, and food prices compromised middle class budgets.’²⁵⁴ However in Glasgow, the number of women employed in the profession increased by 50 per cent between 1921 and 1931.²⁵⁵ This offers support to the view that in Glasgow many middle class incomes were unaffected or better during the recession since they continued to have the disposable income necessary to afford domestic help.²⁵⁶ Indeed, a number of historians agree that the middle class were among the chief beneficiaries of the improvements which occurred, living in an era when they “never had it so good”.²⁵⁷ This is not to say that the middle class escaped unemployment

²⁵² *Ibid.*, p. 210; SOHCA/038/001 (1912); One woman recalled, for example, how the ship owners wives used to go with their carriages and shop in ‘beautiful’ Sauchihall Street, ‘the ladies and the well-to-do’ (2000 *Glasgow Lives*, Faye Doran (1907)); For details of wealthy, middle class life in interwar Glasgow see E. Forbes, *The Aul’ Days* (1984) and M. Lindsay, *As I Remember* (1979), in T.C. Smout and S. Wood, *Scottish Voices 1745-1960* (London: Collins, 1990), pp. 46-51.

²⁵³ Maver, *Glasgow*, p. 210.

²⁵⁴ L. Delap, *Knowing Their Place: Domestic Service in Twentieth Century Britain* (Oxford: Oxford University Press, 2011), pp. 13, 14.

²⁵⁵ Maver, *Glasgow*, p. 209; The number of women employed as domestic servants increased by 7,555 between 1921 and 1931 (Census Report, City of Glasgow 1931, p. 49).

²⁵⁶ *Ibid.*, p. 209; Interestingly, this is contrary to the experience in England and Wales where, according to the census, the proportion of houses employing domestic servants narrowed during the interwar period. However Delap notes that the proportion of women employed in service was generally higher in ‘distressed’ areas. This also says something about the living standards of working class girls and women. A host of evidence suggests that women in this period only turned to domestic service due to financial necessity or in the absence of alternatives. It is therefore unlikely that if wages or opportunities had been increasing for this group that the increase in Glasgow would have occurred – women would not have worked as domestic servants unless they had to (Delap, *Knowing Their Place*, pp. 13-4, 240).

²⁵⁷ Stevenson, *British Society*, p. 130; Constantine, *Social Conditions*, p. 19; Devine, *Scottish Nation*, p. 348; Burnett, *Idle Hands*, p. 202.

and considerable salary reductions.²⁵⁸ Even so, the middle class represented little more than 5.5 per cent of the unemployed in Scotland and Gazeley similarly found that in England and Wales ‘in general terms, the risk of unemployment decreased with higher social class’.²⁵⁹ Indeed, in an article published in the *GH* it was stated that it was the ‘lower middle class woman’ who was ‘always worrying lest her husband or son lose his job.’²⁶⁰ This is consistent with the historiography, and Knox also found that nominal wages for the Scottish middle class increased by approximately 10 per cent while those of workers remained stagnant or decreased.²⁶¹ Laybourn has commented that ‘there is no contradiction in improving living standards occurring alongside acute poverty, and even worsening standards of life for a substantial minority of the nation,’ and writers such as Hardy, Glynn and Oxborrow describe the history of the interwar period as a ‘paradox’.²⁶² This also applied to public health, the complexity of which will be emphasised throughout this thesis.

²⁵⁸ ‘Letters to the Editor’, *GH*, 12th February 1932, p. 9 regarding unemployed architects; ‘Employees of Scottish Banks: Demonstration in Glasgow’, *GH*, 22nd March 1935, p. 6; Gladstone Robertson, *Gorbals Doctor*, p. 53; Blake, *The Shipbuilders* (Edinburgh: B and W Publishing, (1935), 1993); Muir, *Scottish Journey*, p. 139; *2000 Glasgow Lives*, Joyce Booth (1912); Gazeley, *Poverty*, p. 110; Finlay, *Modern Scotland*, p. 83; Thorpe, *Britain in the 1930s*, p. 90.

²⁵⁹ Harvie, *No Gods*, p. 48; Gazeley, *Poverty*, p. 110.

²⁶⁰ ‘Women’s Topics: Her Real and Imaginary Fears’, *GH*, 29th July 1935, p. 8.

²⁶¹ Knox, *Industrial Nation*, p. 194; Also, from the records of a Greenock bank, Hughes found that there was an almost steady increase in savings among the professional class throughout the interwar period (Hughes, ‘Effects of Recession and Depression’, p. 289).

²⁶² Glynn and Oxborrow, *Interwar Britain*, p. 13; Laybourn, *Britain on the Breadline*, p. 53; M. Gorsky and B. Harris, ‘The Measurement of Morbidity in Interwar Britain: Evidence from the Hampshire Friendly Society’, in Borowy and Gruner eds., *Facing Illness in Troubled Times*, pp. 129, 130.

Conclusion

Stevenson has argued that 'unemployment represented an affront to rising standards of living and a painful reminder of social inequality.'²⁶³ Indeed, most, if not all researchers recognise that variations were pronounced and that neither the 'optimist' nor 'pessimist' perspectives fully account for the experiences of the population as a whole. In Glasgow the industrial environment of the city was significant, as was the higher levels of poverty and unemployment experienced as a consequence of industrial depression. Nonetheless, whilst Glasgow's socio-economic conditions could seem particularly grave, the realities of living in the period between the two World Wars were complex. Experiences were unequal and characterised by diversity, varying according to variables including social position, occupational skill and geographic region. In short, there was no universal experience in Glasgow in social, economic or environmental terms. The following chapters will assess how far the complex and diverse make-up of the city impacted upon health experiences there.

²⁶³ Stevenson, *British Society*, pp. 295, 466.

Chapter 3 Measuring and Mapping Ill Health

The statistics again point to an improvement in the national health and physical wellbeing of the population. Death rates declined, children were on average fatter and healthier than their parents had been, and the worst forms of malnutrition diseases, such as rickets and scurvy, had all but disappeared by the Second World War.²⁶⁴

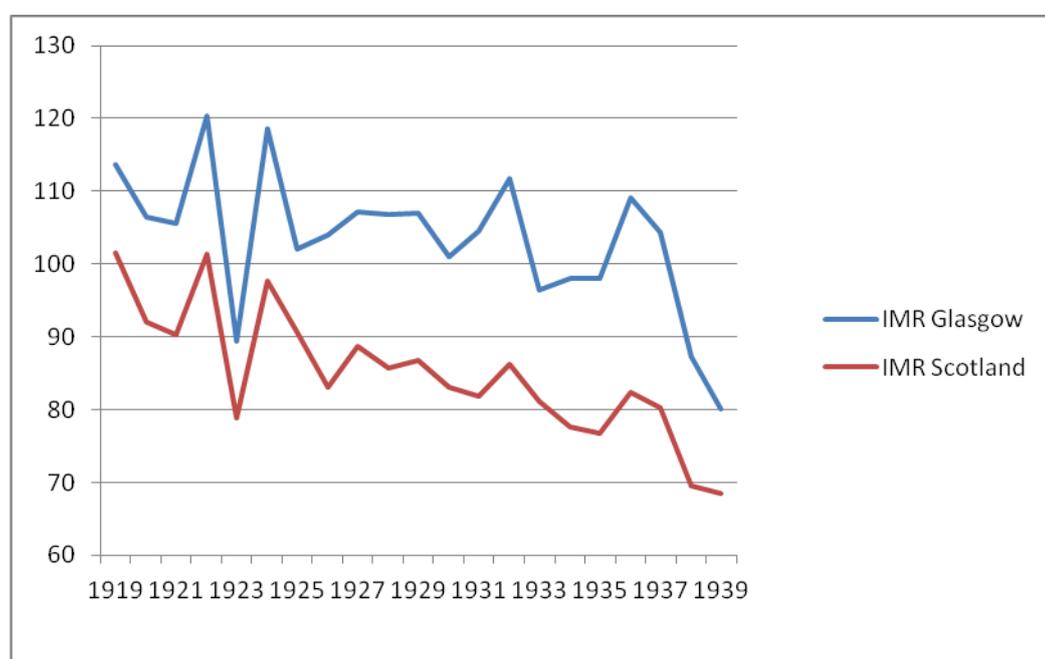
Historians have examined public health statistics such as the mortality and nutritional status of the population to evaluate the extent to which the interwar era was one of improvement. For historians such as Stevenson, Aldcroft and Winter, this data depicts the interwar period as one of progress, and their views broadly mirror that of the quote above. This chapter traces the pattern of these key health indicators for Glasgow and assesses whether they support optimist or pessimist readings. Firstly, the pattern of infant mortality, the city's crude and standardised death rates, and the information collated by the school medical authorities on the physical condition of the school population will be examined. Secondly, health trends according to cause of death are analysed to provide an additional dimension to the question of how far the city's health improved. Qualitative data is then examined to indicate the ways in which this can bring an alternative layer of understanding. Health experiences are disaggregated according to age, geographic region and social class throughout to introduce the wide range of experiences across Glasgow. This chapter suggests that diversity characterised interwar health trends more distinctively than conclusive improvements or deteriorations.

²⁶⁴ Aldcroft, *Interwar Economy*, p. 375; Also cited in Webster, 'Healthy or Hungry Thirties?', pp. 110-1.

Healthy and Hungry?

A survey of secondary and primary sources reveals widespread agreement that Glasgow was an unhealthy city in the interwar period. Historians' who argue that health was notably poor in areas particularly affected by the recession often cite the city's undesirable health records in support of their case. Indeed, some have gone as far as to suggest that high levels of death and disease north of the border were statistics which the Ministry of Health conveniently ignored (see chapter 1).

Figure 3.1: Infant mortality rate in Scotland and Glasgow, 1919-39

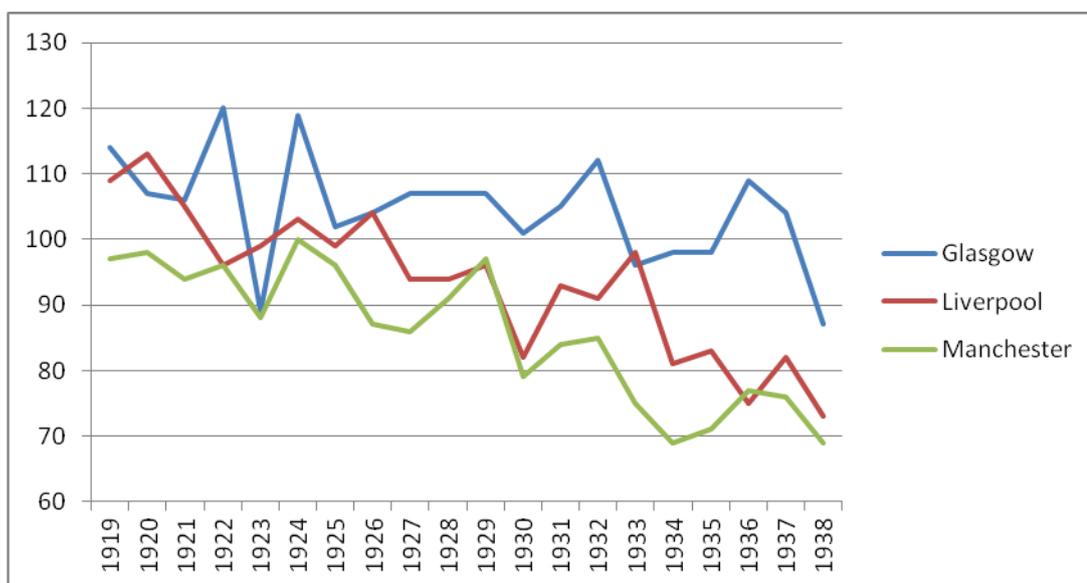


SOURCE: *RMOHG 1919-1939; ARSBH 1919-1929; ARDHS 1930-39.*

The infant mortality rate (IMR) is widely recognised as a 'useful indicator of the economic prosperity and sanitary conditions of a community' and it is regarded as a useful statistic for determining the health of a population

overall.²⁶⁵ IMR in Glasgow was consistently higher than the Scottish average, while the rate in Scotland was significantly worse than that south of the border (Figure 3.1).²⁶⁶

Figure 3.2: Infant mortality rate in cities of a similar industrial character: Glasgow, Liverpool, Manchester, 1919-38



SOURCE: RMOHG 1919-1938.²⁶⁷

Its public health achievements also compared unfavourably to cities with similar industrial profiles. IMR was, for the most part, higher than in the English industrial centres of Liverpool and Manchester and this gap had widened by the end of the period, the data showing that IMR in Manchester

²⁶⁵ Lee, 'Regional Inequalities in Infant Mortality in Britain, 1861-1971', p. 55; Also cited in Thompson, *Unemployment*, p. 217; Nicholas, *Social Effects of Unemployment*, p. 72.

²⁶⁶ 'House of Parliament: The Scottish Estimates', *GH*, 23rd June 1933, p. 7; 'The Health of Scotland', *Public Health (PH)*, June 1938, p. 25; Johnman and Murphy, 'Introduction', p. 237; *ARDHS 1936*, pp. 61-2; *Department of Health for Scotland: Report of the Committee on Scottish Health Services*, HMSO 1936 (5204), p. 390; Jenkinson also provides data demonstrating the inferior position of Scotland in an international context, comparing Scottish IMR rates with that of New Zealand, Netherlands, Australia, Norway, Sweden and the United States. The data shows that IMR in Scotland in the interwar period was significantly higher than each of these countries being, for example, 92 in 1921-25 compared to 43 in New Zealand, 64 in the Netherlands and 52 in Norway. By the 1930s some of these differentials had widened further with, for example, an IMR of 45 in the Netherlands and 81 in Scotland in 1931-35 (See Jenkinson, *Scotland's Health*, p. 187 for more details).

²⁶⁷ These are rounded to whole numbers as presented in the MOH annual report; IMR data was only published for these regions in the Glasgow MOH reports until 1938.

for example, improved by 25.6 per cent between 1919-20 and 1937-38 compared to only 13.6 per cent in Glasgow (Figure 3.2).²⁶⁸ Nevertheless, while Glasgow was a 'pocket' of regional deprivation and ill health, its infant mortality statistics actually support the optimist interpretation of continual advance in public health. This was emphasised by the national and local health authorities and throughout the interwar period they celebrated the gradual decline in the infant death rate. This fell from 113.7 to 80.1 deaths per 1,000 births between 1919 and 1939 and by the end of the period the MOH for Glasgow was able to report that 'the city was healthier than it had ever been before' (Figure 3.1 and 3.2).²⁶⁹

The city's crude death rate also fell from 16,361 deaths per million of the population in 1919 to 13,301 in 1939. Important methodological issues complicate the use of crude mortality data since this fails to account for the effect of changes in the age-sex profile of the population. This is problematic as the mortality rate of a region can be significantly influenced by the age of its residents, where an elderly population tends to have a higher death rate compared to one where residents are young. Thompson has demonstrated the importance of regional demographics and the unreliability of crude data, which suggested, for example, that the mortality rate for south Wales was increasing in the interwar period. In fact, 'due to the fall in the birth rate and the emigration of large numbers of young people from south Wales during the interwar period, the average age of the population increased, and the area thus experienced higher mortality risks, thereby making it appear that mortality increased.'²⁷⁰ The age profile of Glasgow also changed over the period under review (Appendix 3.1 and Appendix 3.2). Like in Thompson's south Wales, the 1931 census report for Glasgow recorded that many had

²⁶⁸ *National Archives of Scotland (NAS)*, DD6/83, Note of a meeting at the Treasury on Thursday on the subject of the proposed Housing Board; Diseases like the more severe type II strain of pneumonia was also significantly higher in Glasgow than Manchester (*Pneumococcal Pneumonia and its Treatment in Glasgow 1938-1942* (Glasgow: Committee on Health), p. 3).

²⁶⁹ *RMOHG 1939*, p. iv.

²⁷⁰ Thompson, *Unemployment*, pp. 182, 184.

left the city in search of work (see below).²⁷¹ There were clearly a lower percentage of young people residing in the city when comparing 1921 to 1931, and the percentage of adults in the 55-64 years, 65-74 years, and 75 and over categories increased (Appendix 3.1).²⁷² The falling birth rate in Glasgow also contributed to this ageing population, although it was said that Scotland had a much younger population than England (Appendix 3.2).²⁷³ The age profile of mortality in Glasgow also changed where the total percentage of deaths occurring in the over 65 years category almost doubled from 23.5 per cent to 41.1 per cent between 1919 and 1939, while that for those under five fell from 28.7 per cent to 14.9 per cent.²⁷⁴

Table 3.1: Mortality rates in Glasgow, 1921-25 and 1931-35

Population Data	Standardised death rate per 1,000				Crude death rate per 1,000 ²⁷⁵
	Male		Female		
	Glasgow Corporation (corrected)	Census	Glasgow Corporation (corrected)	Census	
1921	17.1	17.7	15.4	16.0	14.5
1922	18.9	19.6	17.5	18.2	16.5
1923	16.3	16.9	15.3	15.9	13.7
1924	18.1	18.8	17.2	17.9	15.4
1925	17.1	17.7	15.8	16.4	14.0
1921-25	17.5	18.1	16.2	16.9	14.8
1931	15.7		14.2		14.2
1932	16.1		14.9		14.7
1933	15.5		13.4		13.4
1934	15.7		13.8		13.7
1935	16.1		14.5		13.8
1931-35	15.8		14.2		14.0
Percentage decrease	9.7	12.7	12.3	16.0	5.4

SOURCE: *RMOHG 1921-1935*; Census Report, City of Glasgow, 1921 and 1931; W. Jones (Secretary, Public Health Department, Corporation of Glasgow), *The Expectation of Life in the City of Glasgow* (Glasgow, 1925), p. 32.

²⁷¹ Census Report, City of Glasgow 1931, p. 41.

²⁷² This also applied to Scotland as a whole (*DHS: Summary of Report of Committee on Scottish Health Services*, HMSO, 1937), p. 5; *Committee on Scottish Health Services Report*, p. 32.

²⁷³ 'The Prevention of Heart Disease', *PH*, April 1926, p. 220.

²⁷⁴ As is similarly demonstrated by Thompson (S. Thompson, 'A Social History of Health in Interwar South Wales' (PhD Thesis: University of Wales, 2001), pp. 278-79).

Also see Whiteside, 'Counting the Cost', p. 239.

²⁷⁵ *RMOHG 1921-35*.

Crude mortality rates can be standardised to account somewhat for this problem. Standardising the death rate relies on age-specific population data. This is problematic as this information was only published for Glasgow in the 1921 and 1931 census reports. Among other methodological issues with census data, Thompson explains that 'since the calculation of the rates has been on the basis of the proportions of population in an age-group, as enumerated by the census, the age-specific rates are dependent on the age-structure of the population in any district remaining the same as in the previous census.'²⁷⁶ This means that the figure published in 1921 might not apply during the entire 1920s due to possible changes in the age structure of the population between intercensal years. It can be assumed that the age-structure of the population was unlikely to alter significantly in the years immediately following the publication of the interwar census reports, being more likely to change gradually over time. Therefore, the mortality figures according to age are only calculated for the quinquennia 1921-25 and 1931-35.²⁷⁷

However, the census data published for Glasgow in 1921 is additionally problematic. On the date in which the census was taken, it was estimated that as many as 50,000 people were absent from the city as it was a public holiday. Consequently, when completing a series of life tables in 1925, Glasgow Corporation used and published adjusted population data which they claimed went some way to account for this discrepancy.²⁷⁸ Table 3.1 shows the standardised mortality rate using both sets of data and will be the method adopted throughout this thesis where age-specific death rates have been used. Standardising Glasgow's mortality rate using the direct method suggests that the city's crude death rate (CDR) may have been

²⁷⁶ Thompson, *Unemployment*, p. 195.

²⁷⁷ The age ranges used to standardise Glasgow's mortality rate were 0-4, 5-9, 10-14, 15-19, 20-24, 25-34, 35-44, 45-54, 55-64, 65-74 and 75 and above according to the 1931 census data for England and Wales; Thompson, *Unemployment*, pp. 182, 194-96.

²⁷⁸ GCA, DTC 7/11/6, Jones, *The Expectation of Life*, p. 32.

affected by the population's changing age-structure (Table 3.1).²⁷⁹ The percentage decrease of the standardised death rate (SDR) between 1921-25 and 1931-35 was 9.7 per cent for males and 12.3 per cent for females (or 12.7 and 16.0 per cent based on the census figures actually published). This is compared to 5.4 per cent implied by the CDR. Nevertheless, the crude and standardised mortality rates suggest that there is clearly a case for the 'optimist' reading of interwar public health in Glasgow. Life tables, an additional statistic which can be used to gauge the health of a population, also endorse this view.²⁸⁰ Life expectancy data calculated by Glasgow Corporation for 1920-22 and 1930-32 show that the average life expectancy increased by 3 years to 51.3 and 55.2 for males and females respectively.²⁸¹ Therefore, these mortality statistics suggest that significant improvements were experienced despite the severity of industrial depression in the region.

Unsurprisingly, this was the view adopted and promoted by Glasgow's health authorities, and there was good reason for them to assert that the general health of the population had improved. Writers like Aldcroft have cited figures relating to the heights, weights and nutrition of school children to suggest that this similarly follows a pattern of progress.²⁸² Based on this data, Glasgow's health authorities also stated in 1934 that it was 'gratifying to be able to report that in spite of the adverse conditions, no evidence of general impairment of nutrition has been detected in the school population.'²⁸³ This next section charts the data collated by Glasgow's school medical inspectors to evaluate how far these records shed light on the extent to which the city's health improved. The Education (Scotland) Act 1908 had implemented the systematic medical inspection of children

²⁷⁹ R. Pressat, *Demographic Analysis: Methods, Results, Applications* (London: Edward Arnold, 1972), pp. 89-90; B. Benjamin and J.H. Pollard, *The Analysis of Mortality and Other Actuarial Statistics, 2nd Edition* (Cambridge: Cambridge University Press, 1970).

²⁸⁰ D.J. Oddy, 'The Health of the People', in T. Barker and M. Drake, *Population and Society in Britain 1850-1980* (London: Batsford Academic and Educational, 1982), p. 135.

²⁸¹ GCA, DTC 7/11/5, *Corporation of Glasgow: Resume of Work of Public Health Department, 1935-36*, p. 4.

²⁸² Aldcroft, *Interwar Economy*, p. 375.

²⁸³ GGNHSBA, HB38/1/6, *RMITSC 1934*, p. 1.

throughout Scotland – a pursuit which has resulted in a wealth of data on the health of children of school, and to a lesser extent, pre-school age.²⁸⁴ For the most part, this data also confirmed that the population was healthier than ever before. This was particularly significant as it was reasoned that deteriorations in health would manifest themselves within this group since children were the most vulnerable section of the population.²⁸⁵

These records on nutritional status are, for a host of reasons, methodologically flawed.²⁸⁶ For example, no systematic measure was in place to ensure that the recordings were scientific, systematic and consistent – a failure that Glasgow Corporation and the Scottish health departments acknowledged themselves.²⁸⁷ The subjective nature of the classification of children into whether they were of good, fair, bad or very bad nutrition relied on the observer's opinion. This meant that medical officials in poorer areas could perceive childhood ailments as normal and consequently adopt a lower standard of judgement than those in more prosperous wards.²⁸⁸ It was also noted that the gradual impact of unemployment may have caused officers to 'become unconsciously familiar with and accustomed to a lower standard of nutrition in the school child.'²⁸⁹ Politics also came into the question and writers like Webster draw attention to the political pressure on medical inspectors to portray their area in a favourable light.²⁹⁰ These flaws obviously have important implications for analyses of this nature. In fact, the Glasgow education authorities were criticised for reporting real improvements in children's health from statistics which relied on the inclusion of records from

²⁸⁴ *RMOHG 1931*, p. 47; *ARDHS 1935*, p. 74.

²⁸⁵ Thompson, *Unemployment*, p. 93; *GGNHSBA*, HB38/1/2, *Report of the Medical Inspection and Treatment of School Children (RMITSC)*, 1929, p. 3.

²⁸⁶ Nicholas, *Social Effects of Unemployment*, p. 94.

²⁸⁷ *Corporation of Glasgow: Evidence to be Submitted to Committee on Scottish Health Services re The Medical Services* (Glasgow: Corporation of Glasgow, 1934), p. 90; *GGNHSBA*, HB38/1/2, *RMITSC 1930*, pp. 17-8.

²⁸⁸ The term 'ward' is used by the MOH for Glasgow to refer to areas within Glasgow itself; E.P. Cathcart, 'Food and Nutrition', *BMJ*, 27th February 1937, p. 435; Jones, *Health and Society*, p. 75; Thompson, *Unemployment*, p. 93.

²⁸⁹ 'Malnutrition', *Medical Officer*, 31st October 1925, p. 189.

²⁹⁰ Webster, 'Healthy or Hungry Thirties', p. 119.

more affluent areas surrounding the city – although this was denied.²⁹¹ Hence, Thompson asserts that ‘for these (and a number of other) various reasons, the subjective judgements of school medical officers are of limited value in ascertaining the nutritional status of the child population’ and Webster maintains that it ‘difficult to stave off fears that [this] elaborate body of statistical data rested on totally unsound foundations.’²⁹²

However, the information gathered is still informative when combined with the collection of records on the heights and weights of Glasgow’s school population. These are regarded as an insightful and more robust measure of the health and nutritional status of the population, and were an index also advocated by the Glasgow education authorities and contemporary investigators like Boyd Orr.²⁹³ This is not to say that this data is free from error. It is possible, for instance, that fluctuations in the height and weight of children could be affected by their exact age at the time of the recording. For example, in 1937 the education authorities pointed out that the average age of the scholars examined in years and months was lower than it had been in 1936, and it was claimed that this difference explained the lack of improvement between these years for the 5 and 13 years age groups.²⁹⁴ Thompson also points out that variations in daily water retention, the influence of heredity and genetics, and inaccurate weighing devices are just some of the issues which can complicate the accurate collection of this information – although he notes that the arrangement of this vast body of data into general averages helps to correct and balance errors of recording.²⁹⁵ One particular feature of the data in Glasgow is that this was

²⁹¹ GGNHSBA, HB38/1/4, RMITSC 1932, pp. 7, 20-1; GGNHSBA, HB38/1/8, RMITSC 1936, p. 5.

²⁹² Thompson, *Unemployment*, p. 93; Webster, ‘Healthy or Hungry Thirties’, p. 119.

²⁹³ P.B. Eveleth and J.M. Tanner, *Worldwide Variation in Human Growth* (Cambridge: Cambridge University Press, 1976), p. 1; Also cited in Thompson, *Unemployment*, p. 93; GGNHSBA, HB38/1/2, RMITSC 1930, pp. 17-8; Boyd Orr, *Food, Health and Income*, p. 38.

²⁹⁴ GGNHSBA, HB38/1/9, RMITSC 1937, p. 6.

²⁹⁵ Thompson, *Unemployment*, p. 94.

not rounded up to whole numbers, which makes it possible to identify small improvements or deteriorations which took place more accurately.

Throughout the interwar period the education authorities maintained that the physical condition of Glasgow's school population was improving.²⁹⁶ Even during the nadir of the recession they confidently claimed that 'it is very gratifying to be able to report that so far no evidence of deterioration in the nutrition of the school children, as judged by average heights and weights, has appeared.'²⁹⁷ These improvements were broadly attributed to state intervention and 'the valuable work which has been done by the various agencies responsible for providing for the nutrition of the school children.'²⁹⁸ It seems more likely that a combination of factors including the development of child and maternal welfare clinics, improvement in milk supplies, welfare provisions including unemployment benefit, the increasing disappearance of rickets, and reform in housing and slum clearance all aided the advance in the stature and weight of children, alongside the benefits of the milk scheme and the school medical service.²⁹⁹ The data demonstrates that school children were bigger and heavier in 1939 than they had been in 1919. The average weight of children aged 5, 6, 9 and 13 years improved by 1.3, 5.0, 9.4 and 8.8 per cent respectively between 1919-20 and 1938-39. Similarly the average height of Glasgow scholars improved by 1.8, 3.4, 4.3 and 3.9 per

²⁹⁶ Jenkinson, *Scotland's Health*, pp. 260-61.

²⁹⁷ GGNHSBA, HB38/1/4, RMITSC 1932, p. 6.

²⁹⁸ GGNHSBA, HB38/1/4, RMITSC 1932, p. 6; The early MOH Chalmers similarly claimed that the decline in IMR could be associated with welfare schemes which 'have done so much in recent years to tide them over periods of trade depression and economic stringency' (Chalmers, *Health of Glasgow*, p. 257).

²⁹⁹ A.W. Boyne and F.C. Aitken, 'Secular Change in Height and Weight of British Children, including an Analysis of Measurements of English Children in Primary Schools: 1911-1953', *Nutrition Abstract and Reviews*, 27 (1) (1957), p. 10; The Glasgow health authorities also recognised that 'social and public health legislation has contributed to this tendency, but there is no doubt that the general application of the principles of hygiene to school life has been in large measure responsible. Schools have gradually set up higher standards of personal hygiene and nurture, which have in turn reacted upon domestic habits and customs' (*Evidence to be Submitted to Committee on Scottish Health Services re The Medical Services*, p. 92).

cent during the same time periods (Appendix 3.3).³⁰⁰ This was also the experience of other regions notably affected by the Depression like the Rhondda district in south Wales.³⁰¹ Therefore, the records on the health of Glasgow's school population further suggest that the interwar period was one of progress.

Analysing a number of public health indices which have been used to evaluate the health of a population overall, including life expectancy, the infant, crude and standardised mortality rates and data on the physical condition of school children, reveals that Glasgow was undoubtedly the 'unhealthy city' described by historians of health. This was due to its unfavourable position within Scotland and in relation to regions of a similar industrial profile. Nonetheless, this evidence tentatively suggests that this was only in relative terms. In Glasgow, death rates declined, life expectancy increased, children were indeed fatter and healthier than their parents had been, as the chapter's opening quote by Aldcroft proposed. Tracing the trends of key health indicators to assess how far health improved reveals that in spite of the severity of the economic recession in the city there is a strong case for an 'optimist' reading of public health in Glasgow.

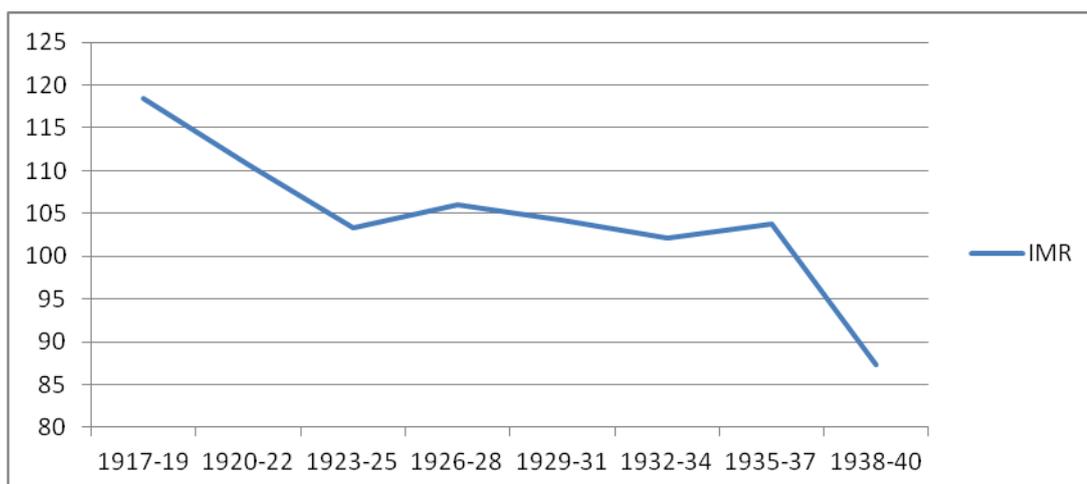
However, here it will be shown that the city's public health data is complex and contradictory, and the same records can be used to challenge this view. It is easy to show that despite the obvious improvement in the infant death rate by the end of the period, regional differentials intensified, improvements stagnated and advances in public health could reverse. For

³⁰⁰ B. Harris, 'The Height of Schoolchildren in Britain 1900-50', in J. Komlos ed., *Stature, Living Standards and Economic Development* (1994), p. 33, cited in Gazeley, *Poverty*, pp. 60-1; Boyne and Aitken, 'Secular Change in Height and Weight of British Children', pp. 3, 14.

³⁰¹ Thompson does point out that 'the rate of increase was more gradual, and therefore regional inequalities intensified over the period' – although it had been suggested by Harris that this was not solely due to unemployment (B.J. Harris, 'Medical Inspection and the Nutrition of Schoolchildren in Britain, 1900-1950' (Unpublished PhD Thesis: University of London, 1989) referenced by Thompson, *Unemployment*, pp. 96-7).

example, Glasgow did not share proportionately in the overall health gains of the Scottish population. Between 1919-1923 and 1935-39 IMR in Glasgow decreased by 10.6 per cent compared to 18.6 per cent for Scotland as a whole.³⁰² Hence, while the city's IMR improved overall, it deteriorated in relative terms.³⁰³ Organising the IMR data for Glasgow into three year intervals substantiates this trend. Like annual health data, the arrangement of mortality figures into averages entails analytical difficulties in that it ignores the unique and often diverging experiences of individual groups within a population, while masking small annual changes which took place. However, as Thompson points out, 'any population study of mortality must necessarily employ averages to make meaningful and comprehensible generalisations.'³⁰⁴ When displaying the data in this way it is again clear that IMR had improved over the period under review (Figure 3.3).

Figure 3.3: Infant deaths per 1,000 births for Glasgow in three year intervals, 1917-1940



SOURCE: RMOHG 1917-1940.

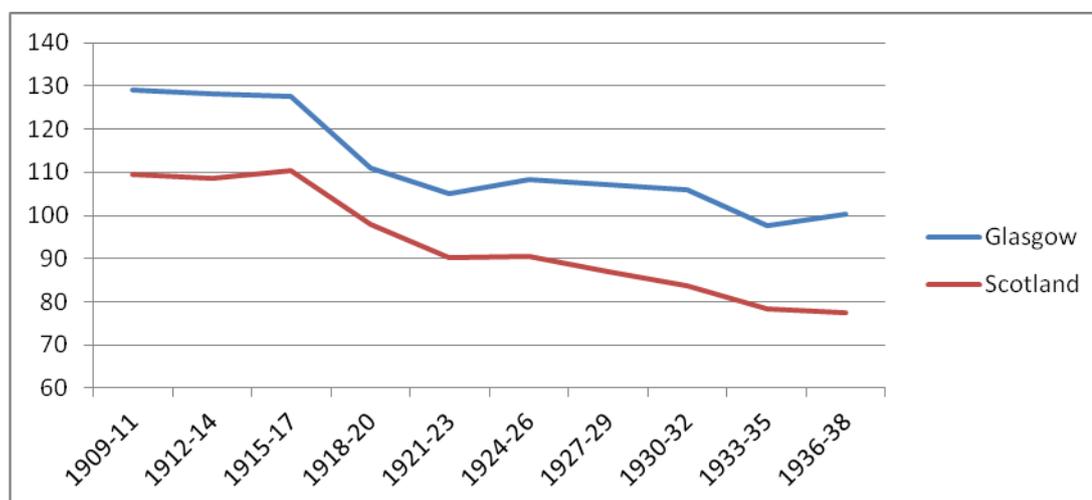
³⁰² Comparing the rates for 1919-20 to 1938-39 also reveals a reduction of 23.9 per cent compared to 28.7 per cent in Scotland as a whole.

³⁰³ This was also the case in the depressed region of interwar south Wales, where the rate of infant death declined at a slower rate compared to England and Wales (Thompson, *Unemployment*, p. 241).

³⁰⁴ Thompson, *Unemployment*, p. 180.

However, figure 3.3 also reveals that the rate of improvement as measured by infant deaths stagnated significantly during the interwar years even if IMR did not markedly worsen.

Figure 3.4: IMR in Glasgow and Scotland in three year intervals, 1909-1938



SOURCE: RMOHG 1909-1938.

Plotting the IMR rate from 1909 also implies that up until the interwar period, the disparity between Glasgow and Scotland had been narrowing (Figure 3.4).³⁰⁵ Nonetheless, the gap between them visibly widens, especially from the mid 1920s, further suggesting that a relative deterioration in health occurred.

The infant death rate in Glasgow did decline between 1919 and 1939. However, when comparing the city's rate to that of other industrial regions or Scotland as a whole, the relative decline of IMR in Glasgow is slight. Similarly, when taking Scotland as a whole, the gap between the Scottish infant death rate and that of England and Wales also widened significantly

³⁰⁵ The Committee on Scottish Health Services detailed that improvements in health had been relatively faster in Glasgow since 1870-72 as the city recovered from high rates of ill health brought about by early industrialisation (*Committee on Scottish Health Services Report*, p. 46).

over the interwar period and Jenkinson claims that there was 'no clear downturn in the Scottish level of IMR until 1938'.³⁰⁶ For Jenkinson 'these figures appear to be at odds with Winter's assessment for the whole of Britain that "the data for 1930, 1932-35, and 1937-39 demonstrate conclusively that infant mortality had diminished during both the upswings and downswings of the trade cycle."³⁰⁷ Likewise, in interwar south Wales, a region notably depressed south of the border, the decline in IMR was also slower than that of England and Wales until the mid 1930s at least meaning that 'regional inequality was growing in the fifteen years before the mid 1930s.'³⁰⁸ However, in Glasgow this narrowing of the IMR rate towards the end of the period did not occur.

Nicholas argues that it is in this context that interwar health trends should be considered, 'the chief question being whether the effects of unemployment in any way retarded the general improvement.'³⁰⁹ If adopting this argument, these mortality trends clearly challenge the interpretation that the interwar period was one of progress for Glasgow or Scotland as a whole. The extent to which this was solely due to the economic fortunes of the period does, however, have to be treated with caution. It has been noted above that during the interwar period large numbers of workers left both Glasgow and Scotland in search for work. For example, the 1931 census report recorded that when accounting for population changes due to natural causes (i.e. births and deaths) that:

As the recorded increase in the population at the recent census is slightly under 37,000, there has been during this decade an apparent loss by migration of over 50,000, and even this figure would fail [sic] to be increased if regard be had to the absence of persons on holiday at the date of the 1921 census. It is clear that Glasgow suffered a heavy

³⁰⁶ Jenkinson, *Scotland's Health*, p. 184.

³⁰⁷ *Ibid.*, p. 185.

³⁰⁸ Thompson, *Unemployment*, p. 218.

³⁰⁹ Nicholas, *Social Effects of Unemployment*, p. 73.

loss of population by migration during the intercensal period, due no doubt to local industrial depression.³¹⁰

Historians like Finlay note that workers leaving Scotland generally tended to be young, urban, skilled or professional workers. For example, one in three Scottish engineers located elsewhere.³¹¹ Evans' research also suggests that this was the case in Glasgow in the early 1920s at least and Harper claims that greater numbers of workers left from the industrial belt.³¹² If Glasgow followed the same pattern as Scotland emigration would have slowed significantly in the 1930s. Nonetheless, there is the possibility that the stagnating infant death rate may have been affected by the movement of wealthier workers out of the city – leaving behind a less healthy, poorer population whose children were less likely to survive.³¹³ The extensive research required to establish the profile of workers who left Glasgow in this period, to determine the impact that this could have had on mortality patterns, is out with the scope of this thesis.³¹⁴ Nonetheless, these figures clearly

³¹⁰ Census Report, City of Glasgow 1931, p. 41.

³¹¹ Finlay, *Modern Scotland*, pp. 102-03; Also see Devine, *Scottish Nation*, pp. 471-72.

³¹² During the first four months of 1923 at least (Evans, 'Emigration of Skilled Male Workers from Clydeside', pp. 270-71, 272; M. Harper, *Emigration from Scotland between the Wars: Opportunity or Exile?* (Manchester: Manchester University Press, 1998), p. 12.

³¹³ This has also been raised by Hughes who claims that in neighbouring Greenock, 'high levels of unemployment and the emigration of the healthier and wealthier and more skilled intensified the impact of poverty and poor health' – a phenomenon she claims was manifest in increasing rates of infectious diseases (Hughes, 'Effects of Recession and Depression on Greenock between the Wars', p. 297); Although by the 1930s the rate of emigration from Scotland began to fall as job opportunities in other countries also contracted. In fact, Evans and others have claimed that many Scottish workers returned home and that the inability of many to move in the 1930s could actually aggravate unemployment and social problems at home (Smout, *Century*, p. 116; Harvie, *No Gods*, p. 47; Anderson, *Population and Family Life*, p. 14; Evans, 'Emigration of Skilled Workers from Clydeside', pp. 278, 280; Harper, *Emigration from Scotland*, pp. 10, 29, 32, 65, 203, 210-11). Furthermore, Evans highlights that those arriving in destination ports he examined were far from rich, 'unlike what we might have expected in the case of skilled workers' (Evans, 'Emigration of Skilled Workers from Clydeside', p. 276).

³¹⁴ For example, these statistics are 'notoriously difficult' as immigration also has to be accounted for in the calculation (Finlay, *Modern Scotland*, p. 101). Marked gaps in the data, inconsistencies, and methodological issues around the disaggregation of Glaswegian workers from Scottish figures complicate this further. Published Board of Trade data also fails to provide detailed occupational or Scottish regional data (although it is contained in the mass of original raw data that made up these reports. See Evans, 'Emigration of Skilled Workers from Clydeside', pp. 256-57, 268 and Harper, *Emigration from Scotland*, p. xii, 24). Moreover, the country of arrival, rather than the country or city of departure, tended to record passenger information making the tracing of workers difficult. Evans has exploited the Ellis Island Database and Scottish Emigration Database which includes regional, occupational

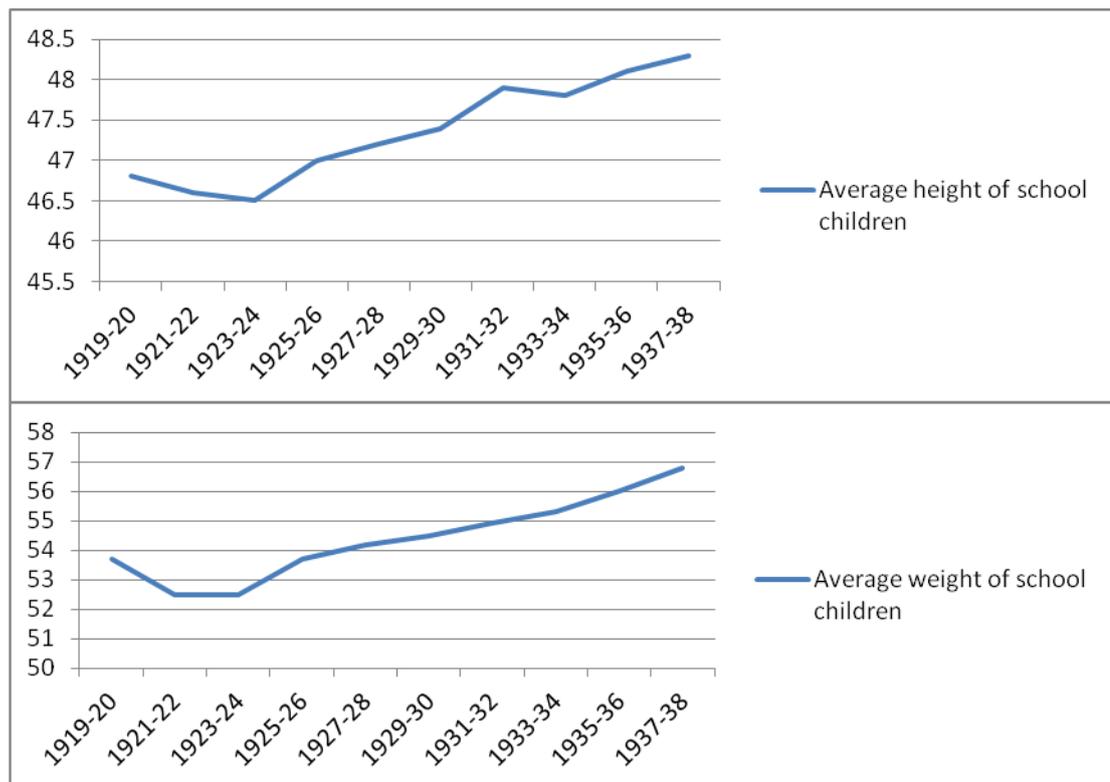
reveal both the importance of demographic factors, as is emphasised by Thompson, when considering mortality rates, and the extent to which the same statistics, used by both optimists and pessimists, can be reinterpreted to support contrasting interpretations. What is clear, however, is that geographically, the health position of Glaswegians (and Scots in general) deteriorated in relative terms, supporting the notion that Glasgow became an increasingly unhealthy city during the interwar period.

The records collated by the education authorities can also be reinterpreted to challenge the 'optimist' view. Data on the heights and weights of Glasgow school children demonstrates that the rate of improvement slowed during the worst points of the recession – a trend also highlighted by J.B. de V. Weir (Figure 3.5).³¹⁵

and destination data (although the latter only provides information for travellers to non-European ports during the first four months of 1923). The scale of research required to map the number and profile of migrating Glaswegian workers over the interwar period was simply not possible within the constraints of this PhD thesis. However, that this could have had an effect should be considered and would benefit from further research; For a study of this nature in a modern context see F. Popham, P.J. Boyle, D. O'Reilly and A. Leyland, 'Selective Internal Migration: Does it Explain Glasgow's Worsening Mortality Record?', *Health and Place*, 17 (6), (2011), 1212-217.

³¹⁵ J.B. de V. Weir, 'The Assessment of the Growth of Schoolchildren with Special Reference to Secular Changes', *British Journal of Nutrition*, 6 (1952), p. 22.

Figure 3.5: Average height and weight of Glasgow school children in two year intervals, 1919-38



SOURCE: RMITSC 1919-38.

The average height of school children in Glasgow reveals that improvements made to their physical stature reversed during the worst points of the recession in the 1920s and the 1930s (Figure 3.5). Similarly, the combined average weight of Glasgow's school population reversed during the 1920s slump, although this was not the case in the 1930s. Plotting these figures from 1920 when the recession commenced, however, also substantiates a pattern of relative decline when the recession was most severe in the 1920s and 1930s (Appendix 3.4). As such the data collected by the school medical authorities can also be interpreted to suggest that the rate of development was arrested during the worst points of economic depression. A complex picture emerges which provides evidence for aspects of both 'optimist' and 'pessimist' perspectives. When taken as a whole the interwar period saw improvements in various health indicators. However, in times of economic recession within that period these improvements slowed or were reversed.

Explaining the 'Paradox'

While the conclusions derived from this attempt to measure the extent to which health improved or deteriorated can seem contradictory, it clearly demonstrates the 'paradox' proposed by writers such as Glynn and Oxborrow.³¹⁶ How can this be explained? Using a myriad of evidence to support their case, historians of health have debated and disagreed over the extent to which health improved or deteriorated. However, all accept one thing – that standards of health varied significantly for distinct sections of the population. It is widely agreed that statistical averages can mask diverse and diverging experiences within a population. This was the case in interwar Glasgow and whilst maintaining that their policies were principally successful, the city's health departments and education authorities admitted that there were important qualifications to the achievements which had been made. For example, the Corporation generally found that while the health of school children demonstrated a clear tendency to improve, that of the pre-school child did not.³¹⁷ This discrepancy was widely acknowledged and the Glasgow education authorities accepted that while the number of school children found to have a medical defect varied annually, 'the significant point which stands out is that the condition of the entrant child does not show any appreciable improvement.'³¹⁸ To some extent, the mortality rates for children in the pre-school and school age categories reflects this trend. Depending on what population data is used (the corrected population figures published by Glasgow Corporation or those published in the 1921 census report) this is supported to varying degrees. While the death rate among both groups improved, the rate of progress was somewhat faster among those of school age, declining by at least 8.6 per cent (corrected figures) or 13.5 per cent

³¹⁶ Glynn and Oxborrow, *Interwar Britain*, p. 13; Hardy, *Health and Medicine*, p. 109.

³¹⁷ GGNHSBA, HB38/1/2, *RMITSC 1930*, p. 7; GGNHSBA, HB38/1/3, *RMITSC 1931*, p. 17; *ARDHS 1936*, p. 13; 'Health of Glasgow School Children', *GH*, 6th February 1933, p. 10; 'Health of School Children', *GH*, 6th February 1933, p. 12; 'Scotland's Health', *GH*, 13th April 1938, p. 14; 'Health in Scotland', *Scotsman*, 6th July 1926, p. 8.

³¹⁸ GGNHSBA, HB38/1/2, *RMITSC 1930*, pp. 1, 7.

(census figures) between 1921 and 1931, compared to only 8.5 per cent (corrected) or 11.8 per cent (census) for children aged one to four years (Appendix 3.5).

Furthermore, rickets – a softening of the bones caused by nutritional deficiencies, and an ailment which had plagued the Scottish city – still existed among the child population of Glasgow (Illustration 3.1).³¹⁹ The incidence of children suffering from slight and marked rickets declined overall during the period under review (Appendix 3.6). However, in 1932 it was recorded that ‘at the same time it should be noted that there are indications that rickets of a minor degree among pre-school children shows a distinct tendency to increase’ and that ‘this tendency is at present confined to the first year or two of life and has not yet reached the school population.’³²⁰ This was apparently not specific to Glasgow and journals reported that this ‘same fact has also been noted in other industrial areas.’³²¹

³¹⁹ ‘President’s Address’, *BMJ*, 28th July 1923, p. 138.

³²⁰ *GGNHSBA*, HB38/1/4, *RMITSC 1930*, p. 6.

³²¹ ‘Health of Scotland: Department’s Annual Report: Maternity and Child Welfare Services’, *BMJ*, 1st July 1933, p. 20; ‘School Medical Inspection Notes’, *Medical Officer*, 11th March 1933, p. 98.

Illustration 3.1: Glasgow child with rickets, early twentieth century



SOURCE: *Heatherbank Museum of Social Work* (print 6371).

One study commenting upon the lack of improvement in the stature and weight of children aged one to four years, listed inefficient maternal care as a primary reason.³²² Certainly, the attendance figures of children aged one to five years at infant welfare centres was low in Glasgow where it was found to be less than three per cent in 1931.³²³ However, the claim that this was the single most significant factor influencing the health of the pre-school child is unlikely. Rather, it seems that this was because health provision was more restricted for this group. Ante-natal and child welfare clinics were specifically available to ensure, as far as possible, the healthy development of infants. On the other hand, the education authorities at least alleviated some of the defects found among the school population, and Holton has similarly argued that school medical provisions in Glasgow spared children's

³²² Paton and Findlay, 'Poverty, Nutrition and Growth', p. 303.

³²³ M. Emslie, 'War in the Family', *PH*, 46 (12), (1933), p. 389, cited in Jenkinson, *Scotland's Health*, p. 214.

health from the worst of the recession.³²⁴ However, a void in the health care system existed from when children left maternal and child welfare clinics until they went to school.³²⁵ The *DHS* acknowledged that the health of pre-school children in Scotland was failing to improve, stating it was ‘clear that generally speaking no adequate measures have been taken for attending to the health of children between the ages of one year and five years’ – a complaint also made by Glasgow’s early MOH Dr. A.K. Chalmers.³²⁶ By 1935 little had been done to secure the health of this section of the population, and by 1937 the *DHS* continued to view the pre-school era as the ‘dark age of childhood.’³²⁷ Mapping Glasgow’s public health trends demonstrates that improvements and deteriorations were felt unequally across the population with clear *divergences* according to age.

Similarly, a void in the health care system existed for adolescents leaving school aged 14 to 16 years until they became insured under the National Insurance Scheme, and it was realised by the Ministry of Health that while achievements in the health of school children had been made (in England and Wales), this advance reversed after the child left school.³²⁸ In response to this, the principal medical officer of the Glasgow Authority, Dr. Ernest T. Roberts claimed that there was no existing evidence indicative of whether this was the case in Glasgow, ‘because the children had passed

³²⁴ B. Holton, ‘The interwar depression and social welfare on Clydeside, with particular reference to the work of the education authorities’, paper delivered to the Anglo-Dutch Labour History Conference, Amsterdam, April 1974, cited in Winter, ‘Infant Mortality’, p. 462.

³²⁵ E.P. Cathcart, ‘Health Policy of the Future’, *Proceedings of the Royal Philosophical Society of Glasgow*, 63, 135th and 136th sessions 1936-37 and 1937-38 (Glasgow: The Society, 1938), p. 43; *Summary of Report of Committee on Scottish Health Services*, p. 16; G.F. McCleary (formerly a Deputy Senior Medical Officer in the Ministry of Health), ‘What We Have to Do for the Pre-School Child’, *Medical Officer*, 29th June 1935, pp. 257-58.

³²⁶ *ARDHS 1929*, p. 56; ‘Health Service “Gaps”’, *Scotsman*, 29th February 1936, p. 13; A.K. Chalmers, ‘Our Provision for Treating the Sick’, *GMJ*, 118 (1932), p. 11.

³²⁷ *ARDHS 1935*, p. 19; *ARDHS 1937*, p. 14; ‘Scotland’s Age’, *GH*, 13th April 1938, p. 14; ‘Current Topics: Empire Exhibition, Glasgow: Conference on Health Education’, *GMJ*, 130, (1938), p. 154.

³²⁸ *GGNHSBA*, HB38/2/5, ‘Saving of 3,000 lives in England and Wales: Breakdown of the Adolescent: Lack of Medical Attention for the Younger Worker’, *Herald*, 7th January 1929.

beyond their purview.³²⁹ However, giving a paper to the Scottish Association of Insurance Committees A.S.M. Macgregor, the MOH for the city, stated that it was ‘well known that some degree of physical deterioration is apt to set in among adolescents after leaving school, and it was in large part in order to counteract this tendency that the physical training scheme of the Government was introduced.’³³⁰ Unfortunately, it is not possible to assess whether this was reflected in the mortality records as this data does not exist for the 14-16 year age group. Some attempts were made to protect their health. This included the distribution of a booklet titled “The Rules of Health” to school leavers in 1938 which included ‘a short and simple summary of the main health lessons that all should bear in mind and carry into practice’, and which was intended to ‘enlist the interest of the young in the health services organised by the community of which they are members’.³³¹ However, it was not until April 1938 and the implementation of the National Health Insurance (Juvenile Contributors Young Persons) Act, 1937, that the health of this group was fully addressed.³³² Therefore, engaging with the optimist-pessimist debate and examining the extent to which health improved in Glasgow, undermines how far this is the most useful way to analyse these public health statistics. It has been shown that improvements were felt by some but not others with regards to age at least. Identifying, examining and emphasising the marked range of experience across the city seems to provide a more accurate picture of interwar public health trends.

The vast disparities which existed were widely recognised and featured regularly at the time in the popular press. For example, when the *Daily Record* reported in 1939 that ‘Glasgow’s school children of all social grades are improving in physical health – height and weight averages, today,

³²⁹ GGNHSBA, HB38/2/5, ‘Health of School Children: Medical Inspection in Glasgow: Sun Ray Treatment’, *GH*, 8th January 1929; *Medical Officer*, 3rd January 1925, p. 32.

³³⁰ A.S.M. Macgregor, *Some Observations on Sickness Experience: Annual Conference of Scottish Association of Insurance Committees* (September, 1937), p. 9.

³³¹ *ARDHS 1938*, p. 93.

³³² Jenkinson, *Scotland’s Health*, p. 383.

are the best ever' – the *GH* pointed out that while this had been 'shared in almost equal degree by the children of all social grades... attention is drawn to the fact that scholars in poorer class schools still fall considerably short of the standards reached by those attending schools in better class districts; there is room for levelling up.'³³³ It is well documented that the working class tended to occupy smaller homes with fewer rooms, and analyses assuming that the number of rooms per house reflected social position revealed significant variations in height and weight according to class (see chapter four). Essentially, as the number of rooms increased the height and weight of children of all ages tended to improve.³³⁴ Nutritionist Boyd Orr similarly found that there was a 'marked difference in the heights of boys drawn from different social classes', in that the heights of 'public school' boys from the higher income group compared more favourably to those attending 'council' schools. However, a difference was also mapped between 'industrial' and 'artisan' boys, revealing divergences within the working class itself.³³⁵ Smout claims that 'social inequality could be literally measured by height and weight'.³³⁶ Nonetheless, the medical authorities concluded in 1931 that 'boys and girls nowadays entering school from whatever social group are appreciably taller and heavier than formerly'.³³⁷ It seems that the height and weight of children from all classes improved to some extent over the period, where medical commentators reported that gains had been recorded among children living in one apartment housing – therefore supporting the notion that gains among the lowest class had taken place.³³⁸ However, it is clear that inequalities were the marked and *defining* feature of the interwar period, and that this was the pattern consistently found when examining a number of health indices.

³³³ 'Children Bigger, Heavier', *Daily Record*, 3rd February 1939; *GGNHSBA*, HB38/2/5, 'Health of Glasgow School Children', *GH*, 3rd February 1939.

³³⁴ Paton and Findlay, 'Poverty, Nutrition and Growth', p. 115.

³³⁵ Orr, *Food, Health and Income*, p. 39; Also see A.M.T. Tully, 'A Study of the Diets and Economic Conditions of Artisan Families in May, 1923', *GMJ*, 101 (1924), p. 9.

³³⁶ Smout, *Century*, p. 124.

³³⁷ *GGNHSBA*, HB38/1/3, *The Corporation of Glasgow Education Committee: Report on the work of the Education Committee 1931*, pp. 1-2.

³³⁸ *GGNHSBA*, HB38/1/8, *RMITSC 1936*, p. 5; E.M.B. Clements, 'Changes in the Mean Stature and Weight of British Children over the Past Seventy Years', *BMJ*, 2 (1953), pp. 900, 901.

This next section analyses Glasgow's infant mortality data and introduces its relationship with social class. This is important as one of the key debates in the literature is the extent to which class inequalities eroded (see chapter 1). A host of evidence illustrates that ill health in the city correlated with socio-economic position. Although primarily taken to reflect economic status, class is a relatively fluid concept and a host of academics and historians have discussed the social, economic and cultural factors which could be used to identify social status.³³⁹ As Stevenson comments, 'the boundaries of class are at best blurred and usually quite difficult to establish definitively... Habits of work, dress and speech, inherited notions of status attached to particular careers and lifestyles, and in Britain as a whole, regional differences all contribute to the complexity of the concept of class.'³⁴⁰ However, Szreter has argued that it is effective to analyse 'health and mortality differentials and their evolution over time, in terms of place and social environment rather than just in terms of social class differentials alone.'³⁴¹ This was because certain areas not only had a higher proportion of wealthier persons and professionals, but because these groups also made more effective use of their political 'voice' and contacts to ensure that their environments were maintained at a higher standard.³⁴² As such, Szreter argues that the 'dynamic interactions between class and "place", typically operating (in his case) in English communities through the process of residential segregation, need to be more fully recognised in research on the relationship between inequality and health,' and that the 'most exacting historical research recently completed has established that residence in different kinds of local environments or "places" c.1900 had a greater influence on mortality among the very young than the class status of their

³³⁹ See Bourke, *Working Class Cultures in Britain*, pp. 1-3.

³⁴⁰ Stevenson, *British Society*, pp. 340-41.

³⁴¹ S. Szreter, *Health and Wealth: Studies in History and Policy* (Rochester: University of Rochester Press, 2005), p. 352.

³⁴² *Ibid.*, p. 352.

household and their parents.³⁴³ Clearly then, while considering districts of a city according to social status is problematic, it can be revealing.

In Glasgow it was observed that regions including Cowcaddens, Dalmarnock, Govan, Hutchesontown, Bridgeton, Springburn, Shettleston, Tollcross and Gorbals, contained a 'working class population', that they were 'industrial and working class wards', or 'wards where the artisan classes reside,' while areas including Kelvinside, Langside, Pollokshields, Camphill and Cathcart regularly featured as examples of 'residential wards', or areas where the 'better' classes lived (Illustration 3.3).³⁴⁴ As the early MOH Chalmers pointed out, 'every industrial town has its residential and poorer neighbourhoods – its Kelvinside and Cowcaddens – and the differential death rates which occur among the wards, and smaller areas within them, still remain as a guide to administrative action.'³⁴⁵ It is clear that a number of indices corroborate the class descriptions used by the MOH of Glasgow to describe the regions to which he was responsible. From official health texts to lay observations and personal testimonies these class definitions were perceived on the basis of the housing, environmental and material conditions of these regions, and, consequently, on the class of inhabitants that could afford to reside in them (Illustration 3.2). For example, the density figures of these regions varied markedly, ranging from only 8 persons per acre in Pollokshaws to 169 in working class Gorbals in 1939, suggesting a degree of overcrowding common in working class households (Appendix 3.7). In 'working class' Dalmarnock 69.3 per cent of homes were found to be overcrowded, in Mile-End 66.7 per cent, Hutchesontown 63.8 per cent, and

³⁴³ Szreter, *Health and Wealth*, p. 13; E. Garrett, A. Reid, K. Schürer and S. Szreter, *Changing Family Size in England and Wales: Place, Class and Demography, 1891-1911* (Cambridge: Cambridge University Press, 2001), pp. 105-209; For Scottish IMR data from 1939 according to the occupational status and 'social class' of the father, see *Eighty-Eighth Annual Report of the Registrar General for Scotland 1942*, HMSO (1945), p. lxxvii. This broadly demonstrates that IMR increased as social status decreased.

³⁴⁴ *RMOHG 1923*, pp. 24, 30; *RMOHG 1925*, p. 13; *RMOHG 1929*, p. 26; *RMOHG 1930*, p. 66; *RMOHG 1931*, pp. 36, 46; *RMOHG 1932*, p. 49; *RMOHG 1935*, p. 41; 'Glasgow Today', *BMJ*, 11th February 1922, p. 244; GCA, DTC 7/11/5, *Glasgow Corporation: Resume of the Public Health Department, 1926-27*, p. 16.

³⁴⁵ Chalmers, *The Health of Glasgow*, p. 73.

Govan, Cowcaddens, Gorbals, Calton and Parkhead recorded rates of over 50 per cent. On the other hand, residential areas Kelvinside, Pollokshields, Langside, Camphill and Cathcart, registered rates of less than ten per cent (see chapter 4).³⁴⁶

Illustration 3.2: Interior of a slum tenement in Bridgeton, 1933 and a home in Kelvinside, 1935



SOURCE: Mitchell Library, Glasgow City Libraries and Archives. Virtual Mitchell (3002 and C5877)

One contemporary also observed that the sanitary condition of Glasgow ‘in the main seems very unsatisfactory’, but that this was ‘especially in the poorer districts [and] no wonder there is so much disease and ill health when the streets and closes are allowed to be so dirty. What diseases must lie in those dust laden and ill-ventilated closes that one finds so common.’³⁴⁷ Not all persons in these particular districts were members of the same social class. For instance, as is discussed in more depth below, the census reports recorded a significant spatial shift over the period, and the movement of those from traditionally working class communities outwards and into suburban regions. As such, few ‘middle class’ areas remained purely

³⁴⁶ Census Report, City of Glasgow 1931, pp. 56, 77-80.

³⁴⁷ ‘Letter to Editor: Glasgow Sanitation’, *GH*, 16th October 1920, p. 8.

residential.³⁴⁸ Certain streets could also be associated with social position.³⁴⁹ For example, Glasser comments on Rose Street as being ‘the lowest of the low in slums, even by Gorbals standards’ – an observation reflected in the health statistics for this community commented on in the *BMJ*.³⁵⁰

The material environment of the city’s social classes was grossly unequal. Loudon notes that even those enduring poverty were not a homogenous group, that ‘different degrees of poverty’ existed, and that ‘amongst the poor there were always hierarchies, well known to the poor themselves.’³⁵¹ Indeed, individual working class districts could be identified with a certain level of respectability.³⁵² One article published by the *Medical Research Council* referred to Pollokshields as a residential district, Springburn as a ‘good working class district, and Cowcaddens a slum.’³⁵³ However, despite these complexities, the general class composition of certain districts were recognised widely, being described as such by Scottish M.P.’s in Parliament, in the MOH annual reports, medical journals, contemporary newspapers and literature, autobiographies and personal testimonies.³⁵⁴ The social distribution of the population had been established before the interwar period, Szreter also noting that ‘from a health and social status point of view, class in Britain has increasingly manifested itself, since

³⁴⁸ *RMOHG 1930*, p. 71; *RMOHG 1938*, p. 51.

³⁴⁹ Rountree, *Govan*, p. 184.

³⁵⁰ Glasser, *Growing Up* (Kent: Mackays and Chatham PLC, 1990), p. 57; The *BMJ* reported on the high infant death rate of 235 per 1,000 in this street – a rate significantly higher than the city average and that of Gorbals as a whole (‘The Scottish Board of Health’, *BMJ*, 6th August 1927, p. 241).

³⁵¹ I. Loudon, *Death in Childbirth: An International Study of Maternal Care and Maternal Mortality* (Oxford: Clarendon Press, 1992), p. 46.

³⁵² This was still the case in the 1940s (Osborne, *The Social Survey*, p. 5).

³⁵³ J. Brownlee, ‘The Use of Death Rates as a Measure of Hygienic Conditions’, *SRMRC*, 60 (1922), p. 9; Also see J. Faley, *Up Or Close: Memories of Domestic Life in Glasgow Tenements, 1910-1945* (Oxford: White Cockade Publishing, 1990), pp. 19, 26, 165.

³⁵⁴ Housing Progress in Glasgow: Parliamentary Debates, House of Commons, 18th December 1936, p. 2877; E. Muir, *Scottish Journey* (London: Heinemann, 1935), pp. 155-56; Glasser, *Growing Up*, p. 17.

the beginning of the Victorian era, as different kinds of places in which families live and where children grow up.³⁵⁵

It is instantly apparent from the reports of the MOH that 'middle class' areas like Cathcart and Kelvinside returned significantly better annual health figures than poorer regions like Gorbals and Cowcaddens, and that they indicate the 'long-standing geographical dimension to what we call class differentials in health and inequality.'³⁵⁶ This is suggested from a host of medical data including the infant death rate, crude death rate, and the incidence and mortality rate from infectious and respiratory disease, and the MOH, and other commentators such as Hutt, often deduced that these disparities reflected health inequalities according to class.³⁵⁷ To analyse this, the average rate of infant deaths from four districts regularly featured as examples of middle class residential wards was calculated and compared to the average IMR of four districts commonly cited as working class areas.³⁵⁸

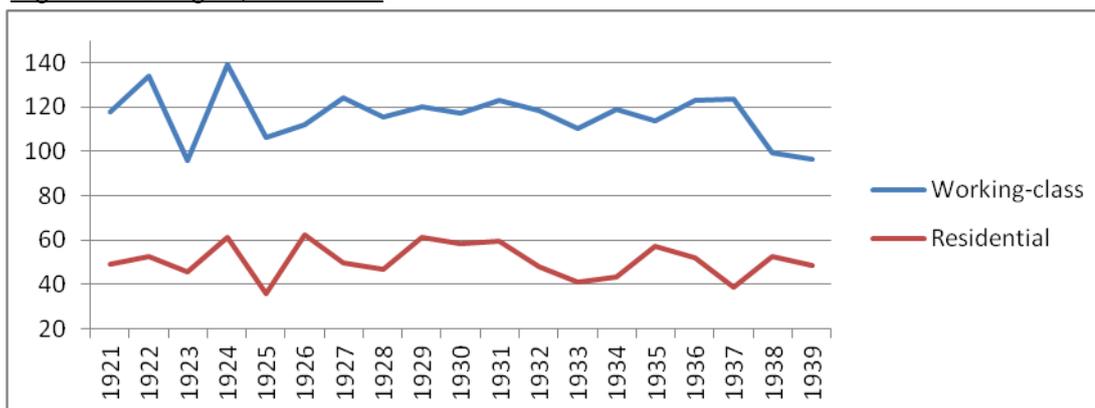
³⁵⁵ Szreter, *Health and Wealth*, p. 349.

³⁵⁶ *Ibid.*, p. 345.

³⁵⁷ Hutt, *Condition*, p. 117.

³⁵⁸ For 'residential' areas the average IMR was calculated from regions Cathcart, Langside, Pollokshields and Camphill. The 'working class' wards considered were Cowcaddens, Dalmarnock, Hutchesontown and Gorbals. From notes collated from the MOH reports, five regions in particular were frequently cited as examples of 'residential wards'. These were Kelvinside, Cathcart, Langside, Pollokshields and Camphill. Excluding Kelvinside, these regions are clustered together in the south of the city. Thus, Cathcart, Langside, Pollokshields and Camphill were considered together in order to represent a relatively large area of the city which was considered residential. For comparison four 'working class' regions were selected. This was more difficult as the MOH termed many more wards 'working class' than residential. However, Cowcaddens, Dalmarnock, Hutchesontown and Gorbals were cited as 'working class' or 'poor' three times or more and the IMR figures for these areas were considered.

Figure 3.6: Average infant death rate per 1,000 births for residential and working class regions of Glasgow, 1921-1939



SOURCE: RMOHG 1921-39.

Figure 3.6 provides a visual depiction of the marked health inequalities across the city where the rate was significantly lower in middle class areas.³⁵⁹ These data reveal that the IMR in working class districts was more than double that found in residential areas. This is a variance reflected in a number of different approaches to establishing the relationship between social class and health.³⁶⁰ The reporting of lay observers did, in contrast to the public health and medical authorities, tend to accentuate the worst interpretation of the statistics including instances, for example, where IMR was found to be seven times higher in working class regions.³⁶¹ This was the case in Whitevale for example, the death rate being seven times higher than Kelvinside in 1932 with many other regions such as Anderston not far behind – an observation which led one ex-Baillie to conclude that ‘the slum death rate is more devastating than that of the Great War.’³⁶² These rates starkly

³⁵⁹ Statistical trends regarding class commence from 1921 instead of 1919 due to the reorganisation of the city districts which took place during 1920 (*RMOHG 1921*, p. 1: Preface). Therefore these figures begin from 1921 to provide a fair comparison.

³⁶⁰ For example see J. Agnew, ‘Mortality-Rates in Glasgow Families: An Analysis of the Various Kinds of Wastage of Child Life in Well-To-Do and in Poor Families of Varying Size’, *GMJ*, 3 (1922), pp. 150-52, 160; Housing Progress in Glasgow: Parliamentary Debates, House of Commons, 18th December 1936, p. 2877; ‘House of Commons: Rent Restrictions Debate’, *GH*, 3rd March 1938, p. 6.

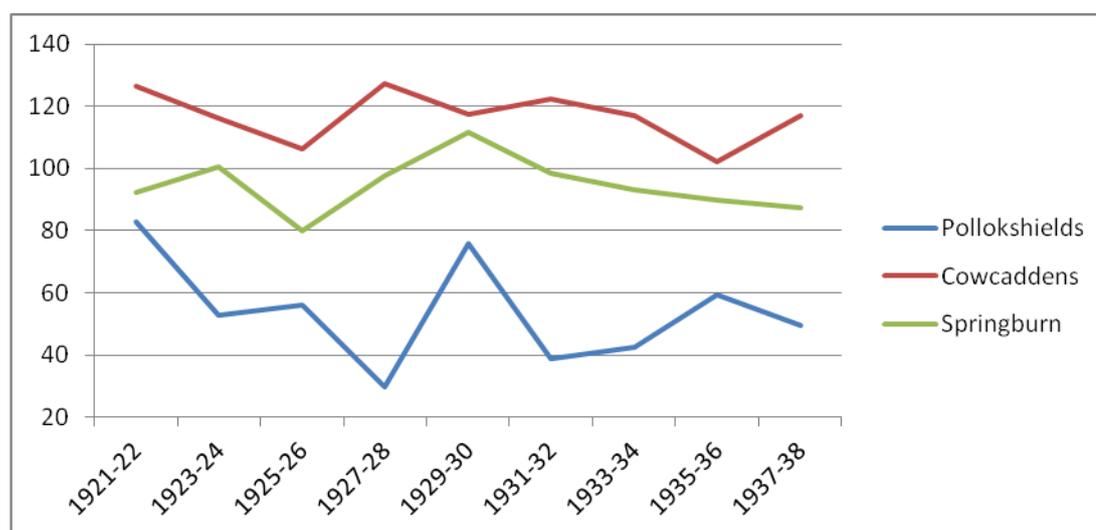
³⁶¹ *NAS*, DD6/1169, ‘Glasgow: A Dying City’, article by Ex-Baillie Richard Williamson. Many of his articles were also published in the *Glasgow Eastern Standard*.

³⁶² *NAS*, DD6/1169, ‘Glasgow Slums and the Cure’, article by Ex-Baillie Richard Williamson.

demonstrate the distinct ‘geography of class and poverty’ which characterised interwar health trends.³⁶³

Diverging health standards occurred within the working class itself, and observations regarding the ‘respectability’ of certain working class regions also correlated with IMR.

Figure 3.7: Infant death rate for residential Pollokshields, ‘respectable working class’ Springburn and slum region Cowcaddens, Glasgow



SOURCE: RMOHG 1921-38.

Perhaps unsurprisingly, the rate of infant death decreased with ascent in social position, ‘slum’ Cowcaddens recording the highest rates of IMR, ‘good working class’ Springburn being slightly better, but worse than ‘middle class’ Pollokshields (Figure 3.7). These figures highlight distinct health experiences, even within the working class itself, illustrating the complex ‘mortality landscape’ of interwar Glasgow.³⁶⁴

³⁶³ Szreter, *Health and Wealth*, p. 369.

³⁶⁴ Thompson, *Unemployment*, p. 180.

Table 3.2: Table published by the MOH regarding the average IMR (1921-24) in relation to geographic region

Residential rates, 40-65		Residential and industrial rates, 65-100		Mainly industrial rates, 100-120		Industrial and poor rates, 120-140	
Langside	44	Whiteinch	73	Parkhead	100	Anderston	119
Cathcart	47	Govanhill	74	Shettleston and Tollcross	104	Blythswood	120
Camphill	48	Fairfield	74	Partick, East	104	Cowcaddens	120
Kelvinside	49	Cowlairs	74	Townhead	111	Kingston	123
Park	61	Pollokshaws	81	Woodside	111	Dalmarnock	124 [sic]
Pollokshields	63	Maryhill	86	Kinning Park	112	Whitevale	125
Dennistoun	64	Partick, West	88	Sandyford	112	Exchange	126
		North Kelvin	88	Hutchesontown	114	Gorbals	127
		Ruchill	92	Provan	115	Calton	128
		Springburn	96	Govan	116	Mile-End	139

SOURCE: *RMOHG 1925*, p. 40.

The MOH for Glasgow published the table above in 1925 to show ‘a convenient though broad stratification of the city’ in terms of infant deaths (Table 3.2).³⁶⁵ These figures starkly illustrate the wide range of experience existing throughout the individual districts of the city.³⁶⁶

³⁶⁵ *RMOHG 1925*, p. 40.

³⁶⁶ It is unclear in this presentation whether the IMR rates were categorised with these regional-class descriptions due to the IMR found there, or the actual social-economic composition of these areas. However, the class labelling of these regions is consistent with other sources including oral testimony and autobiographies. It is also significant that all regions described here as residential were ‘No License’ areas under the Temperance (Scotland) Act, 1913, further suggesting affiliation with social class (see Illustration 7.1).

Most, if not all writers acknowledge these class variations within the context of overall improvements (or deteriorations) in public health standards. The mortality disparity in the regions detailed was evident before the interwar recession, variations between the rich and the poor had always existed, and it is likely that this would have continued to be the case with or without the Depression.³⁶⁷ However, historians writing on health in the interwar years have debated the extent to which inequalities intensified. Now that a 'class' composition of Glasgow's mortality profile has been identified, the following analysis will use this data to investigate whether these differentials widened or narrowed over the period. For the most part, the infant mortality figures for Glasgow tentatively suggest that there was a certain amount of levelling between the classes. The IMR rate fell by 22.1 per cent between 1921-22 and 1938-39 in communities deemed working class compared to less than one per cent in regions associated with the middle class. Likewise, when comparing the average for the quinquennia 1921-25 and 1935-39 the rate in working class areas decreased by 6.2 per cent whilst increasing in residential wards by 2.0 per cent, endorsing the claim of writers like Winter and Levine that divergence according to class decreased during the recession.³⁶⁸

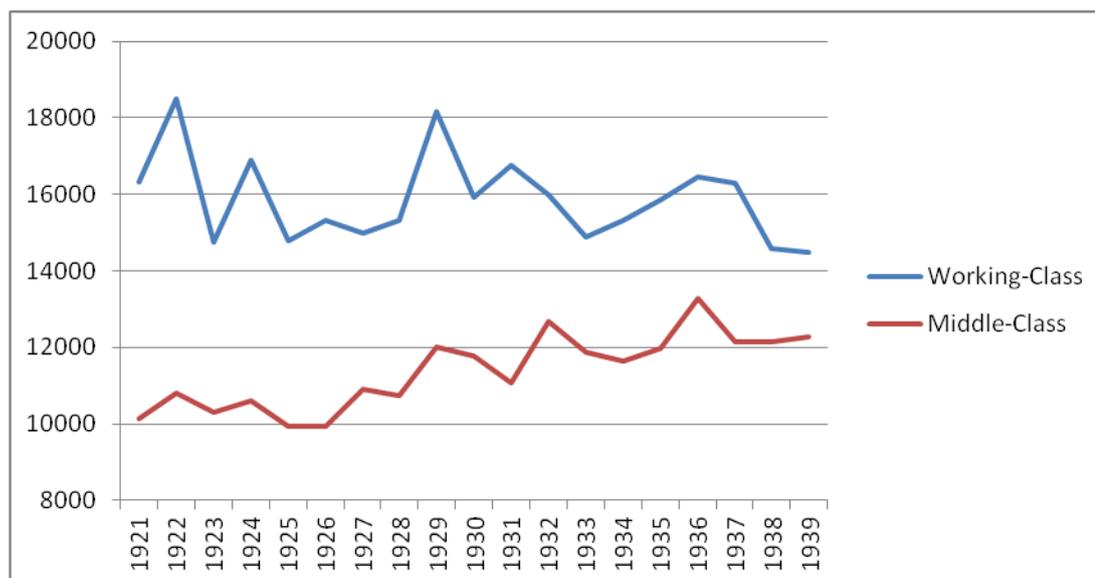
Narrowing differentials according to social status were further implied by the crude mortality rate of Glasgow's individual regions. In 1935 the city's health authorities reported that with 'the reduction of the death rate to a comparatively low level since the war, there is not now the same marked disparity between the good residential and the poorer working class districts' (Figure 3.8).³⁶⁹

³⁶⁷ Corporation of Glasgow: 1) Reports on Insanitary and Obstructive Building in Congested Areas in Glasgow, with suggestions for their improvement, by the Medical Officer of Health 2) On the Provisions of the Existing Law under which the Corporation could deal with such Buildings, by the Town Clerk (Glasgow: Corporation of Glasgow, 1911), p. 3; GCA, PA11/1, Miscellaneous Pamphlets, Baillie J. Stewart, Glasgow, 'Health and Housing' (paper read at the conference of the Sanitary Inspector's Association, Cardiff, 1916).

³⁶⁸ Winter, 'Infant Mortality', p. 203; Levine, *Reproducing Families*, p. 203.

³⁶⁹ *RMOHG 1935*, p. 41.

Figure 3.8: Death rate per million of the population in working class and residential areas, 1921-39



SOURCE: RMOHG 1921-39.

These rates could not be standardised to account for possible changes in the age-sex composition of the population because the data required was not available for the individual regions of Glasgow.³⁷⁰ Between 1921-22 and 1938-39 the crude death rate in working class areas also fell by 16.5 per cent whilst increasing by 16.6 per cent in residential regions.³⁷¹ This rise was probably affected to some extent by the increasing age of the population in residential areas (see section on cancer below). However, the lack of improvement in residential districts demonstrates a similar trend to infant mortality. This suggests that this mortality pattern cannot solely be explained by the changing age-structure in middle class regions since infant mortality is not influenced by the age composition of the population.³⁷² This mortality pattern seemingly refutes the findings of writers like Thompson, Webster and Jones that regional inequalities between poorer and more prosperous

³⁷⁰ Age-sex specific mortality and population data was only available for Glasgow as a whole. Indirect standardisation also fails to accurately account for changes in the age-structure of individual regions (Thompson, *Unemployment*, p. 185).

³⁷¹ Similarly, between 1921-25 and 1935-39 the rate fell by 4.4 per cent and increased by 19.4 per cent in working and middle class wards respectively.

³⁷² Pressat, *Demographic Analysis*, pp. 89-90.

neighbourhoods deepened during the interwar years.³⁷³ According to the MOH for Glasgow, 'the improvement has been general, but the rate of improvement has been greater where it originally was worst... there is a tendency towards levelling.'³⁷⁴

However, an outstanding feature of the interwar period in terms of social policy was national and local house building and slum clearance campaigns which were the product of a number of Acts passed throughout the period (Appendix 3.8). These are discussed in depth in the following chapter on housing, rehousing and health, but it is important to consider them here to try to understand the spatial characteristics of the city, and their influence on mortality trends. These years witnessed the construction of 50,227 new houses, particularly on the outskirts of the city, and the eradication of slum dwellings where health was notably poor.³⁷⁵ The 1931 census report revealed that areas like Pollokshields, Cathcart and Whiteinch recorded substantial population increases, whilst in areas like Calton, Cowcaddens, Dalmarnock and Gorbals, where slum clearance took place, the greatest decreases occurred.³⁷⁶ Between 1921 and 1939 the population of the four working class districts collectively analysed here also decreased by around 20 per cent compared to an increase of some 50 per cent in residential ones (Appendix 3.9 and 3.10).³⁷⁷

³⁷³ Thompson, *Unemployment*, pp. 101, 243, 244; Jones, *Health and Society*, pp. 75-6.

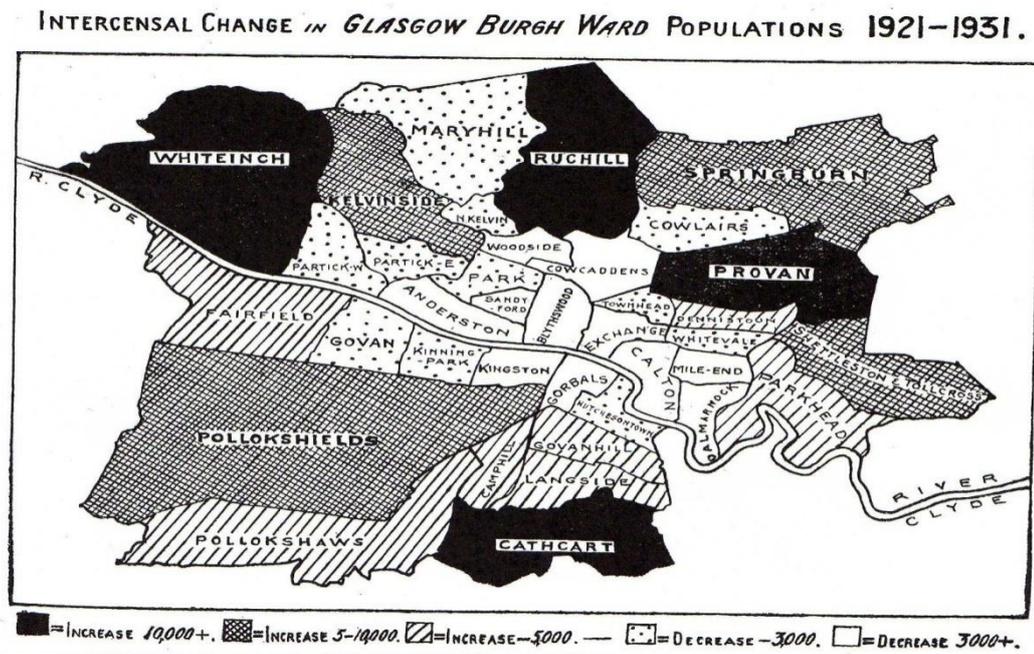
³⁷⁴ NAS, HH76, Minutes of Evidence taken before the Committee on Scottish Health Services, First Day, Thursday 23rd November 1933.

³⁷⁵ N.J. Morgan, '£8 Cottages for Glasgow Citizens': Innovations in Municipal House-Building in Glasgow in the Interwar Years', in R. Rodger, ed., *Scottish Housing in the Twentieth Century* (Leicester: Leicester University Press, 1989), p. 125.

³⁷⁶ *RMOHG 1930*, p. 71; *RMOHG 1931*, pp. 24-5, 223; *RMOHG 1932*, p. 240; *RMOHG 1934*, p. 24; *RMOHG 1935*, p. 259; *RMOHG 1938*, p. 5.

³⁷⁷ The corresponding rate for working class regions between 1921-25 and 1935-39 was a decrease of 18.6 per cent compared to an increase of 42.3 per cent in the residential regions.

Illustration 3.3: Map of Glasgow indicating significant intercensal population change 1921-31



SOURCE: Census Report, City of Glasgow 1931, p. 43.

The figures published by the census suggested that a demographic shift had occurred and that there was a movement of people from traditionally working class communities into residential regions. A map of Glasgow published in the 1931 census report visually demonstrates the growth of the suburbs and the outward movement from the city centre into more prosperous surrounding areas (Illustration 3.3).³⁷⁸ This tentatively suggests that the lack of improvement in health in residential areas may have been affected by the movement of unhealthy 'working class' Glaswegians into surrounding suburban areas following the building campaigns. This was also reasoned in the census report and it was stated that 'it will be observed that the greatest [population] increases are recorded in wards at or near the City boundary, where presumably house building has been most active'.³⁷⁹

³⁷⁸ Also see Osborne, *The Social Survey*, p. 5.

³⁷⁹ Census Report, City of Glasgow 1931, p. 44.

There are, however, two issues with this inference that need clarification. Firstly, the increased population in residential areas may not have been as large as the census data suggests. It has been noted that Glasgow Corporation expected that as many as 50,000 people were absent from the city on the day in which the census was taken in 1921. It was also noted that in areas 'especially where the houses were of a larger size about ten per cent were closed on the night of enumeration.'³⁸⁰ Given the low proportion of the population living in homes of one or two rooms in typically middle class areas, it can be assumed that this would apply particularly to residential communities. Indeed, the 1931 census report acknowledged that 'of the fifteen wards showing increases seven [had] exhibited a decrease in 1921, but these were mainly suburban wards which were possibly affected more than others by the absence of holiday populations at the time of that census... All the more centrally situated wards without exception show a decline.'³⁸¹ As a result, the population data published by the MOH which attempted to account for this error, does not always mirror the population increases implied by the census map.

³⁸⁰ *RMOHG 1921*, p. 12.

³⁸¹ It was also said that 'in considering this increase, however, it should be borne in mind that the 1921 census was taken in June and that, but for the absence of persons then on holiday, the increase of 25,687 recorded at the census would have been appreciably greater, and the present increase of 36,934 correspondingly less' (Census Report, City of Glasgow 1931, pp. 41, 44).

Table 3.3: Regional distribution of Glasgow's population (estimated by MOH) 1921 and 1931

	1921	1931	Increase/decrease (-) in population
Shettleston and Tollcross	31270	39869	8599
Parkhead	36772	39418	2646
Dalmarnock	41179	35824	-5355
Calton	38976	34389	-4587
Mile-End	26174	21430	-4744
Whitevale	25299	22439	-2860
Dennistoun	24077	25560	1483
Provan	28359	41788	13429
Cowlairs	28375	22512	-5863
Springburn	17001	25547	8546
Townhead	29920	27376	-2544
Exchange	21121	16523	-4598
Blythswood	17723	13705	-4018
Anderston	30321	26909	-3412
Sandyford	24393	20232	-4161
Park	23379	20727	-2652
Cowcaddens	44347	35723	-8624
Woodside	37665	33072	-4593
Ruchill	25510	41243	15733
North Kelvin	25301	21029	-4272
Maryhill	23804	25524	1720
Kelvinside	23143	23348	205
Partick (east)	31873	28541	-3332
Partick (west)	28720	23730	-4990
Whiteinch	30108	56430	26322
Hutchesontown	40816	38851	-1965
Gorbals	52214	46831	-5383
Kingston	34163	30336	-3827
Kinning Park	37922	35763	-2159
Govan	36444	35969	-475
Fairfield	30379	32188	1809
Pollokshields	20009	28842	8833
Camphill	22568	19007	-3561
Pollokshaws	18462	21171	2709
Govanhill	32271	32514	243
Langside	19146	17980	-1166
Cathcart	15796	26121	10325
Total	1075000	1088461	13461

SOURCE: RMOHG 1921 and 1931.

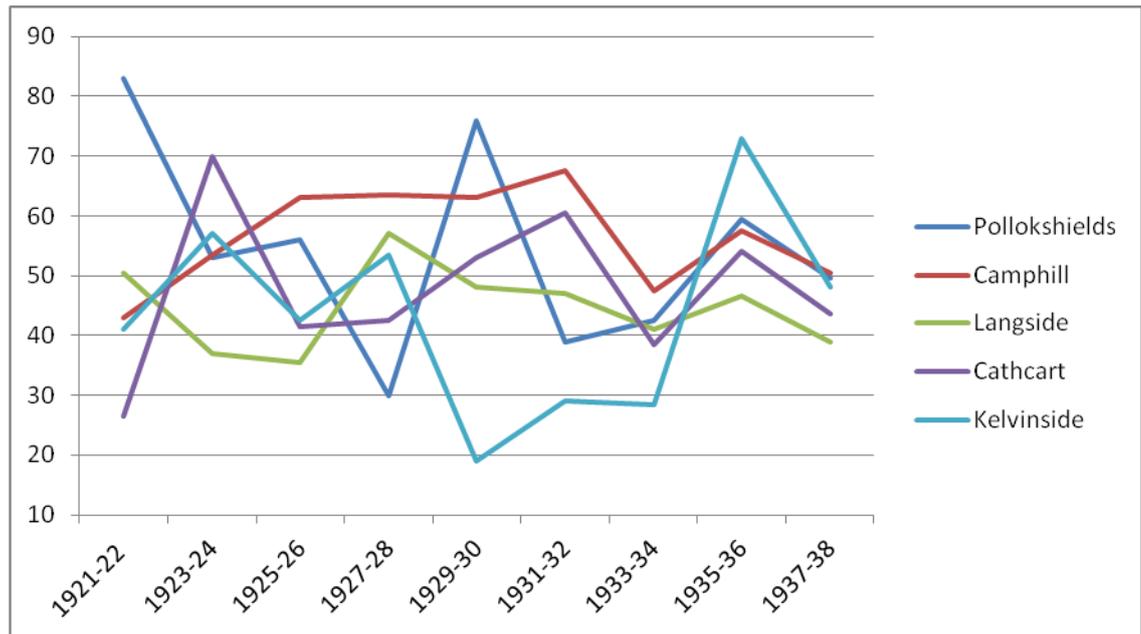
Residential areas like Cathcart and Pollokshields did record significant growth in both the 1931 census and MOH annual reports (Table 3.3 and Illustration 3.3). However, according to the figures published by the MOH, the increases in population could be smaller than that suggested by the census, and an actual decrease – rather than increase in population as suggested by the census – occurred in Camphill and Langside. Thus, the demographic change in residential areas is somewhat exaggerated by the census.

Secondly, the MOH repeatedly commented that the characteristics of districts like Pollokshields, Ruchill, Whiteinch and Cathcart had been affected due to the construction of Corporation and private enterprise housing.³⁸² A map published by Morton shows in detail all houses built in Glasgow between 1919 and 1939, the housing act and year with which they were associated, and the category of housing which they were labelled – ordinary, intermediate, rehousing or private. This essentially refers to their cost and material superiority and this is discussed in depth in chapter four (Appendix 3.8).³⁸³ However, assuming that Morton's representation is accurate, this map undermines the idea that the redistribution of the population was solely the result of the building campaigns. A focus on the infant death rate for the individual districts defined as residential in the city, and the house building activity in these areas, complicates the notion that the resulting movement of unhealthy Glaswegians into more affluent communities may have dragged down the rate of improvement in affected areas (Figure 3.9).

³⁸² *RMOHG 1931*, p. 25.

³⁸³ G.M. Morton, *The Layout of Glasgow Corporation Housing Schemes, 1919-39* (Unpublished Thesis (Dip.): University of Glasgow/Department of Town and Regional Planning, Glasgow, 1968).

Figure 3.9: Graph showing IMR in individual residential districts of Glasgow, 1921-1938



SOURCE: RMOHG 1921-38.

This data shows that IMR did not correlate in each residential area, or in tandem with housing developments. In Pollokshields for example, where in relation to the population the proportion of houses built was highest, improvements in IMR were made. On the other hand, in Cathcart, where comparatively few houses were built, infant deaths increased (Figure 3.9 and Appendix 3.8). Therefore, the notion that the IMR record in residential regions was affected by the movement of unhealthy Glaswegians into these areas as a direct result of house building was not conclusively demonstrated from this data.

However, that changes in the demographic characteristics of the city and its individual areas could impact upon mortality rates was also stated by Glasgow's medical authorities.³⁸⁴ In 1938 the MOH declared for example:

Districts that were formerly purely residential, such as Kelvinside and Cathcart, now contain a considerable working class population, so that exceptionally low infant mortality rates such as 24 in Kelvinside and 28 in Cathcart as recently as 1934 are absent from the ward rates of the present year.³⁸⁵

In Kelvinside, a residential district towards the north-west of the city, IMR increased from 41 to 48 deaths per 1,000 births between 1921-22 and 1937-38 (Figure 3.9). Indeed, concurrent with the expected movement of the city's population as a direct result of building campaigns, it seems that there was a more general exodus from the city centre to the surrounding regions. In Cathcart for example, it is unlikely that the massive population increase experienced can be explained solely by building developments. Only 179 new houses were built in this district between 1919 and 1939 according to Morton's figures (Appendix 3.8)³⁸⁶ yet according to the details published by the MOH, the population increased by 10,325 people between 1921 and 1931 (and by 16,674 between 1919 and 1939). In 1926 Cathcart was affected by the Glasgow Boundaries Act (1925). However, its population increased by only 601 between 1925 and 1926.³⁸⁷ Figure 3.10 demonstrates that in this area the population increased significantly between 1928 and 1934, and this was undoubtedly affected to some extent by the completion of houses as part of the 1924 and 1930-35 housing Acts (Figure 3.10 and

³⁸⁴ *RMOHG 1927*, p. 39.

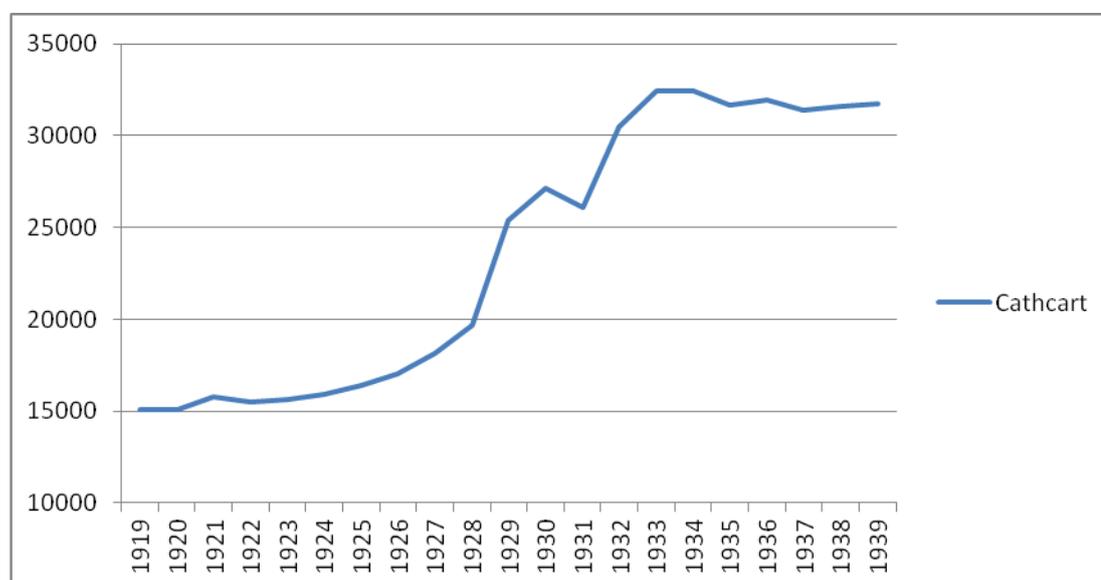
³⁸⁵ *RMOHG 1938*, p. 51.

³⁸⁶ There is the possibility that this may have been slightly higher. A housing estate constructed in Langside was built very close to the Cathcart boundary. It is therefore possible that there may have been some overlap, although this does seem unlikely. Nonetheless, even when assuming that *all* this Langside estate was actually under the Cathcart boundary, this would still amount to only 347 houses and the argument is not undermined.

³⁸⁷ There was another boundary extension in 1930 but this only affected the east end areas Riddrie and Shettleston (*RMOHG 1938*, opening map) and added only 63 people to the population (*RMOHG 1932*, p. 24).

Appendix 3.8). However, it seems unlikely that the relatively few houses built in Cathcart wholly explain the marked rise in the population in this area at least.

Figure 3.10: Graph showing population growth in 'residential' Cathcart, 1919-39



SOURCE: RMOHG 1919-1939.

It is also unlikely that this increase in Cathcart's population can be solely explained by the increasing age of the population.³⁸⁸ Rather, it seems that a more general redistribution of the population occurred. For example, there was notable discontent among the city's SI's regarding the movement of a *number* of working class families into traditionally 'middle class' homes intended to occupy one, wealthy family.³⁸⁹ For example, the SI of the South Eastern Division wrote:³⁹⁰

³⁸⁸ Although in the absence of age-specific population data (which was not published by the Glasgow census reports at ward level) the extent to which this contributed to the rising population is impossible to measure exactly.

³⁸⁹ RMOHG 1930, p. 289; RMOHG 1938, pp. 154, 262.

³⁹⁰ The South Eastern Division included areas such as Cathcart, Hutchesontown, Govanhill, Langside and Pollokshaws. The other administrative areas were the South Western Division (including Pollokshields, Kinning Park, Kingston and Govan); Northern division (including Provan, Springburn, Ruchill, Maryhill, Cowcaddens), Central Division (including Whiteinch, Kelvinside, Exchange, Blythswood), Eastern Division (including Shettleston and Tollcross, Mile End, Parkhead, Dalmarnock).

There is, however, another form of housing, spreading fairly rapidly, which is far from satisfactory. The practice is that a tenant rents a house of five or six apartments with his own family and sub-lets all the other rooms to separate families... A charge of from 5s to 10s per week from each sub-tenant is made, and the business is proving to be so lucrative that several houses are now actually being rented by one individual, all the rooms being sub-let to separate families.³⁹¹

The SI of the South Western division also commented:

A disquieting feature has been the spread of subletting in a residential district. These houses, sublet as service flats, are virtually farmed out houses, and the following details regarding one such house will serve to illustrate their undesirable nature, both from the sanitary and housing point of view.³⁹²

The house referred to was a ten apartment, £40 to £55 per annum, three-storey-and-attic house. The problem for the authorities was that every room was treated as a 'house'.³⁹³ Dr. Elizabeth Sloan Chesser, a regular columnist in the *GH* also wrote in 1935: 'Who would dream that in a house owned not so long ago by a city magistrate you could find six persons cramped into two apartments? Who would ever dream to find slum conditions prevailing at such a good address?'³⁹⁴ The extent to which the subdivision of large homes affected residential areas is evident. In 1938, the SI of the Central Division commented upon the rise of one and two apartment homes in Kelvinside which he found 'interesting in view of Section III of the Housing (Scotland) Act, 1925, which forbids the erection of houses of less

³⁹¹ *Report of the Sanitary Inspector of the South Eastern Division (RSISED), RMOHG 1934, p. 270; Also see RSISED, RMOHG 1925, p. 262.*

³⁹² *RMOHG 1937, p. 288; The occupation of this kind of house was also recalled in oral testimonies (2000 Glasgow Lives, Katy Lang (1913)); R. Davidson, Dangerous Liaisons: A Social History of Venereal Disease in Twentieth Century Scotland (Rodopi: Amsterdam, 2000), p. 29.*

³⁹³ *RMOHG 1937, p. 288; Also see GH, 1st May 1935, p. 11.*

³⁹⁴ 'The Social Problems of the New Slum', *GH*, 26th August 1935.

than three apartments save in exceptional circumstances.³⁹⁵ According to the SI, the Valuation roll for the year 1938 recorded 1,108 one apartment houses compared to only 14 in 1929. The number of two apartment homes also rose from 94 in 1929 to 538 in 1938.³⁹⁶ The SI reported that:

This large increase is due entirely to the breaking up of large houses into service rooms... In the majority of cases the rooms are let to single persons or husband and wife, but in the poorer type, families have been accommodated in one room, with the result that overcrowding and pressure on the existing sanitary arrangements have taken place.³⁹⁷

This highlights two things. Firstly, it is clear that even within environments that were broadly superior, the socio-economic status of the family continued to determine the degree to which surroundings were conducive to health. Indeed, Cage has demonstrated statistically that 'what matters most for infant mortality is not district, but room density. Furthermore, it is room density in small, one roomed houses and large, multiple occupancy houses which matters most.'³⁹⁸ Secondly, although from this analysis the effects are impossible to measure, it does seem that demographic changes and the influx of unhealthier, working class tenants into typically middle class areas, may have affected the slower rate of improvement in these regions of Glasgow. This undermines the extent to which the disparity between 'residential' and 'working class' regions narrowed over the period.

³⁹⁵ *RSICD, RMOHG 1938*, p. 239.

³⁹⁶ *Ibid.*, p. 239.

³⁹⁷ *Ibid.*, p. 239; Another survey found that 'in Glasgow a particularly undesirable arrangement was that of the house of four and five apartments let out as single rooms. This occurred often in the older residential areas, where the houses could not be let as whole units' (*Disinherited Youth (1936-1939): A Report on the 18+ Age Group, Enquiry Prepared for the Trustees of the Carnegie United Kingdom Trust* (Edinburgh, 1943), p. 56).

³⁹⁸ Cage, 'Infant Mortality Rates and Housing', p. 134.

While the relationship between changing health statistics, class and geography is a complex one, some clear conclusions are possible. In the period 1921-25 children born in certain districts of Glasgow associated with the working class were more than twice as likely to die before reaching their first birthday compared to those born in residential districts ($118.5/48.8 = 2.4$). This remained largely unchanged by 1935-39 and the IMR data demonstrates that children born in areas deemed to be less prosperous continued to be more than twice as likely to die before reaching the age of one ($111.1/49.8 = 2.2$). Inequalities in health were often associated with social class. Subsequent chapters will explore why this might be the case in greater detail. For now what is clear is that whatever the overall picture in terms of improvements or declines from the public health statistics examined thus far, experiences were unequal throughout the city.

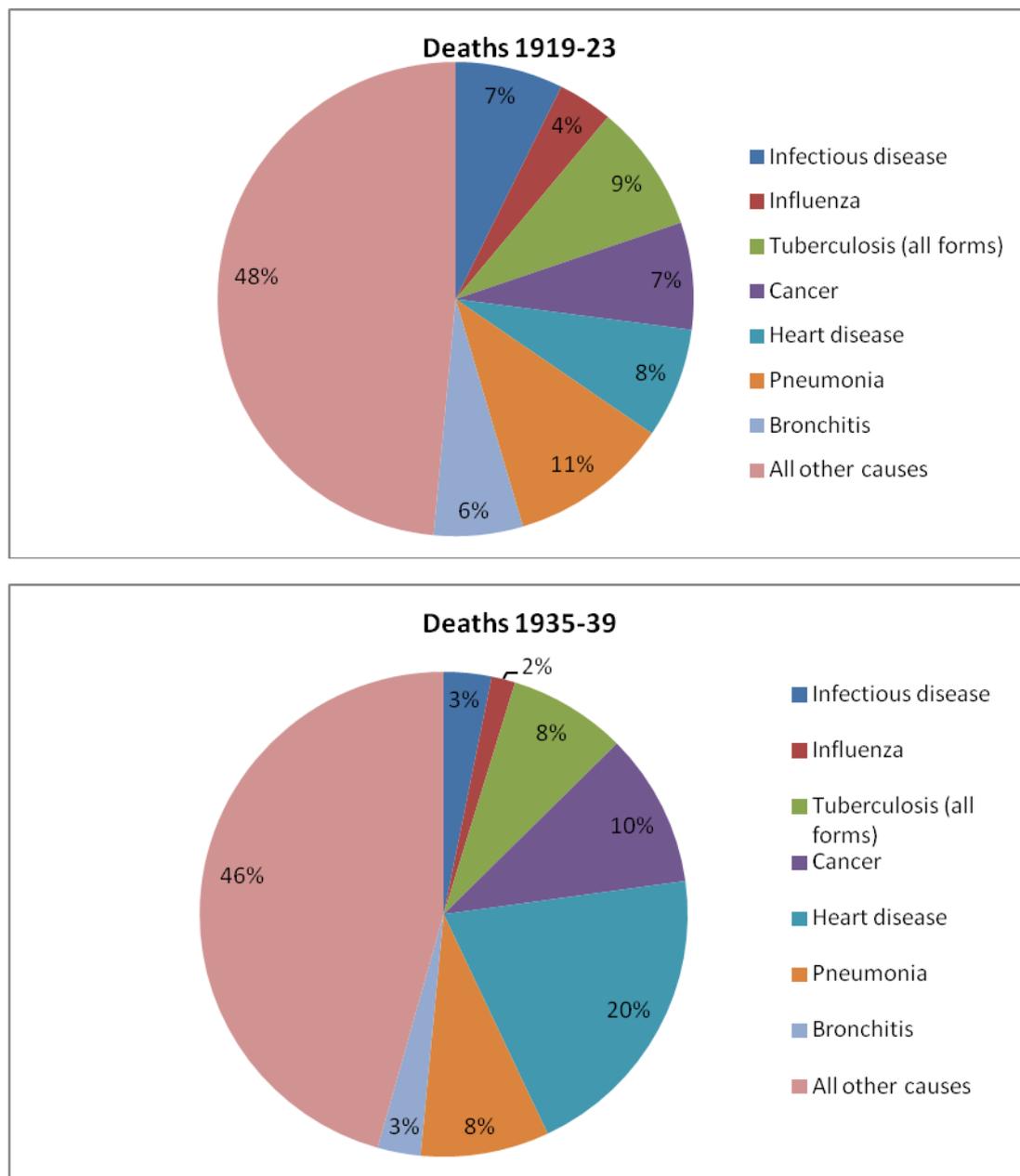
This next section analyses the cause of death data published by Glasgow's MOH and examines how far this sheds light on the city's mortality profile, the health challenges faced by different sections of the population, and the extent to which health experiences improved. These records are undoubtedly flawed. For example, a rise or fall in mortality from a particular cause may represent increased accuracy or adjustments in the diagnosis of certain conditions, rather than a real change. For example, in 1931 'senility' began to feature as a 'cause of death'.³⁹⁹ Nonetheless, arranged in the order of highest mortality when categorised as following, the main causes of death in the 1919-23 period were pneumonia, tuberculosis (all forms), heart disease, cancer, infectious disease, followed by bronchitis and influenza.⁴⁰⁰

³⁹⁹ A fact itself which illustrates the different challenges faced by health authorities due to the increasing age of the population (*RMOHG 1931*, p. 249).

⁴⁰⁰ Chalmers, *The Health of Glasgow*, p. 85; The individual infectious disease death rates considered (Enteric fever/typhoid, typhus fever, smallpox, measles, scarlet fever, whooping cough, diphtheria and membranous croup, and cerebro-spinal fever) were grouped together under the heading 'infectious disease', as categorised by the 'infectious disease' death rate presented in the *Glasgow Corporation: Resume of the Work of the Public Health Department* annual reports (For example, see GCA, DTC 7/11/5, *Corporation of Glasgow: Resume of Work of the Public Health Department 1926-27*, p. 16). The specific causes of death detailed here were the seven *principal* causes of death in 1919 (Also see A.R. Butler and J.L. Hogg, 'Exploring Scotland's Influenza Pandemic of 1918-1919: Lest We Forget', *Journal of Royal*

However, the mortality landscape of the city had changed significantly by 1939 (Figure 3.11).

Figure 3.11: Proportion of deaths from various causes in Glasgow, 1919-23 and 1935-39



SOURCE: RMOHG 1919-39.

College of Physicians of Edinburgh, 37 (2007), 362-66). The seven *principal* causes of death (from largest to smallest) over the 1919-23 taken as a whole were also broadly the same being pneumonia, tuberculosis (all forms), heart disease, cancer, infectious disease, congenital debility and malformation (including premature birth) and bronchitis. For the sake of comparison, the format adopted is consistent with that of Steven Thompson in *Unemployment, Poverty and Health in Interwar south Wales*.

The percentage of communicable infectious diseases in Glasgow notably decreased throughout the period as was the case in Scotland and Britain as a whole, and as Thompson notes, the 'great killers of nineteenth-century childhood had become relatively insignificant by the interwar period in terms of overall mortality rates.'⁴⁰¹ For example, figure 3.11 reveals that the proportion of deaths from infectious disease had more than halved from 7 to 3 per cent between 1919-23 and 1935-39. Also, while mortality from pneumonia was the primary cause of death in 1919-23, the disease was comparatively insignificant in public health terms by the end of the period falling from 11 to 8 per cent of deaths between 1935-39.

As these mortality rates declined the number of people dying from heart disease increased markedly, doubling over the period, and overtaking pneumonia and tuberculosis as the biggest killer in the city. By the end of the period, the climbing incidence of death from cancer – a phenomenon which was attributed to the increasing age of the population alongside more accurate diagnosis⁴⁰² – had become a primary public health concern at both the local and national level, rating as the second highest cause of death in Glasgow after heart disease in the 1935-39 period. This increasing trend of death from cancer mirrored the experience of Scotland as a whole.⁴⁰³ In 1932 the Lord Dean of Guild observed that cancer was 'unfortunately becoming more common, and I think there are few households that have not lost friends and relatives from cancer.'⁴⁰⁴ The cause of death data for Glasgow demonstrates an important change in the mortality profile of the city and of the diseases representing the greatest challenges to public health.

⁴⁰¹ *Seventy-Eighth Annual Report of the Registrar-General for Scotland 1932* (HMSO, 1933), p. xxxvii; Thompson, *Unemployment*, p. 202.

⁴⁰² *RMOHG 1924*, p. 19; *RMOHG 1937*, p. 44.

⁴⁰³ *RMOHG 1920-39*; *RMOHG 1938*, p. 288; S.I.A. Laidlaw, *Modern Methods of Prevention and Treatment of Tuberculosis* (Glasgow: Committee on Health, 1949), p. 4; Harvie, *No Gods*, p. 74; *Summary of Report of Committee on Scottish Health Services*, p. 7.

⁴⁰⁴ *GGNHSBA*, HB11/4/33, *Forty Second Annual Report of the Glasgow Royal Cancer Hospital 1932*, p. 9.

Certain conditions were more fatal among different social groups. Diseases or complications of the respiratory system – including bronchitis, pneumonia, influenza, measles and whooping cough – had the greatest effect on infant death rates in Glasgow. However, sources at the time detailed that these were geographically differentiated, and it was among the poorer quarters of the city where these complaints were most prevalent.⁴⁰⁵ This was often closely related to the material environment of certain regions, and in 1925 the MOH noted that ‘respiratory affections are more severe in poor and congested areas, and one of the main causes of the dissimilarity in the infant death rates as between the several wards of the city is the enhanced opportunities for infection in crowded and congested areas.’⁴⁰⁶ Ailments like rickets were also more common among the working class, and the physical and nutritional condition of this social group was generally recognised as inferior.⁴⁰⁷ Whilst it might be argued that factors including environment and housing were more significant to the acquisition of these illnesses rather than class per se, social position was an important determinant of the living standards which could be afforded, as was also recognised by the Glasgow MOH.⁴⁰⁸ This data further demonstrates how the mortality pattern of the city was uneven and characterised by inequality.

⁴⁰⁵ C.M. Smith, ‘Housing Conditions and Respiratory Disease: Morbidity in a Poor Class Quarter and in a Rehousing Area in Glasgow’, *SRMRC*, 192 (1934), p. 3; ‘Epidemic Encephalitis: The Outbreak in Glasgow in 1923’, *PH*, July 1924, p. 246.

⁴⁰⁶ *RMOHG 1925*, p. 35; *RMOHG 1929*, p. 50.

⁴⁰⁷ *GGNHSBA*, HB38/2/5, ‘Sunlight: Winter Rays Inactive in Glasgow: Yorkhill Experiments’, *GH*, 4th March 1925; Charles P. Childe, ‘Environment and Health’, *Lancet*, 28th July 1923, p. 157; ‘President’s Address’, *BMJ*, 28th July 1923, p. 138; Glasser, *Growing Up*, p. 2; ‘Discussion of Defects in School Children: Opening Paper’, *BMJ*, 26th August 1922, p. 348; ‘Glasgow Shawl Condemned’, *GH*, 28th July 1922, p. 8; *GGNHSBA*, HB38/1/6, *RMITSC 1934*, p. 4; *GGNHSBA*, HB38/2/5, ‘Health of the School Child’, *GH*, 29th January 1935; *GGNHSBA*, HB38/1/7, *RMITSC 1935*, p. 4; ‘Scotland’s Health’, *GH*, 13th April 1938, p. 14.

⁴⁰⁸ *RMOHG 1927*, p. 110.

That particular ailments were associated with poverty is well documented. However, certain diseases also characterised mortality experiences in the more prosperous districts, yet the middle class as a group is rarely analysed in depth by historians of interwar public health. Class *inequalities* are detailed.⁴⁰⁹ However, discussions tend to highlight the health of the working class – probably due to the nature of the questions being asked and the fact that recession, and aims to improve or at least maintain the health of this group, dominated contemporary political debates and publications subsequently consulted by historians. In fact, cancer, whilst increasing throughout the period, was a more significant health issue for the residential districts of Glasgow. The climbing incidence and death rate was attributed to the increasing ‘number of persons living at the ages at which the disease becomes active.’⁴¹⁰ Nonetheless, in 1925 the MOH summarised that ‘the cancer death rate in four residential wards of the city was from two to three times as high as in three typically artisan wards’ and is a discrepancy frequently repeated throughout his annual reports.⁴¹¹ For example, in 1929 the highest death rates from cancer recorded were 1,863 in Kelvinside and 1,682 in Pollokshaws – regions primarily associated with the middle class – whilst the working class regions Cowlairs and Provan experienced the lowest rates.⁴¹² These crude death rates suggest that if geographic region was taken to indicate social status cancer was more common among the well-to-do.

⁴⁰⁹ For an exception see Zweiniger-Bargielowska, *Managing the Body*, p. 293 where she notes the higher rates of degenerative disease among the highest social group. She also details the increasing concern over obesity and heart disease among this section of the population (see chapter 7).

⁴¹⁰ GGNHSBA, HB11/4/28, *Thirty-Seventh Annual Report of the Glasgow Royal Cancer Hospital 1927*, pp. 11-2.

⁴¹¹ ‘Cancer and the Middle Class’, *BMJ*, 26th September 1925, p. 582.

⁴¹² *RMOHG 1929*, p. 47; Also see *RMOHG 1930*, p. 66.

Nonetheless, a letter published in the *BMJ* in 1925 stated that ‘the number of late or inoperable cases of cancer still met’ were particularly higher among Poor Law hospitals.⁴¹³ Indeed, one Glasgow study published in 1926 which specifically probed the relationship between cancer and social class found that the standardised death rate of the disease was not likely to increase with ascent in the social scale, and that ‘cancer mortality tends to increase with descent in social status.’⁴¹⁴ The MOH explained the higher rate in more affluent areas as being due to the older age of their residents, compared to ‘artisan wards’ which had ‘usually lower rates because of the more numerous child population’.⁴¹⁵ It should also be kept in mind however, that the middle class may have been more susceptible to the contraction of cancer due to certain class-specific health-related behaviours, and in their own research, writers such as Thompson have claimed that there is justification for the description of cancer as a ‘disease of affluence’ due to a higher standardised death rate in more prosperous regions.⁴¹⁶ Razzell and Spence have also been able to show that in the nineteenth century, mortality per se could also be higher among the ‘elite’ wealthy, partly due to ‘excessive consumption of food, alcohol and tobacco, linked to physical inactivity and other lifestyle factors’ (see chapter 7).⁴¹⁷

⁴¹³ ‘Correspondence’, *BMJ*, 19th December 1925, p. 1198.

⁴¹⁴ M. Young, ‘Variation in the Mortality from Cancer amongst Persons in the Different Districts of Glasgow and its Relationship to Social Status’, *GMJ*, 105 (1926), p. 210; This conclusion relied on data from 1910-13 but the point made is still relevant.

⁴¹⁵ *RMOHG 1929*, p. 47; *RMOHG 1925*, p. 30.

⁴¹⁶ Thompson, *Unemployment*, p. 214; T. Barker and M. Drake, *Population and Society in Britain 1850-1980* (London: Bastford Academia and Educational Ltd, 1982), p. 136; An article in the *Medical Officer* acknowledged overeating as a potential cause and that ‘whatever cancer may be, it is not a disease of poverty’ (‘Cancer Causation’, *Medical Officer*, 2nd May 1925, p. 205).

⁴¹⁷ P. Razzell and C. Spence, ‘The Hazards of Wealth’, *Social History of Medicine*, 19 (3), (2006), pp. 381-82.

It was not possible to examine this in depth within Glasgow's prosperous regions since required data was not available.⁴¹⁸ For now, the evidence from contemporary Glaswegian medics suggests that the probability of death after developing cancer was not significantly greater among the middle class compared to those lower down the social scale and rather, it appears that the chance of contracting the disease was more likely due to the greater life expectancy of those in a more favourable social position. Nevertheless, this disparity between the 'residential' and 'working class' districts of Glasgow reveals a key distinction in the diseases which characterised the mortality profile of the city, reinforces the notion of class inequalities, whilst offering an insight into the less documented area of middle class health experiences. What this data also shows is the 'epidemiological transition'⁴¹⁹ of the period, and they corroborate Thompson's claim that 'a significant aspect of twentieth-century mortality patterns is the transition from a vital regime characterised by acute communicable diseases to a lower mortality pattern which featured higher levels of chronic "degenerative" illnesses associated with older age-groups' – a trend also observed by historians like Hardy writing about Britain in general.⁴²⁰

However, this mortality data can also be interpreted in contradictory ways. The changing profile of disease complicates the notion that falling death rates resulted in improving health experiences. For example, in her book *Measuring Disease*, Ann Bowling highlights that the 'debate focuses upon whether the extra years of life are spent in good or poor health quality, with one side arguing with some evidence, that chronic morbidity is being compressed into an increasingly short period before death, and the other arguing that there is an expansion of morbidity in old age' – a matter also

⁴¹⁸ Age-sex specific mortality and population data was not available for individual regions of Glasgow.

⁴¹⁹ P. Weindling, 'Interwar Morbidity Surveys: Communities as Health Experiments', in Borowy and Gruner eds., *Facing Illness in Troubled Times*, p. 75; Stewart, 'Sickness and Health', p. 228.

⁴²⁰ Thompson, *Unemployment*, p. 214; Hardy, *Health and Medicine*, pp. 90-1.

addressed by writers like Whiteside and Imhof.⁴²¹ For example, Imhof points out that although 'the earlier infectious and parasitic causes of death have been eliminated they have been replaced by chronic ailments. Therefore death for many of us, no longer occurs swiftly, but slowly and painfully.'⁴²² Whilst this statement refers to a later period, the point can be equally applied to the interwar years.

Moreover, while the statistical analyses for this research primarily concern mortality data and those who succumbed to disease, the experience of those who survived cannot be overlooked. Even taking into consideration the incidence of those contracting infectious disease fails to account for the fact that acquiring a disease could also incur an unpleasant period of recovery, a damaged body, and increased susceptibility to other illnesses. One medical article reported for example that 'the aftermath of rheumatic infection occurring among children, and of a type sufficiently severe to call for inpatient hospital treatment, is more tragic than is generally realised.'⁴²³ Of 700 cases admitted to the Royal Hospital for Sick Children one third developed heart disease and one third were 'permanently incapacitated' to some extent after 10 years.⁴²⁴ George Rountree also recalled that for those who did not die from pneumonia the reality 'was a lifetime of susceptibility to chest complaints' and the Glasgow Corporation discussed the 'train of consequences' and 'permanent disability' which followed outbreaks of diseases like whooping cough.⁴²⁵ The Committee on Scottish Health Services also realised that reductions in mortality rates were not conclusive evidence of improved *health*.⁴²⁶ Drawing conclusions from the statistical data about health in interwar Glasgow is a complex business. While many lived longer and grew up healthier, large numbers endured early deaths or

⁴²¹ Bowling, *Measuring Disease*, p. 9; Whiteside, 'Counting the Cost', p. 239.

⁴²² Imhof, 'Methodological Problems in Modern Urban History Writing', p. 129.

⁴²³ L. Findlay, 'The Rheumatic Infection in Childhood', *PH*, 45, 1932, p. 158.

⁴²⁴ *Ibid.*, p. 158.

⁴²⁵ Rountree, *Govan*, p. 73; *Evidence to be Submitted to Committee on Scottish Health Services re The Medical Services*, p. 18.

⁴²⁶ *Committee on Scottish Health Services Report*, p. 46.

lingering fatal diseases. This draws attention to the experience of health in this period and the importance of qualitative data which tackles questions about how far the health changes of the period were experienced and perceived by those alive at the time.

Popular Perceptions and Public Health Experiences

Death and disease was part and parcel of everyday life in Glasgow. In fact, one woman remembered that mothers in Stirling were concerned that their children would catch 'germs and things' from the city's children evacuated there in 1939.⁴²⁷ Hence, the health status of Glaswegians could be perceived as inferior by outsiders, even after the gains made by the end of the period under review. It is also significant that the 'epidemiological transition' and changing profile of disease does not seem to have been realised by the population at large. The prominent health 'improvements' of the era such as the reduction in mortality and morbidity from infectious disease were not reflected in personal perceptions and recollections of health in the period. According to public memory and lay opinions, tuberculosis was the outstanding killer.⁴²⁸ This was consistently detailed in the oral history interviews consulted as part of this thesis, whilst heart disease and cancer, which were growing in significance in public health terms throughout the interwar years and accounted for more than three times the number of deaths than tuberculosis, were never mentioned.⁴²⁹ One man claimed for example: 'The scourge at that time was T.B., the majority of people that was

⁴²⁷ SOHCA, Stirling Women's Project, Mrs Y3 (1901).

⁴²⁸ The historiography on health in Scotland also tends to be dominated by discussions on infectious diseases including tuberculosis. For example, see Smout, *Century*, p. 122.

⁴²⁹ The death rate from tuberculosis (all forms) was higher than cancer and heart disease only until 1923. Taking pulmonary tuberculosis by itself reveals that deaths from heart disease were higher from 1919 and that by 1921 cancer had over taken respiratory tuberculosis. Pneumonia also remained higher until about 1934 than cancer and tuberculosis (but not heart disease which over took pneumonia about 1930) yet this is also not mentioned.

dying, because you could'nae get doctors, because we could'nae pay for them... T.B. That's what I'm trying to tell you. The majority of people died, hundreds, thousands, T.B.'⁴³⁰ Another woman recalled that when she was at school in the 1920s 'T.B. was rife in Anderston... at least one third were wiped out. I know personally a whole family that were wiped out.'⁴³¹ One woman also explained that 'there was a lot of bad health', 'What caused that?', 'T.B.', 'What was causing the T.B.? Was there a reason for it?' 'Aye, undernourishment.'⁴³² The high death rate, primarily from tuberculosis but also other infectious diseases, was consistently recalled. Another woman remembered having whooping cough and 'taking everything that was going' including scarlet fever, mumps, measles and diphtheria – 'which was raging in Glasgow at that time.'⁴³³ Actually, the incidence of these diseases displayed a sharp decline, yet they continued to dominate popular memory. How can this be explained? On the one hand, this may simply reveal the challenges of oral testimony, particularly the use of existing oral history archives as a source. For example, it may be the case that if these statements had been probed further, or questions directly relating to cancer for example had been asked, additional 'memories' would have been recalled. A further problem is that the exact date of the memories cannot be established. However, given that at least three of the interviewees asserting high levels of tuberculosis and infectious disease were born in 1916, 1917 and 1927, and also seemed to be discussing timeframes in which they were young adults, their memories refer to the later years of the interwar era. Thus, if referring to a later period, where the incidence of cancer but particularly heart disease was proportionally highest, this reveals an important feature in the lay perception of health in the interwar years (Figure 3.11). This would then be consistent with the conclusion of Diack, who also found that a number of myths surrounded public health experiences which

⁴³⁰ *2000 Glasgow Lives*, Robert Young (1902).

⁴³¹ *2000 Glasgow Lives*, Katy Lang (1913).

⁴³² SOHCA/009, Domestic Violence, 1995-97, Ms AJ (unknown). Also see Ms AO (1916), Ms AT (1907), Ms AH (1902), and Ms AC (1917).

⁴³³ *2000 Glasgow Lives*, Betty Hodge (1927).

were recalled as fact years later, due to the way they were understood at the time and since (see chapter 1).⁴³⁴

Understanding the reasons for the propagation of this potential ‘myth’ is difficult. However, one explanation may be that the emotional impact of tuberculosis and other infectious diseases was more significant, causing them to be more deeply embedded in popular memory. While the proportion of deaths from these afflictions was in decline, they continued to be highly concentrated in the youngest age groups and as Thompson points out, the death of children from an outbreak of diphtheria for instance would have a much greater emotional effect on a community than an ‘equivalent number of deaths from heart-disease in older age-groups.’⁴³⁵ This may explain why mortality from tuberculosis was profoundly ingrained in popular memory, it tending to affect young men and women in their ‘prime’ and ‘at the beginning of adult life’, where children and partners were left behind.⁴³⁶ The personal

⁴³⁴ Diack, ‘Myths of a Beleaguered City’, 62-72.

⁴³⁵ Thompson, *Unemployment*, p. 202; *RMOHG 1938*, p. 94.

⁴³⁶ Laidlaw, *Modern Methods*; Smout, *Century*, p. 122; Hardy, *Epidemic Streets*, p. 211; This ‘memory’ was not specific to Glasgow. For example, in the recent BBC series *The Reel History of Britain*, one Londoner asserted the prominence of tuberculosis in the 1930s. However, interestingly, his brother died aged 18 from the disease, reinforcing the suggestion that the emotional impact of tuberculosis mortality may have helped engrain this perception on national memory. Similarly Beier highlights that ‘oral history informants remembered a lot of tuberculosis in their communities’ and that ‘smallpox and tuberculosis, were feared more than others, such as mumps and chickenpox’ (Beier, *For Their Own Good*, pp. 66, 69, 148, 163, 164, 207). The infectious nature of the disease and the continuous threat it would have posed to informants throughout their lives (in comparison to cancer and heart disease which at this point affected those in the older age groups) may also be a contributing cause of public fixation with tuberculosis. Furthermore, it would be interesting to assess whether the mass T.B. eradication campaign cemented the disease in popular memory. Certainly, this was recalled with notable detail by at least one oral history informant (*M74 Dig Oral History Project (M74)*, *Glasgow Museums*, Jane Robertson, 1933). It may also be the case that this was simply confused with pneumonia, but arguably this is still significant in itself. The stigma of tuberculosis and its association with poverty may have also contributed (Beier, *For Their Own Good*, p. 149). Several articles also indicated a silence surrounding cancer. Commenting on the need for public education one article stated that ‘cancer, for some unknown reason, is one of those diseases which are not mentioned in polite society... The cook of the duchess may be epileptic or tuberculous, she may be rachitic, dropsical and alcoholic – but not cancerous. Even the word tumour is taboo. The result of the hush-up policy regarding cancer is this; that the early signs of symptoms of the disease are unknown to the people at large (‘Cancer and Propaganda’, *Medical Officer*, 18th February 1922, p. 67). It was also said that ‘cancer is a “hush-hush” disease and people refer to it as if it were something not quite respectable, like a rather nasty divorce case a quarter of a century ago.

impact of even the threat and contraction of infectious disease was regularly captured by oral testimonies. For example, one man from Blantyre, a region just outside Glasgow, recalled:

When I was a wean I took diphtheria. That wis death at that time, that wis death. I was the first to get the hole in the throat tae breathe. And I survived that. It was death! See the diphtheria at that time – that was you finished. They cut a' my hair off. And, och, there was hundreds died of tuberculosis.⁴³⁷

Even non-life threatening illnesses which were unlikely to result in complications could contribute significantly to health experiences. For example, Rountree also recounted the humiliation school children faced when contracting lice. He recalls:

Apart from the life-threatening illnesses, less serious infectious diseases seldom encountered today were rife, such as scabies and impetigo, and head lice too, weren't uncommon... Then, if any vermin are found have their hair shaved off, which made them stand out like a beacon and a target for ridicule by others.⁴³⁸

Molly Weir similarly recalled: 'Oh the shame and misery of that shaved head! To be a skin head in our tenements meant only one thing - ringworm! It shouted aloud as though I had carried a bell, and intoned "unclean, unclean."⁴³⁹ This could also be embarrassing for mothers, who were deemed responsible for preventing ill health and such diseases from affecting their families (see chapter 5). Indeed, in some cases, mothers would actively withhold their children from treatment to maintain an outward appearance of respectability (see chapter 7). One Glasgow woman recalling a time when

The venereal disease occupied much the same position in the public mind as cancer does today' ('The Conquest of Cancer', *Medical Officer*, 25th April 1925, p. 184); However, the 'myths' surrounding tuberculosis merit deeper examination than has been possible here given time restraints.

⁴³⁷ John Carroll (1918), from Blantyre but worked in Glasgow, MacDougall, *Voices* 2, p. 360.

⁴³⁸ Rountree, *Govan*, p. 184.

⁴³⁹ M. Weir, *Best Foot Forward* (London: Hutchison, 1972), p. 49; Also cited in Bourke, *Working Class Cultures*, p. 161.

she caught impetigo, stated: 'It was amazing the things that you caught and you just didn't know... of course those diseases, scabies, and impetigo. When we were young, in Govan, we got impetigo and that was dreadful. Because, those, my mother had to do the dressings and what not. And it was painful. It must have been painful for her.'⁴⁴⁰ As Beier notes, 'the woman's role as a health authority and care provider was a significant component of her responsibilities and self-image.'⁴⁴¹ Thus, consideration of the human experience behind the statistics provides an alternative understanding to that captured by linear mortality trends. In short, the personal perceptions and experiences of death and disease suggest that the achievements in public health reflected by the numbers were not always recognised at the ground level, and were often not the popular perception and public understanding at the time. This offers an additional insight into the contradictory and contrasting nature of 'measurable' public health trends versus public health *experiences* and adds to our understanding of what was going on in the interwar era.

Conclusion

Mapping key health indicators to assess how far Glasgow's health improved between 1919 and 1939 reveals the shortcomings of overarching, one-dimensional approaches to interwar health statistics. Data collated on mortality, morbidity and the physical condition of the school population, consistently reveal that the traditional optimist interpretation of continuing progress applied to Glasgow. Public health standards clearly improved in spite of the economic recession. However, this data can be interpreted in

⁴⁴⁰ *2000 Glasgow Lives*, Jean Glen (1920); One woman also recalled that their mother refused to allow them to go back on holiday with the 'Fresh Air Fortnight' group as they had previously returned with lice (*2000 Glasgow Lives*, Katy Lang, (1913)).

⁴⁴¹ Beier, *For Their Own Good*, p. 36.

other ways to show the localised deterioration of Glasgow's health in relation to Scotland as a whole, clear stagnation of the rate of improvement, and actual deteriorations in public health standards. Also, even where there were apparent changes in health phenomena in the interwar period, it is not clear that they impacted upon how people themselves experienced their health and wellbeing. Recollections from the period suggest that the diseases which people feared the most were not necessarily the most threatening or damaging to health.

This chapter has suggested that analysing and emphasising the extent to which health improved or worsened between 1919 and 1939 may not be the most useful way to understand and interpret the interwar health experience. Public health statistics can be manipulated to support the view that the era was one of improvements *and* deteriorations in health. However, what is conclusive and where most historians agree is that inequalities were pronounced and experiences diverse. Mortality trends in relation to cause of death and life chances, and the data on the physical condition of the school population varied significantly according to age, geographic region and social class, with marked disparities also being noted within distinct groups of the working class itself. Szreter points out that 'a number of important studies have shown both a remarkable persistence of health inequalities during the twentieth century and also no linear pattern of either gradual decline or gradual improvement.'⁴⁴² This was similarly the case in Glasgow in the interwar years. The following chapters of this thesis attempt to explain the unevenness of Glasgow's public health profile. They disentangle, explore and *emphasise* the wide range of health experiences across the population and suggest that this provides a more accurate understanding of interwar public health. Improvements and deteriorations both occurred, but among different sections of the population. By adopting a comparative approach, this thesis moves away from the optimist-pessimist debate and argues that

⁴⁴² Szreter, *Health and Wealth*, p. 346.

public health was a complex and intricate lattice, characterised by marked variations in experience according to a number of socio-economic and regional factors, rather than conclusive achievements or failures in public health measures.

Chapter 4 Housing, Rehousing and Health

The four million houses built in the interwar years represented an improvement in living conditions for the individual families concerned as well as, in the case of major slum clearance schemes, the removal of a significant source of infection and other health hazards.⁴⁴³

The previous chapter has outlined the broad health trends of Glasgow from key health indicators. The following chapters will attempt to understand what contributed to these patterns whilst engaging with some of the key features of the historiographical debate outlined in chapter one. It is to housing we now turn. The interwar period was one of ambitious house building campaigns. How these affected Glasgow's population profile and the spatial arrangement of city residents has been examined in chapter three. This chapter looks at the housing in which Glaswegians lived and how it impacted upon their health. This is important as it was widely accepted then and since, that overcrowding and poor housing were central to Glasgow's poor health record.⁴⁴⁴ As Thompson asserts, 'the vast majority of people spent a considerable proportion of their time in the home and the nature of that home had important implications for the health and life-chances of the population.'⁴⁴⁵

It was generally accepted that housing conditions in Glasgow were among the worst in Scotland, and indeed the United Kingdom. McFarlane notes that 'the tradition of tenement building in Glasgow made it the most

⁴⁴³ Stevenson, *British Society*, pp. 206-07.

⁴⁴⁴ This was also true of Scotland as a whole. The *DHS* stated that 'bad housing is probably the most serious of the influences which adversely affect the health of the Scottish people' (*ARDHS* 1937, p. 12).

⁴⁴⁵ Thompson, *Unemployment*, pp. 102-03.

densely populated as well as the most overcrowded city in Britain.⁴⁴⁶ In the academic literature on the interwar years, historians have debated the success of housing policy and building projects in numerical and structural terms.⁴⁴⁷ With specific reference to health, writers like Stevenson and Knox have said that these developments were largely a success and acted favourably upon mortality and morbidity patterns. On the other hand, others like Thorpe, McFarlane and MacDonald highlight that the harmful effects of overcrowding continued to blight the lives of thousands of Scots in particular.⁴⁴⁸ Official reports, contemporary literature, autobiographies and personal testimonies on interwar Glasgow are rich in references to excessive overcrowding, observations of more than ten to a room, and of the general dirt, bugs, squalor and insanitary surroundings in which many lived.⁴⁴⁹ Poor housing conditions were central to the memories of Glaswegians who lived during the twenties and thirties, and housing is commonly quoted as being the area where they have witnessed most improvement over their lifetimes.⁴⁵⁰ This chapter revisits Scotland's housing data, aims to examine how far and in what ways the housing situation in interwar Glasgow improved, and the extent to which the building campaigns were successful with reference to public health. It will be maintained that housing-related health trends were multifarious, that often what went on inside the house was more important than the house itself, and that experiences were fashioned by

⁴⁴⁶ McFarlane, 'Hospitals, Housing and Tuberculosis in Glasgow', p. 79.

⁴⁴⁷ Butt, 'Working Class Housing in Glasgow'; McKee, *Working Class Housing*; Damer, *From Moorepark to 'Wine Alley'*; Damer, *Last Exit to Blackhill*; Morgan, '£8 Cottages for Glasgow Citizens'.

⁴⁴⁸ Stevenson, *British Society*, pp. 206-07; Knox, *Industrial Nation*, p. 192; Thorpe, *Britain in the 1930s*, p. 100; MacDonald, *Whaur Extremes Meet*, pp. 123, 124; McFarlane, 'Hospitals, Housing and Tuberculosis in Glasgow', 59-85; Cage, 'Infant Mortality Rates and Housing', pp. 123-37; Cage and Foster, 'Tale of Two Cities'.

⁴⁴⁹ GCA, D-HE, 9/4/3/1, *Corporation of Glasgow: Glasgow Improvement Scheme, Central Division: Evidence of Divisional Medical Officer* (Glasgow, 1928); GCA, D-HE, 9/4/3/2, *Corporation of Glasgow: Glasgow Improvement Scheme, Northern Division: Evidence of Divisional Medical Officer* (Glasgow, 1928); GCA, D-HE, 9/4/3/2, *Corporation of Glasgow: Glasgow Improvement Scheme, Eastern Division: Evidence of Divisional Medical Officer* (Glasgow, 1928); DHS: *The Bed Bug: Prevention of House Infestations: A Study for Public Health Purposes*, HMSO 1933, p. 4; NAS, DD6/306, 'Report on Housing and Other Conditions in 50 Slum Houses in Glasgow', pp. 3, 40; R. Baird, 'Housing', in J. Cunnison and J.B.S. Gilfillan, eds., *Glasgow: The Third Statistical Account of Scotland* (Glasgow: Collins, 1958), pp. 448-74.

⁴⁵⁰ *2000 Glasgow Lives* (particularly responses to question by interviewer James McKenna).

the complex interaction of a number of variables including geographic region, gender, social class and employment status. While the city is commonly depicted as a 'city of tenements' and slums, the rehousing programmes pursued by Glasgow Corporation helped accentuate a complex matrix of housing conditions and public health standards.⁴⁵¹

Housing, Health and Policy

To begin, this section introduces the relationship between housing and health. It outlines the housing densities which drove interwar housing policy and indicates how these were manifest in the public health statistics of Glasgow. This is necessary in order to contextualise and examine the extent to which the situation improved. Pre-war concerns over housing conditions and the acute shortage experienced in the aftermath of the First World War drove the government's interwar housing policies.⁴⁵² Politicians were also all too aware that this was an important obstacle in their attempts to improve public health. The relationship between housing and health is well established.⁴⁵³ This was realised and researched before the First World War, and quality of housing and levels of overcrowding were associated with a number of diseases, ailments and public health trends, including tuberculosis, respiratory disease per se, rickets, diarrhoea, measles, whooping cough, life expectancy, the height and weight of school children, and rates of infant death.⁴⁵⁴ This relationship has been examined extensively

⁴⁵¹ GCA, LP 1/135, *The Glasgow Tuberculosis Scheme*, July 1926 (Corporation of Glasgow, Public Health Department), prepared in connection with the 12th Annual Conference of the National Association for the Prevention of Tuberculosis, to be held at Glasgow, July 1926.

⁴⁵² M. Pugh, *State and Society: A Social and Political History of Britain* (London: Arnold, 2002), p. 175; Stevenson, *Social Conditions*, p. 175.

⁴⁵³ McFarlane, 'Hospitals, Housing and Tuberculosis in Glasgow', 59-85; Cage, 'Infant Mortality Rates and Housing', pp. 123-37; Also see footnote 454 below.

⁴⁵⁴ Constantine, *Social Conditions*, p. 34; GCA, D-TC 7/11/6, A.K. Chalmers, *The House as a Contributory Factor in the Death Rate* (1913), printed for the Royal Philosophical Society of

and was a feature of discussion in both official sources and the public press.⁴⁵⁵ There is broad agreement that Scotland, and Glasgow in particular, was among the most poorly housed population in Britain.⁴⁵⁶ Aldcroft has described Scotland as 'easily the worst area' and that 'there were no areas which quite matched the Scottish position in England and Wales.'⁴⁵⁷ The housing survey conducted by the *DHS* under the Housing (Scotland) Act 1935,⁴⁵⁸ for example, highlighted that overcrowding in Scotland was six times greater than in England at 22.6 per cent compared to 3.8 per cent south of the border. In Glasgow this figure reached 29.1 per cent, revealing the severity of the housing problem in the city within Scotland as a whole.⁴⁵⁹

This was not specific to the interwar years, and in common with other industrial centres throughout the UK, rapid industrialisation over the previous century had resulted in high levels of overcrowding and unfit living conditions

Glasgow; *RMOHG 1923*, p. 15; Smout, *Century*, p. 124; 'Diarrhoeal Diseases in Glasgow', *BMJ*, 1st February 1941, p. 152; J.L. Halliday, 'Housing Conditions and Infectious Disease', 21st April 1928, *Lancet*, p. 819; 'An Inquiry into the Relationship between Housing Conditions and the Incidence of Fatality from Measles', *SRMRC*, 120 (1928), p. 20; *RMOHG 1934*, p. 6; *RMOHG 1925*, p. 34; *GGNHSBA*, HB38/1/2, *Annual Report on the Work of the Authority to which is appended the RMITSC session 1924-25*; *ARDHS 1929*, p. 25; *RMOHG 1933*, pp. 139-40; *GUSC*, Hunt Add, q90, J. Brownlee, 'No Room for the Baby! Overcrowding and Infant Mortality: Facts from Glasgow' (8th July 1917); L.J. Boyd, 'Thesis on the Prevalence of Tuberculosis in Certain Ayrshire Villages with Special Reference to Housing and Living Conditions and Prophylaxis' (Unpublished M.D. Thesis: University of Glasgow, 1917); W.M.A. Horne, 'Health', in J. Cunnison and J.B.S. Gilfillan, eds., *Glasgow: The Third Statistical Account of Scotland* (Glasgow: Collins, 1958), p. 478.

⁴⁵⁵ Cage, 'Infant Mortality Rates and Housing', pp. 123-37; *NAS*, DD6/325, 'Housing Scotland Act, Housing Conditions: News of the World Special Report' and *GGNHSBA*, HB38/25, 'Single Apartment Houses: Startling Facts and Figures in a Big Glasgow Problem', *Evening News* (published after 1931 census figures revealed); 'Housing and Child Life: Labour and Rent Restrictions Act: Effects of Bad Housing', *GH*, 10th April 1922, p. 10; *RMOHG 1926*, p. 209.

⁴⁵⁶ 'Housing and Infectious Disease', *Medical Officer*, 26th December 1925, p. 283.

⁴⁵⁷ Aldcroft, *Interwar Economy*, p. 383.

⁴⁵⁸ Conducted during the winter of 1935-36 and based on a sex-separation and space definition of overcrowding: 'A dwelling-house by Section 2 (1) of the Housing (Scotland) Act is deemed to be overcrowded when the number of persons sleeping in the house (a) is such that any two of these persons, being persons 10 years of age or more of opposite sexes and not persons living together as husband and wife, must sleep in the same room, or (b) exceeds the permitted number of persons as defined in the First Schedule to the Act in relation to the number and floor area of the rooms which the house consists' (*RMOHG 1935*, p. 155).

⁴⁵⁹ Glasgow (29.12 per cent), Dundee (23.94 per cent), Aberdeen (22.05 per cent) and Edinburgh (17.17 per cent) (*ARDHS 1936*, pp. 21, 141; *ARDHS 1937*, p. 20).

for many of Britain's big cities. However, even when compared to English regions of a similar industrial character, the city's inferior housing situation in the interwar era, and the health consequences that this entailed, are apparent.⁴⁶⁰ For instance, one article published in the *BMJ* claimed that only two per cent of houses in Liverpool and one per cent in Manchester and Birmingham were occupied by three or more persons per room compared to 27 per cent in Glasgow.⁴⁶¹ The table below highlights the higher proportion of small houses in the Scottish city in 1931, where the number of one and two room dwellings in Glasgow was 58.5 per cent compared to 1.9 and 3.0 per cent in Manchester and Liverpool respectively (Table 4.1).

Table 4.1: Percentage of houses of different sizes (census 1931)

Number of Rooms	1	2	3	4	5
Glasgow	14.8	43.7	23.7	9.1	8.7
Edinburgh	6.7	31.8	25.5	14.8	21.2
Birmingham	0.2	1.1	17.1	19.8	61.8
Liverpool	0.3	2.7	9.7	21.8	65.5
Manchester	0.2	1.7	10.0	40.0	48.1

SOURCE: *RMOHG 1933*, p. 146.

Ex-Baillie Richard Williamson wrote that 'there are not streets but miles of slums in Glasgow,' and McKee notes that in general, conditions in Glasgow were 'distinct from that of the nation as a whole solely because of its extent and depth.'⁴⁶²

The higher incidence of respiratory disease among Glasgow children under one year, compared to that in Liverpool and Manchester, was explained by the Glasgow MOH as being due to the city's inferior housing. He claimed that 'the essential difference is that the housing conditions in

⁴⁶⁰ W.M. Ballantine, *Rebuilding a Nation* (Edinburgh: Oliver and Boyd, 1944), p. 60; Stevenson, *The Slump*, pp. 47-8.

⁴⁶¹ 'Victoria Infirmary, Glasgow', *BMJ*, 12th March 1927, p. 489.

⁴⁶² NAS, DD6/1169, Ex-Baillie Richard Williamson, 'Article 3', Conditions in Glasgow; McKee, *Working Class Housing*, p. 128.

Glasgow are such that there is much more intimate contact of child with child,' and that:

The greatest difference in the mortalities is in respect of infectious diseases, the rate of 3.7 in Birmingham being little more than one-fourth that of Glasgow which has a rate of almost double those in Liverpool and Manchester. Diseases of the respiratory system are also definitely lower than the rate in Glasgow, which is almost double that of Birmingham. Disease of the immaturity groups are also somewhat more fatal in Glasgow.⁴⁶³

Using census data Lee has demonstrated statistically that in Scotland, the slower rate of improvement in IMR compared to England and Wales, could be attributed to high room densities north of the border, that the significant variation between the two regions was the proportion of the population living in homes with two or fewer rooms, and that 'almost half the variation in infant mortality between the regions in 1921 can thus be explained in terms of housing density.'⁴⁶⁴ In Glasgow, where housing was even worse, Cage has also calculated that the greater levels of overcrowding in Glasgow compared to Edinburgh help explain the higher IMR in the city, demonstrating the centrality of housing to Glaswegian public health experiences.⁴⁶⁵ The *Report of the Scottish Departmental Committee on Housing* published in 1933 had 'consider[ed] it a tribute to the public health authorities that under such conditions the health of the people remains at its present high standard.'⁴⁶⁶ In fact, Scotland, but Glasgow in particular, recorded some of the highest levels of ill health in the United Kingdom (see chapter 3). It is clear that Glasgow was among the worst housed areas in Britain, that this is important for understanding the health of the population, and that it is paramount to Glasgow's reputation as an unhealthy city.

⁴⁶³ *RMOHG 1928*, p. 31; Also see D.N. Paton, 'Rickets: The Part Played by Unhygienic Social Conditions in Predisposing to the Disease', *GMJ*, 97 (1922), p. 130.

⁴⁶⁴ Lee, 'Regional Inequalities in Infant Mortality in Britain', p. 63; Also cited in Cage and Foster, 'Overcrowding and Infant Mortality', p. 132.

⁴⁶⁵ Cage and Foster, 'Overcrowding and Infant Mortality', pp. 129-49.

⁴⁶⁶ P.P. *Report of the Scottish Departmental Committee on Housing*, HMSO 1933 (4469), p. 24.

However, high rates of overcrowding and insanitary housing in Glasgow were unequally dispersed across the city. In the Eastern Division of Glasgow for example – a district said to be ‘essentially an industrial area where the houses are of the smaller types’ – the percentage of small one and two roomed houses was much higher.⁴⁶⁷ In 1927, 79 per cent of houses in this area were said to be of one or two apartments.⁴⁶⁸ Essentially, ‘residential’ districts of the city recorded significantly lower levels of overcrowding than industrial, working class communities. These regional variations contributed significantly to distinctive health experiences according to geographic area – a feature, introduced in chapter three, with an important relationship to social status. Certain areas were recognised health hazards and were nominated to be destroyed as part of slum clearance programmes. The extent to which poor housing played out in the vital statistics of the designated regions is significant, and they indicate not only the relationship between housing and health but also the wide range of health experiences across the city. For example, a proportion of the district of Calton which was to be demolished as part of the Housing (Scotland) Act, 1925, recorded significantly higher mortality rates compared to the region of Calton as a whole – an area already infamous for its poor health and high levels of mortality.⁴⁶⁹ The IMR in the region to be cleared was 141 compared to 128 for Calton and 106 for Glasgow. Even then the city’s MOH reported that ‘certain of the streets give even higher figures’, affirming the extent to which inequalities prevailed at the community level.⁴⁷⁰ The MOH noted that ‘as regards the distribution of infant mortality throughout the city, the same gradations are noticeable in the different areas, depended largely upon housing conditions.’⁴⁷¹ Numerous investigations had also shown that the heights and weights of Glasgow’s school children correlated with house size,

⁴⁶⁷ J.A. Wilson, ‘Pulmonary Tuberculosis in the Eastern District of Glasgow’, *GMJ*, 1927 (107), p. 31.

⁴⁶⁸ In this period, ‘apartment’ is taken to mean the number of rooms; Wilson, ‘Pulmonary Tuberculosis in the Eastern District of Glasgow’, p. 31.

⁴⁶⁹ *RMOHG* 1929, p. 198.

⁴⁷⁰ *Ibid.*, p. 198; ‘The Scottish Board of Health’, *BMJ*, 6th August 1927, p. 241; For similar evidence of significantly higher IMR in slum clearance streets and areas see *Evidence to be Submitted to Committee on Scottish Health Services re The Medical Services*, p. 179.

⁴⁷¹ *RMOHG* 1937, p. 47.

and that these measurements tended to increase alongside the number of rooms at home (Table 4.2).⁴⁷²

Table 4.2: Height and weight in relation to size of house

	Age group	Size of house (Rooms at home)				
		1 apartment	2 apartment	3 apartment	4 apartment	5 apartment
		Boys (Height)	5 yrs	40.2	40.3	41.3
	13 yrs	54.1	54.4	55.7	56.5	57.4
Girls (Height)	5 yrs	39.3	40.1	41.2	41.7	42.1
	13 yrs	55.2	54.6	56.5	57.3	56.8
Boys (Weight)	5 yrs	38.1	37.8	39.9	40.6	41.6
	13 yrs	72.2	73.2	78.1	79.2	85.8
Girls (Weight)	5 yrs	37.3	38.0	38.5	39.5	40.3
	13 yrs	76.3	76.8	80.0	81.6	80.1

SOURCE: GGNHSBA, HB38/1/2, *Annual Report on the Work of the Authority to which is appended the RMITSC session 1924-25*, p. 54.

Thus, responding to this evidence, a policy drive to provide larger, 'healthier' homes was rational. According to the MOH, 'in the interests of young children new houses should be designed.'⁴⁷³ A front page special investigation conducted by the *GP* in 1938 similarly argued that 'houses and yet more houses still' had to be built to control stubbornly high rates of tuberculosis in the region.⁴⁷⁴

In interwar Scotland a host of ambitious legislative attempts were implemented to alleviate its health problems. How far was this successful? In this period, the national and local governments undertook a large-scale

⁴⁷² Also see GGNHSBA, HB38/1/8, *RMITSC 1936*, p. 22 and HB38/1/2, *RMITSC 1929*, p. 17; *Evidence to be Submitted to Committee on Scottish Health Services re The Medical Services*, p. 91.

⁴⁷³ 'Housing Reform', *GH*, 15th December 1926, p. 6.

⁴⁷⁴ 'Govan T.B. Menace', *GP*, 5th August 1938, p. 1.

campaign to provide the population with larger, healthier homes with basic amenities including extra rooms and a toilet.⁴⁷⁵ Measures began with the passing of the Housing and Town Planning (Scotland) Act of 1919 which 'imposed on local authorities a specific duty to consider the housing needs of their district and to submit to the *SBH* proposals to build houses for the working class.'⁴⁷⁶ Between 1919 and 1939 a further six acts were passed which revised and refined the terms of this legislation.⁴⁷⁷ Most of the literature has emphasised the continuity of poor housing in the city, with writers such as Butt, Damer and McKee arguing that improvements resulting from interwar housing legislation were slow to materialise.⁴⁷⁸ However, the majority of new houses built by Scottish local authorities were constructed in Glasgow and some writers have been favourable about the success of Glasgow Corporation.⁴⁷⁹ For example, Rodger claims: 'That Scottish council house building did not achieve the annual production of houses sought is no condemnation of their efforts [and] given the difficulties encountered that local authorities built so many was almost miraculous.'⁴⁸⁰ In a British context, writers such as Stevenson have argued that 'the progressive advance in housing' which was made contributed to improvements in health.⁴⁸¹ In spite of the distinctly inferior housing position, Scottish historian Knox also claims that housing developments were implicit to the public health achievements which were made north of the border and there was a degree of progress.⁴⁸²

⁴⁷⁵ Chalmers, *The Health of Glasgow*, p. 40.

⁴⁷⁶ Pacione, *Glasgow*, p. 158.

⁴⁷⁷ Including the Housing (Chamberlain's) Act in 1923, the Wheatley Act in 1924 which provided state subsidies for rented accommodation, the Greenwood Act of 1930 and the Housing (Scotland) Act of 1935 which explicitly linked slum clearance and overcrowding with the provision of new houses (Devine, *Scottish Nation*, pp. 346-47); R. Cook, 'Housing and Deprivation', in Cook and Brown eds., *Scotland: The Real Divide*, p. 177; Bourke, *Working Class Cultures*, p. 14; Also see Morton, *Layout of Glasgow Corporation Housing Schemes* for an extensive summary of Corporation developments in interwar Glasgow.

⁴⁷⁸ Butt, 'Working Class Housing'; Damer, *From Moorepark to 'Wine Alley'*; McKee, *Working Class Housing*.

⁴⁷⁹ *ARSBH 1923*, p. 16.

⁴⁸⁰ Rodger, 'Introduction', in Rodger, ed., *Scottish Housing in the Twentieth Century*, p. 7; Also see Morgan, '£8 Cottages for Glasgow Citizens', pp. 125, 145.

⁴⁸¹ Stevenson, *British Society*, pp. 206-7.

⁴⁸² Knox, *Industrial Nation*, p. 192.

Certainly, census information on the percentage of the population living in houses of one and two rooms, and the number of persons per room, suggests that the period was one of relative improvement. These indices are commonly cited throughout the historiography and in official and lay sources of the time.⁴⁸³ In 1931, 44 per cent of Scots lived in homes of one or two rooms, compared to Glasgow's respective rates of 11.0 and 44.4 per cent.⁴⁸⁴ However, in Glasgow, these rates had fallen from 12.8 per cent and 49.8 per cent in 1921. Also, the percentage of the Glaswegian population that lived in accommodation with three persons per room fell from 26.3 per cent in 1921 to 23.4 per cent in 1931.⁴⁸⁵ From some contemporary sources it seems that these developments were thought to have been advantageous for health. For example, the *GP*, when publishing details on the greater expectation of life and falling death rates, claimed that 'to these results, sanitary, social, medical and educational influences contribute, but probably the most important factor has been improvement in environmental conditions generally' associated with housing reform.⁴⁸⁶ A comparison of the census data from 1921 and 1931 suggests that in spite of the continued inferiority of the housing situation in Glasgow, there is a case for the more optimistic interpretations advanced by writers such as Stevenson and Knox.

However, it is clear that the Corporation's ambitious campaign was only partly realised. The 1919 Addison Act optimistically set a target of 57,000 houses for Glasgow to solve the post-war housing problem. By 1927

⁴⁸³ *GUSC*, MS GEN, 1669/25, Personal notebook of Dr. J.L. Halliday, includes numerous newspaper clippings, 'Where Glasgow Lags Behind', *Evening Citizen*, 16th March 1928; Ballantine, *Rebuilding a Nation*, p. 36; Jenkinson, *Scotland's Health*, p. 186; Smout, 'Scotland', pp. 253, 254, 257; Smout, *Century*, pp. 32-3, 50; Knox, *Industrial Nation*, p. 192; Harvie, *No Gods*, pp. 70, 139; Devine, *Scottish Nation*, p. 349; M. Anderson, 'Family Life', in Dickson and Treble (eds.), *People and Society in Scotland: Volume 3*, pp. 40-1; McKee, *Working Class Housing*, p. 39.

⁴⁸⁴ Census Report, Scotland 1931, p. xivi; *ARDHS 1936*, p. 20; Census Report, City of Glasgow 1931, p. 55.

⁴⁸⁵ Census Report, City of Glasgow 1921, p. 47; Census Report, City of Glasgow 1931, p. 56.

⁴⁸⁶ 'The Single End', *GP*, 31st May 1935, p. 4.

just over 6,000 had been built.⁴⁸⁷ Local surveys often contradicted the more flattering interpretations which can be deduced from high level reports like the decennial census. They revealed increases in overcrowding concurrent with housing reform, and that public health achievements in terms of housing were hardly impressive by 1939. For example, a number of Glasgow's SI's recorded that overcrowding in the ticketed houses of the city often demonstrated a tendency to increase.⁴⁸⁸

Table 4.3: Percentage of overcrowding in the ticketed house, Central Division, Glasgow

	1913	1914	1923	1924	1925	1926	1927	1928	1929	1930	1931	1932
O/C	6.98	6.58	11.24	10.21	10.59	10.09	11.12	12.13	9.94	8.14	9.0	9.55

SOURCE: *RMOHG 1932*, p. 227.⁴⁸⁹

Ticketed houses were considered to be the epitome of bad housing and the table demonstrates that overcrowding here was worse in 1932 than 1913, that it increased significantly between 1926 and 1928, and that despite legislative attempts to improve conditions the rate of overcrowding was more than a third higher than 1913 (Table 4.3).⁴⁹⁰ The school medical authorities reiterated in 1931 that 'one striking feature of the statistics' was that the 'average number of inmates in one-apartment houses was higher in 1931

⁴⁸⁷ Horsey, *Tenements and Towers*, p. 13.

⁴⁸⁸ In an attempt to reduce overcrowding in slum houses, a small metal plaque was fixed at the entrance stating how many people, based on the cubic feet of space per person, were entitled to live there. They were then subject to inspection, often late at night, in order to catch and penalise those failing to adhere to these restrictions. Ticketing was not an interwar phenomenon – it existed before and Glasgow's housing, as a consequence of rapid industrialisation, was always notoriously overcrowded (See F. Wordsall, *The Tenement: A Way of Life, A Social, Historical and Architectural Study of Housing in Glasgow* (Edinburgh: Chambers, 1978), p. 13 or Baird, 'Housing', p. 464). However in the interwar period, the SI noted that investigating houses for overcrowding had little remedial value as once identified, the housing shortage meant the excess inhabitants had nowhere to go, and that regular visitation of ticketed houses 'serve[d] as an index to the grossly overcrowded condition of many of the houses' (*Report by the Sanitary Inspector of the Eastern Division* (RSIED), *RMOHG 1927*, pp. 258, 259); *RMOHG 1924*, p. 210.

⁴⁸⁹ In other regions, including the Northern Division, the percentage of overcrowding in ticketed houses was much higher at 16 per cent in 1927 (*Report by the Sanitary Inspector of the Northern Division* (RSIND), *RMOHG 1927*, p. 255).

⁴⁹⁰ Also see *Report by the Sanitary Inspector of the South Western Division* (RSISWD), *RMOHG 1924*, p. 224.

(5.2 inmates) than in 1924 (5.1) or 1921 (4.4).⁴⁹¹ Commenting on the higher incidence of overcrowding in Glasgow compared to pre-war levels, Hutt argued that this was a 'striking index of the real worsening of housing conditions, despite all the municipal schemes and the new Council houses.'⁴⁹²

Furthermore, a considerable proportion of the new Corporation housing built in the 1920s in particular was actually still characterised by a high percentage of small, overcrowded dwellings, and this problem persisted until the end of the period under review.⁴⁹³ In 1925 one survey of 835 new homes in the rehousing estates of Hamiltonhill, Newbank, Polmadie and Yorkhill, found that 14 per cent of the two apartment houses were occupied by more than three persons per room. Among three apartment houses 13 per cent were overcrowded – although a breakdown provided revealed the persistence of geographic variations with the Hamiltonhill region having 21.6 per cent overcrowding in its two roomed houses compared to only 5.6 per cent in Yorkhill.⁴⁹⁴ An article featured in the *BMJ* in 1927 also observed that 'even in the new houses 28 per cent of those who had come from the slums were living in overcrowded conditions.'⁴⁹⁵ In 1935 the SI of the Northern Division further remarked that 'the schemes are by no means free from overcrowding; indeed, some of them show as high a percentage of overcrowding as is found in any other class of house in the city.'⁴⁹⁶ By 1938 overcrowding continued to be a feature of rehousing estates, and as the following table published by SI of the Central Division demonstrates, in some cases this could increase (Table 4.4):

⁴⁹¹ *GGNHSBA*, HB38/1/3, *RMITSC* 1931, p. 58.

⁴⁹² Hutt, *Condition*, p. 116.

⁴⁹³ *RSICD*, *RMOHG* 1938, p. 245.

⁴⁹⁴ Similarly, Polmadie registered 31.2 per cent overcrowding in its three apartment houses compared to none in Yorkhill (*RMOHG* 1925, p. 186).

⁴⁹⁵ 'The Scottish Board of Health: Housing', *BMJ*, 6th August 1927, p. 241; Also see *RMOHG* 1933, p. 245.

⁴⁹⁶ *RSIND*, *RMOHG* 1935, p. 262.

Table 4.4: Overcrowding in 2,130 houses in rehousing schemes, 1931 and 1938

	Number and size of house	Number and percentage overcrowded
1931	1,273 2 apartments	628
		49.4
1938		479
		37.6
1931	857 3 apartments	468
		54.6
1938		481
		56

SOURCE: *RMOHG 1938*, p. 245.

Therefore, investigating the extent to which the housing policies of the 1920s and 1930s were a success further demonstrates the contradictory interpretations which can be derived from the statistics. The paradoxical nature of the era is clear. Broad improvements in housing could coexist with worsening conditions and prevailing overcrowding even within new local authority estates. The following section attempts to disentangle this complexity and indicate exactly where in terms of health improvements were made.

Better Housing, Better Health

For many, new, local authority housing and the clearing of slums represented a marked improvement in living standards. One Glaswegian recalled the 'wonderful new standard of living that rehousing seemed to offer' stating, 'you had nothing: that's why my mother fought so hard to get a Corporation house with a bathroom. That was like gold, like getting a lump of gold.'⁴⁹⁷ Another described their new local authority house as a 'mansion'.⁴⁹⁸ Corporation rehousing estates, materially and structurally at least, were undoubtedly healthier for those moving from the city's slums, as was often recognised by

⁴⁹⁷ H. Clark and E. Carnegie, *She Was Aye Working: Memories of Tenement Women in Edinburgh and Glasgow* (Oxford: White Cockade Publishing, 2003), p. 19.

⁴⁹⁸ Faley, *Up Oor Close*, p. 48.

tenants themselves.⁴⁹⁹ Broader environmental gains were also made. In 1923 the MOH for Glasgow commented with reference to the Cowcaddens and Woodside wards, that 'in certain sections of the areas to be cleared, the density of population exceeds 1,000 per acre; while at Hamiltonhill the principal rehousing site – the number of houses had been restricted to 27 per acre, which gives a density of population of approximately 122.'⁵⁰⁰ Glasgow's slums were also insanitary and structurally unsafe.⁵⁰¹ A number of inspectors described the 'passages and stairways' as 'mostly dirty and always depressing' and that 'stairs were so worn as to be positively dangerous.'⁵⁰² Indeed, one woman interviewed as part of this thesis remembered witnessing a school friend being killed by a falling chimney:

No we went home for our dinner [during school]. But I remember, we used to go through this lane. And, where the boys shouted at the coal engines. And it was an awful blowy lane. The winds, it was terrific and we were going through, and I was going through with a girl who was in my class, and her wee brother and her wee sister was with her, the four of us were going along this lane. And suddenly the wind got up, oh! And it was terrible, it was blowing us and the next thing was, a rattle, and a chimney stack fell from one of the buildings where we were and it killed Emily Mathews in front of us. And, I couldn't believe it, she was just killed with it in front. Now that was the other three children, four of us and three, one, one was killed. It was such an experience and evidently, the, the building was needing renewed, something renewed and it hadn't stood up to the storm and she was killed.⁵⁰³

⁴⁹⁹ For example see M74, Christina Wilson (1918).

⁵⁰⁰ *RMOHG 1923*, pp. 146-47; Also see *RMOHG 1924*, p. 11.

⁵⁰¹ *RMOHG 1927*, p. 252.

⁵⁰² *NAS*, DD6/306, 'Report on Housing and Other Conditions in 50 Slum Houses in Glasgow', pp. 3, 40; Damer, *From Moorepark to Wine Alley*, p. 101; Glasser, *Growing Up*, pp. 74-5, 198.

⁵⁰³ SOHCA/038/001 (1912).

This was not an isolated incident and collapsing tenements and structurally unsafe environments were reported repeatedly in the Glasgow press and in personal testimonies.⁵⁰⁴ In one instance it was said that people stayed in buildings known to be on the verge of collapse because ‘they had no houses to go to.’⁵⁰⁵ However, on the other hand, the MOH for Glasgow reported that the tenants of one building already partially collapsed ‘refused to leave’ as ‘they were paying no rent; and on that account were prepared to take risks’ – an indication that even within the context of the housing problem, people continued to be active agents in their own health experiences (see chapter 7).⁵⁰⁶

The unhealthiness of the material environment of many tenement homes is obvious. Another article researching rheumatism in Glasgow similarly pointed out:

In Glasgow, where the children live mainly in tenement buildings, in flats opening off a common stair, the stairway and passage from the street are nearly always cold, damp, and extremely draughty and often form the playground for the children. Even careful mothers cannot always be watching, and it is likely that there is a considerable element of exposure in sitting on cold stone steps, playing in a draughty passage or in the wet streets and backlands in winter (Illustration 4.1).⁵⁰⁷

In a study of pre-war housing and health, the early Glaswegian MOH A.K. Chalmers had acknowledged that ‘in the unhealthy area it is impossible to disentangle the injury done by the house from that which is done by its

⁵⁰⁴ For example, see ‘Glasgow Tenement Collapses: Six Persons Injured: Distressing Experience of Tenants’, *GH*, 2nd January 1922, p. 10; H. Savage, *Born Up a Close: Memoirs of a Brighton Boy* (Argyll: Argyll Publishing, 2006), p. 93.

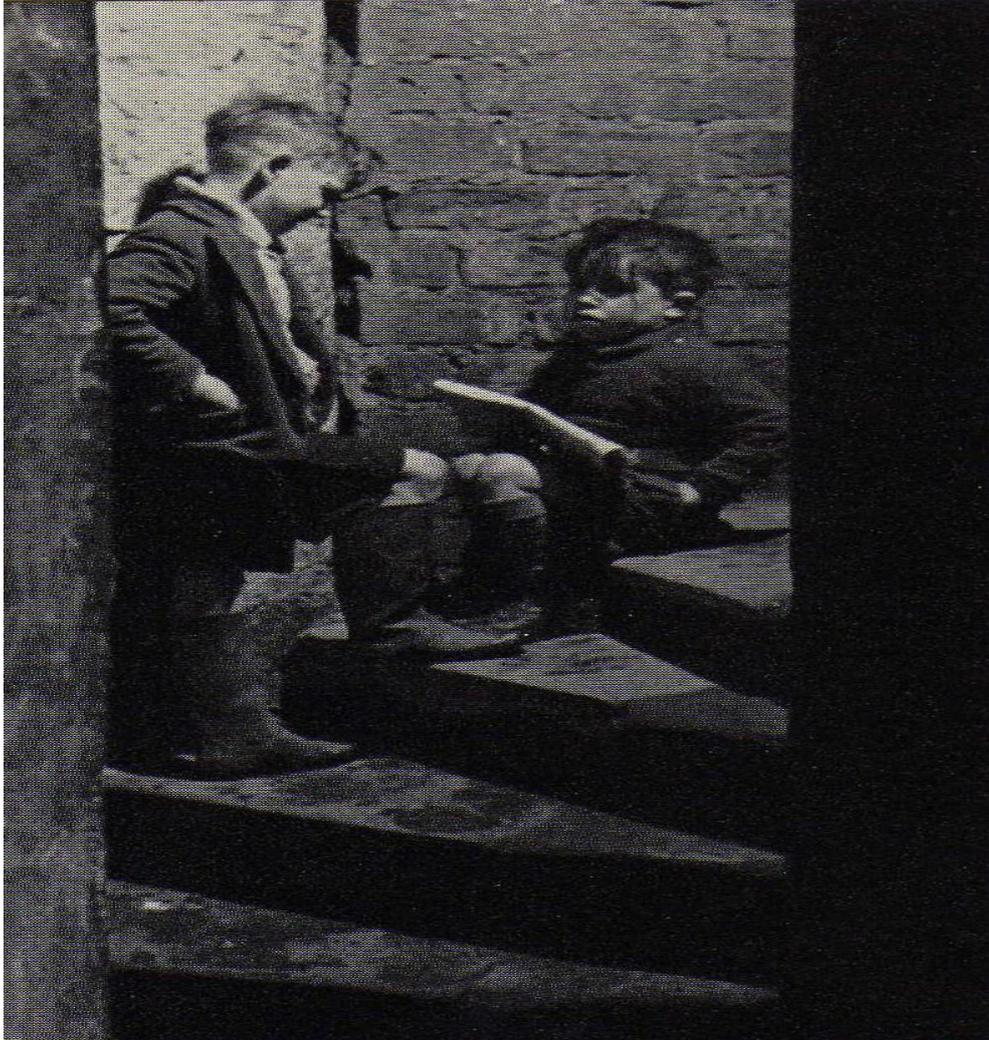
⁵⁰⁵ ‘Dangerous Glasgow Tenement’, *GH*, 5th October 1935, p. 9.

⁵⁰⁶ *RMOHG 1925*, p. 148.

⁵⁰⁷ ‘Child Life Investigations: Social Conditions and Acute Rheumatism’, *SRMRC*, 114 (1927), p. 51.

surroundings,' and undoubtedly, the clearing of structurally unstable, hazardous areas resulted in an environment more conducive to health.⁵⁰⁸

Illustration 4.1: Glasgow children playing on tenement stairs



SOURCE: Gladstone Robertson, *Gorbals Doctor*.

Indeed, the SI of the Central Division stated that 'the carrying out of the [Parliamentary Road] Scheme has resulted in a complete transformation of the area, and apart from the removal of many unhealthy dwellings, has effected a very considerable improvement of the lighting and ventilation of

⁵⁰⁸ A.K. Chalmers, *Health and Housing* (London: The Medical Officer, 1916), p. 5.

the remaining houses in the front tenements.⁵⁰⁹ It is interesting that one rehoused father, 'although unemployed with five small children', had 'refused to allow them to take advantage of the "Fresh Air Fund" holiday arrangements because he thought they would displace city children, who were in greater need of fresh air.'⁵¹⁰ Even the notorious Corporation scheme Blackhill was remembered by one interviewee as being initially a 'great healthy place.'⁵¹¹ This clearly supports the view of Stevenson outlined in the opening quote, that the clearance schemes benefited the health of both displaced and neighbouring tenants due to the wider environmental gains which were made.⁵¹²

The mental health of rehoused children was also said to be better. Rodger asserts that 'personal interaction with the built environment therefore remains under-acknowledged in Britain; the impact of grey stone tenements is confined to the physical, to their effect on light and ventilation, to public health rather than to mental health... Further attention could usefully be devoted to the interaction of resident and his/her home'.⁵¹³ An article printed in the *Lancet* published details of the correlation between rehousing and mental health, and discussed a study where 'in Glasgow some children were tested at the time of their removal from slum houses to a rehousing area, and again about 18 months later.'⁵¹⁴ Among the rehoused children, the investigators found evidence of progress, 'whereas a control group that did not move from their slums showed no such improvement.'⁵¹⁵ Also, the Director of Housing claimed during an inquiry at the Glasgow City Chambers that 'eighty per cent of tenants were greatly improved physically and *mentally*', and at a meeting of the Royal Philosophical Society in 1934

⁵⁰⁹ *RSICD, RMOHG 1926*, pp. 252-53.

⁵¹⁰ *ARDHS 1934*, p. 31.

⁵¹¹ GCA, 'Moving to Blackhill': Extracts from interviews with some of the first residents of Blackhill, conducted 1989 (Resource Book, Twentieth Century Glasgow).

⁵¹² Stevenson, *British Society*, pp. 206-7.

⁵¹³ Rodger, 'Introduction', p. 22.

⁵¹⁴ 'Psychology and Social Problems', *Lancet*, 15th September 1934, p. 609.

⁵¹⁵ *Ibid.*, p. 609.

'emphasis was laid on the importance of housing in relation to physical and *mental* health [my italics].'⁵¹⁶ When reporting to the Committee on Scottish Health Services, one doctor commented upon the broader environmental problem of atmospheric pollution and smoke abatement, and mentioned the 'psychological effect of a clean atmosphere.'⁵¹⁷ Findings like this have to be treated with caution. There is the possibility, as is the case with other medical reports, that high level health officials, or politically motivated doctors with an interest in social welfare, would have been keen to establish a positive relationship between improved housing and the health of residents in order to encourage and demonstrate the success of the campaigns. However, this was also captured by less 'official' medical observations where writer Molly Weir remembered that upon visiting a doctor due to her 'peely-wally' (pale) complexion her prescription was a room of her own. She recalled 'the doctor was suggesting a reprieve from having to live in the constant whirl of family life in our wee room and kitchen, which he said was slowly undermining my nervous health.'⁵¹⁸

Unsurprisingly, official observers also commonly emphasised the physical improvement of the tenants of new houses, especially that of young children.⁵¹⁹ For example, Dr. W.C. Gunn stated that 'particular attention has been paid to the physical condition of children in the rehousing areas, and this aspect of rehousing is most encouraging. The child showing malformations from rickets is the exception.'⁵²⁰ Dr. M. Poldores MacCunn (Senior Child Welfare Medical Officer) repeated that the physical wellbeing of

⁵¹⁶ 'New Houses: Provision for Slum Dwellers', *GH*, 17th September 1926, p. 10; 'Current Topics: Care of Children in the Pre-School Period', *GMJ*, 121 (1934), p. 110.

⁵¹⁷ *NAS*, 02024, HH76-1-00057, p. 33 (or p. 62 *NAS*).

⁵¹⁸ Weir, *Best Foot Forward*, p. 198; Thompson has also commented upon the psychological strain of overcrowding, quoting one south Wales MOH that subletting caused a 'large amount of unhappiness and even ill health owing to constant worry' (Thompson, *Unemployment*, p. 112).

⁵¹⁹ *RMOHG 1930*, p. 323; *GCA*, DHE 1/1/3, Scottish Branch of the Society of Medical Officers of Health: Memorandum to the Committee on Scottish Health Services, p. 6; *GCA*, D-TC 6/606/3(7), Correspondence between the Town Clerk and MOH: Private: For the Information and Consideration of the Committee on Housing.

⁵²⁰ *RMOHG 1933*, p. 171.

rehoused children was better than those from slum housing and 'the infant death rate in housing schemes where an epidemic was not prevalent compared favourably with that in the better class districts of the city.'⁵²¹ This was reportedly recognised by the tenants themselves and in 1928 the Supervising Nurse Inspector claimed that in the Belvidere scheme 'the mothers often remark how their children have improved in health since coming to these surroundings.'⁵²² The escape from 'crammed up back courts' into open spaces and fresh air was often cited as a reason for children's improved physique, in spite of continued poverty and evidence of financial hardship in these schemes.⁵²³ Hence, a closer look at the health experiences of the rehoused population also suggests that these homes provided an environment which was conducive to health.

However, for some, the gains made from the construction of structurally and environmentally superior housing could be particularly important. Most women spent a greater proportion of their lives within and around the home and it is clear that materially inferior houses impacted particularly adversely upon their health. The *SBH* acknowledged that housing and the ill health of mothers and children was 'closely allied'.⁵²⁴ Throughout the interwar period there was a direct attempt by the national and local governments to improve maternal and child health (Chapter 5). While measures to provide advice and treatment to pregnant women and pre-school children were welcomed, Glasgow's early MOH A.K. Chalmers regarded this as 'essentially auxiliary so far as Glasgow was concerned, in as much as it could only produce the best result if associated with reform in the housing conditions of the city on a wider scale than had up till then been

⁵²¹ 'Current Topics: Child Welfare: Rickets in Housing Schemes', *GMJ*, 1933 (119), p. 172.

⁵²² *RMOHG 1928*, p. 160.

⁵²³ *RMOHG 1928*, p. 161; Report on the Eastern District slum clearance schemes by the Supervising Nurse Inspector, *RMOHG 1928*, p. 206; *RSIED*, *RMOHG 1929*, pp. 212, 214; *RMOHG 1930*, p. 323.

⁵²⁴ *ARSBH 1928*, p. 15.

attempted.⁵²⁵ Life expectancy surveys carried out by Glasgow Corporation's public health department suggested that the lower rates among Glasgow females compared to those from comparable English cities like Manchester and Liverpool could be explained in terms of housing standards. It was claimed that 'the conspicuous feature' of these figures was 'the greater expectation of life among females at practically all ages in the English cities, and also among males at the higher ages. Better housing may account for the improved condition among females'.⁵²⁶ Another study in 1927 similarly found that 'in males, despite the fact that the house per se has less influence than in females, owing to considerations of employment etc., a relationship of definite character has been established between the size of house and the average annual incidence of [tuberculosis]'.⁵²⁷ However, the report illustrated a clear differential according to gender where 'in comparing the sexes with the housing state, it is interesting to note that in the one apartment house the female incidence exceeds the male at age groups 0-5, 11-15, and 21-45 years, while in the larger houses the female rate exceeds the male from 6-20 years only, the male predominating in the other groups'.⁵²⁸ This evidence suggests that the effect of housing upon health and the impact of spending prolonged periods in small, unhealthy dwellings was particularly harmful to women – a notion supported by McFarlane.⁵²⁹ Hence, it seems that the movement into structurally superior housing conditions was particularly important for women.

⁵²⁵ 'A Century of Health Progress in Glasgow', *BMJ*, 23rd August 1930, p. 292.

⁵²⁶ GCA, DTC 7/11/6, Jones, *The Expectation of Life*, p. 25; Also detailed in 'Expectation of Life in Glasgow', *BMJ*, 4th April 1925, p. 866.

⁵²⁷ Wilson, 'Pulmonary Tuberculosis in the Eastern District of Glasgow', p. 32.

⁵²⁸ *Ibid.*, p. 32.

⁵²⁹ McFarlane, 'Hospitals, Housing and Tuberculosis in Glasgow', p. 82.

Rehousing and Inequalities

While broad improvements were made these were felt unevenly across the population. Indeed, the observation that ‘the house, in an industrial area, is only a reflex of the economic condition of the inhabitants, so that any scheme of prevention must deal with the problem from both angles’ should also be kept in mind.⁵³⁰ The higher incidence of disease among women from one apartment houses would also have been affected by other social factors including poverty, unemployment and the unequal allocation of resources *within* the home (see chapter 5). However, the maternal mortality rate, the death rate of women in childbirth, was also influenced to some extent by housing conditions. While a host of evidence reveals that maternal mortality per se did not directly correlate with overcrowding (see chapter 5),⁵³¹ the poor lighting and ventilation caused by overcrowded houses contributed to the high incidence of rickets in Glasgow’s poorest areas, and it was recognised that resulting pelvic deformities could contribute to maternal death as this made childbearing in later life more dangerous.⁵³² Kerr for example, claimed that deformities of the pelvis were a ‘common cause of [maternal] difficulty, especially in Glasgow where rickets is so prevalent.’⁵³³ Another Glasgow doctor who studied the geographical distribution of this condition in Scotland also found that ‘the incidence of contractual pelvis of all types is highest in Glasgow and Lanarkshire,’ whilst suggesting that rickets was a significant cause of the higher rates in these regions.⁵³⁴ A report by

⁵³⁰ Wilson, ‘Pulmonary Tuberculosis in the Eastern District of Glasgow’, p. 31; Also see *RMOHG 1933*, p. 140; Hutt, *Condition*, p. 116.

⁵³¹ Winter, ‘Infant Mortality’, p. 454; *Report on an Investigation into Maternal Mortality*, HMSO 1937, pp. 63, 279.

⁵³² Smout agrees that ‘the girls deformed by rickets today become the deformed mothers of tomorrow, and furnish the maternity hospitals with some of their most tragic cases’ (Smout, *Century*, p. 124); Paton, ‘Rickets: The Part Played by Unhygienic Social Conditions in Predisposing to the Disease’, p. 132; *Committee on Scottish Health Services Report*, p. 56.

⁵³³ J.M. Munro Kerr, ‘Preventative Medicine as Applied to Obstetrics’, *BMJ*, 12th June 1926, p. 977; ‘High Maternal Mortality in Certain Areas’, *Medical Officer*, 15th October 1932, p. 158.

⁵³⁴ *Report of the MRC 1934-35*, p. 82; The impact of the high incidence of rickets in Glasgow upon the success of childbirth was also mentioned in ‘Scotland: Glasgow Royal Maternity and Women’s Hospital’, *BMJ*, 23rd February 1935, p. 375.

the *Glasgow Royal Maternity and Women's Hospital* (GRMWH) similarly asserted that the 'large number of abnormal cases [occurring in the hospital] is explained by the fact that the Hospital serves a large industrial population, where the incidence of rickets and malnutrition is high.'⁵³⁵ Hence, maternal mortality among working class and poorer women was more affected by housing standards, even if indirectly, due to the consequent development of rickets and this pelvic condition. This suggests then that the gains made from the structural and environmental superiority of interwar local authority housing would have been particularly significant for this group, and that the improvements felt among 'women' were particularly significant for those from the working class and poor. While improvements were made, the degree to which this was the case depended upon the complex interaction between housing, gender and socio-economic status.

Even within the Corporation housing developments financial position remained paramount to health experiences. The local authority building campaigns ensured that social class, and the financial status that this entailed, continued to define housing conditions and standards of health. This had always been the case. Even within the working class, important divisions were apparent, and in the Northern Division for example, it was found that 'among 620 houses of better type occupied chiefly by the labouring classes, 19 per cent are overcrowded; and that among 464 houses occupied chiefly by artisan classes, almost all two apartments, the overcrowding was only 2 per cent'.⁵³⁶ Similarly, the *UAB* reported that the more serious forms of overcrowding were predominantly found among unskilled industrial workers.⁵³⁷ On the other hand, one Glasgow study

⁵³⁵ *GGNHSBA*, HB45/3/24, *GRMWH 1937*, p. 7.

⁵³⁶ *RMOHG 1928*, p. 174.

⁵³⁷ *RUAB 1936*, p. 132; This somewhat undermines McFarlane's claim that those with superior incomes endured poor housing conditions due to the housing shortage, revealing a clear correlation between better housing and the ability to pay (McFarlane, 'Hospitals, Housing and Tuberculosis in Glasgow', p. 80); Also see A.K. Chalmers speaking before the Housing Commission, 'Slum Menace: Urgency of Glasgow Problem', *GH*, 11th January 1922, p. 14.

recorded that a superior type of house tended to be occupied by working class artisans, in that they all had 'at least a room and a kitchen.'⁵³⁸ In spite of the structural destruction of insanitary houses, social inequalities continued to characterise interwar Corporation housing developments, and writers including Devine, Damer and McKee assert that the interwar building policies actually *intensified* the boundaries and inequalities between the classes.⁵³⁹

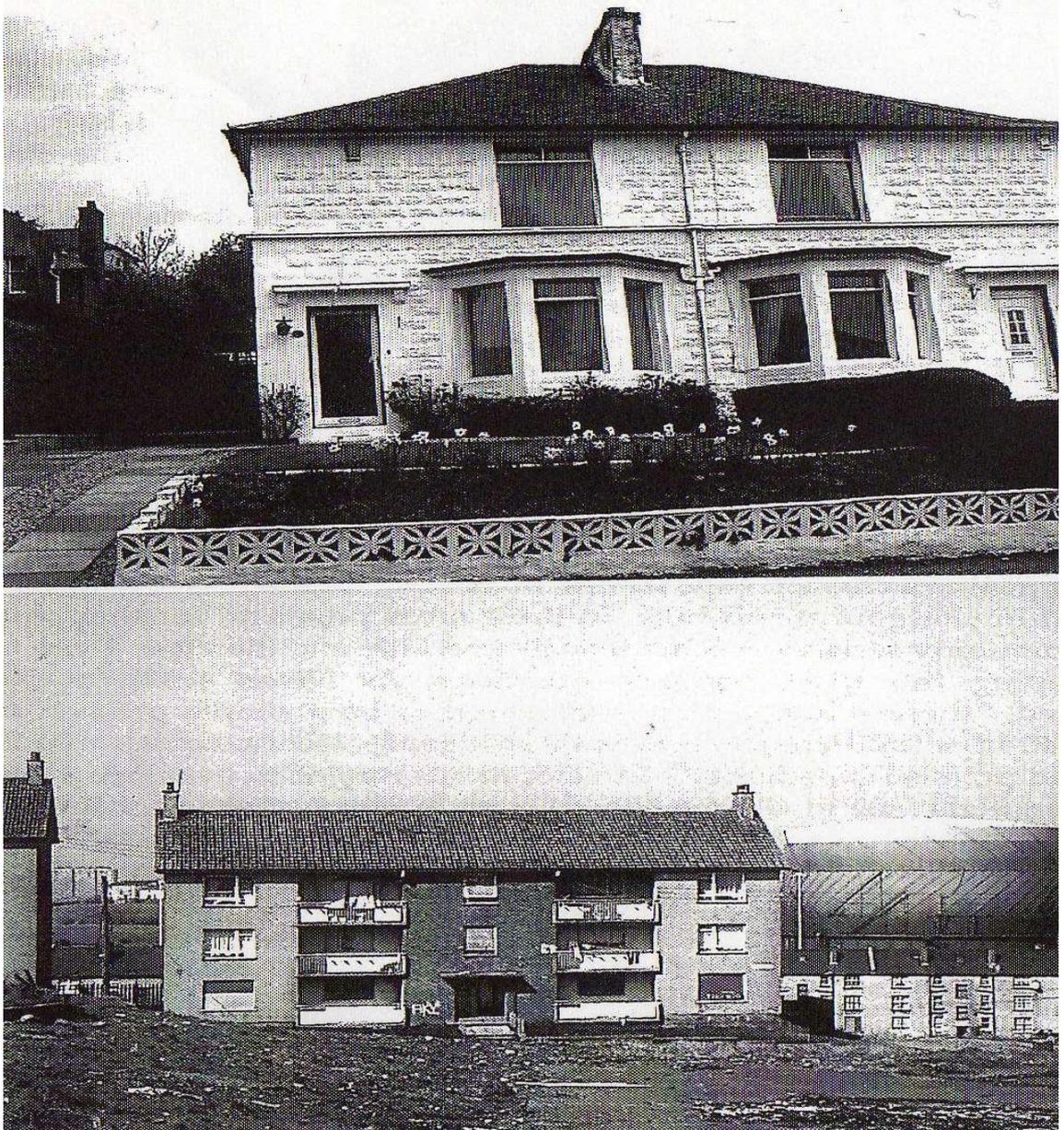
As previously noted, the housing campaigns resulted in the construction of three types of houses with different rent rates; 'ordinary' houses which were the most expensive, 'intermediate' houses which had slightly lower rates, and 'rehousing' homes – which were structurally poorer, cheaper and deliberately intended to rehouse those displaced as part of slum clearance programmes who could not afford the higher rents of 'ordinary' and 'intermediate' housing. The first of the interwar housing Acts, the 1919 Addison Act resulted in the building of 'ordinary' houses at Mosspark and Riddrie for example (Illustration 4.2). These superior homes were constructed with the reasoning that those who were financially able would move into these better estates, and free up their own homes for those enduring unsatisfactory housing standards due to the post-war shortage.⁵⁴⁰

⁵³⁸ A.M.T. Tully, 'A Study of the Conditions of Artisan Families in Glasgow', *GMJ*, 1 (1924), p. 2.

⁵³⁹ Devine, *Scottish Nation*, p. 347.

⁵⁴⁰ A. Ravetz, *Council Housing and Culture: The History of a Social Experiment* (London: Routledge, 2001), p. 77; D-AP 7/5, James Brand, 'Glasgow's Largest Housing Scheme' (paper read to the Institution of Civil Engineers, Glasgow Association of Students), 1923.

Illustration 4.2: Interwar council housing: Image of superior 'ordinary' home at Mossspark and 'rehousing' estate at Blackhill



SOURCE: Pacione, *Glasgow*, p. 160.

The high rents of 'ordinary' accommodation were often out with typical working class budgets – the result being that they benefited those higher up the social scale. In the Mossbank scheme for example, where rent was £28 per year, 16.2 per cent of tenants were professionals, 30.3 per cent were of 'intermediate class', 27.5 per cent 'skilled non-manual' and 18 per cent manual workers.⁵⁴¹ Indeed, one man recalled teachers living in 'high end' council houses with separate kitchenettes and gardens.⁵⁴² The less expensive 'intermediate' home, typically built under the 1924 Acts, also reinforced the discrepancy between housing and social position, Damer noting that the tenants of these homes were 'mainly skilled and semi-skilled manual workers, with a sprinkling of the unskilled.'⁵⁴³ Sanitary Inspectors throughout Glasgow repeatedly acknowledged that the rent rates of intermediate housing were too high for households with lower incomes and the MOH admitted that these homes had also failed to benefit those most in need.⁵⁴⁴ In 1929, there was a realisation that the relief of overcrowding was 'very unequal' and by 1938 it was still the case that 'some of these families [unable to pay for an intermediate or ordinary house] might have been able to pay for a new house in the "rehousing" category, but these houses are reserved for families removed from unfit houses and are not available for families from overcrowded fit houses.'⁵⁴⁵

The Acts of 1930 and 1935, primarily responsible for 'rehousing' estates, were tailored towards improving the living conditions of those lower down the social scale in overcrowded, structurally inferior housing, and in 1930 the MOH published that the housing legislation was 'one of the most important and valuable measures yet undertaken in the public health

⁵⁴¹ Pacione, *Glasgow*, pp. 158-59.

⁵⁴² *2000 Glasgow Lives*, Stan Gilmore (1929).

⁵⁴³ Damer, *From Moorepark to 'Wine Alley'*, p. 75.

⁵⁴⁴ *RSICD*, *RMOHG 1927*, p. 256; *RMOHG 1928*, p. 172.

⁵⁴⁵ *RMOHG 1929*, p. 193; *NAS*, DD6/267, Housing Progress in Glasgow: Glasgow Housing: Rents, Department of Health for Scotland, 25th January 1938.

interests of the poorer classes of the community.⁵⁴⁶ Tenants of slum clearance schemes were relocated to estates such as Blackhill and Moorepark⁵⁴⁷ (Illustration 4.2). Structurally, the home was better than slum dwellings and featured basic commodities such as extra rooms, a toilet and kitchen, and those transferred benefited to some extent. However, these homes were of a lower quality to the ordinary and intermediate types and eventually created a myriad of social problems themselves – to the extent that some have re-labelled them slums and akin to being sent to the poorhouse.⁵⁴⁸ Environmentally, rehousing schemes were also inferior. For example, an article published in the *GH* reported on a memorandum by the National Smoke Abatement Society which had been sent to all local authorities, ‘warning about the rapid degeneration of new housing estates as the result of atmospheric pollution.’⁵⁴⁹

For the most part, Damer agrees that ‘quite simply, these three categories of estates contained populations with quite different class characteristics’ and this was clearly reflected in the health statistics from these developments.⁵⁵⁰ For example, MOH Macgregor noted that ‘the houses in the intermediate schemes had a population of 13,500 and an infant mortality rate of 85 per 1,000 births.’⁵⁵¹ However, this figure was notably lower than that of the Hamiltonhill rehousing scheme (Table 4.5).⁵⁵²

⁵⁴⁶ *RMOHG 1930*, p. 228.

⁵⁴⁷ Not to be confused with Mossspark in which superior ‘Ordinary’ houses were built. See Damer, *From Moorepark to ‘Wine Alley’* for an extensive study on the social problems of this rehousing scheme.

⁵⁴⁸ Devine, *Scottish Nation*, p. 348; Smout, *Century*, p. 56; McKee also argues that for the unskilled workers rehoused to Govanhill, improvements were marginal and their new home ‘left them [only] slightly better off than the private tenants of neighbouring Polmadie’ (McKee, *Working Class Housing*, p. 115).

⁵⁴⁹ ‘Effect of Smoke on New Housing Estates’, *GH*, 18th December 1933, p. 12.

⁵⁵⁰ Damer, *From Moorepark to ‘Wine Alley’*, pp. 74-5; Macgregor, *Public Health*, p. 50.

⁵⁵¹ Macgregor, *Public Health*, p. 50.

⁵⁵² *Ibid.*, p. 50; *RMOHG 1933*, p. 148.

Table 4.5: Table showing the vital statistics of housing scheme Hamiltonhill compared to Glasgow as a whole

Years	Hamiltonhill Scheme						City		
	1928	1929	1930	1931	1932	1928-32 combined	1929-32 combined	1928-32 combined	1929-32 combined
Death rate per 1,000 population									
All causes	20.47	17.24	12.93	16.70	13.47	16.16	15.09	14.77	14.85
Pulmonary TB	1.35	0.81	1.08	1.35	0.54	1.02	0.94	0.87	0.87
Respiratory Disease	4.04	4.31	2.42	3.50	2.69	3.39	3.23	2.54	2.57
IMR	164	106	107	127	119	124	114	106	106
Birth rate per 1,000 population	32.87	35.56	32.87	29.63	29.36	32.06	31.86	21.17	21.04

SOURCE: *RMOHG 1933*, p. 152; The number of houses in Hamiltonhill was 728, population 8,712.

Another table published in the MOH's 1933 annual report illustrated significantly higher rates of pulmonary tuberculosis, respiratory disease and IMR in slum clearance areas compared to these rates (Appendix 4.1), and the MOH asserted that the 'rates [in this rehousing scheme] are definitely lower than the corresponding rates for the slum areas, but are slightly in excess of the general city rates', in an attempt to illustrate the gains which had been made.⁵⁵³ Nevertheless, interwar health experiences within local authority homes were overwhelmingly characterised by inequality. For instance, following an outbreak of diarrhoeal infections and a halt in the city's downward infant mortality rate in 1936, it was found that the 'investigation of rates in different areas shows that it is steeply graded throughout the various housing schemes from a low rate in Knightswood and similar districts, upwards through the intermediate and rehousing schemes to its highest rate in slum areas.'⁵⁵⁴ In short, as one contemporary observed, 'a survey of the rehousing schemes furnishes an endless variety of contrasts.'⁵⁵⁵ Therefore, even if we accept that new housing could benefit health, this was

⁵⁵³ *RMOHG 1933*, p. 148.

⁵⁵⁴ *RMOHG 1936*, p. 5; Macgregor, *Public Health*, p. 50.

⁵⁵⁵ *RMOHG 1935*, pp. 188-89.

experienced unevenly and housing standards helped shape inequalities in mortality trends according to social and financial position.

New Housing, Poorer Health?

Examining the housing situation in Glasgow and the success of interwar housing policy for public health is clearly complicated. It reveals that while general improvements were probably made for many of those relocating to local authority schemes, experiences were varied – notably in relation to gender and financial status. This is important as it undermines the extent to which it is useful to try and measure how far the housing policies were broadly successful (or unsuccessful) in terms of public health. What is clear is that health improved for some more than others. Experiences were diverse and unequal. This was the defining feature of housing-related health trends.

Indeed, it must also be kept in mind that not everyone got a house and a shortage of affordable housing for the city's working class prevailed.⁵⁵⁶ The breaking up of large houses in residential areas into one apartment homes discussed in chapter three is testament to this point. Moreover, a host of evidence suggests that providing better housing with more rooms did not always impact positively upon health. For some, health could actually *deteriorate* upon relocation to local authority housing, reinforcing the notion that experiences were varied. For example, it is significant that South Pollock, where 'rehousing' developments were constructed, became known as 'The White Man's Grave' due to the number of tuberculosis sufferers living

⁵⁵⁶ Also see McFarlane, 'Hospitals, Housing and Tuberculosis in Glasgow'.

there.⁵⁵⁷ Oral testimonies also revealed the concerns tenants had about tuberculosis in Corporation housing estates. One woman claimed: 'My brother-in-law died of TB in the house we moved to... Sugarhill in Govan they called it, and it was a TB scheme, every second house had TB then.'⁵⁵⁸

Another woman recalled:

I was only in mine two days when someone stopped me in the street to say 'Do you think you will like it here?' and I said, 'I'm sure I will', and she said, 'The old lady didn't because her daughter died of TB in that house'. I was only two days in with very young children at the time. I immediately sent out for the Health Board and they got the place fumigated. I felt a bit happier then.⁵⁵⁹

This perception may have been affected by the decision made by the Corporation in 1929 that up to 10 per cent of new houses should be allocated to families where a member was suffering from tuberculosis.⁵⁶⁰ Indeed, McFarlane has argued that the persistence of high levels of tuberculosis in Glasgow's new Corporation schemes was essentially because the disease was 'exported to the new housing estates from the old.'⁵⁶¹ Damer has also written that in rehousing estate Blackhill, the environmental pollution in the area meant that 'in the appropriate weather, the scheme was blanketed with malodorous fug. Then the very construction of the houses with concrete blocks has ensured that they are endemically damp' – an occurrence featured in the public press, remembered years later and scientifically proven to lead to respiratory disease.⁵⁶² As a result, in at least one instance a man

⁵⁵⁷ I. McLean, *The Legend of Red Clydeside* (Edinburgh: John Donald, 1983), p. 232 quoted in I. Paterson, 'Sectarianism and Municipal Housing Allocation in Glasgow', *Scottish Affairs*, 39 (2002).

⁵⁵⁸ Clark and Carnegie, *She Was Aye Working*, p. 169.

⁵⁵⁹ *Ibid.*, p. 169.

⁵⁶⁰ Jenkinson, *Scotland's Health*, p. 309; This policy was later extended in 1932 'to houses in rehousing schemes as they fall vacant, priority being given to families in which there is a tuberculosis case when arranging for the reletting of vacated houses' (*Evidence to be Submitted to Committee on Scottish Health Services re The Medical Services*, p. 37).

⁵⁶¹ McFarlane, 'Hospitals, Housing and Tuberculosis in Glasgow', p. 80.

⁵⁶² *2000 Glasgow Lives*, Hugh Docherty (1926) recalling being rehoused to somewhere in the Govan or Temple area; *2000 Glasgow Lives*, J.G. (1917); *2000 Glasgow Lives*, James Phillips (1917); Reference to C.J. Martin, D.S. Platt, S.M. Hunt, 'Housing Conditions and Ill Health', *BMJ*, 1987, p. 294, in S. Damer, *Last Exit to Blackhill: The Stigmatisation of a*

refused to pay the rent of his new home, and a doctor testified that the family living there had 'continued to suffer from illness, such as septic throats and swollen feet and ankles, commonly due to dampness.'⁵⁶³ Here, it was also said that 'despite a large amount of coal used to keep down the dampness it became pronounced, and recently the family had been crammed into one room.'⁵⁶⁴ Undoubtedly, similar challenges to health were experienced by many living in the slums. Nonetheless, it is clear that the movement into these schemes could have a negative impact upon physical condition and health perceptions, reinforcing the extent to which experiences were unequal.

The 'cramming' of tenants in one room also highlights the important point that overcrowding was not necessarily eradicated by the provision of more rooms. It has been indicated that because the number of rooms per house has been used as an index of social position, it is difficult to determine the extent to which health figures in relation to this were a reflection of inhabitants' economic status, or whether it was the small structure, and often overcrowded interior of the house itself, that undermined the health of its occupants. The poor condition of the house was often an *indirect* consequence of poverty, and only one of many related social variables impacting upon health.⁵⁶⁵ This became increasingly apparent following the transfer of Glasgow's 'slum dwellers' to Corporation rehousing estates and it was widely acknowledged that once relocated, many could not afford the health-enhancing commodities installed in their new homes. Complaints that electricity was too expensive were common and many could not afford fuel to operate gas fires. Even as late as the 1940s, one woman living in Glasgow

Glasgow Housing Scheme (Glasgow: University of Glasgow, Centre for Housing Research, 1992), p. 52.

⁵⁶³ 'Craigton Tenant Refuses to Pay Rent: Alleged Dampness of Corporation House: Entitled to Reduced Rent', *GP*, 16th April 1926, p. 3.

⁵⁶⁴ *Ibid.*, p. 3.

⁵⁶⁵ It will be demonstrated throughout this thesis for example, that poverty was related to a number of health affecting variables including the amount and type of food consumed and access to medical care; 'Housing and Health', *Medical Officer*, 1st May 1926, p. 181.

recalled sleeping in the kitchen – ‘it was the warmest place.’⁵⁶⁶ This had significant implications for health where the ‘slum habit’ of crowding together into one room for heat was reintroduced in new houses. In the new Springfield Road scheme the SI noted that ‘often the whole family sleeps in the living room, leaving the bedroom and occasionally the two bedrooms empty. On pointing this out, the tenants invariably complain that the rooms are too cold, because of the expense of gas fires.’⁵⁶⁷ The inspector of the Govanhill scheme similarly wrote that ‘many of the tenants complain that the electric heaters are too expensive. There is a tendency to crowd the family into one room for sleeping purposes.’⁵⁶⁸ Hence, providing homes which had a greater number of rooms did not always reduce overcrowding.

This was a common phenomenon and is frequently repeated throughout contemporary reports.⁵⁶⁹ One Glasgow medical investigation comparing conditions in slum and rehousing homes reiterated these observations, and acknowledged its implications for health and role in spreading respiratory disease. The investigators found that:

As regards sleeping accommodation, therefore, they showed serious overcrowding, although on the conventional basis of persons per available room there was only a fifth of the amount of overcrowding found in the slum. The author accordingly suggests that the standard of sleeping arrangements, rather than the cubic capacity of the

⁵⁶⁶ *2000 Glasgow Lives*, Gertrude Black (1921).

⁵⁶⁷ *RMOHG 1928*, p. 165.

⁵⁶⁸ *Ibid.*, p. 166.

⁵⁶⁹ *RSIED, RMOHG 1924*, p. 210; The practice of sleeping in one bed was also acknowledged by Hardy, *Health and Medicine*, p. 90; Thompson also mentions the sleeping arrangements of tuberculosis sufferers in interwar south Wales and that by 1939, ‘only 50 per cent of new cases had a bedroom to themselves’ (Thompson, *Unemployment*, p. 110); C. Hamilton, *Modern Scotland: As Seen by an Englishwoman* (London: J.M. Dent and Sons, 1937), pp. 37-8.

dwelling is the measure of environmental conditions that is important in relation to the spread of respiratory infection.⁵⁷⁰

Indeed this report also demonstrated that by this definition the situation in rehousing estates was not much improved:

Overcrowding in the two areas may be compared, first, on the conventional standard of more than three person per apartment (children counted as equal to adults), and then on the standard of sleeping arrangements i.e. more than three persons per bedroom. On the former standard, 43.4 per cent of the slum tenants were overcrowded compared with 8.5 of the rehoused people, while, on the latter standard, overcrowding in the slum was 42.8 per cent, and in the rehousing scheme was 35.3 per cent, i.e. on the basis of sleeping arrangements overcrowding was not much less in the new houses than the old.⁵⁷¹

However, despite acknowledging the affordability issue of Corporation homes, investigators continued to blame the rehoused 'slum dwellers' for their failure to make the most of their new environments. This report stated that while the cost of heating 'may have been the reason in some instances', many 'had not been sufficiently long in their new quarters to give up their former habits [and] in view of the finding in respect of 'bedroom' overcrowding, the influence of rehousing on the prevalence of disease spread by droplet infection can scarcely be looked for until the former slum habits have been eradicated.'⁵⁷² When commenting upon the 'shocking state of affairs' of housing in Glasgow one doctor also wrote that 'several factors are responsible for it: shortage of houses, poverty, economy, bad housing conditions, and a genuine love of the people for herding together for the sake of companionship.'⁵⁷³ Whilst the patronising tone of medical and housing

⁵⁷⁰ Smith, 'Housing Conditions and Respiratory Disease', pp. 3-4; Also cited in 'Housing Conditions and Respiratory Disease', *PH*, March 1934, p. 183.

⁵⁷¹ Smith, 'Housing Conditions and Respiratory Disease', p. 22.

⁵⁷² *Ibid.*, p. 22.

⁵⁷³ "'Intelligence and Disease": A Survey of Glasgow Children', *BMJ*, 30th January 1932, p. 206; 'Overcrowding and Moral Degeneration: Pigs and People', *GH*, 26th February 1926, p.

officials was often obvious, they may nevertheless have had a point. One informant stated of their improved housing conditions that 'it took a while before you got accustomed to it.'⁵⁷⁴ Molly Weir similarly recalled:

After our room and kitchen tenement house I had never seen so much space. Fancy having rooms devoted entirely to *sleeping?*... What a waste it seemed. Fancy a whole bed for each of us when we could easily have managed two in each bed. It would have been warmer too. I had always been used to the comfort of a warm body to coorie into in bed, and it seemed chill and strange to find only draughty spaces in front and behind me when I tried to go to sleep.⁵⁷⁵

In the context of public health this is crucial. Smout has claimed that the success of housing policy from 1919 can be 'seen in the reduction of overcrowding (as measured by the number of persons per room) by one quarter between 1921 and 1951'.⁵⁷⁶ However, this evidence clearly illustrates the importance of considering the reality behind the statistics, and challenges the simple conclusion that better housing equalled a healthier environment and better health. The investigators of this report also noted that 'the value of the work from this stand point of view, indeed, lies rather in the attention it draws to the difficulty of reaching reliable conclusions on the important question of the relation of housing to health.'⁵⁷⁷ Nonetheless, what it does show is that overcrowding was not necessarily reduced with the provision of more rooms as the census figures suggests, and it was what went on inside the house, as well as the house itself, which was important for health.⁵⁷⁸ People had to adapt and that took time – as well as being able to afford to fully utilise and benefit from their new houses.

10; Also see Hamilton, *Modern Scotland*, pp. 37-8; Highton, 'Working Class Housing in Scotland Today and Tomorrow', pp. 102, 103.

⁵⁷⁴ M74, Christina Wilson (1918).

⁵⁷⁵ Weir, *Best Foot Forward*, p. 15.

⁵⁷⁶ Smout, *Century*, p. 53.

⁵⁷⁷ Smith, 'Housing Conditions and Respiratory Disease', p. 3.

⁵⁷⁸ Thompson has also shown that in interwar south Wales, adopting an overcrowding standard of 'two or more families per house' reveals significantly higher levels compared to the census scale 'more than two persons per room' (Thompson, *Unemployment*, p. 111).

Also, for some, the cost of new Corporation housing and its impact on domestic budgets was more harmful for health than the slums themselves. A greater incidence of poor health in local authority housing estates compared to areas where slum housing predominated was often detected.⁵⁷⁹ Historians such as Seaman have acknowledged that 'rents were usually higher and fares to work cost more, so that the health of both mothers and children might decline in consequence of there being less money to spend on food.'⁵⁸⁰ This is a phenomenon frequently mentioned in the historiography on interwar health, regularly due to discussions on the observations of G.G.M. McGonigle (the Medical Officer of Health for Stockton-on-Tees) and J. Kirby. Nicholas explains that in attempting to 'prove scientifically the extent of undernourishment among the poor of Stockton' McGonigle and Kirby had tried to demonstrate that the unemployed who moved to these estates and 'had to pay higher rents, were likely to be under-fed if the breadwinner was unemployed,' and similar findings were found in other places including areas of London.⁵⁸¹

This survey clearly stimulated concern in Scotland as to whether the cost of local authority housing was affecting the nutrition of its inhabitants. At the inquiry of the Committee on Scottish Health Services health advisers were asked on at least three occasions whether rent rates were impacting upon food consumed and in at least one instance McGonigle was actually quoted.⁵⁸² Renowned Scottish nutritionist E.P. Cathcart similarly voiced his

⁵⁷⁹ *RMOHG 1933*, p. 87.

⁵⁸⁰ Seaman, *Life in Britain between the Wars*, p. 149.

⁵⁸¹ Nicholas, *Social Effects of Unemployment*, pp. 94-5; Stevenson, *The Slump*, pp. 49-50.

⁵⁸² *NAS*, HH76, Minutes of Evidence taken before the Committee on Scottish Health Services (Seventh Day), 9th February 1934, pp. 62-3. The following comments were made when McKinna was being examined: 'From her [Miss Michael] observations in going around, [she] does not seem to think that the people are suffering in any particular way from that.'; 'You know the result of the Stockton-on-Tees inquiry. We have no information of that kind?' Here McKinna denies the responsibility of his department to collect this information. When asked 'Do you not think that is one of the subjects on which the Department should endeavour to collect data? To this he replied 'our job has meant that all our activities have been directed towards erecting new houses', p. 75; Later Miss Michael is questioned on this subject and although she denies a conclusive relationship, defences are vague and by no means convincing, p. 87.

concerns stating, 'another difficulty arises when a family, without any rise in the family income, is transferred from a slum house to one in a new housing area. This change in many instances entails increased expenditure on, for example rent, fuel, transportation charges all at the cost of the money available for expenditure on food.'⁵⁸³ In answering to the Committee on Scottish Health Services, one inspector denied a link between high rent rates and the malnourishment of children, but admitted this could vary according to age in that 'some of the older people do suffer from lack of nutrition because they are so desperately anxious to pay their rent, but, generally speaking I cannot say there is much of that.'⁵⁸⁴ However, the MOH report of 1923 also quoted one elderly woman's protests at the Corporation 'turning her out of her "cosy wee hoose" and bringing her to a place where she was certain she would "starve to death with cold."⁵⁸⁵

Indeed, the conclusions of this well known report were actually repeated by the study in Glasgow which similarly compared the health of slum and rehoused inhabitants. This survey found that the incidence of respiratory disease was higher among the rehoused tenants compared to those from the slums, highlighting, in the authors opinion, 'a striking degree of similarity in the findings to those of Dr. McGonigle at Stockton-on-Tees which cannot be overlooked especially in view of the worsened financial position of the rehoused population.'⁵⁸⁶ The report also demonstrated that when 'employing the average number of days in bed as a measure of severity [of respiratory infection] the author works out for the slum area 2.104 days in bed per head, and for the superior rehousing area 2.425 days.'⁵⁸⁷ The reader was urged to exercise caution due to the existence of a foreign population in the slum region who benefited from better diets and lower levels

⁵⁸³ E.P. Cathcart and A.M.T. Murray, 'A Dietary Survey in Terms of the Actual Food Stuffs Consumed', *SRMRC*, 218 (1936), p. 54.

⁵⁸⁴ *NAS*, HH76-1-00057, p. 87 or p. 334.

⁵⁸⁵ *RMOHG 1923*, p. 147; This same story was also repeated in Macgregor's autobiography, *Public Health*, p. 52.

⁵⁸⁶ 'Housing Conditions and Respiratory Disease', *Lancet*, 10th February 1934, p. 304.

⁵⁸⁷ *Ibid.*, p. 304.

of unemployment. Nevertheless, a summary of the report published in the *BMJ* asserted that 'when these aliens, whose record of respiratory disease was for the reasons suggested low [better diet and employment rates] are deducted from the total, the days in bed for the slum inhabitants rise to 2.229, higher than the previous figure but still below that for the rehousing area.'⁵⁸⁸ Moreover, although the exact region is not stated, the *DHS* reported in 1929 that while the degree of complaint varied among different areas, one 'local authority have tenants who find it difficult to make ends meet [and] some are unable to provide sufficient nourishment for their families'.⁵⁸⁹ Another survey which encompassed Glasgow also commented that while the living conditions of new housing estates were 'much more satisfactory', the 'higher costs laid an additional burden on the young housewife and nullified some of the advantages.'⁵⁹⁰ Therefore, this suggests that relocation to local authority housing could be harmful, undermining the extent to which the building campaigns were successful in relation to public health.

However, it is important to be clear that public demand for Corporation housing was apparent. Butt notes for example that the Glasgow housing list was closed in 1933 with 80,000 names on it, and the *Daily Herald* reported that 4,000 applications for new homes were received in three days in 1934.⁵⁹¹ Thompson has noted that in south Wales 'the massive numbers of applications that councils received is evidence of the attraction that the new houses held for most families.'⁵⁹² It seems that this was also the case in Glasgow. This is difficult to reconcile with the negative view of local authority housing which can be deduced from the evidence detailed above. However, again, this experience was not universal and by disentangling the distinct

⁵⁸⁸ 'Housing and Respiratory Disease: A Glasgow Inquiry: Slum and Rehousing Areas Compared', *BMJ*, 10th March 1934, p. 432.

⁵⁸⁹ *ARDHS 1929*, p. 27; P.P. *Report of the Royal Commission on the Distribution of the Industrial Population*, HMSO, 1939-40 (6153), p. 71.

⁵⁹⁰ *Disinherited Youth*, p. 54.

⁵⁹¹ Butt, 'Working Class Housing in Glasgow', p. 165; *NAS*, DD6/325, '4,000 People ask City Department for Homes', *Daily Herald*, 8th August 1934.

⁵⁹² Thompson, *Unemployment*, p. 127.

health experiences within local authority housing estates, it is possible to clarify some of these contradictions. It is apparent that standards and experiences within rehousing homes strongly depended upon the ability to pay. For example, one report revealed that the initial enthusiasm for Corporation housing could wear off. In 1937, the SI of the South Western Division published details of a survey which had re-assessed 3,296 private houses which had been found to be 'seriously' overcrowded in the 1935 national survey. He found that 'of the tenants who were resident in the houses at both surveys, more than half had on at least one occasion made application for a Corporation house. An offer of such a house had been made in 376 cases but was refused.'⁵⁹³ Also, six per cent of these residents had at some point lived in a Corporation house. The 'main reason for leaving in the majority of cases was that the rents were too high.'⁵⁹⁴ Other reasons for departure or refusing a house when offered included 'unemployment, distance from place of employment, arrears of rent, and in some cases, that the houses had become too large for the needs of diminishing families.'⁵⁹⁵

This was understood by the national and local health authorities. At the inquest of the Committee on Scottish Health Services held in 1933-34 it was acknowledged that 'in the larger towns Edinburgh and Glasgow, these rehousing schemes obviously have to be some distance from the centre of the city, and complaint is made that, the people find it rather difficult to pay the rent plus the increased travel expenses.'⁵⁹⁶ This was also recalled years later where one Glasgow man claimed, 'people used to say it was a week's wages for travelling, you know, because you had further to come by bus.'⁵⁹⁷ The expense of living in new estates was commonly cited as a deterrent. There were also complaints that the estates were too far removed from

⁵⁹³ *RSISWD, RMOHG 1937*, p. 293; Also see Wordsall, *The Tenement*, p. 133.

⁵⁹⁴ *RSISWD, RMOHG 1937*, p. 293.

⁵⁹⁵ *Ibid.*, pp. 293-94.

⁵⁹⁶ *NAS, HH76, Minutes of Evidence taken before the Committee on Scottish Health Services (Seventh Day)*, 9th February 1934, pp. 88-9.

⁵⁹⁷ *Faley, Up Oor Close*, p. 170.

cheaper food stores and second hand shops – which for many Glaswegian women were vital to the management of household budgets and the maintenance of essentials within the home (see chapter 5).⁵⁹⁸ Most evidence suggests that the cost of Corporation housing was simply too high for a *proportion* of the Glaswegian working class and an additional strain on what was for many, already scarce resources.

It was particularly apparent that rehoused tenants who were unemployed, and families affected by the loss of work who chose to remain in Corporation housing, could often do so only at the expense of their health. The relationship between rents, diets and health discussed was notably significant for those experiencing unemployment. For example, in 1925 the SI of the Eastern Division noted that ‘in some cases the people are complaining of the rents being rather high, but there is an excuse for this as almost 60 per cent of the tenants are receiving parish relief or the “dole”’.⁵⁹⁹ In 1929 it was also observed that in rehousing estates ‘many are still unemployed, and find the rent a strain on their resources, but are *struggling* to pay rather than go back to their old surroundings [my italics].’⁶⁰⁰ In 1928 the Supervising Nurse Inspector to the new housing estates, Catherine Matheson, alluded that this was affecting the amount that could be spent on food:

The problems [existing in rehousing schemes] are social and economic. The tenants are mainly from the lower classes of the community, and as such have been brought up in sordid surroundings, and accustomed to constant hardship. They have left the sordid surroundings, but the hardships still continue. The majority are receiving parish relief or unemployment benefit. In relation to the present cost of living these reliefs are not enough to maintain even a

⁵⁹⁸ McKee, *Working Class Housing*, p. 40; *ARDHS 1929*, p. 29; This was not specific to Glasgow. See *Report of the Royal Commission on the Distribution of the Industrial Population*, p. 69.

⁵⁹⁹ *RSICD, RMOHG 1925*, p. 259.

⁶⁰⁰ *RMOHG 1929*, p. 211.

fair degree of comfort, keeping in mind the burdens that have to be borne. The people all say the rents are too high; rates, taxes, fuel and light have to be set aside, so that there is little left for food and clothing, quite apart from luxuries.⁶⁰¹

There is also evidence that this struggle to make ends meet was reflected in the health of rehoused children affected by unemployment. Many contemporaries commented upon the positive impact of rehousing upon the physical appearance of children. However, some headmasters used unemployment to explain the lack of improvement among those where progress was not pronounced. For example, the headmaster from Springfield Public School remarked that 'because both families [were] often receiving money, clothing and food aid from the same sources i.e. the Public Assistance Department, as a result there is little perceptible difference between the slum child and the other [rehoused] so far as clothing and nutrition are concerned.'⁶⁰² The MOH stated himself that 'where little improvement has been observed, this can be accounted for by the general economic depression.'⁶⁰³ Therefore, while evidence suggests that health could deteriorate upon removal to local authority estates, this did not affect the relocated population per se. The extent to which this was the case depended upon financial position *within* Corporation housing – a trait which reveals the extent to which interwar health experiences were diverse and dependent upon the employment status of the household.

On the other hand, many of the unemployed simply could not afford to live in new housing schemes and some of those who found themselves out of work soon moved out.⁶⁰⁴ As Macgregor wrote many years after his post as the MOH, 'the industrial depression and unemployment in the interwar years,

⁶⁰¹ *RMOHG 1928*, p. 162.

⁶⁰² *RMOHG 1930*, pp. 233-34.

⁶⁰³ *RMOHG 1931*, p. 158.

⁶⁰⁴ Indeed, one survey also found that 'unemployment at the time of offer' was the third main reason for refusing a corporation house when offered, rents too high and distance from place of employment being the top two reasons (*RSISWD, RMOHG*, p. 293). Also see the discussion above on the housing investigations of the SI of the South Western Division.

especially in the thirties, was a severe handicap. Some tenants lost heart and left the schemes for lower rented houses.⁶⁰⁵ These shifts have also been captured by oral testimony.⁶⁰⁶ One man recalled for example that 'if you were unemployed you had no chance.'⁶⁰⁷ Hutt also observed:

Craftsmen who at one time had a tolerable standard of living sink deeper and deeper as the months and years drag by; the trim clothes become shabbier and more and more threadbare, the collar and tie is abandoned; if they had been able to get decent housing accommodation that had to go too, and the family is driven into a noisome one-or-two room apartment in a Cowcaddens or Anderston slum.⁶⁰⁸

The early MOH Chalmers also calculated that twenty per cent of those living in inferior farmed out houses 'had fallen on evil days through idleness or illness.'⁶⁰⁹ That the unemployed shared unequally in the housing improvements of the era was widely acknowledged and commonly published.⁶¹⁰ Indeed Knox, who has highlighted the importance of housing to the public health achievements which were made, also argues that 'for those too poor to afford council rents, the slum was still the only option.'⁶¹¹ Unemployment affected not only the standard of housing which could be bought but also the living conditions within. Overcrowding was particularly pronounced among these households.⁶¹² For instance, an investigation in Glasgow in 1922 found that the housing conditions of the unemployed, irregular and short time workers had deteriorated since the preceding year

⁶⁰⁵ Macgregor, *Public Health*, p. 59.

⁶⁰⁶ *2000 Glasgow Lives*, Janet Gray (1917).

⁶⁰⁷ SOHCA/038/002 (1927). Respondent from neighbouring Rutherglen, but its close geographical proximity suggests that the experience was likely to be similar.

⁶⁰⁸ Hutt, *Condition*, p. 110.

⁶⁰⁹ A.K. Chalmers speaking before the Housing Commission, 'Slum Menace: Urgency of Glasgow Problem', *GH*, 11th January 1922, p. 14.

⁶¹⁰ For example, see *RMOHG 1927*, p. 188; *RMOHG 1930*, p. 11; Robbie, *Privileged Boyhood*, p. 20.

⁶¹¹ Knox, *Industrial Nation*, p. 193.

⁶¹² *RMOHG 1922*, p. 146.

and overcrowding had increased.⁶¹³ The correlation between unemployment and living standards was repeated in figures published by the SI of the Eastern Division of Glasgow in 1932, where of 14 per cent of ticketed houses found to be overcrowded, 'the extent of unemployment among those occupying the 396 overcrowded houses was almost 87 per cent.'⁶¹⁴ Overcrowding among the unemployed was also exacerbated by subletting which supplemented payments for rent.⁶¹⁵

Table 4.6: Table showing relationship between subletting and employment, South Western Division

Occupation	Householder		Second Family	
	Employed	Unemployed	Employed	Unemployed
Labourers (dock, shipyard)	154	147	24	53
Other occupations	173	103	21	36
	327	250	45	89

SOURCE: *RMOHG 1926*, p. 269.

The *UAB* noted that this practice was particularly prevalent in Glasgow, and table 4.6 suggests that the proportion of homes occupied by lodgers was considerably greater among those affected by unemployment. The SI of the South Western Division was also aware that 'these data show clearly enough the part which employment plays in the conditions described.'⁶¹⁶ Thus given the relationship between overcrowding, housing and physical condition it can be argued that Glasgow's unemployed endured a particularly inferior housing-related health experience in the interwar years.

⁶¹³ Tully and Urie, 'A Study of the Diets and Economic Conditions of Labouring-Class Families in Glasgow in June, 1922', pp. 360-61.

⁶¹⁴ *RSIED, RMOHG 1932*, p. 237.

⁶¹⁵ 'Scotland: Health in Glasgow', *BMJ*, 20th July 1929, p. 120.

⁶¹⁶ *RUAB 1935*, p. 274; *RSISWD, RMOHG 1926*, p. 269.

Conclusion

Historians discussing the interwar years in Britain have commented at length upon the housing conditions of the period and on the government's building strategy which aimed to address the post-war housing shortage. While writers like Stevenson and Knox have highlighted the improvements that were made others such as Damer, McFarlane and Butt have been more critical. That Glasgow's health profile was heavily influenced by its inferior housing situation is widely understood. This fact, recognised at the time, led to a number of ambitious housing campaigns aimed at improving the housing and health of the city's population. On the one hand, it is clear that local authority housing, structurally at least, provided an environment more conducive to health. The statistical evidence also reveals that on average, overcrowding was somewhat relieved. There is no doubt that improvements were made, and despite the persistence of high levels of overcrowding and unhealthy housing the city's experience offers support to the view that housing conditions substantially improved. However, this positive interpretation must be qualified by conclusive evidence of deteriorations in health among rehoused tenants, increasing levels of overcrowding at times throughout the period, and suggestions that local authority housing could also be insanitary, damp, associated with high levels of disease and an environment harmful to health.

Nevertheless, these seemingly contradictory interpretations can be explained by the wide range of experience across the population. Even if we accept the argument that rehousing had a beneficial impact upon health this was enjoyed unevenly throughout Glasgow. In terms of the health advantages gained from the structural superiority of housing developments, working class women experienced some improvement where the movement from unsafe, insanitary slum dwellings, where prolonged periods of time were

spent, was notably important for this group. Also, those of adequate financial means and 'middle class' status, were among the main beneficiaries of the new houses built. Housing developments accentuated the boundaries between the classes where the type of house afforded and the health benefits incurred clearly depended on social status and the financial position this entailed. On the other hand, rehousing did not always have a positive impact and could actually damage health in certain instances. The unemployed were clearly a disadvantaged group who shared unequally in the health improvements resulting from local authority housing, and essentially, they were a group to which a 'pessimist' interpretation could apply. Therefore, again, it seems that adopting a comparative interpretative framework can provide a more balanced understanding of public health experiences than attempts to evaluate the extent to which conditions improved. In interwar Glasgow inequalities characterised housing and health experiences. As such, it can be argued that identifying and underlining the distinct experiences among different sections of the population can provide a more precise picture of the impact of housing in shaping public health trends.

Chapter 5 Women, the Home and the Family

This paper does not contend that standards of adult health were unaffected by chronic unemployment and insecurity. Its main point is rather that such deprivation as undoubtedly existed did not affect adversely the life expectation of the infant and maternal population. Consequently, the infant and maternal survival rates of England and Wales and of Scotland were higher in 1939 than they had ever been before.⁶¹⁷

As historians have attempted to understand public health in the interwar period evaluations of the health of women is a recurring theme. As chapter one has outlined, the portrayal of their health in the interwar years is largely depressing, in that discussions for the most part, tend to examine the high maternal death rate of the era, and the indirect socio-economic effects of the recession upon this group. There is some debate among historians on the extent to which this was the case. According to writers like Whiteside, 'it seems probable that poverty took a worse toll on the health of wives and children than on workers themselves,' and Mitchell argues that 'a strong statistical relationship has emerged between chronic deprivation and the condition, if not the very survival, of many women and children in the 1930s.'⁶¹⁸ However, these views are in stark contrast to the statement asserted by Winter in the opening quote, and their comparison aptly captures the debate on public health in interwar Britain. However, there is widespread agreement that where the poverty resulting from unemployment had adverse effects, this was often more severe for women, particularly due to the unequal allocation of resources in the home which favoured male wage earners and other family members.⁶¹⁹ Thus, from the outset, this indicates

⁶¹⁷ Winter, 'Infant Mortality', p. 440.

⁶¹⁸ Whiteside, 'Counting the Cost', p. 242; Mitchell, 'The Effects of Unemployment', p. 112.

⁶¹⁹ Constantine, *Unemployment*, pp. 31, 34; Mitchell, 'The Effects of Unemployment', p. 111; Glynn and Booth, 'Introduction', p. 22; Whiteside, 'Counting the Cost', pp. 242, 244; Webster, 'Healthy or Hungry Thirties', p. 125; Gazeley, *Poverty in Britain*, p. 128; Crowther, *Social*

that health experiences were different for certain social groups varying according to gender, therefore endorsing the view advanced by this thesis that public health trends were diverse and unequal throughout the population.

This chapter engages with this theme of the historiography and aims to address how far 'gender' contributed to public health experiences in interwar Glasgow. Although often related, discussions in the literature tend to refer to the high levels of ill health found among women themselves and on their responsibility for securing the health of their families. This also explains why, for the most part, this chapter deals with the experiences of women, rather than gender per se. Firstly then, the health of women is analysed in isolation by considering sex-specific mortality rates including that for tuberculosis, crude and standardised death rates, life expectancy tables and details on maternal mortality and abortion. Here, an attempt is made to account for the health impacts of women's cultural role as carer and their biological one as child bearer. Hereafter, the role of women to health experiences within the family is considered, looking at their participation in ante-natal and child welfare programmes, their care of family members within the home and practice of domestic medicine, the effectiveness of the domestic strategies employed to make resources stretch, and the much less documented contribution of gender to male health experiences within this arena. However, throughout this chapter it will be shown that while health experiences in Glasgow could vary according to 'gender' this also interacted with other determinants including social class, marital status, and the employment position of the household. As such, the notion that health experiences were characterised by inequalities and divergences, rather than conclusive improvements or deteriorations, is further advanced.

Policy, p. 71; Burnett, *Idle Hands*, p. 254; Constantine, *Social Conditions*, pp. 40, 228; Jones, *Health and Society*, p. 73; R. Johnston and A. McIvor, 'Dangerous Work, Hard Men and Broken Bodies: Masculinity in the Clydeside Heavy Industries, c. 1930-1970', *Labour History Review*, 69 (2004), p. 138; Mowat, *Britain between the Wars*, p. 487; S. Rowbotham, *Hidden from History* (1973), p. 145, cited in Winter, 'Infant Mortality', p. 439; Thompson, 'Unemployment, Poverty and Women's Health', p. 117.

Women's Ill Health and Tuberculosis

A recurrent observation in the historiography on health in the interwar years is that the unequal allocation of resources in the home, aggravated by unemployment and the social effects of the Depression, impacted adversely upon the health of women. For example, writers like Thompson argue that the accompanying hardships of economic depression affected women due to the gendered distribution of resources in the home which favoured men.⁶²⁰ This is widely recognised and is often accepted by those writing more favourably of conditions in the interwar period (Chapter 1). While biological differences between men and women, including childbearing and the draining effect of menstruation on the body's nutrients, could render females more liable to a host of infectious diseases, most agree that culturally prescribed feminine responsibilities within the private sphere could create an additional challenge to maintaining an acceptable standard of health.⁶²¹ The unequal allocation of resources in the home has been well documented, and the practice of feeding family members at the expense of the mother reinforces the view that inequalities existed at the family level.⁶²² One man from Anderston recalled, for example, how his mother 'had to do a lot of doing without, after the First World War, fae 1918 up tae the Second World War started, we were all just young.'⁶²³ Similarly, when one woman was asked 'what was a good wife?' she replied:

⁶²⁰ Thompson, *Unemployment*, pp. 191, 210.

⁶²¹ *Ibid.*, pp. 200, 211.

⁶²² Thompson, *Unemployment*, pp. 84, 210; Finlay, *Modern Scotland*, p. 87; Hannington, *Distressed Areas*, p. 62.

⁶²³ *2000 Glasgow Lives*, Robert Young (1902).

One that attended – put her family first. Now am the last of ten and like that your mother would dish up tae the breadwinner, that's yer father, and the family and there wisnae much left fur her by the time she did that and she never grumbled. She was quite happy as long as everybody got. She seen that the man, the breadwinner, her husband, and the family got fed.⁶²⁴

While this was detailed repeatedly by interwar contemporary medics and others, it was not a universal experience.⁶²⁵ One working class woman from Cambuslang near Glasgow recalled that her mother 'ate well too, oh yes, she got what we got.'⁶²⁶ Nevertheless, it was accepted that this occurrence was widespread. The city's health authorities acknowledged that this was a regular feature of domestic life and they realised that the health and nutrition of mothers could be adversely affected as a result during harsh financial times.⁶²⁷ For instance, when commenting upon the provision of milk to mothers and children the Glasgow MOH stated in 1922 that 'the last thing to go should be the power of granting milk both to mothers and children, because of the tendency of the mother invariably to feed the child if she can, to her own detriment.'⁶²⁸

Thompson has commented upon the relationship between tuberculosis and the gendered distribution of resources, arguing that the high incidence of the disease prevailing among women of childbearing age in areas of south Wales could to some extent be explained by these dietary inequalities.⁶²⁹ Was this the case in interwar Glasgow? Firstly, it is important

⁶²⁴ SOHCA/009, Domestic Violence, Ms AN (1907).

⁶²⁵ NAS, HH76, Minutes of Evidence taken before the Committee on Scottish Health Services (Fourth Day), 19th January 1933, p. 5; Gladstone Robertson, *Gorbals Doctor*, p. 61; Also see Clark and Carnegie, *She Was Aye Working*, p. 106; *Strathkelvin Local Studies Project Oral Archive*, T0022, Mr. C interviewed by T. Barbour, 21st September 1983.

⁶²⁶ SOHCA, Stirling Women's Project, Mrs. H3.1 interviewed by K. Connal, 10th November 1987; 'I.C.F. Report on Malnutrition among Children', *GP*, 21st January 1938, p. 6.

⁶²⁷ C.A. Douglas and P.L. McKinlay, *Department of Health for Scotland: Report on Maternal Morbidity and Mortality in Scotland*, HMSO 1935, p. 19.

⁶²⁸ *RMOHG 1922*, p. 32.

⁶²⁹ Thompson, *Unemployment*, p. 210.

to note that other factors influenced susceptibility to this disease. The city's housing conditions during this era undoubtedly contributed to the high rates of tuberculosis in the region (see chapter 4). It was also noted that mothers were more likely to contract infectious ailments brought into the home when caring for family members, and when commenting on the distribution of diphtheria and membranous croup according to gender the Glasgow MOH reported that 'this disparity in the attack-rate of the sexes is true only of ages after 15, when females are much more heavily affected, probably due to the fact that their constant contact with children gives them more frequent opportunity of infection.'⁶³⁰

In addition, the extent to which women's domestic chores could weaken resistance to diseases like tuberculosis and impact upon health is often overlooked. Housework was a gruelling task for working class women in particular. It is interesting for example that physiotherapy pioneer Thomas McLurg Anderson filmed women carrying out domestic work such as ironing, as well as men performing manual work and sports, as a lecture resource for classes at the *Glasgow Physiotherapy School*. One film titled 'Housework with Ease: How to Avoid Cumulative Strain' is a clear indication of the perceived impact of this chore upon the body.⁶³¹ Domestic appliances such as vacuum cleaners were increasingly available, although it is difficult to estimate the extent to which these had made their way into Glasgow's working class homes before the war.⁶³² On the one hand, the SI of the Central Division complained in 1938 that a 'fault' of one rehousing scheme was 'their overindulgence in articles obtained by the higher-purchase system, such as electric vacuum cleaners and electric washing machines, the latter

⁶³⁰ *RMOHG 1920*, p. 63; Also see J.W.S. Blackwood (Pathologist: Royal Hospital for Sick Children, Glasgow), 'Tuberculosis in Infancy and Childhood', *BMJ*, 15th August 1936, p. 325; Also see *Evidence to be Submitted to Committee on Scottish Health Services re The Medical Services*, p. 34.

⁶³¹ *GGNHSBA*, HB94/12/4. Anderson practiced as a physiotherapist in Motherwell from the early 1920s to 1928, had a private practice in Glasgow from 1928-64 and was the principal of the Glasgow Physiotherapy Hospital and School from the 1930s to 1964.

⁶³² 'Health and Hygiene in the Home', *Medical Officer*, 10th September 1932, p. 116.

especially, seemingly superfluous, as each house has a perfectly good wash-boiler.⁶³³ On the other hand, Rountree estimates that in the late 1930s still less than half of homes in Govan at least were connected with electricity, and this was broadly reflective of the national rate.⁶³⁴ The harmful effect of 'women's work' upon their physical condition was captured by personal testimony.⁶³⁵ When recalling the intensity of daily household chores, one Glaswegian claimed that he believed his mother's death was a consequence of overwork: 'Oh she died of a whole complication of things... She died of hard work as so many women did.'⁶³⁶

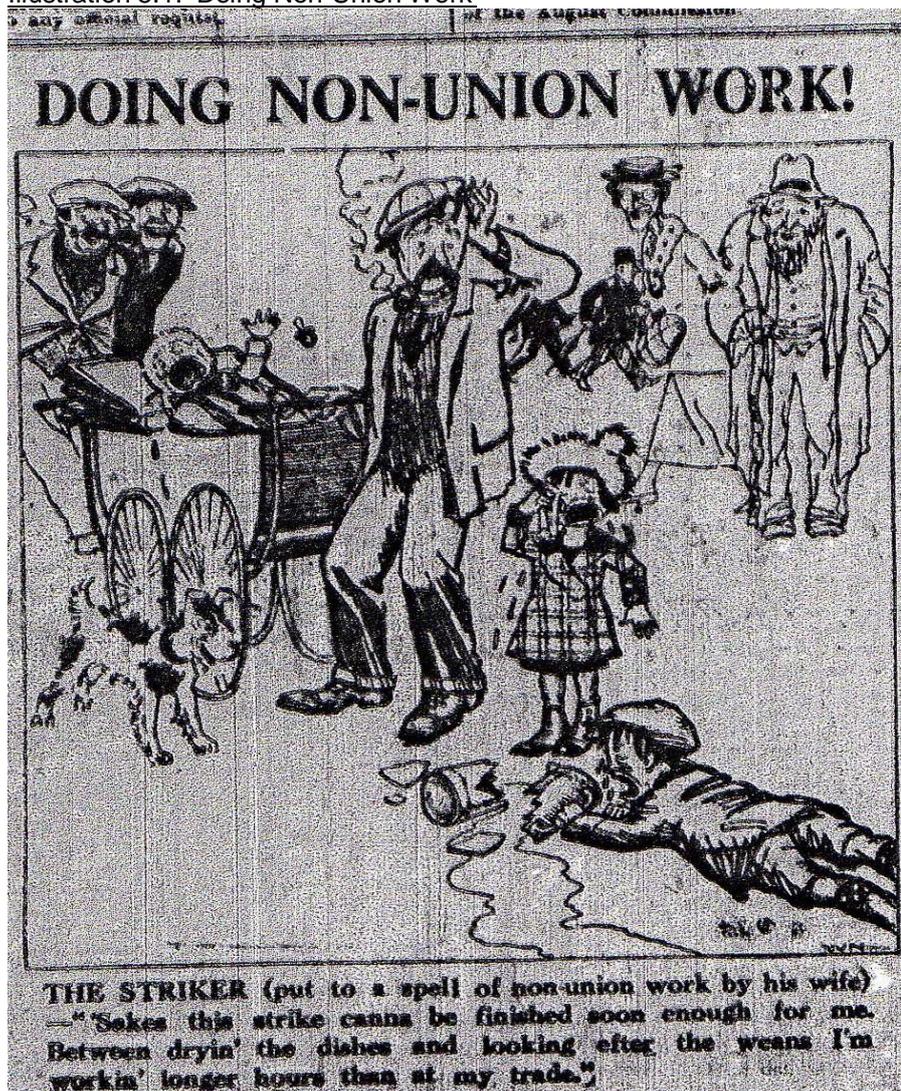
⁶³³ *RSICD, RMOHG 1938*, p. 235.

⁶³⁴ Rountree, *Govan*, p. 27; For national figures see P. Scott, 'Consumption, Consumer Credit and the Diffusion of Consumer Durables', in F. Carnevali and J.M. Strange, eds., *Twentieth Century Britain* (London: Longman, 2007), p. 169.

⁶³⁵ Rountree, *Govan*, p. 79.

⁶³⁶ Councillor Davidson (1909), Clark and Carnegie, *She Was Aye Working*, p. 13.

Illustration 5.1: 'Doing Non-Union Work'



SOURCE: *GH*, 8th May 1926, p. 4, caption reads 'THE STRIKER (put to a spell of non-union work by his wife) – “Sakes this strike canna be finished soon enough for me. Between dryin’ the dishes and looking efter the weans I’m workin’ longer hours than at my trade.”

Indeed, some held the view that housework was more arduous than manual work in the public sphere, and the *SBH* acknowledged that ‘the woman who is employed at home looking after her house and children had often much harder work in a worse environment than others who work out of doors or in factories (Illustration 5.1).⁶³⁷ Hence, a host of culturally imposed ‘feminine’

⁶³⁷ *ARSBH* 1928, pp. 165-66; Spring Rice, *Working Class Wives*, p. 92; Rountree, *Govan*, p. 170.

responsibilities could impact adversely upon health separate from the effects of nutritional inequality.

However, contemporaries often remarked upon the relationship between nutrition and tuberculosis.⁶³⁸ Thompson found that in areas of south Wales the rate of tuberculosis among females of childbearing age was greater in the 1930s compared to the 1920s – a rise which he suggests could be attributed to the economic situation of the times.⁶³⁹

Table 5.1: Tuberculosis mortality rates per 1,000 living for Glasgow as a whole, males (total), females (total), and males and females aged 15-44 years, 1921-25 and 1931-35⁶⁴⁰

	Female (Total)	Female (15-44)	Male (Total)	Male (15-44)	Total Population
1921	0.83 ⁶⁴¹ (0.87)	1.20 (1.25)	1.02 (1.06)	1.33 (1.38)	0.92 (0.96)
1922	0.79 (0.83)	1.18 (1.23)	1.10 (1.15)	1.49 (1.55)	0.95 (0.98)
1923	0.74 (0.77)	1.03 (1.08)	1.06 (1.11)	1.34 (1.40)	0.90 (0.93)
1924	0.84 (0.87)	1.24 (1.29)	0.93 (0.97)	1.26 (1.31)	0.89 (0.92)
1925	0.73 (0.76)	1.08 (1.13)	0.96 (1.00)	1.22 (1.27)	0.84 (0.87)
1921-25	0.79 (0.82)	1.15 (1.2)	1.02 (1.06)	1.33 (1.38)	0.90 (0.93)
1931	0.78	1.18	0.96	1.32	0.86
1932	0.78	1.23	1.02	1.35	0.89
1933	0.66	1.07	1.03	1.38	0.84
1934	0.69	1.04	0.92	1.19	0.80
1935	0.80	1.22	1.00	1.21	0.89
1931-35	0.74	1.15	0.98	1.29	0.86
Percentage decrease	6.3 (9.8)	0 (4.2)	3.9 (7.5)	3.0 (6.5)	4.4 (7.5)

SOURCE: RMOHG 1921-35; *Census Report, City of Glasgow, 1921 and 1931*.

⁶³⁸ Orr, *Food, Health and Income*, p. 44; J.L. Barona, 'Nutrition and Health: The International Context During the Interwar Crisis', *Social History of Medicine*, 21 (1), p. 89; 'Health of the People: Our Medical Correspondent: Tuberculosis', *GH*, 12th May 1922, p. 5; 'Tuberculosis: Failure of Sanatoria: Good Food and Housing as Preventatives', *GH*, 8th October 1920, p. 6; L. Bryder, 'Tuberculosis, Silicosis, and the Slate Industry in North Wales 1927-1939', in P. Weindling, ed., *The Social History of Occupational Health* (London: Croom-Healm, 1985), p. 109; A.S.M. Macgregor, 'Discussion on Administrative Requirements of the Various Types of Tuberculosis', *BMJ*, 26th August 1922, p. 368; E.P. Cathcart, 'Food and Nutrition', *BMJ*, 27th February 1937, p. 436; NAS, HH76, Minutes of Evidence taken before the Committee on Scottish Health Services (Fourth Day), 19th January 1933, p. 5.

⁶³⁹ Thompson, *Unemployment*, p. 210.

⁶⁴⁰ These figures start from 1921 and 1931 to ensure that population data is accurate following the publication of the census in 1921 and 1931 (see chapter 3 for explanation).

⁶⁴¹ These figures are based on the corrected population data published by Glasgow Corporation. The figures in brackets are based on the population data published in the 1921 census report (see chapter 3 for explanation).

The figures reveal that the death rate from tuberculosis among females of childbearing age (15-44) was notably greater than the rate for males, females and Glasgow as a whole (Table 5.1).⁶⁴² However, the death rate was higher for males aged 15-44 years than females of the same age.⁶⁴³ There are a number of possible explanations for this mortality pattern. For example, it is likely that the high tuberculosis rates recorded among men of working age may have been excessive due to occupational health hazards and inaccurate diagnosis. The polluted environment and nature of industrial work predominantly performed by men could have an adverse effect on the respiratory system.⁶⁴⁴ Johnston and Mclvor note that as a result, lung diseases like pneumoconiosis – a condition caused by the inhalation of dust particularly in the workplace – could be incorrectly diagnosed as tuberculosis before medical opinions on these conditions became more accurate.

In addition, employment in heavy industrial work could have an accumulative effect upon the lungs meaning men of this age were more vulnerable to lung and respiratory conditions. According to Mclvor and Johnston, ‘there may also have been a greater propensity to contract TB with respiratory organs damaged by pneumoconiosis’.⁶⁴⁵ Indeed, there was a recognised synergistic pathological relationship between tuberculosis and pneumoconiosis enshrined in statutory workmen’s compensation from 1925. Nonetheless, although the tuberculosis mortality rate was higher for males aged 15-44 years than for females, the mortality rate among women of this age group in Glasgow did not significantly improve. The percentage decrease of deaths was noticeably lower for females of childbearing age (15-44), even if the overall rate remained higher for men. Based on the corrected

⁶⁴² Except in 1923 when the rate for males (total) was slightly higher.

⁶⁴³ Except in 1935 when the rate for females aged 15-44 was slightly higher.

⁶⁴⁴ The census reports reveal that the greatest proportion of male workers were ‘metal workers’ in 1921 (28.4 per cent) and in 1931 (18.5 per cent) whereas the majority of women worked in ‘personal service occupations’ (18.9 per cent) in 1921 and as ‘clerks’ (including civil service and local authority) in 1931 (23.6 per cent). (Census Report, City of Glasgow, 1921, p. 48; Census Report, City of Glasgow, 1931, p. 47).

⁶⁴⁵ A. Mclvor and R. Johnston, *Miners’ Lung: A History of Dust Disease in British Coal Mining* (Hampshire: Aldershot, 2007), p. 277.

population figures published by Glasgow Corporation, the rate of tuberculosis among this age group failed to improve, compared to a reduction of 6.3 per cent for the female population as a whole, 3.9 per cent for the male population as a whole, 3.0 per cent for males aged 15-44 and 4.4 per cent for the Glasgow population as a whole (Table 5.1).⁶⁴⁶ Therefore, when presenting the data in this way, these figures tentatively suggest that Glasgow women of childbearing age did not share equally in the general improvement which occurred and that they experienced a relative deterioration in health.

However, Thompson highlights the value of disaggregating the tuberculosis death rate according to age and sex to understand the mortality pattern of this disease.⁶⁴⁷ When doing this for Glasgow some interesting trends emerge.

Table 5.2: Age-sex specific tuberculosis mortality rates for age groups 15-19, 20-24, 25-34 and 35-44 years, Glasgow 1921-25 and 1931-35

Age	15-19		20-24		25-34		35-44	
	Male	Female	Male	Female	Male	Female	Male	Female
1921	1.18 ⁶⁴⁸ (1.23)	1.16 (1.21)	1.27 (1.32)	1.12 (1.17)	1.39 (1.44)	1.34 (1.39)	1.40 (1.45)	1.12 (1.16)
1922	0.75 (0.78)	1.11 (1.15)	1.38 (1.43)	1.31 (1.36)	1.63 (1.69)	1.22 (1.26)	1.93 (2.01)	1.10 (1.15)
1923	0.91 (0.95)	1.01 (1.05)	1.60 (1.66)	1.10 (1.15)	1.27 (1.33)	1.05 (1.09)	1.57 (1.63)	0.98 (1.02)
1924	0.68 (0.70)	1.22 (1.27)	1.66 (1.73)	1.33 (1.38)	1.16 (1.21)	1.42 (1.47)	1.52 (1.58)	0.97 (1.01)
1925	0.77 (0.80)	1.20 (1.25)	1.42 (1.48)	1.18 (1.22)	1.16 (1.21)	1.14 (1.18)	1.49 (1.55)	0.86 (0.90)
1921-25	0.86 (0.89)	1.14 (1.19)	1.47 (1.52)	1.21 (1.26)	1.32 (1.38)	1.23 (1.28)	1.58 (1.64)	1.01 (1.05)
1931	1.08	1.31	1.43	1.69	1.23	1.07	1.52	0.89
1932	1.02	1.56	1.28	1.54	1.36	1.32	1.64	0.69
1933	1.08	1.18	1.22	1.48	1.43	1.06	1.65	0.72
1934	0.60	1.00	1.26	1.44	1.27	1.07	1.49	0.76
1935	0.71	1.49	1.31	1.69	1.33	1.14	1.37	0.80
1931-35	0.90	1.31	1.30	1.57	1.32	1.13	1.53	0.77
Perc. inc/dec	+4.7 (+1.1)	+14.9 (+10.1)	-11.6 (-14.5)	+29.8 (+24.6)	0.00 (-4.4)	-8.1 (-11.7)	-3.2 (-6.7)	-23.8 (26.7)

SOURCE: RMOHG 1921-35; *Census Report, City of Glasgow, 1921 and 1931*.

⁶⁴⁶ The rates based on the 1921 census report population data follow a similar trend.

⁶⁴⁷ Thompson, *Unemployment*, p. 207.

⁶⁴⁸ These figures are based on the corrected population data published by Glasgow Corporation. The figures in brackets are based on the population data published in the 1921 census report (see chapter 3 for explanation).

These figures clearly reveal diverging health trends according to age among Glasgow's women. In terms of mortality from tuberculosis, the position of young adult females aged 15-24 worsened, particularly for females aged 20-24, increasing significantly between 1921-25 and 1931-35. On the other hand, the rates among women aged 25-44 years notably improved (Table 5.2).⁶⁴⁹ The highest percentage of married women in Glasgow were found in the 40-45 age group in 1921 (72.6) and 1931 (71.9).⁶⁵⁰ Furthermore, the average age of marriage for Glaswegian females was 26.9 and 26.5 in 1921 and 1931 respectively, undermining the extent to which nutritional deprivation and the gendered distribution of household provisions was reflected by the city's tuberculosis mortality pattern.⁶⁵¹

This does not mean, however, that women were unaffected by the unequal allocation of resources within the home. Indeed, Webster and Thompson also claim that the impact of the feminine domestic role not only affected married women and mothers but young females per se.⁶⁵² This was acknowledged by the MOH who, when discussing the change in the age distribution of pulmonary tuberculosis in the east end of Glasgow, wrote in 1926:

During the 1910-14 period the incidence [of pulmonary tuberculosis among females] is lower under 10 years – 0.59 from 0-5 and 0.45 from 6-10. In the next age group, 11-15, the higher susceptibility of the female become apparent, the rate rising to 1.01, compared with 0.49 in the male of similar years. This higher susceptibility is usually ascribed to the developmental changes occurring at this period, but in industrial areas it is found that the girl on coming home from school

⁶⁴⁹ This was different to Merthyr in south Wales where Thompson found that the rate among women aged 15-24 and 25-44 increased (Thompson, *Unemployment*, p. 210).

⁶⁵⁰ This age profile was also true for men (Census Report, City of Glasgow 1921, p. 46; Census Report, City of Glasgow 1931, p. 46).

⁶⁵¹ Figures provided by Demography Division, National Records of Scotland.

⁶⁵² Webster, 'Health, Welfare and Unemployment', p. 212; Thompson, *Unemployment*, p. 85; Thompson, 'Unemployment, Poverty and Women's Health', p. 102; Jones, *Health and Society*, p. 62.

has usually to undertake numerous domestic duties, while her more fortunate brother is playing games in the street.⁶⁵³

Oral testimonies reveal that children were heavily involved in household chores. However, it is important to note that often fathers but not sons were exempt, and the participation in the Friday night ritual of house cleaning was recalled by women discussing their brother's allocated jobs, and also by men themselves.⁶⁵⁴ The statement by the MOH regarding tuberculosis also refers to figures from an earlier time period, but figures from the 1920s reflect a similar trend (Table 5.3).

Table 5.3: Tuberculosis mortality rates in Glasgow for males and females aged 0-14 years, 1921-25 and 1931-35

	0-4 years		5-9 years		10-14 years	
	Male	Female	Male	Female	Male	Female
1921	0.3 ⁶⁵⁵ (0.33)	0.29 (0.30)	0.27 (0.28)	0.21 (0.22)	0.26 (0.28)	0.32 (0.34)
1922	0.28 (0.29)	0.36 (0.38)	0.12 (0.12)	0.13 (0.14)	0.21 (0.22)	0.42 (0.43)
1923	0.34 (0.35)	0.25 (0.26)	0.15 (0.16)	0.21 (0.22)	0.19 (0.20)	0.42 (0.43)
1924	0.34 (0.35)	0.21 (0.22)	0.08 (0.08)	0.17 (0.18)	0.15 (0.16)	0.49 (0.51)
1925	0.28 (0.29)	0.19 (0.20)	0.08 (0.08)	0.10 (0.10)	0.15 (0.16)	0.51 (0.53)
1921-25	0.31 (0.32)	0.26 (0.27)	0.14 (0.14)	0.16 (0.17)	0.19 (0.20)	0.43 (0.45)
1931	0.14	0.37	0.11	0.17	0.04	0.32
1932	0.30	0.28	0.10	0.10	0.21	0.42
1933	0.16	0.14	0.13	0.06	0.17	0.30
1934	0.14	0.20	0.02	0.06	0.17	0.36
1935	0.16	0.37	0.13	0.15	0.19	0.34
1931-35	0.18	0.27	0.10	0.11	0.16	0.35

SOURCE: *RMOHG 1921-1935*.⁶⁵⁶

⁶⁵³ *RMOHG 1926*, pp. 139-40; Also see Wilson, 'Pulmonary Tuberculosis in the Eastern District of Glasgow', pp. 29-30.

⁶⁵⁴ A. McGuckin, 'Moving Stories: Working Class Women', in E. Breitenbach and E. Gordon, eds., *Out of Bounds: Women in Scottish Society 1800-1945* (Edinburgh: Edinburgh University Press, 1992), p. 211; SOHCA/009, Domestic Violence, Ms AR (1909), Ms AA (1907), Ms AS (1907), Ms AJ (unknown); *2000 Glasgow Lives*, Helen Conroy (1918); For details of male participation see Faley, *Up Oor Close*, pp. 55-7; Robbie, *Privileged Boyhood*, p. 180.

⁶⁵⁵ Based on the corrected population data published by Glasgow Corporation. Figures in brackets are based on the rates published in the 1921 census report.

⁶⁵⁶ These figures have been calculated using the age-sex specific population data produced by Glasgow Corporation in 1921, in the census reports of 1921 and 1931, and age-sex specific data on pulmonary tuberculosis published in the *RMOHG* appendices section.

Table 5.3 shows that tuberculosis mortality rates for 1921-25 and 1931-35 were higher for girls of all ages (apart from in 1921-25 when that for boys aged 0-4 years was higher), particularly in the 10-14 year age group, and we have seen that the rate increased significantly for females aged 15-24 years (Table 5.2). Commenting in 1934 on the fact that 18 per cent of male deaths from the disease occurred in the 15-25 years bracket compared to 32 per cent for females, the MOH wrote that although 'this feature of post-war tuberculosis is generally attributed to the increase in the number of women engaged in industrial employment' this was a 'doubtful explanation.'⁶⁵⁷ While it is clear that census data omits the 'hidden' female workforce engaged in community employment such as child minding and laundry, the recorded percentage of working women registered by the census increased only slightly from 28.1 per cent to 29.1 per cent between 1921 and 1931, and the percentage of women working in 'industrial occupations' like metal work did not noticeably increase.⁶⁵⁸ Rather, a proportional increase was recorded among jobs in personal service and commercial occupations reflecting the changing nature of the economy. It therefore seems reasonable that the higher incidence of pulmonary tuberculosis among young women was not significantly affected by their engagement in industrial employment.

Hardy notes that the causes of tuberculosis 'whether by activation of existing infection or by re-infection, are known to include personal domestic hygiene, diet, overcrowding, occupational exposure to infection, environmental exposure to agents liable to cause lung damage, and the effects of previous infectious-disease episodes.'⁶⁵⁹ It is therefore impossible from this data to state with confidence the most significant determinant of this mortality trend. However, the MOH for Glasgow claimed that the pulmonary tuberculosis discrepancy for young adult females was probably affected by

⁶⁵⁷ *RMOHG 1934*, p. 48.

⁶⁵⁸ Census Report, City of Glasgow 1921, p. x, 48; Census Report, City of Glasgow 1931, p. 47; Unfortunately age-specific data on the number and/or percentage of working women in Glasgow was not included in the census reports.

⁶⁵⁹ Hardy, *Epidemic Streets*, p. 213.

the 'economic stringency on the nutrition of the female adolescent when she is undergoing the strain of sexual and physical development,' suggesting that girls were affected by the unequal provision of resources within the home.⁶⁶⁰ On the complicated etiology of tuberculosis Hardy points out that it is 'extremely difficult to disentangle the significance of nutritional status from other, especially related social, factors which can contribute to the disease', that 'where the relationship between poor diet and the development of infection are concerned, "beyond broad correlations the mechanisms are little understood"', and 'any explanation of the behaviour of phthisis which hinge on nutritional status should be treated with caution.'⁶⁶¹ The evidence from Glasgow does show that young women were one group of the population who experienced lapses in health during the interwar years in relation to tuberculosis mortality at least. However, this analysis clearly demonstrates the value of disentangling the statistics to highlight *diverging* health trends in order to provide a more accurate understanding of health in this period. Even when taking a group of the population where there is relative agreement that health could be worse, this shows that experiences were diverse and contradictory and sex-specific mortality data can also be presented to endorse contrasting interpretations. This is also evident upon consideration of the crude and standardised death rates and life expectancy charts for the city. It is to these health indices we now turn.

⁶⁶⁰ 'Annotation: Report of the Medical Officer of Health for Glasgow 1934', *GMJ*, 124 (1935), pp. 283-4.

⁶⁶¹ Although she does recognise that 'tuberculosis is one of the few communicable diseases whose association with nutrition continues to be considered positive, if obscure' (Hardy, *Epidemic Streets*, pp. 249-50, 282).

Death Rates and Life Expectancy

Contemporaries of interwar Glasgow and Scotland regularly asserted statements to the effect that ‘the mother, in fact, has not shared equally with her child in the benefits arising from the improvement of public health.’⁶⁶² In Glasgow, the MOH tellingly stated in 1923 that ‘all are agreed that there is marked ill health among mothers, worse than former years,’ and in 1934 the Scottish authorities reiterated that ‘such signs of [malnourishment] as can be detected affect rather the mothers of the families’.⁶⁶³ Glasgow in the period between the two World Wars experienced sharp increases in the incidence of unemployment and poverty, and the city is widely regarded as an area where the social effects of the recession were severe. Thus, it is perhaps unsurprising that evidence of the impact of the economic vicissitudes of the era were traced to the city’s women. However, an important problem with this argument is that the life expectancy of females continued to exceed that of males – as is the case today – and the discrepancy did not narrow in the period under review. If anything, the gap slightly increased (Table 5.4).

⁶⁶² ‘Public Health in 1931’, *GH*, 12th September 1932, p. 11.

⁶⁶³ *RMOHG 1923*, p. 44; *ARDHS 1934*, p. 20.

Table 5.4: Variations in expectation of life for males and females at several ages for 1920-22 and 1930-32 in Glasgow

Age	1920-22			1930-32		
	Male	Female	Difference	Male	Female	Difference
0	48.41	52.22	-3.81	51.3	55.2	-3.9
1	54.25	56.92	-2.67	57.1	59.8	-2.7
2	55.95	58.34	-2.39	58.2	60.8	-2.6
3	55.95	58.36	-2.41	58	60.5	-2.5
4	55.44	57.86	-2.42	57.3	60	-2.7
5	54.77	57.23	-2.46	56.6	59.2	-2.6
10	50.81	53.19	-2.38	52.5	55	-2.5
15	46.38	48.76	-2.38	48.1	50.6	-2.5
25	38.03	40.42	-2.39	39.6	42.2	-2.6
35	29.92	32.5	-2.58	31.2	33.9	-2.7
45	22.24	24.8	-2.56	23.4	25.8	-2.4
55	15.27	17.47	-2.2	16.2	18.1	-1.9
65	9.57	11.31	-1.74	10	11.6	-1.6
75	5.5	6.48	-0.98	5.7	6.5	-0.8

SOURCE: *Evidence to be Submitted to Committee on Scottish Health Services re The Medical Services*, p. 154.

The expectation of life for females at birth, and throughout their lifetimes, was higher than that of males. This disparity is also reflected in sex-specific mortality data. According to Thompson, the crude death rate (CDR) in most developed, modern societies is generally lower for women than males at all ages.⁶⁶⁴ For the most part this also applied in Glasgow. Although it is noticeable that the age-specific death rate was sometimes greater for female adolescents and women of childbearing age, this demonstrated no real consistency (Appendix 5.1).⁶⁶⁵ Therefore as expected the total CDR was consistently higher among men throughout the period (Table 5.5).

⁶⁶⁴ Thompson, *Unemployment*, p. 191; It was also noted by the early Glasgow MOH A.K. Chalmers that 'at "all ages" and, for most periods, the [death] rate for males exceeds that for females' (Chalmers, *The Health of Glasgow*, p. 65).

⁶⁶⁵ These figures are calculated from 1921-25 and 1931-35 because the census reports were published in 1921 and 1931 and this reflects the most accurate population data.

Table 5.5: Crude (CDR) and standardised (SDR) death rates per 1,000 for males and females, 1921-25 and 1931-35

	Male CDR	Female CDR	Male SDR	Female SDR
1921	15.6 ⁶⁶⁶ (16.2)	13.6 (14.1)	17.1 (17.7)	15.4 (16.0)
1922	17.6 (18.3)	15.7 (16.3)	18.9 (19.6)	17.5 (18.2)
1923	14.6 (15.2)	13.1 (13.6)	16.3 (16.9)	15.3 (15.9)
1924	16.5 (17.1)	14.9 (15.5)	18.1 (18.8)	17.2 (17.9)
1925	15.1 (15.7)	13.4 (14.0)	17.1 (17.7)	15.8 (16.4)
1921-25	15.9 (16.5)	14.1 (14.7)	17.5 (18.1)	16.2 (16.9)
1931	15.4	13.2	15.7	14.2
1932	15.7	13.9	16.1	14.9
1933	14.9	12.3	15.5	13.4
1934	15.3	12.8	15.7	13.8
1935	15.4	13.2	16.1	14.5
1931-35	15.3	13.1	15.8	14.2
Percentage Decrease	3.8 (7.3)	7.1 (10.9)	9.7 (12.7)	12.3 (16.0)

SOURCE: RMOHG 1921-35.

The poorer health of women during the interwar period is widely recognised and one might have expected this to be reflected in the mortality rate for the city. These tables fail to support this view and instead suggest that the mortality disparity between men and women widened. Table 5.5 reveals that the reduction in the CDR was greater for females than males. The crude mortality rate does fail to account for changes in the age-sex composition of the population. However, when the rate is standardised by the direct method to somewhat account for this, the notion that women's health improved at a faster rate than men's is maintained, where the standardised death rate (SDR) for males fell by 9.7 per cent compared to 12.3 per cent for females (Table 5.5).⁶⁶⁷ Hence, this evidence points to improvements in the health of women that exceeded that of males. This high level analysis seems to challenge the view that the health of Glasgow women was adversely affected by the recession.

⁶⁶⁶ Based on the corrected population data published by Glasgow Corporation. Figures in brackets are based on the rates published in the 1921 census report.

⁶⁶⁷ Or 12.7 and 16.0 based on the 1921 census population data.

To explain the mortality gap between men and women writers like Sherry have claimed that for twentieth century men, 'violent death remained significant, fewer domestic or workplace accidents partly offset by road traffic casualties. Such features help to explain lower longevity in men despite women enduring the rigours of childbirth, lesser shares in family diets, greater exposure to contagion through nursing the sick and defective domestic environments.'⁶⁶⁸ Still, the optimistic interpretation which can be derived from CDR, SDR and life expectancy data is at odds with many statements asserting a greater amount of ill health among women, and again it is evident that perspectives are essentially dependent upon the kind of mortality data considered and how this is read and analysed. Indeed, one issue with mortality data is that lowering health standards may not have been so severe to result in death, meaning that they can fail to reflect deteriorations.⁶⁶⁹ The difficulty of assessing women's health was also expressed by Janet Campbell who in the introduction to the much cited contemporary publication *Working Class Wives* wrote:⁶⁷⁰

It is one thing however, to be certain in one's own mind that this problem of ill health exists, and quite another to prove it statistically or measure its magnitude with any exactness. Precise data could only be obtained by painstaking and continued medical observation of large numbers of women over long periods, and this is unhappily impracticable.⁶⁷¹

⁶⁶⁸ Cherry, *Medical Services and the Hospitals in Britain*, p. 13.

⁶⁶⁹ Crowther has similarly remarked that 'malnutrition did not necessarily kill, but it seriously debilitated many people' (Crowther, *Social Policy*, p. 71); E.P. Cathcart also commented that death rates 'reflect only mortality' and that 'all those who have eyes can vouch for the fact that too many of our people fall far short of the physical ideal' (E.P. Cathcart, 'Health Policy of the Future', *Proceedings of the Royal Philosophical Society of Glasgow*, 63, 135th and 136th sessions 1936-37 and 1937-38 (Glasgow: The Society, 1938), pp. 37, 44); Minutes of Evidence taken before the Committee on Scottish Health Services (Fourth Day), 19th January 1933, p. 49.

⁶⁷⁰ Dame Janet Campbell (1877-1954) worked as Senior Medical Officer for Maternity and Child Welfare at the Ministry of Health and Chief Woman Adviser to the Board of Education ('Dame Janet Mary Campbell', *Oxford Dictionary of National Biography*, viewed 10th September 2009). She also set up the Women's Health Inquiry Committee (Laybourn, *Britain on the Breadline*, p. 61).

⁶⁷¹ Spring Rice, *Working Class Wives*, p. xvii.

Indeed, many women were themselves apparently unaware that they were physically unsound. When reporting to the Committee on Scottish Health services a Glasgow doctor asserted that some fifty per cent of women attending her clinic for advice on birth control suffered some physical disorder of which they were unaware, stating that 'they often had one or more symptom due to the disorders but they regarded such symptoms as a necessary consequence of childbirth or of being a woman.'⁶⁷² A later Scottish study (the General Household Survey) conducted in the mid 1970s found that despite higher levels of mortality and illness in Scotland than England, as reflected by health statistics, rates of 'self-reported' sickness were lower north of the border. Hubley suggests that 'an explanation may be that the people of Scotland have come to take their worse state of health for granted.'⁶⁷³ A similar interpretation could apply to the health experiences of Glaswegian women in the interwar period. As indicated in chapter three, this also highlights the importance of personal perceptions of illness and the value of considering how people understood their own ill health when examining public health trends. This analysis of mortality and life expectancy has further emphasised the complexity of attempts to analyse the extent to which health improved or deteriorated and the diverse interpretations which can be deduced from different health data. However, within the historiography there is little disputing that the number of women dying in childbirth represented a particularly challenging situation for interwar public health officials. Analysing maternal mortality data provides an additional measure for understanding the health experiences of women.

⁶⁷² Minutes of Evidence taken before the Committee on Scottish Health Services (Fourth Day), 19th January 1933, p. 20; This is not specific to Glasgow. Spring Rice also claimed that working class wives did not exaggerate their ill health, many being unaware of it (Spring Rice, *Working Class Wives*, p. 29); 'They [women] still accept illness and discomfort as a natural accompaniment and ill-health as the natural sequel' ('Puerperal Fever and Maternal Mortality', *Medical Officer*, 18th April 1925, p. 179); This was also found to be true of women suffering from venereal disease (Davidson, *Dangerous Liaisons*, p. 169).

⁶⁷³ J. Hubley, 'Poverty and Health', in Brown and Cook, eds., *Scotland: The Real Divide*, p. 210.

Maternal Mortality

The significance of the maternal mortality rate is debated in the historiography. For example, writers like Mitchell and Webster argue that when emphasising this trend it is difficult to paint an 'optimistic' picture of health in the interwar years, and that this mortality pattern often correlated with economic disadvantage.⁶⁷⁴ On the other hand, Winter argues that the maternal mortality trend shows little or no correlation with the social effects of the recession.⁶⁷⁵ Historians acknowledge the complexity of drawing inferences from this data due to problems in the way it was recorded and its complex relationship with a host of social, economic and medical interactions.⁶⁷⁶ However, there is clearly debate on what this information tells us about public health in the interwar period. The increasing maternal death rate in Glasgow, and throughout Scotland and Britain as a whole, was possibly the most pressing obstacle that health professionals faced in the period under review. The issue featured prominently in official and medical literature between the wars and both repeatedly documented their concern that the maternal mortality rate was no better or even worse than it had been twenty years previously.⁶⁷⁷ However, in 1928 the *SBH* explained that 'the reasons for anxiety [were] not strictly numerical', but because a considerable proportion of the deaths were thought to be preventable, that 'despite improvement in obstetric methods and training', the 'efforts of many workers both administrative and clinical, and the striking degree of popular interest that the subject is now arousing' the incidence and mortality rate had failed to significantly fall.⁶⁷⁸ They also expressed concern that they had 'reason to suspect, if not to believe, that the death rate and the morbidity rate from

⁶⁷⁴ Webster, 'Healthy or Hungry Thirties', pp. 117-18; Mitchell, 'Effects of Unemployment', p. 111; Laybourn, *Britain on the Breadline*, p. 55.

⁶⁷⁵ Winter, 'Infant Mortality', p. 455.

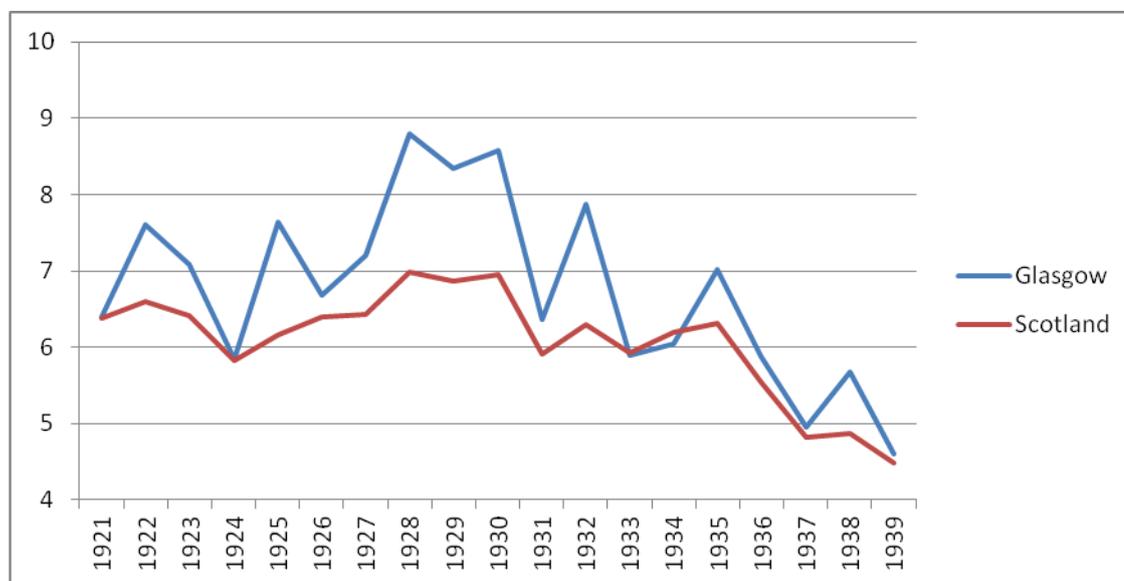
⁶⁷⁶ Loudon, *Death in Childbirth*; Hardy, *Health and Medicine*, p. 94; Jones, *Health and Society*, p. 65; Winter, 'Infant Mortality', pp. 455-59.

⁶⁷⁷ 'Current Topics', *GMJ*, 112 (1929), p. 216; 'Current Topics', *GMJ*, 113 (1930), p. 206.

⁶⁷⁸ *ARSBH 1928*, p. 130.

these causes in Scotland is greater than in England and higher than in certain European countries.⁶⁷⁹

Figure 5.1: Maternal mortality rate (MMR) per 1,000 births in Glasgow and Scotland, 1921-39



SOURCE: RMOHG 1928-39.⁶⁸⁰

Historians of health recognise the shortcomings of recorded maternal mortality rates which, for a number of reasons, are probably inaccurate. However, after extensive consideration of the collection and reliability of these figures, Loudon concludes that ‘there is no justification, however, for rejecting the statistics of maternal mortality as valueless.’⁶⁸¹ Figure 5.1 clearly demonstrates that MMR in both Glasgow and Scotland improved overall between the wars, although it is apparent that the rate increased significantly, particularly in the 1920s. The maternal death rate in Glasgow

⁶⁷⁹ One article estimated that maternal mortality in Scotland was ‘about 40 per cent in excess’ of the English rate (‘Maternal Mortality in Scotland’, *Medical Officer*, 14th August 1935, p. 62); Glasgow was described as ‘perhaps the worst record of any large town from which statistics are available’ (‘Maternal Mortality in Glasgow’, *Medical Officer*, 19th November 1932, p. 208); *ARSBH 1928*, pp. 130-31; ‘Puerperal Fever and Pyrexia’, *BMJ*, 30th April 1932, p. 800.

⁶⁸⁰ Glasgow figures only available from 1921.

⁶⁸¹ For a detailed understanding of the issues surrounding the calculation of the maternal death rate see Loudon, *Death in Childbirth*, p. 38.

was undoubtedly high. The city's maternal mortality figures were in excess of the Scottish national rate and an 'unfavourable comparison of Glasgow with other cities' was recorded.⁶⁸² The marked increase in maternal deaths during the 1925-32 period was also more acute for Glasgow than Scotland as a whole revealing a diversity of experience within individual Scottish regions, the MOH contending that the 'upward tendency is greater in Scotland and greatest in Glasgow.'⁶⁸³ The toxæmias of pregnancy and incidence of still births were also found to be higher and more dangerous in Glasgow and the west of Scotland, and the report by C.A. Douglas and P.L. McKinlay⁶⁸⁴ published in 1935 calculated that the rate of maternal death in the west was 5 per cent higher than the Scottish average and the sepsis rate 13 per cent higher than average.⁶⁸⁵ Indeed, in 1926 it was claimed that 'motherhood in Scotland was still one of the most dangerous trades.'⁶⁸⁶ However this clearly reveals distinctive variations according to geographic region within Scotland itself and the particularly unfavourable position of Glasgow.

The explanation for the interwar maternal mortality pattern is contested. Suggestions include the possibility that the rising maternal death rate was affected by more accurate classification, the increasing proportion of more dangerous first time births due to the declining birth rate, the inferior health of mothers, poorer standards of obstetrical care and increased medical interference in the labour process, the growing rate of abortion, and the virulence of the streptococcus – although no firm conclusion has been reached as to which is correct.⁶⁸⁷ However, in 1935 the maternal death rate

⁶⁸² *RMOHG 1929*, p. 74; *RMOHG 1931*, p. 61.

⁶⁸³ *RMOHG 1931*, p. 61.

⁶⁸⁴ Charlotte A. Douglas was Medical Officer for Maternity and Child Welfare, Peter L. McKinlay was Medical Officer for Statistics ('Maternal Mortality in Scotland', *Medical Officer*, 17th August 1935, p. 62); Gladstone Robertson, *Gorbals Doctor*, p. 100.

⁶⁸⁵ J.N. Cruickshank, 'Some Chemical Aspects of the Toxaemias of Pregnancy', *GMJ*, 108 (1927), p. 3; *ARDHS 1935*, p. 19; Douglas and McKinlay, *Report on Maternal Morbidity and Mortality in Scotland*, pp. 7, 51.

⁶⁸⁶ 'Child Welfare: New Centre in Glasgow', *GH*, 6th October 1926, p. 5.

⁶⁸⁷ Loudon, *Death in Childbirth*, p. 241; Also see M. Flinn, ed., *Scottish Population History from the Seventeenth Century to the 1930s* (Cambridge: Cambridge University Press, 1977), p. 417.

for Glasgow was higher than it had been in 1921, and the pattern here is consistent with the views of Winter, Loudon and Hardy, that the ascent seems only to have been halted by medical advances in the treatment of puerperal fever in the mid thirties with the introduction of the sulphonamides.⁶⁸⁸ Indeed, one Gorbals doctor recognised that ‘it was hard to play God when powerless to save a life. So, when the sulphonamides arrived in 1936, to be followed by penicillin and later antibiotics, our lives were transformed.’⁶⁸⁹ However, Jenkinson states that ‘at the very least, the Scottish aggregate and local figures in MMR (and IMR) between 1919-1948 suggest that some revision of the “optimistic” viewpoint is required.’⁶⁹⁰ In relation to Glasgow alone this is also attempted here.

Mitchell has claimed that the mortality rate of women in childbirth is a useful barometer of the living and health standards of a population due to their vulnerable status.⁶⁹¹ Glasgow’s maternal mortality data tentatively implies that a considerable improvement also followed economic recovery which coincided with the introduction of the sulphonamides.⁶⁹² Commenting on rising levels of maternal mortality between 1923 and 1933 Mitchell asserts that ‘these persistently high and increasing rates should occur after the introduction of the Maternity and Child Welfare Act was particularly surprising and clearly points to a worsening of the economic situation in specific areas

⁶⁸⁸ Winter, ‘Infant Mortality’, p. 458; I. Loudon, *The Tragedy of Childbed Fever* (Oxford: Oxford University Press, 2000), p. 8; Hardy, *Health and Medicine*, pp. 88, 104-5; Crowther, *Social Policy*, p. 70; Suggestions for the decline after 1935 include the more widespread use of blood transfusions, ergometrine and the ‘growth of obstetric flying squads’, better obstetrical care, better nutritional and living standards, and improvements in obstetric education; The rate did begin to fall slightly in Scotland from around 1930 and this is mirrored in the Glasgow figures. However, Loudon claims that this is primarily due to reclassification where from 1931 associated deaths in Scotland were deducted from the maternal death rate (Loudon, *Death in Childbirth*, pp. 246, 255); In Scotland MMR was higher in 1935 than 1920 but slightly lower than the rate in 1921. The MMR data for Glasgow was only published from 1921.

⁶⁸⁹ Gladstone Robertson, *Gorbals Doctor*, p. 185.

⁶⁹⁰ Jenkinson, *Scotland’s Health*, p. 201.

⁶⁹¹ Mitchell, ‘The Effects of Unemployment’, p. 105.

⁶⁹² Stevenson, *British Society*, p. 218.

(Wales and the North).⁶⁹³ Actually, in Glasgow, where the social effects of the recession were widespread (indeed Mitchell singles out Scotland as being one area in 'great distress') it seems that the rising MMR could often have little to do with the changing economic fortunes of the period. The data for Glasgow highlights the danger of over extrapolating from this evidence and substantiates the view of writers like Loudon that the rate does not always display a consistent relationship with unemployment.⁶⁹⁴ Unravelling this data suggests that the maternal mortality rate was less related to the economic problems of the interwar period than writers like Mitchell suggest, and while Winter has been criticised for his overly 'optimistic' view of the situation in Britain, his statement that the economic vicissitudes of the period did not significantly undermine the health of the maternal population is somewhat affirmed by the Glasgow evidence.⁶⁹⁵

This becomes apparent when dissecting and evaluating the marked inequalities which fashioned these mortality statistics – an approach which this thesis argues provides a more accurate understanding of interwar patterns of health. Evaluating maternal health experiences in relation to social status reveals that in Glasgow MMR was often *higher* in the more prosperous regions of the city. Consequently, the climbing maternal mortality rate might say more about the history of medical practice and obstetrics, rather than the economic fortunes of the era.⁶⁹⁶ As Hardy notes:

The picture of maternal death was more complex than that for infant mortality, however, since it involved not only social conditions but also ante-natal provision, obstetric competence and the virulence of the organisms of puerperal fever. The greater likelihood of medical intervention in the birth process among the better-to-do meant that

⁶⁹³ Mitchell, 'The Effects of Unemployment', pp. 110, 111.

⁶⁹⁴ Loudon, *Death in Childbirth*, p. 244.

⁶⁹⁵ Winter, 'Infant Mortality', p. 440.

⁶⁹⁶ Similarly alluded to in 'Maternal Mortality in Scotland', *Medical Officer*, 17th August 1935, p. 62.

death in childbirth was far from uncommon among the middle classes, and better nutrition was of little assistance in combating puerperal sepsis.⁶⁹⁷

Unlike the majority of health indices considered thus far, contemporaries and historians have discussed the largely unique class composition of puerperal fever and maternal mortality per se. As Jones notes, 'one major problem with laying the blame for the loss of so many wives and mothers entirely on social and economic circumstances is that maternal mortality remained high for middle class women as well as working class ones.'⁶⁹⁸ In *The Tragedy of Childbed Fever*, puerperal fever being the primary contributor to the maternal death rate, Loudon argues that 'because the poor were most often delivered by midwives (where interference in the labour process [with forceps for example] was less than by doctors), and the middle and upper class by doctors, puerperal fever was unique in its social class distribution' where it could be less common among the working class than the well-to-do.⁶⁹⁹ It seems that this was the case in Glasgow.

In 1921 for example the MOH for Glasgow claimed that 'puerperal fever has no special association with unhealthy districts and cannot be said to have undergone any diminution within recent years.'⁷⁰⁰ Two years later details were published in the MOH's annual report of a systematic attempt to establish a relationship between puerperal fever and social class. The MOH recorded:

With regard to social and sanitary condition, an enquiry was made into the incidence of puerperal fever in relation to the births in three classes of wards of the city – poor, artisan, and mainly residential districts – which showed that the rate in the first class was equal to 4.5

⁶⁹⁷ Hardy, *Health and Medicine*, p. 94.

⁶⁹⁸ Jones, *Health and Society*, p. 65.

⁶⁹⁹ Hardy, *Health and Medicine*, p. 104; Loudon, *Tragedy*, pp. 189, 204.

⁷⁰⁰ *RMOHG 1921*, p. 7.

per 1,000 births, in the second class 5.8, and in the third class 3.5. This would appear to suggest that insanitary conditions of themselves have little influence on the incidence of the disease, the smaller rate for the good districts probably being due to the economic conditions of the mothers concerned enabling adequate supervision during pregnancy.⁷⁰¹

Later in 1930 the MOH repeated that 'there is no apparent selection or social distribution of the disease' and in 1932 it was reiterated that the incidence of puerperal sepsis occurred 'fairly equally throughout the city; irrespective of the type of residence', there being 'no evidence that the tenement system or congested areas left women more susceptible to the condition.'⁷⁰² Throughout this thesis analysis of health according to social status has primarily relied upon mortality and disease statistics according to geographic region, where individual districts in Glasgow were widely associated with the social position of its residents (see chapter 3). However, the data on the case and death rate from puerperal fever according to geographic region published by the MOH is sketchy and it was impossible to analyse the information in a sound, systematic way. Unlike the mortality data analysed in chapter three, detailed region-specific figures on the incidence and mortality rate from puerperal fever or maternal mortality were not produced in the appendix section of the MOH annual reports, and from the statistics published here it was largely impossible to conclusively determine whether socio-economic factors helped characterise maternal mortality rates in Glasgow (Appendix 5.2 and 5.3).⁷⁰³

⁷⁰¹ *RMOHG 1923*, pp. 70-1.

⁷⁰² *RMOHG 1930*, p. 108; A.S.M. Macgregor, 'Puerperal Fever and Puerperal Pyrexia', *Section of Epidemiology and State Medicine, BMJ*, 22nd April 1932, p. 75; A.S.M. Macgregor, 'Puerperal Fever and Puerperal Pyrexia', *Section of Epidemiology and State Medicine, BMJ*, 30th April 1932, p. 800.

⁷⁰³ However, in the process of finalising this PhD for submission, the archivist of *Glasgow City Archives* advised that the raw data which made up the Glasgow Medical Officer of Health's annual reports was recently deposited to the archive. This material is not yet catalogued, and the weekly returns will require painstaking analysis. Given the late date in which this was realised, it was impossible to analyse this data meticulously or extensively. A sample of the data for puerperal fever in 1924, 1928 and 1939 reveals that based on the classification of regions according to class, the condition was on average higher in 1924 for

This is especially unfortunate as a comprehensive analysis of these figures would have provided a more detailed insight into health trends among middle class women – an area rarely documented in official reports more concerned with improving the poorer health records of the working class. Nonetheless, what can be understood from the existing data is that contrary to most other health indices, it was not uncommon for the ‘good residential districts’ in Glasgow to record some of the highest rates of puerperal fever and maternal death. For example, in 1930 the residential district Park recorded the worst case rate of puerperal fever at 37.8 per 1,000 births compared to a rate of 28.9 per 1,000 births in Anderston – the highest case rate recorded for working class wards mentioned by the MOH that year (Appendix 5.2). It is also significant that the highest death rate that year was recorded in middle class Langside and the lowest in working class Calton (Appendix 5.3).⁷⁰⁴ A number of local investigations also found that the maternal death rate itself was higher in middle class areas. For example, a report on maternal morbidity and mortality published by J.M. Munro Kerr in 1933 analysed information on births and deaths according to different regions in Glasgow for the years 1921-30 conclusive (Table 5.6).⁷⁰⁵

residential regions (although primarily due to a particularly bad outbreak in the Pollokshields area), was lower on average in residential areas in 1928 (although the overwhelmingly highest rate of 33.2 was in residential Camphill. The average rate in residential regions for this year was also dragged down due to no cases occurring in the Cathcart ward), and by 1939 the typical class variation was reinstated, the case rate significantly higher in working class areas (see appendix 5.4). What the sampled data illustrates however is that middle class regions were as prone to outbreaks as working class ones, and the typical discrepancy between the classes is not clearly observed (until 1939 at least). However, this is merely a sample and the analysis is by no means robust. These statistics should prove vital in providing an even clearer picture of the complex mortality landscape of the city with future examination.

⁷⁰⁴ *RMOHG 1930*, p. 108.

⁷⁰⁵ This information was provided by the *Public Health Department of Glasgow* (Kerr, *Maternal Mortality and Morbidity*, p. 251).

Table 5.6: Maternal mortality rate in certain groups of wards in the city of Glasgow, 1921-30

	Births	Deaths	Maternal Deaths per 1,000 births
Residential (7 wards)	18,315	142	7.8
Residential and Industrial (10 wards)	56,342	410	7.3
Mainly Industrial (10 wards)	87,592	620	7.1
Industrial and Poor (10 wards) ⁷⁰⁶	90,057	637	7.0

SOURCE: J.M. Munro Kerr, *Maternal Mortality and Morbidity: A Study of their Problems* (Edinburgh: E.S. Livingstone, 1933), p. 252.

This analysis published by Kerr suggests that the maternal death rate was highest in the more prosperous residential wards ‘in which there is the greatest proportion of births attended by doctors, but the difference is not very pronounced.’⁷⁰⁷ There is the possibility that this mortality pattern could also have been implicated by the movement of poorer, unhealthier Glaswegians into these residential areas, as is discussed in chapter three. However, the data relating to Scotland as a whole also indicated that the ‘death rate during child-bearing from all causes together [was found to be] lower among mothers living in the more overcrowded, and higher in the less overcrowded homes.’⁷⁰⁸ Deaths from ‘failed forceps’ were also greater among the ‘better artisan classes’, and deaths from albuminuria⁷⁰⁹ in pregnancy were higher among homes where overcrowding was less.⁷¹⁰ Assuming that housing conditions reflected social position, this again suggests that maternal complications were more common among the middle class.

⁷⁰⁶ These represent the 37 individual wards of Glasgow.

⁷⁰⁷ Kerr, *Maternal Mortality and Morbidity*, p. 252; A higher MMR occurring in residential areas was also found in other cities such as Leeds (1920-29) (Kerr, *Maternal Mortality and Morbidity*, p. 15).

⁷⁰⁸ Douglas and McKinlay, *Report on Maternal Morbidity and Mortality in Scotland*, p. 69.

⁷⁰⁹ Kidney damage where albumin (protein) is found in urine.

⁷¹⁰ On the other hand however, deaths from uraemia (when the blood contains waste products which should be passed through urine) were greater among women from working class homes (Douglas and McKinlay, *Report on Maternal Morbidity and Mortality in Scotland*, pp. 104, 121, 150).

The report by Kerr also found that comparing the rates between districts in Glasgow where attendance by doctors was 90 per cent or more compared to those where attendance was 10 per cent or less, provided a more conclusive result. It is widely documented that more affluent women commonly opted for the attendance of a family doctor at home, compared to those of the poorer classes who could not afford a private physician.⁷¹¹ With a maternal death rate of 7.9 per 1,000 births among women primarily attended to by doctors compared to a rate of 6.6 among those who were not, the report concluded that there was some justification for the belief that “the mortality rate is lower in the poverty-stricken and badly housed areas of our large towns and higher in the residential areas.”⁷¹² The sample used in this comparison was relatively small.⁷¹³ Nonetheless, it seems that the risk of death relating to childbirth was more of a threat to middle class women.

What contributed to this distinctive mortality pattern? Ironically, and in contrast to most other health statistics, the ability to pay for a private physician may have been the principal reason for the higher MMR among this more prosperous group. It was found that deaths from poor obstetric care were higher among the artisan and semi-professional classes where hurried labours utilising ‘unnecessary interference’ was more common.⁷¹⁴ Furthermore, it was noted that the decline in fertility may have affected the maternal death rate where the MOH for Glasgow commented in 1929 that the ‘reduction in fertility, and the later age of marriage, [were] also important factors, as maternal deaths are usually lowest among young mothers, especially those undergoing their fourth or fifth pregnancy.’⁷¹⁵ As Jenkinson notes, ‘women from better off social backgrounds were generally older at

⁷¹¹ ‘Infant Welfare Conference: Dr. Barbara Sutherland (Glasgow)’, *Lancet*, 15th July 1922, p. 133.

⁷¹² Kerr, *Maternal Mortality and Morbidity*, p. 252.

⁷¹³ Only 4 wards were considered in the 90 per cent or more category and 3 wards in the 10 per cent or less category; GUSC, Spec Coll, 2978, pamphlet, *Scheme for Maternity and Child Welfare*.

⁷¹⁴ Douglas and McKinlay, *Report on Maternal Morbidity and Mortality in Scotland*, p. 22; Also quoted in Loudon, *Death in Childbirth*, p. 249.

⁷¹⁵ *RMOHG 1929*, pp. 74-5.

marriage, they were more likely to be experiencing a dangerous first-birth, and most crucially, they were more likely to consult medical advice and thereby run the risk of contracting infection from their medical attendants.⁷¹⁶ Some were of the opinion that nutritional standards also had important implications for the success of childbirth and an investigation carried out between 1926 and 1930 at the *GRMWH* concluded they were certain ‘that insufficient food... exert[ed] an unfavourable influence on the course of pregnancy and on recovery after labour [and] such factors must be predisposing causes to sepsis and obstetric shock, however difficult it may be to estimate their extent.’⁷¹⁷ While this was undoubtedly true to some extent, Loudon agrees that ‘the important conclusion is not that poverty and malnutrition had no effect on the risk of dying in childbirth, but rather that the effect was surprisingly slight compared to the effect of the standard of maternal care and the type of birth attendant.’⁷¹⁸

This is not to suggest that the health of women in childbirth was unaffected by the economic fortunes of the period. Winter himself has acknowledged that the effects of the recession upon perinatal death may have skipped two generations, and it is here Winter claims that the ‘human costs of the Depression’ can be found.⁷¹⁹ While maternal death represented a real threat to women from more affluent social positions, it can be maintained that poverty continued to be harmful in childbirth. The study

⁷¹⁶ Jenkinson, *Scotland's Health*, p. 193.

⁷¹⁷ *GGNHSBA*, HB45/9/30, J.M. Munro Kerr and A. Sharman, ‘An investigation into maternal mortality and morbidity in the domiciliary services of maternity hospitals (based on the district practice of the Glasgow Royal Maternity and Women’s Hospital from 1926-1930, inclusive), Reprinted from the *Lancet*, 25th July 1931, p. 201; An investigation into the introduction of food supplements for pregnant women in the depressed Rhondda district of south Wales also reinforced the importance of nutrition for successful childbirth (Cherry, *Medical Services and the Hospitals in Britain*, p. 23).

⁷¹⁸ Loudon, *Death in Childbirth*, p. 246; E.P. Cathcart, ‘Health Policy of the Future’, *Proceedings of the Royal Philosophical Society of Glasgow*, 63, 135th and 136th sessions 1936-37 and 1937-38 (Glasgow: The Society, 1938), pp. 39, 40.

⁷¹⁹ Cited in Mitchell, ‘The Effects of Unemployment’, p. 112; Discussed by Smout who also cites Sir Dugald Baird’s suggestion that the rise in certain kinds of stillbirths in the 1950s could be attributed the condition of the mothers of these girls between 1926 and 1937 (Smout, *Century*, p. 123).

published by the *DHS* found that mortality resulting from conditions aggravated by pregnancy like ‘tuberculosis, respiratory, heart, and chronic kidney diseases’ were greater among those of the ‘lower end of the social scale.’⁷²⁰ Indeed, given the deteriorating position of some women with regards to tuberculosis this may also have had an effect. It has also been shown that childhood rickets, a disease primarily associated with poverty, impacted adversely upon the success of childbirth for affected females in later life (Chapter 4). Nonetheless, the evidence from Glasgow suggests that the maternal death rate is largely unhelpful in conclusively gauging the impact of poverty and unemployment upon the health of women – a matter highlighted when considering the class composition of this mortality rate. Unravelling the public health statistics to consider particular mortality trends and those of individual groups demonstrates that experiences were uneven and could actually diverge. However, rather than simply challenging the ‘pessimist’ view, what the maternal mortality rate clearly reveals is inequalities in health, and it further suggests that adopting a comparative interpretative framework provides a more detailed understanding of interwar public health. The experiences of ‘women’ were not homogenous. Where gains and deteriorations were felt, different groups of women were affected in different ways. This will be further developed in this next section which analyses the experience of abortion.

Abortion

One area of relative agreement among contemporary health professionals, and modern day historians alike, is that abortion, often self induced, was a significant contributor to puerperal sepsis and maternal death. Historians

⁷²⁰ Douglas and McKinlay, *Report on Maternal Morbidity and Mortality in Scotland*, pp. 8, 199, 202 (also cited in Jenkinson, *Scotland’s Health*, p. 193).

examining the impact of unemployment and poverty among women have highlighted that many were driven to dangerous abortions due to the financial costs of an additional, unplanned child. Here the relationship between health, poverty and economic position is more decisive. Undoubtedly, mothers lower down the social scale continued to be affected by their poorer financial status, and the relationship between the ability to pay and its adverse effects on maternal health could be very different for this group compared to the middle class experience detailed above. However, even then, this was also characterised by diversity.

Finlay suggests that some self-induced abortions could be an indirect effect of the recession where Scottish anecdotal evidence suggests that 'the prospect of an extra mouth to feed was too much to contemplate' for many women – an occurrence also recognised by Jones.⁷²¹ According to Zweiniger-Bargielowska, abortion was 'an important factor in the rise in maternal mortality rates until the mid-1930s' and this increase and 'declining fertility were closely connected, because the latter was to some extent due to an increase in illegal abortion among married women.'⁷²² Indeed, an official investigation into maternal mortality in England and Wales found that abortions accounted for around 14 per cent of puerperal deaths while the Glasgow MOH calculated that puerperal fever as a result of septic abortion or miscarriage accounted for 24 per cent of the cases admitted to puerperal fever wards.⁷²³ The investigation on maternal mortality and morbidity published in 1933 by Kerr also found that when:

⁷²¹ Finlay, *Modern Scotland*, p. 87; Jones, *Health and Society*, p. 66.

⁷²² Zweiniger-Bargielowska, *Managing the Body*, pp. 257, 258.

⁷²³ *Report on an Investigation into Maternal Mortality*, HMSO 1937, (5422), p. 280; A.S.M. Macgregor, 'Puerperal Fever and Puerperal Pyrexia', *Section of Epidemiology and State Medicine, BMJ*, 22nd April 1932, p. 69.

Considering the evidence available, it would appear that fatalities from abortion (criminal) are increasing to such an extent that they may quite decidedly affect the mortality rate in the near future, and that the trend in this country, as in many other countries, is for abortion to play an ever-increasing part as a cause of maternal mortality.⁷²⁴

The study on maternal morbidity and mortality published by the *DHS* in 1935 further highlighted the issue of abortion and claimed that the occurrence was the main cause of maternal deaths 'in which blame was attributed to the patient', the majority of which were said to be deliberately induced.⁷²⁵ Kerr also found no evidence that the number of 'ordinary' abortions was increasing from the cases of 500 patients at the *GRMWH*, and instead concluded that the increase in death from abortion was either due to more accurate medical certification and/or an 'increase in the number of *criminal* abortions (his italics).'⁷²⁶ The MOH also remarked in 1931 'that sepsis following abortion accounts for 25 per cent of the cases and 20 per cent of the deaths', and that while 'accuracy as regards abortion statistics is difficult to obtain... the suggestion is that this factor as a forerunner of sepsis is tending to increase.'⁷²⁷

Figures relating to abortion are undeniably inaccurate. Few women would openly admit to undergoing a procedure which was deemed illegal by law and immoral by religion. Nonetheless, most interwar observers agreed that the number opting for this procedure was on the increase, and it is possible to measure its incidence to some extent.⁷²⁸ Loudon asserts that 'where a woman died after a spontaneous abortion, death from sepsis was so rare that in the absence of firm evidence to the contrary, post-abortive

⁷²⁴ Kerr, *Maternal Mortality and Morbidity*, p. 133; Similarly published in 'Section of Obstetrics and Gynaecology: Indications for Abortion', *BMJ*, 6th August 1932, pp. 254-55.

⁷²⁵ Douglas and McKinlay, *Report on Maternal Morbidity and Mortality in Scotland*, p. 21.

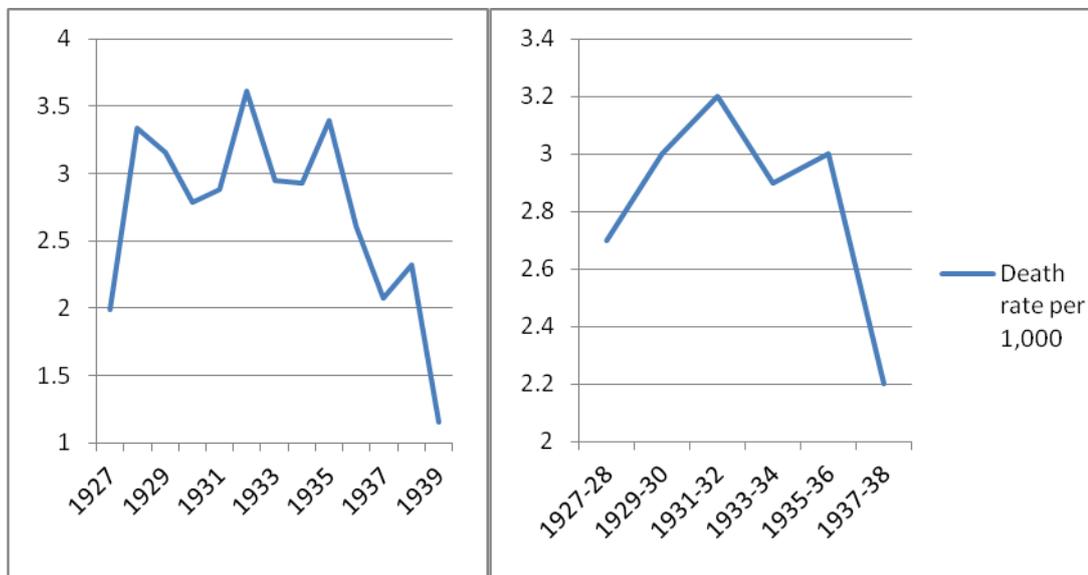
⁷²⁶ Kerr, *Maternal Mortality and Morbidity*, p. 129.

⁷²⁷ *RMOHG 1931*, p. 6; Also see *RMOHG 1930*, p. 113.

⁷²⁸ Minutes of Evidence taken before the Committee on Scottish Health Services (Fourth Day), 19th January 1933, p. 35.

sepsis was an indication that an abortion had been induced, whatever the patient may have said.⁷²⁹

Figure 5.2: Deaths per 1,000 births from puerperal septicaemia in Glasgow, 1927-39



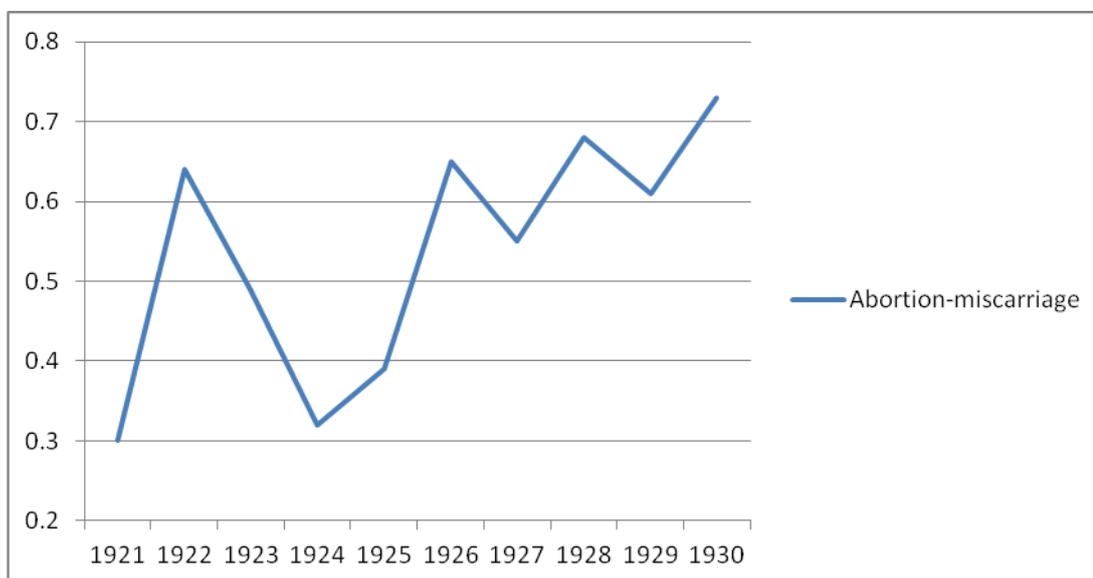
SOURCE: RMOHG 1927-39.

The death rate from puerperal septicaemia, which included deaths from post-abortive sepsis, was published from 1927, and this also suggests that the mortality rate increased over most of the period until the sulphonamides were introduced (Figure 5.2). These records are difficult to interpret as the MOH only actually states from 1931 that post-abortive sepsis was included in these figures. It is therefore ambiguous whether this merely reflects a change in the labelling of the cause of death where deaths from post-abortive sepsis had always been included although not mentioned, or an actual change in the way puerperal septicaemia was recorded. It is also impossible to disentangle the mortality rate from post-abortive sepsis alone from these figures, making it unclear whether it was this that contributed to the increase or some other factor.

⁷²⁹ Loudon, *Death in Childbirth*, p. 108; 'Maternity and Child Welfare: Fifth English-Speaking Conference', London, July 2nd-4th, *Lancet*, 1929, p. 70.

Nonetheless, from 1921-1930 a category titled 'abortion-miscarriage' existed in the Glasgow reports and this also demonstrated a notable mortality increase (Figure 5.3).

Figure 5.3: Death rate per 1,000 births from 'abortion-miscarriage' in Glasgow, 1921-1930



SOURCE: *RMOHG 1921-1930*.

By 1933 the MOH for Glasgow stated that 'there is no doubt that the premature termination of pregnancy is being increasingly practiced.'⁷³⁰ In 1937 the MOH published the following figures to illustrate that 'the actual number of abortions taking place in the City is, of course, unknown, but must be considerable and increasing' (Table 5.7).⁷³¹

Table 5.7: Number of abortions treated in Glasgow hospitals, 1931-1937

	1931	1932	1933	1934	1935	1936	1937
Royal Maternity Hospital	707	529	652	508	355	395	497
Corporation General Hospitals	294	597	709	746	1065	1125	913
Robroyston Hospital	*	30	44	160	145	54	197
Total	*	1156	1405	1414	1565	1574	1607

SOURCE: *RMOHG 1937*, p. 48.

⁷³⁰ *RMOHG 1933*, p. 7; This was not unique to Glasgow. For a London comparison see H. Corry Mann, 'Rickets: The Relative Importance of Environment and Diet as Factors of Causation: An Investigation in London', *SRMRC*, 68 (1922), p. 14.

⁷³¹ *RMOHG 1937*, p. 48.

Oral testimonies and statements published in medical and lay sources, such as autobiographies and novels of the time, give the impression that abortion was widely practiced, a daily phenomenon and essentially a form of birth control.⁷³² For instance, in *Growing Up in the Gorbals*, Glasser recalls his astonishment at the dismissive way in which his sisters spoke about having an abortion. He also recalls another instance in which a female colleague was admitted to hospital after attempting to 'flush out her bowels' i.e. induce an abortion.⁷³³ Similarly, a Glaswegian female doctor, who in the 1930s was conducting an experiment on birth control at a woman's clinic, reported that 'those who confessed to using ecbolics (12 per cent) in the form of just castor oil or Epsom salts, or so on, spoke as if that was the most natural thing to do, and that anybody and everybody do that. I do not know that they are conscious of the danger that it entails.'⁷³⁴ However, Glasser recalled that it was well known that 'girls had died after a visit' to an abortionist on Rose Street, Glasgow suggesting that there was some awareness of the danger this entailed.⁷³⁵

It seems that this climbing rate of abortion in Glasgow was to some extent related to the social effects of the Depression. As Webster writes, 'for the unemployed, every addition to the family meant greater strain in meeting the minimum demands of subsistence.'⁷³⁶ The investigation carried out by Kerr which considered maternal deaths at the *GRMWH* also endorsed this view concluding that 'economic conditions and inadequate means of existence are probably the chief cause of the increase in abortions.'⁷³⁷ The

⁷³² SOHCA/009, Domestic Violence, Ms AH (1902); Advert in the *GP*, 'Woman's Unfailing Friend – Towle's Pills. Immediately you notice any irregularities of the system, take Towles' Pills, they will quickly remove all suffering' (*GP*, 21st Jan 1922, p. 7).

⁷³³ Glasser, *Growing Up*, pp. 106-07, 161.

⁷³⁴ Minutes of Evidence taken before the Committee on Scottish Health Services (Fourth Day), 19th January 1933, p. 19.

⁷³⁵ Glasser, *Growing Up*, p. 109.

⁷³⁶ Webster, 'Health, Welfare and Unemployment during the Depression', p. 209.

⁷³⁷ Kerr, *Maternal Mortality and Morbidity*, p. 138; Also see *GGNHSBA*, HB45/9/30, J.M. Munro Kerr and H. MacLennan, 'An Investigation into the Mortality in Maternity Hospitals and the Influencing Factors (Based on the Indoor Practice of the Glasgow Royal Maternity and

angst caused by pregnancy was also acknowledged by the MOH for Glasgow who stated in 1923 that 'there is, further, a greater dread of pregnancy than before, and breast feeding is prolonged.'⁷³⁸ Interestingly, the female doctor referred to above also reported that the attendance of women affected by unemployment coming to her birth control clinic was 'due to the fact that the husbands desire intercourse with them much more frequently when they are unemployed than when they are employed, and it is that that has determined their coming to the clinic.'⁷³⁹ Therefore, the evidence here suggests that the social effects of the recession could impact upon women's health.

However, again, disentangling the realities behind the statistics complicates and colours this picture. The weight of the evidence suggests that experiences were diverse, varying not least, with regards to marital status. For example, it seems that the social effects of the recession were felt more acutely by married women. It was noted that abortions occurred more often among these females than those who were single, 'the proportion being 13 in the former to 1 of the latter [where] procured or self-induced abortion was admitted in about 20 per cent of these patients.'⁷⁴⁰ This certainly corroborates Loudon's claim that 'the common idea that most criminal abortions were performed on young unmarried girls' "in trouble" is clearly mistaken.'⁷⁴¹ It can be reasonably assumed that the number of pregnancies was greater among married women and so this higher figure can be explained, and given the evidence aforementioned, this does also imply that married women with families may have induced abortion in order to

Women's Hospital for the years 1926-30 inclusive), Reprinted from the *Lancet*, 19th March 1932, p. 635.

⁷³⁸ *RMOHG 1923*, p. 44.

⁷³⁹ Minutes of Evidence taken before the Committee on Scottish Health Services (Fourth Day), 19th January 1933, p. 20.

⁷⁴⁰ *RMOHG 1937*, p. 48.

⁷⁴¹ Loudon, *Death in Childbirth*, pp. 109-10.

escape an additional burden on their resources.⁷⁴² This was not a universal experience. For many, if not most families, expecting a child was a happy event despite the recession. One man recalled that in the 1930s women 'never seemed depressed or cried about [being pregnant] or anything,' and another expressed her disappointment at her failure to immediately fall pregnant and spoke pleasantly of her pregnancy thereafter (although, admittedly, she was in a secure financial position).⁷⁴³ However, it is clear that the procurement of abortion increased during the interwar period.

Nonetheless, while abortions were more numerous among married women, *proportionately*, the procedure was more dangerous for unmarried mothers. One study which examined the cases of 800 puerperal fever patients treated at Belvidere Hospital found that while 'illegitimacy did not increase liability to sepsis' and that it 'plays, if anything, a very minor part in the causation of sepsis or of fatal infection', it was nevertheless indicated that 'illegitimacy was probably of some slight account in determining a fatal issue' where the death rate for women aborting-miscarrying illegitimate children was 14.2 per cent compared to 12.2 per cent among legitimate cases.⁷⁴⁴ A higher proportion of maternal deaths among unmarried mothers were also the case for Scotland as a whole, and it was found that 'unmarried mothers, age for age, have a higher death rate than married from causes connected with childbirth.'⁷⁴⁵ This variation in relation to marital status is perhaps unsurprising given contemporary attitudes towards unmarried mothers and

⁷⁴² This was also raised by a Departmental Committee under the Chairmanship of Sir George Newman in 1928 which claimed that 'there was probably an increasing amount of abortion which appeared to be attempted mainly by married women on economic and social grounds' (*Report on an Investigation into Maternal Mortality*, HMSO 1937, pp. 24-5).

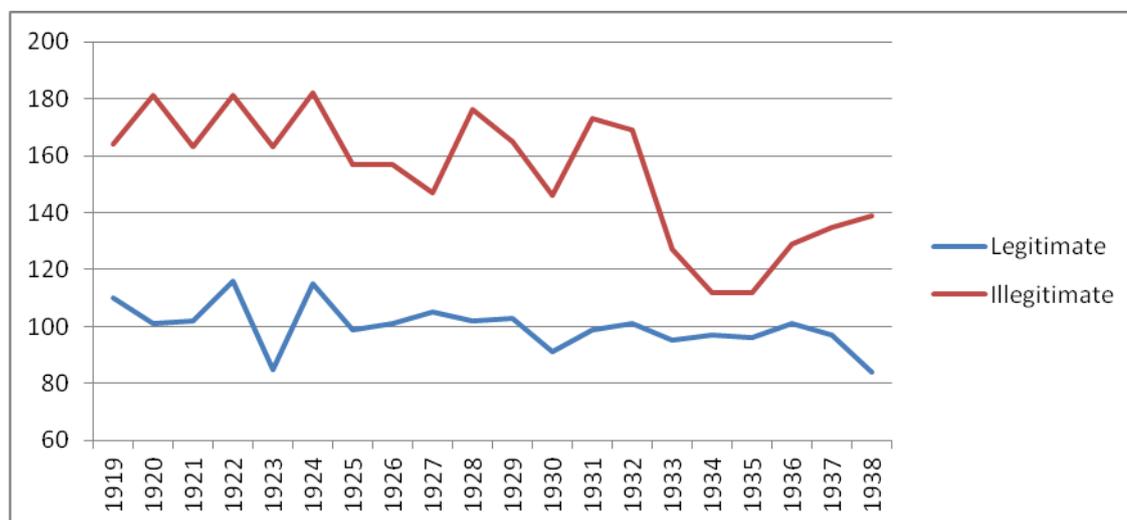
⁷⁴³ SOHCA/038/002 (1927); SOHCA/038/001 (1912).

⁷⁴⁴ *RMOHG 1930*, pp. 114, 118; Also cited in Kerr, *Maternal Mortality and Morbidity*, p. 21; This was more conclusive in a study by Kinloch, Smith, and Stephen in what became known as 'the Aberdeen study' (held at the *GGNHSBA* but also cited in Kerr, *Maternal Mortality and Morbidity*, p. 21); Also see *Report on an Investigation into Maternal Mortality*, HMSO 1937, pp. 222, 280.

⁷⁴⁵ Douglas and McKinlay, *Report on Maternal Morbidity and Mortality in Scotland*, p. 35; Andrew Topping (Senior Medical Officer, London Country Council), 'Maternal Mortality and Public Opinion', *PH*, July 1936, p. 347; Jones, *Health and Society*, p. 66.

illegitimate children. Figure 5.4 demonstrates that the IMR was also distinctly higher among this group, although the disparity had narrowed by the end of the period.

Figure 5.4: IMR for legitimate and illegitimate children in Glasgow, 1919-1938



SOURCE: RMOHG 1919-1938.⁷⁴⁶

Finlay suggests that illegitimate infants were probably less likely to survive their first year of life compared to those born to married parents because unmarried mothers were in the lowest income bracket.⁷⁴⁷ Jones also points out that because of the social stigma associated with having a child outside wedlock and the attempt to hide their condition, these women were less likely to visit ante-natal clinics and more likely to continue to work when their pregnancy was far advanced.⁷⁴⁸ Cage outlines that the higher rate of IMR among illegitimate children was due to 'the attitudes of society to children born out of wedlock, and the fact that many of the mothers would have been from economically disadvantaged backgrounds.'⁷⁴⁹ A similar interpretation also applied to the higher maternal death rate associated with abortion

⁷⁴⁶ IMR figures in this format were only published until 1938.

⁷⁴⁷ Finlay, *Modern Scotland*, p. 118; Also see Thomas and Williams, 'Women and Abortion' pp. 289, 291; 'The Illegitimate Child: From a Correspondent', *GH*, 19th June 1920, p. 4.

⁷⁴⁸ Jones, *Health and Society*, p. 66.

⁷⁴⁹ Cage, 'Infant Mortality Rates and Housing', p. 128.

among unmarried women. Commenting on the incidence of the practice in England and Wales, Loudon found that death following abortion was lowest among social classes I and II and highest in social class V. Loudon suggests that one reason for this was because those of a higher social group were able to pay more for the safest means of termination.⁷⁵⁰ Indeed, one Glasgow woman recalled that 'if you had the money you could get an abortion', and Glasser similarly claimed that for those with financial means, arranging 'for an abortion to be done discreetly in a private clinic was a simple, if expensive matter.'⁷⁵¹ It seems then that the inability to pay played a part in the higher post-abortive death rate among unmarried women. This disparity was also addressed by the *DHS* who mentioned 'lack of medical care' as well as 'a greater proportion of primiparous (first) births' as two possible reasons for the higher death rate among the unmarried group.⁷⁵²

Hence, this analysis has shown that the overall abortion rate suggests that the indirect effects of poverty and recession could undermine the health of women and it supports a 'pessimist' view. While the maternal death rate itself is difficult to relate to poverty, a closer look at different aspects of this mortality pattern reinforces the sense that financial and social position affected women's health experiences. However, the realities and trends of pregnancy and abortion were fashioned by a complex interaction between marital status and financial security. Efforts to disentangle the distinct health trends of individual groups reveals the many layers of experience masked by

⁷⁵⁰ Loudon, *Death in Childbirth*, pp. 111-12; However, Loudon explains that the class composition of abortion is open to interpretation. Other explanations include the greater utilisation of contraception among women of a higher class which therefore minimised the risk of becoming pregnant in the first place. Secondly, he suggests that rather than there being a lower death rate from abortion among this group, the private, and paid for, family doctor may have been more easily persuaded to state another cause of death to save the face and respectability of the woman and her family; Similarly claimed by Zweiniger-Bargielowska, *Managing the Body*, p. 258; Similarly, practitioners could also mask a death from venereal disease and attribute this to another cause for private patients (Davidson, *Dangerous Liaisons*, p. 158).

⁷⁵¹ SOHCA/009, Domestic Violence, Ms AJ (unknown); Glasser, *Growing Up*, p. 161.

⁷⁵² Douglas and McKinlay, *Report on Maternal Morbidity and Mortality in Scotland*, p. 35; Similarly stated in 'Puerperal Sepsis', *Medical Officer*, 6th May 1933, p. 172.

general mortality trends. The abortion rate reveals that the health of married women was more affected by the social consequences of the recession whereas the health of illegitimate mothers, although clearly related to poverty, was affected differently. This has been addressed by historians. However, the argument here is that in the context of interwar public health, it is more accurate to unravel, explore and *emphasise* these distinct mortality patterns to help understand the contradictions in the literature – rather than debate the extent to which improvements in health were made. In terms of maternal health there was no universal experience – a trait which it will be shown also characterised the health experiences of children and other household members, whose health women were deemed responsible for.

Ante-Natal Clinics and Maternal Care

Now that we have dealt with the health of women themselves, these next sections consider how they contributed to health experiences within the family, particularly in relation to their unborn children and dependants within the home. This can essentially be viewed as a different aspect of the same debate where, as Jones notes, mothers were blamed for both their own ill health and their families due to their ignorance and unwillingness to attend ante and post-natal clinics.⁷⁵³ Indeed, Zweiniger-Bargielowska points out that the blaming of mothers for poor health records is still evident in social policy debates today.⁷⁵⁴ National and local health authorities complained that the campaigns pursued to encourage mothers to utilise maternal and child welfare facilities were not always well received, and this was said to be a contributing factor to maternal complications. In 1930 the MOH recorded that

⁷⁵³ Jones, *Health and Society*, p. 60.

⁷⁵⁴ I. Zweiniger-Bargielowska, 'Raising a Nation of "Good Animals": The New Health Society and Health Education Campaigns in Interwar Britain', *Social History of Medicine*, 20 (1), 2007, p. 79.

'many women escape the net of ante-natal care altogether', that they 'either send for the outdoor staff [of the *GRMWH*] or present themselves for admission after labour has set in', and that many women 'who seek advice only at the eleventh hour are already well on the way to becoming obstetric disasters.'⁷⁵⁵ In 1934 the MOH similarly reported that despite a large number of women attending, ante-natal clinics were not 'fully taken advantage of'.⁷⁵⁶ The extensive investigation by Kerr also suggested that in the 'districts where conditions are at their worst' – for which he provided the region covered by the *GRMWH* as an example – it was found that only 27 per cent of women 'attended in their homes sought ante-natal care in the clinic of the hospital or of the "welfare centres" of the city' between 1926 and 1930, that 'there had been no improvement during these years' and that 'it is most disheartening that amongst the industrial classes so few will take this trouble.'⁷⁵⁷ It was also found that only 10-15 per cent of women attended the ante-natal clinic on a regular basis.⁷⁵⁸

While there is no doubt that many women failed to utilise maternal health facilities, the extent to which this was the case, and the extent to which it was detrimental to health should not be overstated – an observation acknowledged by at least one Glasgow doctor at the time.⁷⁵⁹ Firstly, it is clear that willingness to attend ante-natal clinics increased over the period and a growing number of women actively pursued and utilised their services.

⁷⁵⁵ *RMOHG 1930*, p. 84; A similar complaint was made by Kerr, Professor of Obstetrics and Gynaecology, Glasgow University ('Preventative Medicine as Applied to Obstetrics', *BMJ*, 12th June 1926, p. 977).

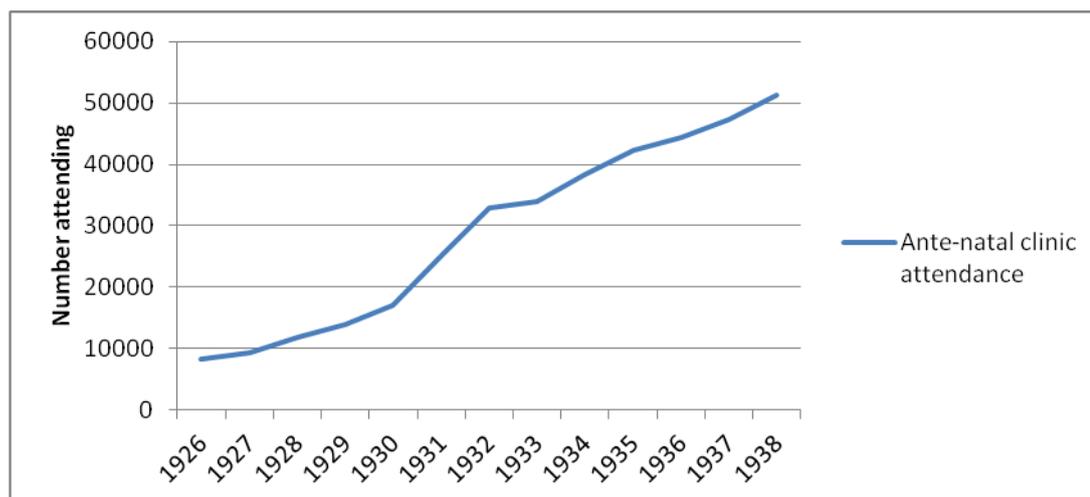
⁷⁵⁶ *RMOHG 1934*, p. 75; Cathcart, 'Health Policy of the Future', p. 43.

⁷⁵⁷ Kerr, *Maternal Mortality and Morbidity*, pp. 8, 189.

⁷⁵⁸ Kerr, *Maternal Mortality and Morbidity*, p. 177; Also see Kerr and Sharman, 'An Investigation into Maternal Mortality and Morbidity in the Domiciliary Services of Maternity Hospitals', p. 204.

⁷⁵⁹ *GUSC*, Spec Coll Hunterain Add, q90, J. Brownlee, 'Interpretation of the Death Statistics of Infancy and Childhood in relation to Development and Environment', reprinted from the *BMJ*, 26th August 1922, p. 2.

Figure 5.5: Attendance at ante-natal clinics in Glasgow, 1926-38



SOURCE: RMOHG 1926-38.⁷⁶⁰

Attendance at ante-natal clinics in Glasgow soared throughout the period from 8,305 attendances in 1926 to 51,236 in 1938 (Figure 5.5). The *GRMWH* emphasised the success of the clinics stating that ‘the general health of the expectant mothers attending the clinics has greatly improved’, and that the service had become so popular it had to be opened six days a week.⁷⁶¹ Some evidence suggests that mothers attending safeguarded their own health at least and probably that of their unborn child.

Table 5.8: Maternal death rate per 1,000 births comparing Glasgow as a whole with patients who attended local authority ante-natal clinics

Year	Maternal death rate (and maternal deaths)						
	1928	1929	1930	1931	1932	1933	1928-1933
Glasgow	8.79 (208)	8.33 (190)	8.58 (200)	6.37 (146)	7.87 (179)	5.90 (126)	7.67 (1,049)
Ante-natal clinics	2.67 (6)	3.57 (9)	5.12 (16)	3.42 (17)	4.37 (30)	4.25 (31)	4.03 (109)

SOURCE: *Evidence to be Submitted to Committee on Scottish Health Services re The Medical Services*, p. 181; Kerr, *Maternal Mortality and Morbidity*, p. 290.

⁷⁶⁰ These figures are sketchy before 1926.

⁷⁶¹ *GGNHSBA*, HB45/3/7, *GRMWH* 1929, p. 5.

Table 5.8 clearly suggests that mothers who attended authority clinics between 1928 and 1931 considerably increased the likelihood of survival following childbirth. Unsurprisingly, this was the interpretation adopted by public health authorities. However, this should be treated with some caution. For example, it might be the case that these women, the proportion *actively* attending welfare clinics, represented a section of mothers deliberately motivated to improve the health of their families and children in general – hence their willingness to attend ante-natal facilities. Therefore, these figures could capture correlation rather than causation – the possibility that the women attending these centres were healthier before as a consequence of their own behaviours, rather than as a consequence of the clinics. Nevertheless, in 1930 another survey found that the percentage of mothers who sought ante-natal advice was as high as 60 per cent in Glasgow, 40 per cent in Aberdeen and 50 per cent in Edinburgh.⁷⁶²

There is also evidence that women actively pursued these services where the *GRMWH* reported in 1930 that ‘the work of the ante-natal and child welfare centre [was] still on the increase [and] many of these patients were sent by their family doctors for consultation, but a very large number sought the advice of the Hospital doctors on their own initiative’.⁷⁶³ This supports Winter’s contention that the expanding provision of ante-natal and child welfare facilities would have been ineffective ‘had not women’s attitudes to public support for their own welfare altered in the 1930s, such that it became the rule rather than the exception for women to attend ante-natal clinics regularly.’⁷⁶⁴ Moreover, in 1938, 6,288 copies of the booklet ‘Health of Mother and Child’ were sold at Glasgow’s child welfare clinics for the cost of two pence per copy.⁷⁶⁵ Parents (but probably for the most part mothers) also increasingly engaged with the medical advice provided by school medical

⁷⁶² ‘Scotland: Maternity Service and Child Welfare’, *BMJ*, 13th June 1931, p. 1042; ‘Maternity and Child Welfare Services’, *BMJ*, 18th June 1932, p. 1144.

⁷⁶³ *GGNHSBA*, HB45/3/8, *GRMWH*, 1930, p. 27.

⁷⁶⁴ Winter, ‘Infant Mortality’, p. 459.

⁷⁶⁵ *RMOHG* 1938, p. 58.

officers by attending the medical inspection of their children. The number of parents present at the routine inspections rose from 59.5 per cent in 1920-21 to 72.6 per cent in 1938-39. The school medical authorities thought that this was particularly useful as it gave doctors the opportunity to personally advise parents on the health of their children, and in 1937 they recognised the contributory role of parents to the downward trend of minor ailments.⁷⁶⁶ However, in 1939 the education authorities remarked that the willingness of parents to attend these consultations dwindled as children got older, reinforcing the notion that public health experiences could vary according to age (see chapter 3).⁷⁶⁷

Even so, the extent to which the participation of women in maternal and child welfare schemes benefited health should be kept in perspective. For instance, ante-natal clinics focused upon diagnosis rather than the provision of treatment.⁷⁶⁸ Crowther argues that they 'were more lavish with advice, often patronisingly given, than practical assistance. Clinics which offered free or cheap milk, crèches and sympathy were popular. Ante-natal examinations, rarely a cheering experience, were in the 1930s unhelpful and humiliating for many working class women.'⁷⁶⁹ In fact, a large proportion of maternal deaths were actually found to be the fault of the delivering attendant and not the ignorance of women. An investigation carried out at the *GRMWH* between 1926 and 1930 found that while 8.1 per cent of maternal deaths could be attributed to 'negligence of the patient or her friends', 14.1 per cent were said to be caused by the 'faulty judgement on the part of those in charge of the patient,' and 'inadequate maternal care was attributable to 35.3

⁷⁶⁶ *GGNHSBA*, HB38/1/2, *RMITSC 1920*, p. 7; *RMITSC 1930*, p. 10; *GGNHSBA*, HB38/2/5, does not say which newspaper but with 1936 clippings; *GGNHSBA*, HB38/1/9, *RMITSC 1937*, p. 8; This was also documented in the public press. See *GGNHSBA*, HB38/2/5, 'Medical Inspections in Schools: Glasgow Authority's Work: Treatment Rather than Inspection', *GH*, 17th November 1923; 'School Medical Inspection Notes', *Medical Officer*, 25th June 1938, p. 272.

⁷⁶⁷ *GGNHSBA*, HB38/1/11, *RMITSC 1939*, p. 19.

⁷⁶⁸ Jenkinson, *Scotland's Health*, pp. 186, 187.

⁷⁶⁹ Crowther, *Social Policy*, p. 70.

per cent of all the deaths in our hospital.⁷⁷⁰ A Scotland wide investigation also found that of 58.7 per cent of maternal deaths deemed preventable, only 21.61 could be ascribed to the fault of the mother while 37.09 per cent were due to some 'faulty technique of the attendant (including doctor, midwife and institution).⁷⁷¹ Ironically, many of the venues which housed ante-natal appointments were materially unhealthy with inadequate facilities, including no heating, no waiting rooms and poor lighting.⁷⁷² Therefore while the failure of some mothers to attend ante-natal clinics was likely to play some part in maternal and infant mortality rates, the extent to which this was the case must be kept in perspective, and the tone of condemnation found in medical and official publications treated carefully.

Despite this, working class mothers were regularly blamed for being negligent mothers and for contributing to the ill health of their children and families.⁷⁷³ According to Beier, like Medical Officers of Health (MOsH) nationally, 'local MOsH agreed that one potentially successful approach was appointment of "Lady" health visitors — a description that reflected the class implications of "ladies" encouraging working class mothers to adopt middle class behaviour'.⁷⁷⁴ However, it is important to note that medical professionals could be quick to condemn the ignorance of middle class wives

⁷⁷⁰ Kerr and MacLennan, 'An Investigation into the Mortality in Maternity Hospitals and the Influencing Factors', p. 637; Also see 'Maternal Mortality: A Discussion by the Fellowship of Medicine', *Lancet*, 30th November 1935, p. 1255.

⁷⁷¹ Douglas and McKinlay, *Report on Maternal Morbidity and Mortality in Scotland*, p. 15; Repeated in public press ('Maternal Mortality in Scotland', *GH*, 9th July 1935, p. 9 and 19th July 1935); However, the 'avoidable death' figure must be treated with caution as it 'included every death in which ante-natal care had been absent or inadequate, even if there was no obvious link between the cause of death and the standard of ante-natal care. The figures also included deaths from abortion and the subjective labelling of negligence on part of the mother, which stringently included allowing herself to come into contact with family members who had recently suffered from a septic condition. However, overall, Loudon argues that the proportional split of blame upon obstetric care 'seems a realistic figure for avoidable causes' (Loudon, *Death in Childbirth*, p. 249).

⁷⁷² GCA, Reports to the Corporation of Glasgow including *Corporation of Glasgow: Maternity and Child Welfare: Memorandum by the Medical Officer of Health re Existing and Further Provision*, p. 908.

⁷⁷³ Crowther, *Social Policy*, p. 70; Jenkinson, *Scotland's Health*, p. 189; Lewis, *Politics of Motherhood*, p. 61; Beier, *For Their Own Good*, p. 36.

⁷⁷⁴ Beier, *For Their Own Good*, p. 83.

and mothers too. Indeed, here the value of considering the distinctive health experiences of individual groups is reinforced. These women were also found guilty of the ignorance and neglect of which working class women were regularly accused. For example, in 1930 the MOH stated that:

Obviously the medically attended births are concentrated in the residential districts, so that in the industrial and slum areas the proportion of doctors' cases is extremely low. Even among these, ante-natal supervision is often inadequate, frequently because the expectant mother puts off booking a doctor till pregnancy is far advanced.⁷⁷⁵

It was also implied that the failure of middle class mothers to obtain ante-natal care may have also contributed to a *higher* rate of ante-natal deaths within this group. For instance, one study found:

Perhaps, however, the most important feature of Miss Agnew's report is the support which it gives to the present-day developments in maternity and child welfare. It reveals in a striking fashion the different behaviour of the ante-natal and post-natal death rates in the two classes of society, and suggests that very different factors are at work at these two periods of life. If anything, the ante-natal death rate is higher in the well-to-do families when families of equal size are contrasted – a fact which is against the idea that environment is the determining cause. On the other hand, all varieties of the post-natal death rate, including the neo-natal rate, are very much lower in the good class families than in the poor class families, the poor class families of medium size occupying an intermediate position.⁷⁷⁶

⁷⁷⁵ RMOHG 1930, p. 84.

⁷⁷⁶ J. Agnew (From the Royal Hospital for Sick Children, Glasgow, and Physiological Department, the University of Glasgow, introduction by Prof. Leonard Findlay), 'Mortality Rates in Glasgow Families: An Analysis of the Various Kinds of Wastage of Child-Life in Well-To-Do and in Poor Families of Varying Size', *GMJ*, 3 (1922), p. 147; Also see *DHS: Neonatal Deaths due to Infection: The Report of a Subcommittee of the Scientific Advisory Committee*, HMSO 1947, p. 10.

In summarising Agnew's report, the *BMJ* similarly asserted that 'as charted, it appears that in respect of miscarriages and still births the well-to-do families are no better off than the poor families. In fact, if these data are to be relied on, the wastage is slightly higher in the former.'⁷⁷⁷

Indeed, there is some indication that the extension of state medical care was less widely welcomed by the middle class. For example, despite commenting extensively on the treatment and care she received by her own family doctor, when asked if the government generally encouraged people to 'be healthy' one middle class woman replied, 'I can't say, I think they kind of left it. I think there was a lot of clinics, but what the people went to the clinics [for], I never knew. You know how you weren't going and you didn't know what was going on in clinics.'⁷⁷⁸ Likewise, when writing to the editor of the *GH* regarding the medical inspection and treatment of school children one man wrote:

Secondly, cut out all this doctor's attendance etc for the children of middle class parents, who neither want it nor like it. It is an insult to these parents to consider them so negligent that they will not take proper care of their children's health. Let the children of parents who really need it have free attendance from their family doctor, and let him be paid out of public money, but only for the visits given.⁷⁷⁹

This is an interesting contrast to the official view that the ignorance and negligent childcare of working class mothers was damaging to infant health. Instead, there is an implicit suggestion of unwillingness among the middle class to utilise local authority health services – a reluctance which may have hindered the rate of improvement among children born to middle class parents. This also raises the important question of how the agency and health-related behaviours of different groups of the population impacted on

⁷⁷⁷ 'The Wastage of Child Life', *BMJ*, 14th October 1922, p. 696.

⁷⁷⁸ SOHCA/038/001 (1912).

⁷⁷⁹ *GGNHSBA*, HB38/2/5, 'Letter to the Editor: Teacher's Salaries', *GH*, 9th February 1933.

health trends related to social variables, and this is discussed in more depth in chapter seven. However, surprisingly, there is also evidence that there were fewer facilities for middle class mothers to turn to during pregnancy and articles published in Glasgow newspapers suggest that there was resentment among this group about the lack of attention they received.⁷⁸⁰ For instance, an article published in the *Bulletin* reporting on developments at *Redlands Hospital* in Glasgow stated that the hospital 'was providing a valuable service to the community in providing maternity and general hospital service at a moderate cost for that section of society that is usually left to fend for itself – the middle class.'⁷⁸¹

Illustration 5.2: Image of mother being interviewed at Cowcaddens Day Nursery dated 1922. Note that the woman in the picture is wearing a shawl – a contemporary indication of a woman of lower social class



SOURCE: *Virtual Mitchell*, Mitchell Library Glasgow, Record Number C2964.

⁷⁸⁰ See *DHS* 1935 publication on maternal morbidity and mortality for discussion on the different types of maternal health care utilised (Douglas and McKinlay, *Report on Maternal Morbidity and Mortality in Scotland*, p. 22).

⁷⁸¹ *GGNHSBA*, HB10/2/15, 'Run by Women for Women'; 'Medical News: Hospitals and Paying Patients', *The Lancet*, 1, 1920, p. 631; Crowther, *Social Policy*, p. 73; Advertisement for Queen Alexandra Hospital – 'The institution is for one class only (for which little is done) i.e. incurable sufferers of the middle classes' (Advert in *GH*, 29th May 1920, p. 8).

Kerr argued that expectant mothers of all social classes could survive pregnancy relatively unharmed if they were committed to ante-natal supervision and the advice they received, and that while maternity institutions were often located 'in densely populated industrial areas' and tended to deal with the 'very poorest class', it was noted that they 'all minister to individuals in very humble circumstances.'⁷⁸² However, it is certainly clear that a number of facilities were in place for the maternal care of working class mothers, and statements suggesting that services were deficient among the middle class are at odds with the favourable experience suggested by the majority of health statistics for this group (Illustration 5.2). This lends further support to the importance of considering the human experience behind the numbers which, as this research has shown, can reveal the contradictory and more complex health experiences from that implied by static statistical analyses. Furthermore, the notion that the 'working class' were the chief beneficiaries of ante-natal welfare provision can be disentangled further where experiences could vary within the working class itself. For example, when commenting upon maternal and child welfare in Glasgow, the study by Paton and Findlay claimed that 'the mothers attending the centres were distinctly poor, but they did not belong to the very poorest and lowest class, which presumably avoids centres altogether [and] the child welfare officer expressed the opinion that the centres did not reach the fringe of society.'⁷⁸³ Therefore, this suggests that while a growing motivated majority were participating in the infant and maternal health campaign, inequalities intensified here also, where this group became increasingly disadvantaged in relation to the maternal population as a whole.⁷⁸⁴

⁷⁸² Kerr, *Maternal Mortality and Morbidity*, p. 189; Kerr and Sharman, 'An Investigation into Maternal Mortality and Morbidity in the Domiciliary Services of Maternity Hospitals', p. 201.

⁷⁸³ Paton and Findlay, 'Poverty, Nutrition and Growth', p. 29.

⁷⁸⁴ This is also important where evidence has shown that a myriad of social problems are created when inequalities widen. See R. Wilkinson and K. Pickett, *The Spirit Level: Why More Equal Societies Always Do Better* (London: Allen Lane, 2009); Also see Beier, *For Their Own Good*, pp. 88, 103, 144.

There are also important reasons why women lower down the social scale did not seek medical advice to improve the health of their families, motives which writers like Jones claim that critics could often fail to understand.⁷⁸⁵ However, at a Westminster conference arranged by the *National Association for the Prevention of Infant Mortality* and the *National Baby Week Council* in July 1921, the attendees visiting from Glasgow played down the impact of maternal ignorance and emphasised the need for improved social conditions. Glasgow M.P. James Stewart (Scottish Labour Party) reportedly claimed 'that many difficulties did not arise through ignorance, but purely and simply owing to social conditions, and until such conditions were adequately ameliorated, and every mother had all that was necessary for the wellbeing and comfort of herself and her child, there would be no good done' – a view that was reiterated by Councillor Angus MacDougall of the *Subcommittee on Child Welfare, Glasgow*.⁷⁸⁶ Indeed, for many women a number of matters had to be considered before attending clinics, including the distance of facilities from the family home and the availability and cost of transport.⁷⁸⁷ For example, the *GRMWH*, which operated a policy never to refuse a woman in labour, commented on the difficulty this created for the hospital and mothers alike:

Under present circumstances it would appear to be possible to depart from this rule, and its strict observance as a criterion of admission gives rise to considerable difficulty, if not hardship, especially as regards cases coming from a distance. There is evidence that women, knowing that they will not be admitted before labour has commenced, are afraid to go to hospital after it has commenced, and the question of transport and distance becomes then a material consideration. From enquiries made there is no doubt that a considerable number of women would avail themselves of institutional

⁷⁸⁵ Jones, *Health and Society*, p. 60.

⁷⁸⁶ 'Conference of Infant Welfare, Westminster', *Lancet*, 16th July 1921, p. 151.

⁷⁸⁷ 'Education for Health', *GH*, 20th July 1938, p. 10.

facilities were it not for fear of undertaking the journey after labour has commenced, or risking refusal of admission.⁷⁸⁸

Moreover, a feature on 'Glasgow's Maternity Problem' published in the *BMJ* noted:

Attendance at the clinic is a social difficulty for most of the patients. Frequently she has long distances to travel, a heavy burden for a pregnant woman in her late weeks; the money necessary for car fares is a drain on her financial resources; and the period of waiting at clinics (unavoidable in their present crowded condition) is a domestic problem for one who has perhaps other young children to look after and household work to do. The difficulties can be overcome only at the expense of opening centres in all parts of the city. Or by allowing the patient to attend the conveniently situated family doctor.⁷⁸⁹

It is significant that the number of calls to the *St Andrew's Association* for an ambulance to the *GRMWH* rose by 75 per cent following the removal of a small fee formerly levied.⁷⁹⁰ Therefore, it is clear that poverty and the ability to pay still contributed significantly to the health of the city's working class women. Variations also existed in relation to geographic region. Glasgow was recognised for the degree of services it offered to women. However, some regions of the city simply lacked adequate provisions.⁷⁹¹ For example the Garngad and Townhead districts were said to be 'not well served' with infant and child welfare facilities.⁷⁹² A memorandum presented by representatives of the *Glasgow Obstetrical Society* at a conference with the *Committee on Child Welfare* in 1925 similarly asserted that 'the hospital accommodation for maternity cases in the city of Glasgow is totally

⁷⁸⁸ *RMOHG* 1929, p. 53.

⁷⁸⁹ 'Glasgow's Maternity Problem: Memorandum of Glasgow Division', *Supplement to the BMJ* (SBMJ), 10th June 1933, p. 251.

⁷⁹⁰ Kerr, *Maternal Mortality and Morbidity*, p. 319.

⁷⁹¹ 'Annual Representatives Meeting: Puerperal Morbidity and Mortality', *SBMJ*, 4th August 1928, p. 58.

⁷⁹² *RMOHG* 1934, p. 56.

inadequate.⁷⁹³ The number of women seeking professional advice during their pregnancy increased. However, this evidence reveals that for some, facilities were simply not available. This unequal distribution of medical resources is consistent with the view that variations according to geographic region also characterised health experiences in interwar Glasgow and that this contributed to the marked inequalities across the city. Again, within broad improvements in terms of ante-natal and maternal care and medical assistance available to mothers, experiences were unequal, varying not least with regards to social position and geographic region.

Caring and Surviving

The previous section has analysed the role of mothers in the care of their children through their participation in ante-natal and child welfare programmes. However, in everyday life, the role of women in relation to health experiences within the home was paramount. Jones asserts that any research into public health should study women in their own right due to their significance in assuring good health in the family.⁷⁹⁴ This was also captured by oral testimony where one man recalled that it was 'your mother and your granny [that] tried to keep you healthy' (Illustration 5.3).⁷⁹⁵ The more recent publication *For Their Own Good* by Lucinda McCray Beier details this extensively, whilst also analysing the importance of mutual aid networks, including other female neighbours and community 'handy women' during labour for example.⁷⁹⁶ It has also been noted that women wanting to avoid

⁷⁹³ *RMOHG 1929*, p. 54.

⁷⁹⁴ Jones, *Health and Society*, p. 58.

⁷⁹⁵ SOHCA/038/002 (1927); Also see Paton and Findlay, 'Poverty, Nutrition and Growth', pp. 5, 233.

⁷⁹⁶ Beier, *For Their Own Good*.

another pregnancy and 'get regular' would consult other women for advice.⁷⁹⁷
This was certainly the case in Glasgow.⁷⁹⁸

Illustration 5.3: Women's parenting role within the home



SOURCE: Gladstone Robertson, *Gorbals Doctor*.

The role of the mother had a biological and social dimension and this was important politically. In 1920 for example the *SBH* commented that 'the local authorities all over Scotland now generally recognise that to secure the health of mothers and young children is to lay the foundations of a healthy

⁷⁹⁷ Szreter and Fisher, *Sex before the Sexual Revolution*, p. 95.

⁷⁹⁸ For example, see Douglas and McKinlay, *Report on Maternal Morbidity and Mortality in Scotland*, p. 22; Robbie, *Privileged Boyhood*, pp. 34-5, 38-9, 44-5, 176.

adult population.⁷⁹⁹ Government schemes aimed at improving infant and maternal welfare viewed the education of mothers as an effective means to combat high maternal and infant death rates.⁸⁰⁰ As Jenkinson states, 'the main and lasting aim of infant and maternal welfare centres and health visitors in this field of care was preventative: to educate women in better habits to look after themselves and their babies.'⁸⁰¹

The drive to educate mothers has been interpreted critically by various authors and Jenkinson notes how 'some historians have suggested that this reveals more about the State's desire to control the lives of mothers, rather than with improving infant and maternal mortality rates.'⁸⁰² Nevertheless, there are indications that a lack of parental knowledge did affect children's health. For example, in 1938 the MOH reported on the need for urgency in the admittance of children suffering from diphtheria to hospital:

There still appears to be some delay by parents in seeking medical advice, and too often the disease is well advanced when the victim is ultimately admitted to hospital. Only 52 per cent of those dying were admitted to an institution within two days of sickening; 73 per cent were removed within three days of sickening; and 87 per cent were removed within four days of sickening. Eleven children were ill at home for one week or longer before removal took place.⁸⁰³

This hesitancy was also captured in the published memories of Rountree who recalled how the doctor 'gave my parents fits for not calling him sooner'

⁷⁹⁹ *ARSBH 1920*, p. 81.

⁸⁰⁰ *GUSC*, Spec Coll, 2978, pamphlet, *Scheme for Maternity and Child Welfare* (1926), p. 12; *Evidence to be Submitted to Committee on Scottish Health Services*, p. 10; GCA, DHS 1/1/4, *Maternity and Child Welfare Schemes*, p. 9.

⁸⁰¹ Jenkinson, *Scotland's Health*, p. 188.

⁸⁰² *Ibid.*, p. 188.

⁸⁰³ *RMOHG 1938*, pp. 95-6; Similar statement made about diphtheria and pneumonia in *Evidence to be Submitted to Committee on Scottish Health Services re The Medical Services*, pp. 17, 22.

following a leg injury.⁸⁰⁴ Commenting upon the failure of someone to notice that his ailment was worsening, Rountree states 'I suppose mum might be to blame for this, because she would have had the task of attending to changing the dressings.'⁸⁰⁵ Some mothers also practiced domestic medicine before admitting family members to hospital. In 1927 the MOH reported:

Many children affected by pneumonia whether primary or secondary, undoubtedly require hospital treatment. It is too serious to be nursed at home, while many homes are quite unsuited for its treatment. Unfortunately, these children are not all admitted in the early stages, and many reach hospital extremely ill after a few days of domestic treatment which includes the free use of ipecacuanha wine, whisky, and poultices, often hot enough to cause burns.⁸⁰⁶

This statement, cited from an official medical text, was almost identically recalled by Glaswegian George Rountree describing his childhood in Govan in the 1930s.⁸⁰⁷ Another man similarly recalled the existence of 'granny's cures' to relieve certain ailments.⁸⁰⁸ Beier argues that 'in times of childbearing, ill health, and death, working class people depended on mutual aid exchanged within family and neighbourhood networks. Indeed, the question of what an informant's childhood neighbourhood had been like almost always elicited a response about the help neighbours gave each other during health crises.'⁸⁰⁹ Indeed, the life story of Molly Weir for example, provides a comprehensive list, several pages long, of home remedies used to cure a number of afflictions from rheumatism to toothache, details the superior skills of her grandmother in the treatment of eye ailments, and

⁸⁰⁴ Rountree, *Govan*, p. 220; However, this was not always the case where one man from neighbouring Rutherglen recalled that 'if you were a child you got the doctor straight off' (SOHCA/038/002 (1927)).

⁸⁰⁵ Rountree, *Govan*, p. 220.

⁸⁰⁶ *RMOHG 1927*, pp. 109-10.

⁸⁰⁷ Rountree, *Govan*, pp. 71-2.

⁸⁰⁸ SOHCA/038/002 (1927).

⁸⁰⁹ Beier, *For Their Own Good*, p.10.

another woman recalled how her mother made her own cough medicine.⁸¹⁰ This was often a consequence of poverty. One woman recalled:

Aye, there were a lotta doctors. But then you did'nae dare get a doctor to come to our hoose. 'Cause few people could afford to have a house call. They could'nae afford to pay a doctor to come unless, as I say, it was an urgent thing. But any minor childhood thing your mother doctored you and that was that. But there was nothing to help you if your mother had'nae the money. Forget it. You wir'nae getting any.⁸¹¹

Again, the acquirement of treatment was often compromised by financial restrictions and the ability to pay, a reality common throughout the UK.⁸¹² As Cherry states, 'fear of the doctor's fee or poor law institution often still accompanied the pain and uncertainties of illness.'⁸¹³

Nevertheless, these allegations of 'negligence' can also be qualified by clear evidence that women played a direct role in attempting to maintain and improve the health of their children and family. The increasing attendance of women at ante-natal clinics and child welfare inspections detailed above is testament to this point. However, the employment of a number of 'survival techniques' also reinforces the extent to which women played a positive role in securing the health of their families, often at their own expense, and these are discussed extensively in the historiography. Mothers had to ensure that meagre budgets were stretched in order to buy basic commodities, and a number of money saving devices were employed.

⁸¹⁰ SOHCA/009, Domestic Violence, Ms AO (1916); Weir, *Best Foot Forward*, pp. 50-5; Similar remedies recalled by *2000 Glasgow Lives*, Faye Doran (1907); For a humorous take on traditional Scottish solutions for ailments and issues such as colds, headaches, bunions, indigestion, hangovers, slimming, beauty aids and general domestic cleaning tips see *Mama Broon's Remedies and Suchlike* (my wee book o' bits an' pieces) (Glasgow: Waverley Books, LTD, 2009). 'The Broon's' is a popular comic strip of a Scottish family first published in the *Sunday Post* in 1936.

⁸¹¹ Faley, *Up Oor Close*, pp. 150, 151, 152.

⁸¹² Beier, *For Their Own Good*, p. 93.

⁸¹³ Cherry, *Medical Services and the Hospitals in Britain*, p. 2.

For example, some did not utilise the appliances provided in new homes, which were intended to enhance living standards, in order to save money (Chapter 4). Whilst this was deemed undesirable in the eyes of housing officials, it was domestic management. The women of interwar Glasgow exercised a number of domestic strategies like this to defend their families from the adverse effects of poverty. In her much cited publication *Working Class Wives*, Margery Spring Rice repeatedly congratulates Scottish women (although she cites Glaswegian examples) for their success in the management of meagre working class budgets, stating that it was 'noticeable that the Scots and women from the north of England are better managers than those in the South.'⁸¹⁴ An article published by the *Lancet* in 1921 similarly reported that 'mother craft in the choice of food-stuffs does not appear to have sunk so low in Glasgow as in many other large towns'.⁸¹⁵ Survival techniques such as borrowing from neighbours, utilising the pawn shop, securing credit from shop keepers, buying discounted stale bread, 'broken biscuits' and 'spoiled fruit', walking to a shop further away to save small amounts of money and buying skimmed as opposed to full milk for children are a few of the methods women employed to make ends meet.⁸¹⁶ Significantly, the effective management of resources was important in more prosperous homes as well. For example, in response to the question 'was your dad's wage an adequate wage or not?' one relatively wealthy woman replied: 'It was an adequate wage and my mother was a good manager, you know.'⁸¹⁷

⁸¹⁴ Spring Rice, *Working Class Wives*, pp. 74, 165.

⁸¹⁵ 'Family Food Budgets: A Maintenance Ration', *Lancet*, 15th July 1922, p. 138.

⁸¹⁶ SOHCA/038/001 (1912); Paton and Findlay, 'Poverty, Nutrition and Growth', pp. 149, 160; GGNHSBA, HB38/2/5, 'Skimmed Milk: Valuable as Food: Glasgow Doctor's Comment', *Citizen*, 5th January 1929; McGuckin, 'Moving Stories', p. 212; Weir, *Best Foot Forward*, p. 173; Clark and Carnegie, *She Was Aye Working*, p. 96; *2000 Glasgow Lives*, Joyce Booth (1912); SOHCA/009, Domestic Violence, Ms AQ (1908).

⁸¹⁷ SOHCA/038/001 (1912).

However, while domestic management would have been universal in most households to some degree, the extent to which this was practiced in poorer homes could be severe. For instance, it was found that some Glaswegian women were frequently 'scantily clad' and could not 'attend consultations because they have pawned their shawls.'⁸¹⁸ One man from the area of Anderston also recalled that his mother often walked a few miles to a meat market in another district to buy cheap tripe bags: 'But the way she got them for next to nothing was they were full of shit. She got them to clean. My mother knew when she got them home [home] she could clean them all up before she put them in a pot tae, boil them up and give us tripe.'⁸¹⁹ These survival strategies were often effective and the authors of one medical survey found that 'during a week of poverty the food consumed is often little if at all decreased; borrowing from neighbours carries the family over these bad times and expenditure on rent, fire, clothes etc, is allowed to lapse, in order that food may be purchased.'⁸²⁰ Commenting on the conditions of nine Glasgow families they quoted that all but two mothers employed efficient domestic strategies which ranged from buying a large number of carbohydrates to satisfy family hunger to making bland meals more appetising.⁸²¹ This was acknowledged by the *Ministry of Labour* who claimed that in Scottish districts notably affected by industrial decline, 'undernourishment and raggedness have only been avoided by good management and most careful spending.'⁸²² Glasgow Corporation similarly stated that 'the widespread and long continued unemployment has thrown a severe strain on family resources, and in the circumstances it is surprising how well, as a rule, the income has been expended.'⁸²³ Clearly, the survival

⁸¹⁸ *RMOHG* 1923, p. 44.

⁸¹⁹ *2000 Glasgow Lives*, Robert Young (1902).

⁸²⁰ Paton and Findlay, 'Poverty, Nutrition and Growth', pp. 149, 160.

⁸²¹ *Ibid.*, pp. 322-23.

⁸²² This report primarily considers Lanarkshire (excluding Glasgow). However, it is thought that the reasons for this were largely political since socio-economic conditions in Glasgow were similar (*Ministry of Labour Reports of Investigations into the Industrial Conditions in Certain Depressed Areas*, HMSO 1934 (4728), p. 220).

⁸²³ *Evidence to be Submitted to Committee on Scottish Health Services re The Medical Services*, p. 123.

techniques employed by working class women went some way to securing the health of their families, as endorsed by Thompson.⁸²⁴

Nonetheless, despite clear class inequalities this was more complicated still, and a complex interaction existed between the effective utilisation of survival strategies, social class and the employment situation of the household. For example, one Glasgow study carried out in the early 1920s by A.M.T. Tully found that survival techniques utilised by the 'unemployed labouring class' included purchasing cheap cuts of meat such as corned mutton or frozen meat and misshapen bread. However, a follow up study considering the conditions of artisan families, found that some of these mothers were guilty of waste and bad marketing by failing to provide families with the maximum energy value which could be procured from scarce resources.⁸²⁵ According to Tully 'the marketing of the greater number of the [artisan] mothers was decidedly poor, most of them not being compelled by necessitous circumstances to consider the value of every penny spent as was the case with the unemployed families studied in 1922.'⁸²⁶ This was illustrated by a table published in the report which compared the diets of these two groups (Table 5.9).

Table 5.9: Table comparing the diets of artisan families with those of labouring-class families (unemployed and short-time)

Average Diet per Man per Day							
Date	Income	Calories	Protein	Fat	Carbohydrate	Amount spent on food per man	Energy value purchased per 1d
	A.Labouring Class Families						
April 1921	Over 8/- per man per week	2466	72.9	77.6	352.5	9/1 ¼	173.8
June 1922		2605	78.4	87.7	358.0	6/1	237.3
April 1921	Under 8/- per man per week	2505	64.1	73.3	380.4	6/1 ¼	219.8
June 1922		2185	62.6	61.3	330.7	3/10 ¼	302.3
	B. Artisan Family						
May 1923		3070	87.9	96.8	441.1	10.38/-	176.6

SOURCE: A.M.T. Tully, 'A Study of the Diets and Economic Conditions of Artisan Families in May, 1923', *GMJ*, 101 (1924), p. 5.

⁸²⁴ Thompson, *Unemployment*, p. 46.

⁸²⁵ Tully, 'A Study of the Diets and Economic Conditions of Artisan Families in May, 1923', p.

6.

⁸²⁶ *Ibid.*, p. 5.

The table reveals that the energy value purchased was lower among the artisan group – a variance which the writer asserted could not be explained by changes in the cost of living between these years. Domestic survival strategies were not as diligently exercised in the everyday life of women from this group who were less used to experiencing poverty. On the other hand, the table suggests that the wives of unskilled labourers, used to low wages and the task of making meagre incomes stretch, were more experienced and efficient in this role. This was reinforced by Paton and Findlay who also documented the importance of good domestic management for Glasgow labouring-class families *in* employment.⁸²⁷

This data suggests that the women from artisan families, in spite of their poorer skills in domestic management and ability to assure maximum energy food values, did secure a higher number of calories overall. However in the artisan group, only 6 of the 17 families studied were affected, or had been previously affected, by unemployment or short time.⁸²⁸ It was also reported that when necessary, this group ‘had savings wherewith to tide them over periods of unemployment’, and so presumably they had more disposable income to spend on food.⁸²⁹ Nonetheless, domestic management practices among this group, combined with notions of respectability and attempts to avoid the stigma of parochial relief, had important health consequences when savings were exhausted and financial security solely relied upon state assistance (see chapter 6). Indeed, in light of the importance of ‘keeping face’, it is unsurprising to learn that the ‘mis-reporting’ of nutritional intake is common even today, and that this could often be influenced by factors including levels of deprivation – the wealthier often showing a tendency to exaggerate food consumption and the poor the opposite (although it is important to note that an inverse relationship has also

⁸²⁷ Paton and Findlay, ‘Poverty, Nutrition and Growth’, pp. 162, 163.

⁸²⁸ Tully, ‘A Study of the Conditions of Artisan Families in Glasgow’, pp. 12-3.

⁸²⁹ *Ibid.*, pp. 12-3.

been recorded).⁸³⁰ Furthermore, recent research suggests that particular food consumption patterns can be an important, deliberate attempt to intimate 'status' and respectability.⁸³¹ Therefore, rather than reflecting inefficiency in the management of resources, there is also the possibility that the wives of artisan workers affected by unemployment actively decided to continue to purchase these menus to outwardly display the living standards they had enjoyed in better financial times, satisfy their families typical dietary expectations, maintain morale within the family, and also protect their own image as competent domestic managers (see chapters 6 and 7). Nonetheless, when considering the varied approaches of women in the management of household resources, the notion that health experiences were multifaceted is further reinforced. As the literature details extensively, women were clearly vital to health experiences within the home. However, the techniques and effectiveness of women in this role was not universal. Experiences were unequal and standards of health were fashioned by the complex interaction between gender, class and employment position at least within this social arena.

Men, Masculinity and Health

Interwar medical, official and lay sources consistently emphasised the responsibility of women as health providers and the effects that the economic depression could have upon their health. It is not surprising therefore that in their analyses, historians have tended to examine the health of interwar women in this way. Macdonald has recently asserted:

⁸³⁰ J.J. Lara, J.A. Scott and M.E.J. Lean, 'International Mis-Reporting of Food Consumption and its Relationship with Body Mass Index and Psychological Scores in Women', *Journal of Human Nutrition and Dietetics*, 17 (3), 209-18; Also thanks to Mike Lean, Professor of Human Nutrition, University of Glasgow, and Consultant Physician at Glasgow Royal Infirmary, for his helpful correspondence and summary of the relationship between 'social position' and the inaccuracies in self reporting of dietary intakes.

⁸³¹ Wilkinson and Pickett, *The Spirit Level*, pp. 25, 96.

Unlike most other areas of Scottish society, women were central to the operation of the family. Males, by comparison, appeared to contribute remarkably little to discourses on family life. But that silence is important. It might either denote a dismissive attitude to the family, marking it out as female territory and hence unimportant, or it simply reflects that men remained in control of what was considered really important – the public world out with the home.⁸³²

However, it seems that discussions on the role of women as carers has been ill focused. Men were also integral to securing the health of their families *within* the home yet, excluding a few like Thompson, in the context of debates on interwar public health this is rarely mentioned by historians.⁸³³ Abrams notes that ‘the history of the family is extraordinarily under researched in Scotland, the historian has traditionally portrayed the (male) culture of industry and the (female) culture of the home and family in different worlds in which the father has been located as ‘elsewhere’ than with his children.’⁸³⁴ Likewise, medical and social investigators rarely, if at all, made reference to the role of fathers and instead continually referred to levels of ‘maternal efficiency’. Indeed, one study which considered health in Glasgow, and aimed to identify the statistical significance of a number of social factors to the health of children, explicitly stated that they would not examine the role of fathers due to the negligible role they assumed that they played, and instead they investigated the role of ‘maternal efficiency’ alongside other social factors such as housing. They stated: ‘the influence of the father is less direct and apart from disease, drink, crime, or unemployment, leading to insufficiency of earnings, is manifestly of secondary importance. This is fortunate, since it is extremely difficult to gain reliable information about

⁸³² Macdonald, *Whaur Extremes Meet*, p. 160.

⁸³³ Thompson, *Unemployment*, p. 85.

⁸³⁴ L. Abrams, ‘There Was Nobody like my Daddy’: Fathers, the Family and the Marginalisation of Men in Modern Scotland’, *Scottish Historical Review*, 77 (1999), p. 219; R. Dixon, ‘Midwives as Husbands? Midwives and Fathers’, in J. Bornat, R. Perks, P. Thompson and J. Walmsley, eds., *Oral History, Health and Welfare* (London: Routledge, 2000); Beier, *For Their Own Good*, p. 73; E. Gordon and G. Nair, ‘Domestic Fathers and the Victorian Parental Role’, *Women’s History Review*, 15 (4), (2006), p. 551.

him.⁸³⁵ Despite admitting that there was a dearth of information on the role of the father, the authors were so confident about his insignificance that they thought it unnecessary to investigate further. This speaks volumes of the strength of conventional notions of masculinity and femininity in the interwar period.

In fact, the cultural responsibilities of parenthood also extended to fathers, and while commentaries on the unequal allocation of resources in the home have focused upon females, this similarly applied to men (Illustration 5.4). Fathers were said to be responsible for the direct provision of food by tending to family allotments where they existed, and they could also adopt self-sacrificing strategies to ensure that other family members were adequately fed.⁸³⁶

⁸³⁵ Later in the report they similarly stated: 'Apart from ante-natal influence and the effects upon the home of drunkenness, laziness, and vice, the influence of the father upon the young child is manifestly much less important than that of the mother. This is fortunate since it is practically impossible to collect information as to the character and habits of the father' (Paton and Findlay, 'Poverty, Nutrition and Growth', pp. 5, 250).

⁸³⁶ M74, Christina Wilson (1918).

Illustration 5.4: Picture taken in the East End of Glasgow. Note the men wearing hats ('bunnets'), one holding a child's hand (left)



Near the Gallowgate, Glasgow, around 1930: unemployment and the pawnshop.

SOURCE: T.C. Smout and S. Wood, *Scottish Voices* (London: Collins, 1990).

In one letter to the editor of the *GH* it was said that 'no normal father – and much less a mother – would ever dream of eating while their children went without food.'⁸³⁷ Another newspaper article asserted that 'the condition of children is not, however, conclusive on the question of malnutrition. It is well known that *parents* will stint themselves so that their children may be fed [my

⁸³⁷ 'Letter to the Editor: Feeding of School Children', *GH*, 23rd November 1922, p. 7.

italics].⁸³⁸ One woman also recalled that during times of unemployment, ‘our parents would have done without to feed us.’⁸³⁹ Consequently, this complicates and adds an additional dimension to the focus of historians that women’s health was affected by the unequal allocation of resources in the home. This sacrificing behaviour could also undermine health standards among fathers. For example the MOH observed that the age-sex distribution of tuberculosis complicated the administration of successful treatment as the high incidence prevailing among women aged 15-35 years meant many were mothers, whilst the high incidence among males in the 35-55 years age group meant that many were breadwinners. Hence the MOH reported that there was unwillingness among these patients to make use of lengthy institutional treatment because mothers had to attend to young families while fathers had to work to support them.⁸⁴⁰ This was also captured by oral testimony. One woman from the Anderston area of Glasgow recalled:

TB was rife. At least one third [of Anderston] were wiped out. I knew personally a whole family that were wiped out [in the twenties]. I remember this young couple that we knew, moved into a place, got into this, and he was standing outside and he was awfully ill, and I was standing chatting to him. And I said to him “Where are you going, is this the day for your clinic up in Glenfarg Street.”⁸⁴¹ He says, “Yes, I’m just going to put on some weights.” I said, “What for?!” He says, “Well, she’s pregnant and I don’t want to go into hospital with my condition” he says “so if I go in there they’ll lend me some weights and I’ll put them in my pocket. So, I go up”, he said, “and what we do, we go on the scale right away and get weighed, so they’ll know I’ve not lost much weight.” To this day I’ve never forgot it, he was only a boy.⁸⁴²

⁸³⁸ GGNHSBA, HB38/2/5, ‘Nutrition’, *The Evening Citizen*, 3rd March 1936.

⁸³⁹ Faley, *Up Oor Close*, p. 62.

⁸⁴⁰ *RMOHG 1937*, p. 118; Also see Gladstone Robertson, *Gorbals Doctor*, p. 63.

⁸⁴¹ A tuberculosis dispensary (See GCA, D-TC, 7/11/6 Notes on Hospital and Infirmary Arrangements in Glasgow (Published by Glasgow Burgh and Panel Committee and the British Medical Association, West of Scotland Branch, 1932), p. 25).

⁸⁴² *2000 Glasgow Lives*, Katy Lang (1913).

In their article 'Dangerous Work, Hard Men and Broken Bodies', Johnston and McIvor also point out that men could continue to work in an environment knowingly detrimental to health due to their responsibility to provide a wage for their families at home.⁸⁴³ Thus, fathers also sacrificed their health to secure the wellbeing of their families.

Men could also be directly involved in the delivery of their children. One Glasgow woman recalled of her childbirth: 'It was traumatic. Nothing was prepared because we had no hot water. I should have had the baby in the hospital but there wasn't enough room so they sent me home. My husband had all the work to do.'⁸⁴⁴ One Glasgow doctor also detailed that during a home birth in the Gorbals tenements, 'the husband too was, as a rule, up to his neck in it. It was his duty to fetch the doctor or nurse and to be completely at the service of his wife and the women about her.'⁸⁴⁵ Indeed, this also substantiates the importance of community health networks advanced by writers including Beier.⁸⁴⁶ Moreover, it is significant that around 1927 a 'Father's Council' was formed in the Govan district, followed by another in Bridgeton in 1930. It was reported that the groups organised social events such as drives in the winter and outings in the summer, children's Christmas parties, and a monthly lecture by a guest speaker was arranged.⁸⁴⁷ In one notable instance, the *GP* published details on a lecture made to the 'men's section' of the Elder Park Welfare Centre in which the role of men in childrearing was the topic of the evening. Presumably, this was related to the Govan Father's Council where in the MOH's 1937 report, the sub heading 'Father's Councils' was replaced by 'Men's Section', and under this details of the Elder Park Welfare Association of the Govan district are discussed.

⁸⁴³ Johnston and McIvor, 'Dangerous Work', p. 145.

⁸⁴⁴ Peoples Palace, Cathy Dodwell, born 1920s Drumchapel; For a similar interpretation see Roberts, 'Working Wives and their Families', in Barker and Drake eds., *Population and Society in Britain 1850-1980*, p. 152.

⁸⁴⁵ Gladstone Robertson, *Gorbals Doctor*, p. 15; Also see Blake, *Shipbuilders*, p. 133.

⁸⁴⁶ Beier, *For Their Own Good*.

⁸⁴⁷ *RMOHG 1932*, p. 57; *RMOHG 1935*, p. 62.

How popular these lectures were (presented regularly by male doctors and also the MOH Macgregor himself) is difficult to determine, although one report mentions an audience of 400.⁸⁴⁸ The social character of the audience is also unclear. The lecture material was often particularly medical, suggesting that it was perhaps not catered towards the ordinary working man, and probably those with a medical or professional interest. Nonetheless, at one meeting on maternal mortality in Scotland it was said that 'the newer members would now be in a better position to discuss some of their household problems with their wives.'⁸⁴⁹ In another lecture delivered in 1935 it was said that:

The authorities made a large step forward when they opened ante-natal and child welfare centres, and altering the law in the interests of midwives in the interest of mothers. However, it must be understood that the husband plays a very important part from a medical standpoint as they have a very large influence over their wives.⁸⁵⁰

The lecture then lists the 'educational' information that women also presumably received when attending the welfare centres, including the importance of breast milk and of the feeding of infants at four hour intervals. However, rather than taking a central role in the upbringing of their children, the fathers were advised:

The part the husband should play is one that encourages the mothers to take advantage of the clinics, to influence and help his wife in the proper methods that are advised by the doctors in charge. By doing this, said the speaker (Dr. D. McKay Hart), the benefits of the welfare will be more appreciated by all, and will result in still more life receiving a better start in life.⁸⁵¹

⁸⁴⁸ The *RMOHG* reported in 1930 that the average attendance 'at last winter's course' was 40 (*RMOHG 1930*, p. 80); An article in 1933 registered 75 attending the lecture with over 100 members of the Elder Park Scheme (*GP*, 10th March 1933, p. 7).

⁸⁴⁹ 'Maternal and Infant Mortality', *GP*, 13th January 1933, p. 9.

⁸⁵⁰ 'Care of the Child: Elder Park Welfare Centre Lecture', *GP*, 6th December 1935, p. 5.

⁸⁵¹ *Ibid.*, p. 5.

Therefore, here, fathers were encouraged to have an educational purpose – implementing medical advice and support as an extension of the medical arena, and reinforcing traditional gendered responsibilities within the home – rather than into adopting a direct role in the health care of their children. Likewise, of fourteen welfare centres in Glasgow in 1934, only two (Bridgeton and Govan) created Father's Councils. The number is small, and it seems that the formation and participation in the councils may have been more for social rather than medical reasons.⁸⁵² Nevertheless, it is clear that men were not absent in the care and welfare of their children, and that they also contributed to health experiences within the home.

On the other hand, it is clear that fathers could contribute negatively to health experiences within the household, as has been more widely recognised by historians. For instance, men carried infection from the workplace into the home (although this relationship could easily work the other way) and Johnston and McIvor note that wives could also develop asbestos-related cancers for example, 'simply through contact with asbestos dust brought home on the work clothes and overalls of their husbands, sons, or fathers'.⁸⁵³ There is also evidence that the strain and tension resulting from male unemployment was detrimental to standards of childcare, and that it could lead to domestic violence within the home. Here, the notion that health experiences were characterised by a number of variables can be maintained where the employment status of the household was clearly important. Bourke claims that the emasculation which many men felt after being forced out of work could aggravate conflict in the home, and that 'quarrels between unemployed husbands and their wives disrupted

⁸⁵² For example, when discussing the efforts of the child welfare schemes, one report stated that 'the social side commonly takes the form of mothers' clubs, and at two of the centres a fathers' council has been formed' (*Evidence to be Submitted to Committee on Scottish Health Services re The Medical Services*, p. 110).

⁸⁵³ R. Johnston and A. McIvor, *Lethal Work: A History of the Asbestos Tragedy in Scotland* (East Lothian: Tuckwell Press, 2000), p. 144.

childcare.⁸⁵⁴ Consequently, the *SBH* reported that the resulting atmosphere was particularly unsuitable for children.⁸⁵⁵

Indeed, when writing about the implementation of the new children's charter in Scotland in 1933, the Scottish Justices and Magistrates Association submitted the following statement to the *GH*:

There must be at present numbers of people who are in an overwrought state of mind, whose mental health is below normal. It is not only the effect of unemployment upon the parents that has to be thought of. Putting aside deprivation of physical comforts as less important, one has to remember children growing up in the atmosphere of constant frustration and discouragement... An unemployed father always about the home to remind a worried mother of the household position, idle older brothers and sisters inevitably deteriorating into squabbling inefficiency, and a constant uncertainty about the tomorrows make no healthy environment for a developing youngster.⁸⁵⁶

An Anderston man also revealed that this could result in domestic violence:

About 1927 or 1928 ma mother was getting it bad, my father wisnae working. And he was, going oot and maybe getting an odd job, a couple of bob but was drinking it. And he was coming in and. She went through a lot. A don't like to talk. Susan used to no like, a tell her about ma father doing, walloping my mother. You know... And my maw was trying to bring us all up, and that, you know... Well my auntie Flora got to know and she was always onto my mother saying "Jail him, gee him the jail, gee him the jail." But ma mother would'nae gee

⁸⁵⁴ Bourke, *Working Class Cultures*, p. 95.

⁸⁵⁵ *ARSBH 1923*, p. 194.

⁸⁵⁶ 'Unemployment', *GH*, 31st October 1933, p. 7.

ma father the jail for big black eyes and this and that. So. Two of they times he thumped me anol [as well].⁸⁵⁷

This was also captured in contemporary literature where in *No Mean City* one character was struck repeatedly after pointing out to her father during an argument that she was the only one working in the house. The author writes 'Richard McKay had been out of work for two years and the taunt was more than he could endure.'⁸⁵⁸ It was also reported that of 527 cases of child cruelty investigated in Glasgow in June 1932, almost two thirds involved unemployed parents, and by 1938 this was still over fifty per cent.⁸⁵⁹ The fact that the cases were reported in this way suggests that there were concerns about childcare within households affected by loss of work.

Finlay also notes that 'as far as the authorities were concerned, mothers were just as likely to be victims as were children.'⁸⁶⁰ Historians acknowledge that men commonly questioned their masculinity when unable to fulfil the respectable, manly role of 'breadwinner'.⁸⁶¹ The association of manliness with employment was clearly problematic if a man found himself out of work. Finlay writes: 'The traditional family structures which had held sway in working class communities collapsed, although the values which underpinned them did not. Men had been brought up to equate work and providing for the family with manhood and unemployment was a psychological form of emasculation.'⁸⁶² Johnston and McIvor state that 'masculinity at its core involves an assumption of power or superiority by men over women', stating that 'aggression and violent behaviour' including domestic violence was viewed by some as an outward display of manly behaviour.⁸⁶³ Evidence from Glasgow reveals that 'toughness' constituted an

⁸⁵⁷ *2000 Glasgow Lives*, Robert Young (1902).

⁸⁵⁸ McArthur and Kingsley Long, *No Mean City*, pp. 161-62.

⁸⁵⁹ *GH*, 11th July 1932, p. 8; 'Preventing Cruelty to Children', *GH*, 7th January 1938, p. 8.

⁸⁶⁰ Finlay, *Modern Scotland*, p. 145.

⁸⁶¹ *Ibid.*, p. 87.

⁸⁶² *Ibid.*, p. 87.

⁸⁶³ Johnston and McIvor, 'Dangerous Work', p. 136.

expression of masculinity where according to Molly Weir from Springburn, Glasgow:

Whether a man was too 'soft' on his wife or too 'hard' on her concerned neighbours. The 'soft', and sober, Englishman in a Glasgow street who handed over his entire wage packet to his wife was ridiculed by wives whose husbands were violent and stingy: 'Nae spunk at a'... A Moose!... Of course he's English. Soft, that's whit he is... If a man wasn't the 'boss' of the home he wasn't considered to be a man.⁸⁶⁴

It seems that some men could resort to beating their wives in an attempt to establish their 'tough' masculine status. Scottish historian Hughes has analysed the relationship between unemployment and 'wife-beating' in interwar Clydeside, arguing that 'the adverse economic climate and the high levels of unemployment between the wars aggravated masculine insecurities', and that the 'emasculat[i]on' of unemployment could encourage domestic violence within the home.⁸⁶⁵ In support, when asked why husbands hit their wives, one Glaswegian woman replied: 'Money. It was always money. You see money was tight then. There wasn't many men worked.'⁸⁶⁶ Women endured a double burden where the psychological decline of men out of work (discussed in depth in the following chapter) often resulted in *mental* and *physical* deterioration for their wives – the result of both the unequal allocation of resources within the home, and the emotional strain and domestic violence they could endure at the hands of their husbands.

⁸⁶⁴ Weir, *Best Foot Forward*, cited in Bourke, *Working Class Cultures in Britain*, p. 72.

⁸⁶⁵ Hughes, 'Representations and Counter-Representations', p. 175.

⁸⁶⁶ A. Hughes, *Popular Pastimes and Wife Assault in Interwar Glasgow* (Unpublished Hons Dissertation: University of Strathclyde, 1996), p. 14; Also see MacDougall, *Voices*, p. 52 and SOHCA/038/002 (1927).

That men and contemporary notions of masculinity contributed significantly to standards of health within the home is apparent. It is widely agreed that there were notable deteriorations in the health of women, both mental and physical, in the period under review, often as an indirect effect of an unemployed husband within the home. In Glasgow the effects of this were apparent. For example, one 1923 *SBH* report claimed:

While it seems clear that the assistance available from public funds has normally been sufficient to prevent undernourishment, distinct signs of nervous strain have been noted. The husband becomes depressed on account of the apparent hopelessness of the position, the wife, anxious for her husband and faced with the task of 'making ends meet', is similarly affected.⁸⁶⁷

When asked what life was like for the wives of unemployed men one Glasgow man replied, 'pure hell, no life at all... the worry all fell on the women, at all times.'⁸⁶⁸ In 1922, a doctor from Gartnavel Hospital claimed that the higher incidence of female patient admissions with psychological conditions was an 'index of the times' and 'partly as a reaction of the strain of the years of war, partly as a result of the high cost of living, and the difficult economic and social conditions of life.'⁸⁶⁹ Another Glasgow health professional commented that 'the facts have been brought to our notice of the burden of unemployment on the housewife who has to make ends meet'.⁸⁷⁰ The *GRMWH* records also frequently mentioned the impact that an unemployed husband could have upon the health of their patients. For instance, in 1934 it was reported that 'unfortunately, there are still a very large number of our patients whose husbands are out of work, and the strain of prolonged unemployment has told on the mothers (and expectant mothers), both mentally and physically.'⁸⁷¹ This evidence underlines the

⁸⁶⁷ *ARSBH* 1923, p. 194.

⁸⁶⁸ SOHCA/038/002 (1927).

⁸⁶⁹ 'Royal Asylum, Gartnavel', *GMJ*, 97 (1922), pp. 175-6; Also cited in *GH*, 17th February 1922, p. 9.

⁸⁷⁰ G.R.F. MacTavish, 'Some Social Aspects of Psychiatry', *GMJ*, 107 (1927), pp. 91-2.

⁸⁷¹ *GGNHSBA*, HB45/3/12, *GRMWH* 1934, p. 28.

important role of men, and conventional notions of masculinity, to health experiences within the family. Indeed, the recognition of the indirect impact of unemployment upon the health of women is where the role of men in shaping health experiences within the home has been most recognised by historians. On the other hand debates on the ill health of the unemployed themselves have tended to focus upon men. It is to the health experiences of the unemployed to which we now turn.

Conclusion

This analysis of health in relation to women, the home and the family has reinforced the difficulty of measuring the extent to which health experiences improved or worsened during the recession. On the one hand, the unequal allocation of resources in the home and the sex-specific tuberculosis mortality rate can be used to show that the health of women was undermined. On the other hand, figures on life expectancy, and the crude and standardised death rates undermine this view, while the maternal mortality rate, regularly cited as a challenge to the 'optimist' case, seems to be far less related to the economic depression than writers such as Mitchell imply. In line with the argument advanced in this thesis, it can be asserted that a clearer picture emerges by disentangling the wide range of experiences which existed throughout the city. Standards of health varied according to a number of social variables. For example, analysing health experiences according to class reveals that at times, the maternal death rate was higher among the more prosperous areas less affected by the recession – a trend obscured from the maternal death rate per se. Also, evidence that medical facilities were lacking amongst the middle class and that this could have detrimental consequences for health is also at odds with the majority of mortality data relating to this group. Furthermore, it is clear that experiences

varied in relation to marital status. Higher death rates among illegitimate children and unmarried mothers were recorded compared to those born in wedlock, although this disparity narrowed somewhat over the period. Whilst this highlights the importance of socio-economic position in defining inequalities in standards of health, it also indicates that for some this could be largely unrelated to the economic depression.

Exploring the distinct health experiences of individual groups gives a more precise indication of what was going on within these general mortality trends. This is not to suggest that the health of women was unaffected by the financial effects of the recession. Whilst difficult to ascertain from the city's mortality rates, there is an abundance of evidence that women in particular were affected by the socio-economic consequences of unemployment, that they experienced lapses in physical and psychological health, and that they were a group to which a 'pessimist' interpretation applies. This is advanced further in the following chapter which deals in more depth with the direct and indirect effects of unemployment upon physical and mental wellbeing. Evidence of the conducive impact that men contributed to health experiences within the home does shed an alternative light on the conventional view that the masculine crisis brought about by the loss of work in the 1920s and 1930s was often manifest in the deteriorating health of women. Nevertheless, domestic violence at the hands of unemployed husbands, the climbing incidence of abortion and increasing rates of tuberculosis among young females at least, all suggest that the health of many women worsened during this period. Here evidence from Glasgow can be found to support the view of writers like Webster and Mitchell that the social effects of the recession were acutely felt by women. However, even then, experiences were not universal, varying according to factors such as age, and between artisan and labouring class families in relation to the approach and efficiency of domestic management within the home. It is also clear that regional variations were pronounced: health

experiences in Glasgow could diverge from the national picture, but in terms of access to ante-natal facilities for example, inequalities existed within Glasgow itself. Evaluating health experiences in relation to gender, the home and the family bolsters the view that there was no universal experience. Rather, interwar public health was a complex and intricate lattice, characterised by marked variations according to a number of social, economic and cultural variables, and it can be argued that emphasising and exploring these discrepancies helps to provide a more holistic view of health trends in this period.

Chapter 6 The Recession, Unemployment and Health

A fair judgement on the statistical evidence would be that the unemployed, in common with the poor generally, shared unequally in the improvements in health standards which the British people experienced between the wars.⁸⁷²

The literature on the interwar period is heavily weighted with debates on the extent to which the Great Depression impacted adversely upon the population's health. This question has dominated the debates of both contemporary observers and modern day historians. Most acknowledge that unemployment could at times have an adverse impact upon the health of the unemployed, although the extent to which this was the case is contested. For example, whilst maintaining that this occurred in the context of general improvement, Stevenson acknowledges that 'poverty and ill health were almost certainly made worse in some areas by unemployment, but there was a striking degree of normality.'⁸⁷³ The previous chapter has used Glasgow's public health records to evaluate the ways in which the experiences of women, and the effects of the recession upon this group, can be used to inform this historiographic debate. This chapter will attempt to address how far unemployment and industrial decline shaped health experiences in more detail, by looking at how the experiences of communities, households and individuals were shaped by the loss of work. The methodological issues of determining the *direct* impact of unemployment upon health have been discussed extensively in the literature (see chapter 1). However, the economic climate of the era makes it impossible to ignore the potential implications of this for public health. In line with the approach advanced in this thesis, the many layers of experience among this notably disadvantaged group will be highlighted and explored, and it will be shown that the impact of

⁸⁷² Burnett, *Idle Hands*, p. 254.

⁸⁷³ Stevenson, *British Society*, p. 285; Stevenson and Cook, *The Slump*, p. 93.

unemployment in Glasgow, in terms of physical and mental wellbeing, varied according to variables such as geographic region, occupational skill, the duration of unemployment and gender.

Unemployment and Public Health

Historians have debated the possible implications that the mass unemployment of the interwar years had upon public health, and the extent to which health improved in the context of industrial recession. For the most part, the statements of Glasgow's health authorities (and national government) reflect the claims of the optimists and they insisted that standards had been maintained or improved despite the Depression.⁸⁷⁴ However, measuring the direct impact of unemployment and industrial decline upon health is difficult and is complicated by a number of complex methodological issues. Firstly, it could be argued that attempts to analyse the extent to which health worsened as a direct consequence of unemployment is largely unfeasible as it is so intrinsically linked with other causal factors including poverty, housing and environment.⁸⁷⁵ As Nicholas explains:

Deciding what contribution unemployment made to standards of health involves assessing the importance of unemployment against many other factors which will influence health. Environmental conditions, public health services, education, and many other conditions are likely to have a powerful effect, and it is far from easy to isolate any one of these and assess its relative impact.⁸⁷⁶

⁸⁷⁴ GGNHSBA, HB38/2/5, 'Glasgow Children', *The Evening Citizen*, 17th February 1932.

⁸⁷⁵ Burnett, *Idle Hands*, p. 252.

⁸⁷⁶ Nicholas, *Social Effects of Unemployment*, p. 70.

Also, whilst the reports of the MOH provide a large body of statistical evidence on health in Glasgow, they do not provide extensive details on the health of the unemployed per se, making it impossible to build separate statistical pictures of the health of the unemployed in isolation from the Glaswegian population as a whole. This is problematic where, as Thompson points out, mortality patterns of districts as a whole are 'complicated by the existence of families which did not suffer the effects of unemployment'.⁸⁷⁷

Chapter three has detailed how the infant mortality rate is often considered to be a useful statistic in gauging the health of a population overall. Here, it has been demonstrated that the rate of improvement slowed significantly throughout the interwar years and that the gap between Glasgow and Scotland as a whole increased (Figures 3.3 and 3.4). It is impossible to disentangle the exact causes of these trends. However, it is reasonable to suggest that the economic fortunes of the period, increased levels of poverty and the effects of this upon expenditure on and the provision of medical care, probably helped put the brakes on the declining infant mortality rate. In this way, the data for Glasgow goes some way to endorsing the claims of the 'pessimists'. Indeed, in the 1920s, the worst IMR rate in Glasgow occurred during the height of the recession in this decade being 120.3 deaths per 1,000 births in 1922. Similarly, during the nadir of the 1930s depression, IMR reached a peak of 111.8 deaths per 1,000 births in 1932 (Figure 3.1). These figures certainly imply that a brief health crisis occurred in Glasgow when unemployment peaked. However, movements in IMR were not totally consistent with the city's unemployment rate, and it is impossible to ascribe these leaps to unemployment alone. For example, a significant reduction in the infant death rate which occurred in 1933 complicates the assertion that IMR rates rose when the recession was most severe. This fell considerably from 111.8 in 1932 to only 96.5 in 1933 and was explained as being due to the advantageous weather conditions that year 'which influenced favourably

⁸⁷⁷ Thompson, *Unemployment*, p. 246.

the mortality from many causes, especially that due to respiratory diseases.⁸⁷⁸ This does not mean that fluctuating infant death rates between 1921 and 1936 especially were unaffected by the economic vicissitudes of the period. Rather, the mortality pattern does not entirely correspond with the unemployment trend, making it impossible to attribute these fluctuations to changes in the labour market alone.

Tuberculosis has been traditionally regarded as a disease of poverty and this provides an additional health index to investigate the possible socio-economic effects of the recession upon the physical condition of the population. Thompson explains that 'due to the nature of the disease, patterns of tuberculosis mortality reveal more about the nature of a society than do other causes of death and have been used by historical demographers as an indicator of the socio-economic condition of communities.'⁸⁷⁹ The MOH for Glasgow acknowledged the possible effects of the recession upon health with reference to pulmonary tuberculosis.⁸⁸⁰ In 1923 he stated that 'the rates for recent years have been more or less stationary, but it is difficult to say to what extent the privations of the war years and the present industrial conditions have been responsible for the arrest in the downward movement of this disease.'⁸⁸¹ Likewise, the *SBH* also alluded to the potential link between the incidence of tuberculosis and the recession when stating that 'for the year 1923, notwithstanding the prevalence of unemployment and distress, the position has at least been maintained.'⁸⁸² Clinical studies similarly commented upon the possible relationship between respiratory illness and unemployment. The investigation published by the *MRC* in 1934 which examined health in a slum and rehoused population in Glasgow, suggested that the lower rates of

⁸⁷⁸ *RMOHG 1933*, pp. 3, 5, 36.

⁸⁷⁹ Thompson, *Unemployment*, p. 205.

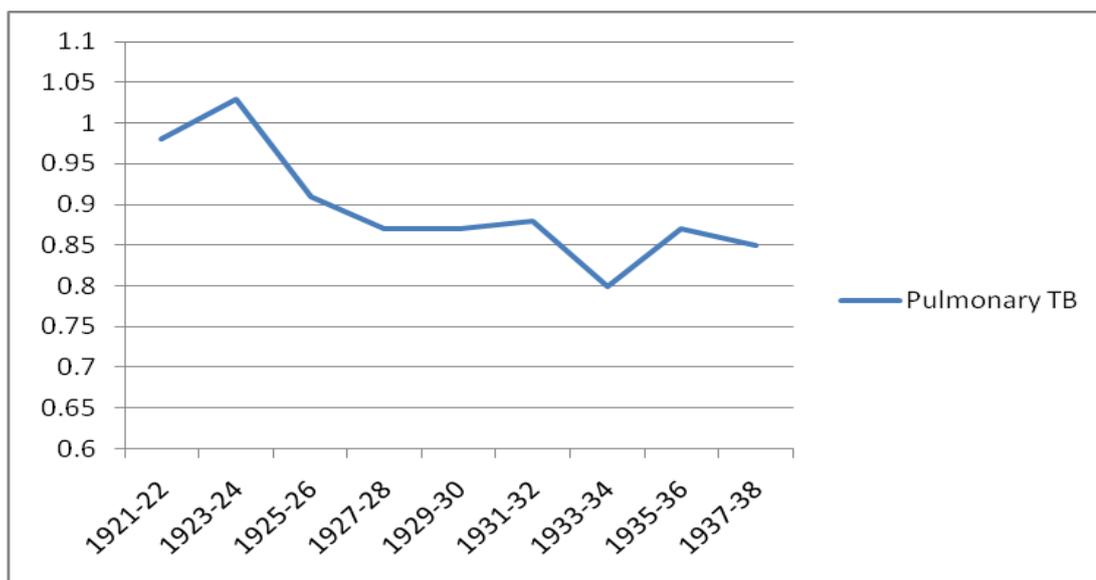
⁸⁸⁰ Similarly stated by an Edinburgh doctor ('Unemployment and Tuberculosis Mortality', *Medical Officer*, 6th November 1926, p. 219).

⁸⁸¹ *RMOHG 1923*, p. 33.

⁸⁸² *ARSBH 1923*, p. 22.

respiratory disease among foreign residents may have been explained by the lower incidence of unemployment among this group, alongside the fact that they tended to have better diets.⁸⁸³

Figure 6.1: Average death rate per 1,000 living from pulmonary tuberculosis in Glasgow in two year intervals, 1921-1938



SOURCE: *RMOHG 1921-1938*.⁸⁸⁴

However, when charting the tuberculosis death rate for the period under review, the role that unemployment played in defining the mortality pattern is also inconclusive (Figure 6.1). In the early 1920s a notable increase from 0.98 to 1.03 deaths per 1,000 living occurs and this is consistent with the industrial slump of these years. However, while the figures reveal a continuous but slowing decline thereafter until 1931-1932 – the peak years of unemployment in Glasgow when the recession was most severe – only a small rise in the death rate takes place from 0.87 to 0.88. Furthermore, an increase then takes place during the 1935-36 period when the economy was recovering and unemployment fell. This does not suggest that the effects of

⁸⁸³ Smith, 'Housing Conditions and Respiratory Disease', p. 20.

⁸⁸⁴ This graph starts from 1921 due to an inconsistency in the recording of this data.

the recession were played out in the vital statistics, even in a notably distressed area like Glasgow. Taking the interwar period overall, pulmonary tuberculosis rates displayed a relatively stable decline (Figure 6.1). Constantine has argued that 'unemployment did not strikingly swell the mortality and morbidity rates of the nation or even of the depressed areas,' and for the most part this is supported by Glasgow's mortality data.⁸⁸⁵

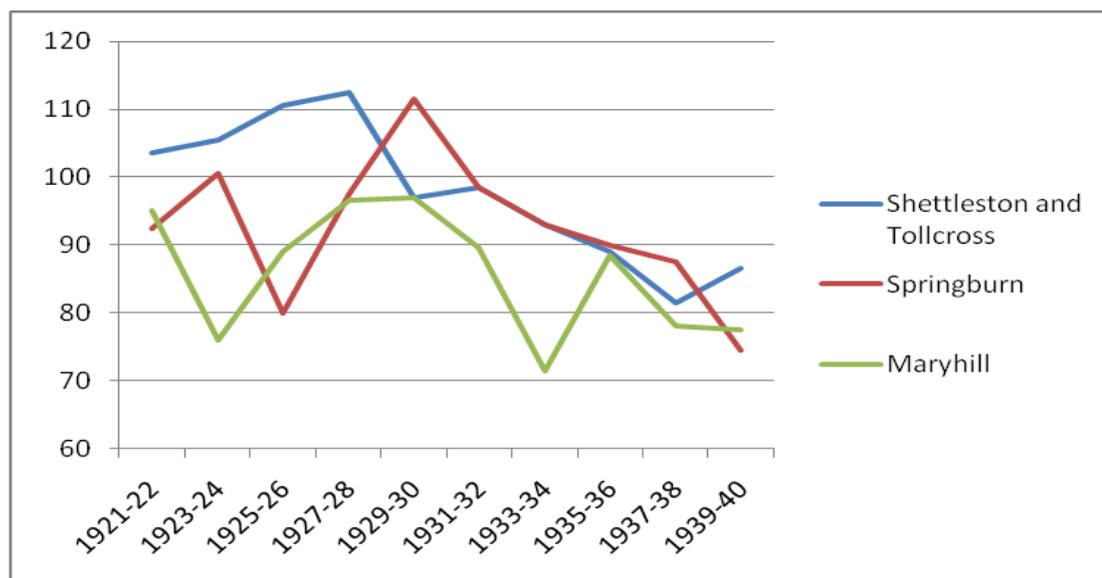
Nevertheless, this mortality data is consistent with Constantine's statement that 'it is difficult to shake off the feeling that this evidence points to unemployment as a cause of deteriorating health, but there remains an element of uncertainty.'⁸⁸⁶ It is clear that geographical districts *within* Glasgow particularly affected by economic recession did not share equally in the health gains of the city. The MOH recorded that Shettleston, Springburn and Maryhill were industrial areas and particularly affected by unemployment, but were reportedly free from 'congested slums.'⁸⁸⁷ Thus, any deterioration in health was less likely to be due to poor housing which officials often used to explain low health standards. Significantly, IMR was again notably better in these areas in 1939 than 1921 (Figure 6.2).

⁸⁸⁵ Constantine, *Unemployment*, p. 36.

⁸⁸⁶ *Ibid.*, p. 34.

⁸⁸⁷ *RMOHG 1930*, pp. 84-5.

Figure 6.2: Infant deaths per 1,000 births for regions in Glasgow particularly affected by unemployment, 1921-1940



SOURCE: RMOHG 1921-40.

The mortality pattern and the data for Glasgow also supports Whiteside's contention that statistics 'do not all point in the same direction; it is not possible to ascribe the variation in infant deaths to unemployment alone.'⁸⁸⁸ Still, this evidence suggests that in these regions where unemployment was high health deteriorated in relative terms. IMR in Glasgow as a whole fell by 25.9 per cent between the periods 1921-22 and 1938-39, compared to only 19.3 per cent, 23.2 per cent and 20 per cent in Shettleston and Tollcross, Springburn and Maryhill respectively – an average rate of 20.9 per cent.⁸⁸⁹ However, this rate was largely comparable to that of the working class areas analysed in chapter three, being 22.1 per cent in the regions considered – a difference of just one per cent. Hence this slower rate of improvement may simply reflect class inequalities, not the impact of unemployment. On the other hand, it may be the case that in general, working class communities were more affected by unemployment and that this was also important for the

⁸⁸⁸ Whiteside, 'Counting the Cost', p. 229.

⁸⁸⁹ The rate of decline when comparing 1921 and 1939 was 24.1 per cent for Glasgow, and 3.2 for Shettleston and Tollcross, 6.0 for Springburn and 27.7 for Maryhill – an average of 12.3 per cent for areas affected by unemployment.

mortality pattern of these areas. Whiteside's claim 'that the depressed areas failed to share the general trend of improving health' could be similarly applied to Glasgow, in that these areas of high unemployment deteriorated in relative terms.⁸⁹⁰ This suggests that even within a 'depressed' city like Glasgow, health trends, and probably the social effects of unemployment and recession, varied in importance according to where you lived.

That unemployment could play a role in undermining standards of health was recognised by official health authorities. The Scottish health departments were more willing to document their concerns about the impact of the recession in the early twenties than they were when unemployment peaked in the 1930s, although it is unclear why this was the case.⁸⁹¹ For example, in 1921, when commenting upon rising claims for sickness benefits, the *SBH* claimed that 'much of this increase is attributable, we think, to lowered vitality as a result of unemployment' and for some individuals, the disability cited for entitlement to sickness benefit was weakness as a result of unemployment.⁸⁹² The socio-economic impact of job loss for those involved was directly probed by the *SBH*, and in 1923 they published their findings of an investigation into the effects of the recession upon a number of social conditions.⁸⁹³ The report by the *SBH* commented upon the potential deterioration of diets due to wage cuts.⁸⁹⁴ However, it was concluded from the data obtained, 'both impressionistic and statistical', that there was 'ample justification for the view that unemployment has not had any serious effect on the physical condition of the population, though in some few individual instances and in special circumstances ill effects may be apparent.'⁸⁹⁵

⁸⁹⁰ Whiteside, 'Counting the Cost', p. 243; Thompson, *Unemployment*, p. 219.

⁸⁹¹ This was also true of the education authorities. See 'Children's Plight: The Restrictions of School Feeding: Position of Glasgow Authority', *GH*, 8th December 1922, p. 5.

⁸⁹² *ARSBH 1921*, pp. 14, 291; Also published in 'The Nation's Health', *Scotsman*, 11th July 1922, p. 7.

⁸⁹³ They considered health, morale, technical efficiency, crime and unrest (*ARSBH 1923*, p. 15).

⁸⁹⁴ *Ibid.*, p. 191.

⁸⁹⁵ *Ibid.*, p. 198.

For most of the period this was the view adopted by local and national health bodies and it was maintained that the efforts employed to relieve the situation for the city's population in terms of state assistance had been successful. However, it is significant that after the worst of the recession had passed, the Scottish health authorities stated that the 'events of recent years' had highlighted the need for adequate family resources to maintain health. In 1936 they concluded that 'there is now a widening appreciation of what health implies and a general recognition of the essential relationship between health and wellbeing. It is no new discovery that poverty begets disease; but events of recent years have raised more acutely the relationship of family resources to the preservation of health.'⁸⁹⁶ This seems a curious statement to make after denying that the recession had impacted upon health. Also, in an article published in the *Scotsman* regarding an address made by the Glasgow MOH to the City Rotary Club in 1933, it was reported that when:

Dealing with unemployment, Dr Macgregor said that, so far as they could measure it, there was no evidence that an increase in unemployment coincided with an increase in the incidence of disease. He had noted last year a slight increase in the incidence of rickets among the children of the unemployed. His department were watching carefully to see what was happening in that direction this winter. If the straightened circumstances in many families caused by unemployment were affecting the health of children it would be his duty to point that out to the city.⁸⁹⁷

Whilst noting that an increase in rickets had occurred in the winter of 1932, his observation that this may have been related to unemployment did not, however, make its way into his annual report.⁸⁹⁸ This does raise suspicion that official public health sources possibly obscured evidence of the effects of unemployment upon health, an argument that has been advanced by

⁸⁹⁶ *ARDHS 1936*, p. 12.

⁸⁹⁷ 'Glasgow's Improved Health', *Scotsman*, 6th December 1933, p. 14.

⁸⁹⁸ *RMOHG 1932*, p. 5.

Webster.⁸⁹⁹ There were systematic medical investigations however which endorsed the official view. For example, in 1935 and 1936, papers produced (although co-authored by the *DHS*'s statistician P.L. McKinlay) found that in terms of height and weight for example, there was no evidence that the physical condition of the unemployed was inferior to that of the employed, and that 'the nutritional state of this section of the unemployed population'⁹⁰⁰ is not at present a cause for more serious concern than is that of employed men of comparable status' – a finding repeated by the *DHS*.⁹⁰¹ The investigators acknowledged that both heights and weights were inferior among the men out of work. However, they reasoned that unemployment would not significantly affect the height of men when maturity was reached, and argued that when the statistics were adjusted to account for the different ages and heights recorded for both groups, there was no significant variation in body weight.⁹⁰² Nonetheless, the writers noted that 'height may be influenced by faulty posture, which sometimes accompanies or follows on under-nutrition or malnutrition'.⁹⁰³ Thus, turning our attention to the diets of the unemployed may provide more of an insight into the health experiences of this group. What this analysis has shown is the difficulty of examining the relationship between unemployment and public health statistics. Various interpretations can be deduced and the health records from Glasgow, a notably distressed city, can also be used to build contrasting conclusions.

⁸⁹⁹ Webster, 'Healthy or Hungry Thirties', p. 123.

⁹⁰⁰ The men examined were 771 'unemployed men with a view to assessing their suitability for reception into training centres organised by the Ministry of Labour.' However, this report acknowledged the importance of 'extending investigation along these and other lines, and to other sections of the unemployed community and their dependants' (P.L. McKinlay and A.B. Walker, 'A Note on the Physique of Young Adult Males During Unemployment', *GMJ*, 126 (1936), p. 321).

⁹⁰¹ McKinlay and Walker, 'A Note on the Physique of Young Adult Males During Unemployment', p. 321; The *DHS* documented: 'Examination of unemployed males, even after prolonged periods of unemployment, shows that their nutritional state, as assessed by body weight or the blood haemoglobin content, is not sensibly inferior to that of the employed and does not show any progressive deterioration with duration of unemployment' (*ARDHS 1936*, p. 13).

⁹⁰² McKinlay and Walker, 'A Note on the Physique of Young Adult Males During Unemployment', p. 320; *ARDHS 1936*, p. 321.

⁹⁰³ McKinlay and Walker, 'A Note on the Physique of Young Adult Males During Unemployment', p. 320; *ARDHS 1936*, p. 320.

The period was one of improvements, deteriorations and relative declines and they indicate the complexity of health in the interwar period.

Poor Diets and Malnutrition

As well as mortality data, historians have also considered contemporary records on nutrition and there is relative agreement that the diets of the unemployed would be worse. For example, Stevenson has noted that 'the most that could be demonstrated was that unemployment was having adverse effects upon standards of diet and nutrition.'⁹⁰⁴ The *DHS* however denied that malnutrition was 'more prevalent among the families of the unemployed than among some sections of the employed in the industrial belt of Scotland,' and this was similarly repeated by Glasgow's education authorities.⁹⁰⁵ It was expected that any deteriorations in health and nutrition would manifest themselves within the school population since children were particularly vulnerable.⁹⁰⁶ However, from the information gathered it was argued that the nutritional and physical condition of children of school age had increasingly improved. In 1934 the MOH for Glasgow reported:

The economic conditions which have prevailed throughout the country for some years past have caused anxiety and concern as to the probable effects on the nutrition of children. In Glasgow, from the commencement of medical inspection, the physical condition of school children has been made a feature of special study, and during recent years the state of nutrition has been intensively supervised. The most careful watch has been maintained throughout the year. It is very gratifying to be able to report that, in spite of the adverse conditions, no evidence of general impairment of nutrition has been detected in

⁹⁰⁴ Stevenson, *British Society*, p. 283.

⁹⁰⁵ *ARDHS 1936*, p. 13.

⁹⁰⁶ Thompson, *Unemployment*, p. 93.

the school population. In point of fact the percentage of children with 'bad' nutrition is the lowest recorded during the past fifteen years... The figures for the present year are in strict accord with the steady and progressive increase in average heights and weights observed for years past [and] in considering the growth and nutritional state of the children it can be said with confidence and conviction that these records are not merely satisfactory; they establish by statistical proof the fact that the physical condition of the children has never been better at any time during the past fifteen years.⁹⁰⁷

The popular press reiterated the claims of the authorities that 'bad times [were] not affecting the health of Glasgow school children'.⁹⁰⁸

The diffusion of optimistic health reports throughout the media however was not enough to suppress concerns about dietary standards in the city. For example, thousands became involved in the Hunger Marches and Glaswegian Harry McShane, organiser of the marches, recalls carrying a banner with the slogan '1914 Fighting – 1920 Starving'.⁹⁰⁹ Ironically, the memoirs of those who took part in the Hunger Marches frequently comment upon the fact that they were better fed on the demonstrations than when they were at home.⁹¹⁰ It was also argued that the financial implications of the Means Test had undermined the diets of those affected by unemployment.⁹¹¹ Remembering the experiences of his own family, McShane recalled:

In May 1923 my wife and I were evicted... All we had to live on was 9s a week. It was a very cautious time for us, a very tough time. We lived on toast; my wife said the lining of her stomach was all scratched from toast with nothing on it. There were many others in just the same

⁹⁰⁷ GGNHSBA, HB38/1/6, *RMITSC 1934*, p. 6; Also cited in *ARDHS 1934*, pp. 75-6.

⁹⁰⁸ GGNHSBA, HB38/2/5, 'Sturdy Bairns in Glasgow: Health Not Affected by Bad Times', *Daily Record*, 29th January 1935.

⁹⁰⁹ H. McShane and J. Smith, *No Mean Fighter* (London: Pluto Press, 1978), p. 121.

⁹¹⁰ MacDougall, *Voices (2)*, p. 253; MacDougall, *Voices (1)*, p. 24.

⁹¹¹ MacDougall, *Voices (1)*, p. 209 (Footnote 94), from SRO, DD10/246/1; *GH*, 23rd February 1932.

situation. I had always said the unemployed should feed their families and not pay the rent, and that is what I finally did.⁹¹²

One Hunger Marcher also explained that he had not tried to join the army because of physical weakness due to malnutrition, and another recalled graffitiing a wall when in his early twenties with the slogan 'Let Glasgow Nourish' – a sarcastic pun on Glasgow's motto 'Let Glasgow Flourish'.⁹¹³ The Hunger Marchers, however, had a political agenda and this was acknowledged at the time. For example, the *Evening Citizen* commented in 1936:

It has proved extremely difficult to get reliable information about the amount of malnutrition caused by unemployment. For a long time socialists, social workers, and doctors have said that there is a great deal of malnutrition. On the other hand, it is also said that there is very little. Unfortunately politics come into the question, and malnutrition is the favourite argument of those who say that the rates of unemployment relief given by the public authorities are inadequate.⁹¹⁴

However, contemporaries also noted that numerical data could fail to illustrate the human realities behind the statistics. Edwin Muir wrote:

The statistician sees these percentages as figures and “comparatively” low figures. But if one throws off the glamour of the arithmetic it is easy enough to perceive in these figures thousands of boys and girls who are hungry and in bad health, and behind them fathers and mothers who cannot like very much to sit and watch their children going without necessary food which they themselves would do anything to earn by hard work, if somebody would only let them. The

⁹¹² McShane and Smith, *No Mean Fighter*, p. 150.

⁹¹³ MacDougall, *Voices (1)*, pp. 148, 169, 215 (Footnote 155).

⁹¹⁴ GGNHSBA, HB38/2/5, *The Evening Citizen*, 'Nutrition', 3rd March 1936.

situation of an unemployed man and of everybody dependent upon him is one of complete helplessness.⁹¹⁵

A host of evidence also contradicted the official government line. It is evident that for many, adequate feeding became increasingly difficult and this is reflected by the rising number of Glaswegians who became 'necessitous cases'. It was said that until 1921 'there had been no widespread need' for local authorities to exercise their right to supply milk and food to deprived mothers and children.⁹¹⁶ However, the MOH for Glasgow explained: 'Milk and meals in necessitous cases continued to be granted under the conditions approved by the Corporation and the Board of Health. The increases in both reflect the continued depressed industrial conditions.'⁹¹⁷

The authorities claimed that the health of the population had been spared because of such state interventions. For example, in 1921 it was said that the nutrition of children had not worsened because more fell under the category of "necessitous children", 'many of whom would receive better feeding from the Authority than they would at home under normal conditions.'⁹¹⁸ However, in 1922 the Glasgow Branch of the Educational Committee controversially claimed that 'owing to the malnutrition of many scholars teachers are not able to carry out the work of education with satisfaction' – a statement strenuously denied and 'deeply resented by the Parish authorities in Glasgow, who regard it as an attack on their administration of relief.'⁹¹⁹ In this case the Parish Council authorities contested that many mothers had decided that the full amount of relief warranted should be allocated to them, rather than a proportion being

⁹¹⁵ Muir, *Scottish Journey*, p. 137.

⁹¹⁶ *ARSBH 1928*, p. 112.

⁹¹⁷ *RMOHG 1925*, p. 36; *GUSC*, Spec Coll, 2978, *Corporation of Glasgow: Public Health Department, Scheme for Maternity and Child Welfare: Prepared by Instruction of the Committee on Health* (1926), p. 23.

⁹¹⁸ *GGNHSBA*, HB38/1/2, *Annual Report on the Work of the Authority to which is incorporated the RMITSC session 1921-22*.

⁹¹⁹ 'Feeding of School Children: Teacher's Allegations: Glasgow Parish Council's Defence', *GH*, 22nd November 1922, p. 13.

deducted for school meals, their reasoning being that they were able to provide adequately for their children themselves. It is interesting that in the context of defending their position as correct and successful in preventing undernourishment that the Parish Council authorities claimed that only three per cent of these children were suffering from malnutrition, 'thus proving the mothers were competent to feed the children.'⁹²⁰ This is a stark and convenient contrast to claims that malnutrition among children was the fault of the mother, and again offers support for Webster's contention that the authorities presented the evidence on health in the way that favoured them the most. On one occasion the education authority also blamed deteriorations in the health of children on bad weather, stating that 'although the continued industrial depression may have influenced the home life of the children adversely, the factor which probably had considerable effect was the continuation of cold weather until late spring. The cold and inclement weather would lead to increased confinement in doors and to an increase in the diseases of the nose and throat in bronchial and glandular conditions.'⁹²¹

However, many medical and political commentators claimed that evidence of malnutrition among the city's population was pronounced.⁹²² For example, one medical study published in 1922 which considered the condition of Glasgow children affected by the recession, found that a satisfactory nutritional standard was achieved in only one family investigated where the eldest child was eligible to receive all his meals at school. In the other four families considered who also received free school meals, the children fell below the standard of adequate nutrition.⁹²³ The investigators vaguely concluded: 'What, indeed, would be the condition of some of the

⁹²⁰ 'Feeding of School Children', *GH*, 24th November 1922, p. 7.

⁹²¹ *GGNHSBA*, HB38/1/2, *Annual Report of the Education Authorities to which is incorporated the RMITSC 1924*, p. 19.

⁹²² *NAS*, ED7/713, *Necessitous Children: Circular 51 Questions in Parliament*. Question Number 39: Mr Hardie (Springburn, M.P.) in conversation/debate with the President of the Board of Education.

⁹²³ Tully and Urie, 'A Study of the Diets and Economic Conditions of Labouring-Class Families in Glasgow in June, 1922', p. 361.

families if it were not for the school meals is difficult to say.⁹²⁴ One headmaster also reported that although improvements in the physical condition of scholars were recorded, 'in some cases, owing to financial circumstances and the general economic depression, there is little improvement, and no doubt this would disappear on the return of more prosperous times.'⁹²⁵ Similarly, when commenting upon the enrolment of a new student and her notably sound appearance, one teacher remarked that 'the contrast with the pale faces of the children of the unemployed gives me quite a shock.'⁹²⁶ As late as 1938 the *GRMWH* noted that 'there is still a large percentage of unemployment among the husbands and families of our patients, and many of them have delicate children.'⁹²⁷ The same year the subcommittee of the Industrial Christian Fellowship argued that when 'studying malnutrition problems' they found 'evidence of malnutrition among school children', stating that 'the general public is not aware of this because of apparently reassuring statements that are continually reiterated by official and interested circles, that malnutrition exists only to a very small extent.'⁹²⁸ Therefore, this evidence provides a stark contrast to the relatively favourable interpretation which can be deduced from the official, high level public health statistics, and it seems that when examining the diets of those affected by unemployment in isolation, that a distinctly inferior health experience was endured.

A host of quantitative evidence also substantiates the view that the diets of the Glaswegian unemployed were inferior and Cage and Foster state that 'Glasgow's workers and unemployed people had amongst the lowest calorie intake of any location within Scotland'.⁹²⁹ A number of local clinical and social researchers also documented their concerns, and Webster claims

⁹²⁴ *Ibid.*, p. 361.

⁹²⁵ *RMOHG 1930*, p. 233.

⁹²⁶ Bowie, *Penny Buff*, p. 86.

⁹²⁷ *GRMWH 1938*, p. 27.

⁹²⁸ 'I.C.F. Report on Malnutrition Among Children', *GP*, 21st January 1938, p. 6.

⁹²⁹ Cage and Foster, 'Overcrowding and Poverty', p. 139.

that 'the types of evidence standing up best to critical examination are the small-scale sample studies, the results of which largely coincide with the much-criticised impressionistic accounts of the '30s.'⁹³⁰ Surveys like this published in the *GMJ*, the *Lancet* and the *MRC* special report series, particularly in the 1920s, often asserted that the economic recession caused deterioration in the diets of the Glaswegian unemployed and their families. The difficulty of examining interwar dietary studies however has been pointed out by Thompson. He explains:

Disparities in food expenditure according to social class, or between the employed and unemployed, are relatively easy to establish but do not reveal a great deal about the nutritional adequacy of the diets of the unemployed. Major methodological problems are inherent in any attempt to assess diets in past societies according to modern nutritional science since precise assessments of the nutritional adequacy of the food consumed by populations or individuals cannot be made. Furthermore, ideas about nutritional adequacy have changed over time and any attempt to assess standards of diet in the past would fail to acknowledge contemporary definitions of an adequate diet. Therefore diets in interwar south Wales are here assessed according to contemporary criteria drawn up by nutritional scientists in the interwar period.⁹³¹

Accepting contemporary measurements of 'nutrition' for now, analyses of the calorie consumption of the employed and unemployed revealed discrepancies between these two groups, and interwar contemporaries implied that this helped explain inequalities in health between them. During the coal miner's strike in 1921, A.M.T. Tully investigated the diets of eleven 'typical labouring class' Glasgow families who were affected by the recession, either because the father of the house was unemployed or

⁹³⁰ Webster, 'Healthy or Hungry Thirties', p. 123.

⁹³¹ Thompson, *Unemployment*, p. 89.

working short time.⁹³² This is a small sample and the extent to which the results can be considered representative can therefore be questioned. However the writer argued that ‘these families were neither better nor worse off than thousands of others round about them and the results may safely be accepted as giving a fair representation of the general condition of this part of the population.’⁹³³ According to nutritional knowledge at the time, a man out of work was said to require 2,500 calories in order to ‘maintain existence’, compared to 4,000 calories for those engaged in arduous work. However, it was explained that because some 10 per cent of the energy provided by food is ‘lost in digestion’ around 3,000 calories had to be consumed to satisfy the 2,500 calories required.

The statistical evidence obtained by the study suggested that the diets of the unemployed were inadequate, being on average 2,481 calories per man per day in 1921, thus falling short of the necessary 3,000 calories.⁹³⁴ The report also highlighted that these figures compared unfavourably to pre-war dietary studies which calculated the average calorie consumption per man per day as 3,136 and 3,298 calories in 1911-13 and 1915-16 respectively.⁹³⁵ However, while the calorie intake of the unemployed was less, current nutritional knowledge recommends a diet of only 2,500 calories per man per day to maintain current weight.⁹³⁶ This suggests therefore, that this diet, in calorific terms, was not necessarily insufficient. The unemployed might have lost weight. Indeed, those previously involved in heavy industrial work often lost muscular physique (see below) and it is reasonable to suggest that the resulting weight loss could have been associated with the diet consumed. However the extent to which diet was deficient, based on

⁹³² A.M.T. Tully, ‘Nutrition and Economic Conditions of Working Class Families in Glasgow in April, 1921’, *The Lancet*, 2nd July 1921, p. 57.

⁹³³ *Ibid.*, p. 57.

⁹³⁴ Although I calculate this as being 2,487 calories.

⁹³⁵ Tully, ‘Nutrition and Economic Conditions of Working Class Families in Glasgow in April, 1921’, pp. 57-8.

⁹³⁶ NHS Choices: Your Health, Your Choices, <http://www.nhs.uk/chq/pages/1126.aspx?categoryid=51&subcategoryId=165>, viewed 21st September 2011.

these figures published by Tully, has to be kept in perspective. Gazeley also points out that 'although the 1921 Glasgow labourers' diets provide less energy than Lindsay's 1912 Glasgow diets, this may be because all of the early 1920s diets were from labouring families, whereas in 1913 Lindsay included diets from other classes.'⁹³⁷ However, the authors were clearly concerned regarding the impact of the recession upon physical condition, stating that the 'results recorded are sufficiently disconcerting', that 'under present conditions an adequate supply is impossible,' and that 'in spite of the careful marketing by most of the mothers, the energy purchasable per penny shows a marked decline from previous years. Nothing could more clearly indicate the serious effect of the present economic situation.'⁹³⁸ Indeed, the average calorie intake of the unemployed cited by these studies masks a range of experience and many would have fell below (and exceed) these consumption rates. For some, diets were undoubtedly worse.

In a study the following year, the same author acknowledged that the effects of the recession upon standards of nutrition may not yet have been felt by 1921 since the 'restricted diet had hardly time to tell very markedly upon the nutrition of the children.'⁹³⁹ Consequently, a follow up study in 1922 which investigated 12 families (94 individuals) presented similar findings, and demonstrated that some further deterioration had occurred from the previous year – thus somewhat undermining Gazeley's claim that discrepancies were due to the inclusion of other classes in the pre-war figures.⁹⁴⁰ The report showed for example, that while the average deficiency in weight among 33 children in 1921 was 12 per cent, in 1922 this had risen to 14 per cent among 55 children.⁹⁴¹ The differing and small sample size is arguably an unfair

⁹³⁷ Gazeley, *Poverty*, p. 73.

⁹³⁸ Tully, 'Nutrition and Economic Conditions of Working Class Families in Glasgow in April, 1921', pp. 57, 58.

⁹³⁹ Tully and Urie, 'A Study of the Diets and Economic Conditions of Labouring-Class Families in Glasgow in June, 1922', p. 354.

⁹⁴⁰ *Ibid.*, pp. 358, 359.

⁹⁴¹ *Ibid.*, p. 363.

comparison. However, this was endorsed by the official statistics where the Glasgow education authorities admitted in their report of 1922-23:

As to the condition of these children at present, the information obtained in the course of medical inspection and treatment seems to justify the conclusion that the lower state of health in evidence during the session 1921-1922 has continued during the twelve months covered by this report.⁹⁴²

Arguably, this is more conclusive evidence of the possible impact of the economic conditions than the lower calorie consumption among the unemployed. The investigators concluded that 'from the poor physique of the children, especially in weight, it would appear that their food has not been sufficient to allow for normal nutrition.'⁹⁴³ Children aged 1 to 5 years were also found to show a state of malnutrition.⁹⁴⁴ This also corroborated the official view regarding the inferior health of the pre-school population (see chapter 3). Collectively, dietary surveys carried out between 1900 and 1923 generally found 'that the energy value of the diets of the poor labouring classes averages about 2,700 calories per man per day (Lusk's standard), but that during periods of trade depression and unemployment it may fall to about 2,200 calories,' and that the approximate calorie intake was around 2,440 calories for Glasgow men affected by unemployment during the slump of early 1920s, compared to 2,810 calories for wholly employed labourers and 3,070 for artisans.⁹⁴⁵ Writers such as Stevenson note that poor diets and nutrition were a symptom of poverty, 'irrespective of the effects of unemployment.'⁹⁴⁶ Whilst this must have been at least in part true, these dietary studies suggest that the standard of diet in some working class

⁹⁴² GGNHSBA, HB38/1/2, *Annual Report on the Work of the Authority with which is appended the RMITSC session 1922-23*.

⁹⁴³ Tully and Urie, 'A Study of the Diets and Economic Conditions of Labouring-Class Families in Glasgow in June, 1922', p. 361.

⁹⁴⁴ *Ibid.*, p. 365.

⁹⁴⁵ Paton was involved in Tully's work and so her findings and data are drawn upon by Paton and Findlay in this report (Paton and Findlay, 'Poverty, Nutrition and Growth', pp. 151, 155-65); Smout, *Century*, p. 129; Tully, 'A Study of the Diets and Economic Conditions of Artisan Families in May, 1923', p. 5.

⁹⁴⁶ Stevenson, *British Society*, pp. 216, 283.

families affected by unemployment worsened. Jones has claimed that ‘the diets of the unemployed were worse than those in work, which suggests that the physical health of the unemployed was also worse,’ tentatively suggesting that the unemployed community were a disadvantaged group to which the ‘pessimist’ interpretation applies.⁹⁴⁷

Inferior Access to Medical Services

Analysing the options of medical provision for the unemployed can also corroborate this view. The unemployed could feel neglected by health services and often they got the impression that they did not enjoy the same degree of medical attention as the employed.⁹⁴⁸ As a result of the recession, it is clear that the provision of medical services was generally impaired. The funding of both physical and mental health institutions in Glasgow was evidently strained and it was frequently noted that financial contributions made to hospitals were less generous due to the economic climate – a situation that consequently affected the amount of health care which could be offered.⁹⁴⁹ In this way, it is possible that the recession impacted upon the maximum standard of health that could have been achieved, an argument

⁹⁴⁷ Jones, *Health and Society*, p. 72.

⁹⁴⁸ NAS, DD10/246/2, Report of Proceeding of Deputation from Scottish Hunger Marchers received at Divisional Office, Ministry of Labour, 44 Drumsleigh Avenue Edinburgh, on Monday 12th June 1933 at 11.45am; *Scottish Trade Union Congress Archive* (STUC), GB1847 *Thirty Seventh Annual Report of the Scottish Trade Union Congress 1934 including Report on the Organisation of Women Annual Conference*, p. 161.

⁹⁴⁹ ‘Current Topics’, *GMJ*, 108 (1927), p. 232; ‘Current Topics’, *GMJ*, 115 (1931), pp. 249-50; ‘Current Topics: Glasgow Royal Infirmary: Annual Meeting’, *GMJ*, 121 (1934), p. 66; ‘Current Topics: Glasgow Royal Infirmary: Annual Meeting’, *GMJ*, 123 (1935), p. 92; ‘Current Topics’, *GMJ*, 97 (1922), p. 112; ‘Current Topics’, *GMJ*, 99 (1923), pp. 56, 94, 167; ‘Current Topics: Victoria Infirmary, Glasgow’, *GMJ*, 101 (1924), p. 43; ‘Royal Maternity and Women’s Hospital’, *GMJ*, 101 (1924), p. 89; ‘Current Topics: Victoria Infirmary Glasgow’, *GMJ*, 103 (1925), p. 51; *GGNHSBA*, HB11/4/32, *41st Annual Report of the Glasgow Royal Cancer Hospital, 1931*, pp. 11-2; *GRMWH 1925*, p. 28; 1926, p. 24; 1930, p. 25; 1931, pp. 10, 25, 30; 1933, p. 23, 31; Hardy, *Health and Medicine*, pp. 78, 95, 96; Loudon, *Death in Childbirth*, p. 265; Nicholas, *Social Effects of Unemployment*, p. 84; Jones, *Health and Society*, p. 76; Stevenson and Cook, *The Slump*, p. 52; Stewart, ‘Health and Sickness’, p. 237.

that has been made by Hardy.⁹⁵⁰ Generally, the working class and the poor were disadvantaged during spells of ill health due to limited access to medical facilities, not just those affected by unemployment. Doctors and medical bills could be expensive and were often out with the financial constraints of meagre working class budgets, although oral testimonies reveal that some doctors could waive their fees for families in need.⁹⁵¹ Crowther also points out that even if an initial consultation could be paid for, this could become financially problematic if the medical complaint required long-term treatment, and if alternative arrangements through insurance or friendly societies for example, had not been made.⁹⁵² Indeed, one Glasgow woman recalled that some had no choice but to continue 'hacking and coughing' as they could not afford a doctor compared to those, like herself, who were more financially able.⁹⁵³ Another woman similarly remarked: 'If you didn't have the money, you just didn't get the doctor out. That's why you listen to a lot of old wives tales about remedies because they helped the weans [children]' (see chapter 5).⁹⁵⁴ Fictional accounts also capture the difficulties which working class families could face that were presumably detrimental to recovery. For instance, in *No Mean City*, when the character Peter and his sister discuss their mother's health, she explains:

She's the same as aw the rest o' them at her age... Something wrong wi' her stomach. Days at a time she canny get a movement. Then she takes terrible doses o' stuff from the chemist's and she's better for a while. But we had the doctor to her three weeks ago an' he said she'd be the better to take a light nutritive diet instead o' so much o' the salts. 'Light' is a good word, is it no', Peter? Mother was always light in her diet that Ah c'n mind so long as there wis one o' us wis

⁹⁵⁰ Hardy, *Health and Medicine*, pp. 8, 95, 96.

⁹⁵¹ Faley, *Up Oor Close*, pp. 163-5; Rountree, *Govan*, p. 73; SOHCA/038/001 (1912).

⁹⁵² Crowther, *Social Policy*, p. 54.

⁹⁵³ SOHCA/038/001 (1912).

⁹⁵⁴ *Peoples Palace*, Mary McLaughlin, Bridgeton, talking about the 1930s; Rountree, *Govan*, pp. 73, 218.

hungry. But the doctor said 'light *an*' nutritive!' That's no sae easy to arrange.⁹⁵⁵

The sensationalist dimension of this fictional story must be kept in mind. However, these memories and descriptions were also confirmed by observations published in official sources, with the MOH for Glasgow acknowledging for example that 'many children suffer from conditions requiring careful medical supervision which their parents are unable to obtain for them on account of poverty.'⁹⁵⁶ Poor Law hospitals could be used. However, even then, writers such as Checkland note that these were 'often in the poorer areas of the city and therefore less able to attract the very best of staff.'⁹⁵⁷ Undoubtedly, this in part contributed to the inferior health records of the Glaswegian poor and working classes, in addition to other determinants such as housing and diet (see chapters 4 and 7). This discrepancy is widely recognised in the historiography by both 'optimists' and 'pessimists', and substantiates Stevenson and Cook's assertion that 'the health services tended to reflect differences of income, class and region, often leaving the most needy inadequately served,' and 'although there had been considerable improvement in the general level of mortality, life expectancy was still determined by social class.'⁹⁵⁸ Indeed, according to these authors this interpretation could be applied to Scotland as a whole where they attributed the poorer health north of the border to the higher levels of poverty and unemployment in the country.⁹⁵⁹

⁹⁵⁵ McArthur and Kingsley Long, *No Mean City*, p. 196.

⁹⁵⁶ *RMOHG 1934*, pp. 6-7; *Committee on Scottish Health Services Report*, p. 187.

⁹⁵⁷ O. Checkland, *Health Care as Social History: The Glasgow Case* (Aberdeen: Aberdeen University Press, 1982), p. 15.

⁹⁵⁸ Stevenson and Cook, *Slump*, pp. 40, 47.

⁹⁵⁹ *Ibid.*, p. 40.

However, the National Insurance Act of 1911 provided insured workers with the right to see a doctor and sickness benefit during times of ill health. While this did not cover wives and dependants, for the long term unemployed this right also expired alongside insurance payments.⁹⁶⁰ Therefore, a more limited access to medical facilities was experienced when insured workers became unemployed. In the absence of membership of a fee paying friendly society, the unemployed had to pay for expensive medical treatment themselves or attend a poor law hospital – which not only carried the same social stigma as receiving parish relief but also offered an inferior level of care and tended to deal with the elderly, the disabled and those with chronic illness. The final option was to face a lengthy wait in a voluntary hospital out-department which often restricted treatment to acute cases.⁹⁶¹ Gladstone Robertson, a general practitioner in the period, also noted that while ‘people without means could apply to the parish for medical aid when a doctor appointed by the parish would call on them’, ‘the demands on this doctor’s time were so great that he could only afford to spend a few minutes with each patient.’⁹⁶² When speaking on behalf of the Scottish Hunger Marchers Shettleston M.P. John McGovern complained about the ‘inadequate provision made for the medical attention of unemployed persons and their families [and] he suggested that it was the first duty of the Department of Health to prevent illness by providing medical advice. At the moment many persons had no option but to allow an illness to continue as they could not call in a doctor.’⁹⁶³ This evidence suggests that those affected by unemployment were more vulnerable and likely to experience periods of illness more acutely than those in work.

⁹⁶⁰ Constantine, *Social Conditions*, p. 38; ‘Unemployment and Medical Benefit’, *Scotsman*, 24th August 1933, p. 7; ‘National Health Insurance’, *Times*, 1st November 1933, p. 6; Cherry, *Medical Services and the Hospitals in Britain*, p. 5.

⁹⁶¹ For a short summary on the healthcare services available in Scotland see Stewart, ‘Health and Sickness’, pp. 235-38.

⁹⁶² Gladstone Robertson, *Gorbals Doctor*, p. 112.

⁹⁶³ NAS, DD10/246/2, Report of Proceedings of Deputation from Scottish Hunger Marchers received at Divisional Office, Ministry of Labour, Edinburgh, 12th June 1933.

Or Personal Perceptions?

However, there are problems with the conclusion that because access to medical services was restricted and calorie intake less, that the health of the unemployed and their families was consequently worse. For example, one Glasgow practitioner explained that in terms of access to doctors:

Medical services to dependants were chargeable, but, owing to the prevalent poverty, at least half were given free. As unemployment rose during the 1920s many names were removed from the doctors' lists under the caption 'ceased to be insured'. This meant that we doctors ceased to be paid for services to those people, but if they were well known to us we felt morally under obligation to attend to their wants.⁹⁶⁴

This challenges the simplistic notion that the unemployed were neglected by medical services because they ceased to pay insurance. Indeed, for insured workers, medical benefit was not stopped immediately when they became unemployed. Moreover, while contemporary statements often referred to malnourishment, the studies by researchers like Tully et. al, despite showing that discrepancies between the employed and unemployed could exist, actually provides limited robust statistical evidence of real *malnutrition*. That the dietary studies located during this research emphasised the calorie intake of the population rather than actual food consumed is also problematic. A host of evidence suggests that the interwar period witnessed a shift to a diet of luxury goods, often high in sugar, and not always beneficial to health. Chapter seven details that a higher percentage of fat was associated with the diets of those with higher incomes, and obesity, with its related health problems, were becoming ever more problematic throughout these years. Thus a diet of less calories, and perhaps less 'unhealthy' luxury goods, may

⁹⁶⁴ Gladstone Robertson, *Gorbals Doctor*, pp. 112-13.

in fact have been nutritionally superior.⁹⁶⁵ For this reason it is especially unfortunate that the nutritional studies carried out in Glasgow understood the sufficiency of diets in terms of calorie intake and failed to provide detailed information on the types of foods consumed. Therefore, the extent to which the health and nutrition of those affected by the loss of work was worse is actually very difficult to establish.

This is difficult to reconcile with the myriad of qualitative literature, personal testimonies and contemporary official observations which frequently portray the era as one of ill health and faulty diets. Details of the effects of unemployment upon diets were also commonly detailed in oral history interviews. For example, one interviewee recalling household eating patterns during difficult financial times in the 1930s stated:

During the week you got up in the morning and it was a quick brekkie. A piece of toast if you were lucky, and of course you were at work all day. And the next meal was at night at five, six, or seven o'clock. But a Saturday and a Sunday was a totally different ball game, as that was your long lies. I think your mother used to try and do better on a Sunday. But my mother always used to try and keep us in our beds as long as possible on a Sunday. And for years I never understood why. And it was to save a meal, breakfast. And she was economizing in her own way.⁹⁶⁶

Another man who personally endured long term unemployment also stated that upon returning home after a day of playing football on Glasgow Green (how many of the unemployed regularly spent their periods of enforced leisure): 'You were starving... [You] were going to go home to 'F' all... because there was nothing for us... It was a hard time... You went without all

⁹⁶⁵ Similarly stated by the MOH for Sheffield ('Industrial Fatigue Following Unemployment', *Medical Officer*, 6th November 1926, p. 220); Thompson similarly notes how expenditure on food does not reflect nutritional adequacy (Thompson, *Unemployment*, p. 89).

⁹⁶⁶ Faley, *Up Oor Close*, p. 73.

day when you were idle.’⁹⁶⁷ Popular perceptions on the effects of unemployment are overwhelmingly depressing, and it is clear that many *perceived* the period as one of declining standards of health for a considerable proportion of the population. Whilst this seemingly contradicts the favourable trends demonstrated by many public health statistics, there is still the possibility that spells of ill health were attributed to being out of work simply because unemployment and its consequences, such as more limited access to medical services and contracting food budgets, was such a vivid aspect of life during the interwar years. Thus, it might be the case that personal perceptions and *experiences* of the era could contradict actual material circumstances. E.P. Thompson has famously argued that statistical figures can fail to provide a realistic measurement. In his contribution to the ‘standard of living debate’, he pointed out that while wages may have increased in coal mining for example, living standards could worsen due to work intensification, greater exploitation and ‘human misery.’⁹⁶⁸ Steven Thompson suggests that a similar argument could be applied to health experiences in the period under review.⁹⁶⁹

Pessimist interpretations dominate popular memory, and the poor health of the unemployed was often recalled decades later by Glaswegians.⁹⁷⁰ For instance, one Glasgow man remembered that ‘their health was very, very bad.’⁹⁷¹ Bouts of ill health were also regularly attributed to unemployment at the time.⁹⁷² Although he had a political agenda, Harry McShane claimed in 1932 that ‘he had been on previous marches but never had so many men fainted. This he said was due to the cuts in unemployment

⁹⁶⁷ *2000 Glasgow Lives*, Robert Young (1902).

⁹⁶⁸ Thompson, *Unemployment*, p. 248; E.P. Thompson, *The Making of the English Working Class* (London: Gollancz, 1963), p. 231.

⁹⁶⁹ Thompson, *Unemployment*, pp. 247-48.

⁹⁷⁰ MacDougall, *Voices (1)*, pp. 377, 380.

⁹⁷¹ *Ibid.*, p. 146.

⁹⁷² ‘They Lie When They Call Us Work Shy’, *GP*, 29th July 1938, p. 1.

benefit and the operation of the Means Test.⁹⁷³ Another Glasgow man recalled:

We had a fellow died (on a Hunger March)... I always remember Haplin. His face was always black wi' smoke and he was always standing stirring porridge... I think he died of malnutrition, I'm not quite sure. Oh, he wasn't very well obviously. He was black as can be you know. You'd ha' thought he was a Negro. An' it was smoke, I think.⁹⁷⁴

This quote is interesting as the memory of the man's ill health was first and foremost attributed to malnutrition, and there is the suggestion that this was due to the recession given the context in which the testimony was given. It is only after recalling that the man was 'always black wi' smoke' that the possible implications of this for his health are discussed. His death was officially attributed to pneumonia which he allegedly caught when on the march.⁹⁷⁵ One married Glasgow woman similarly associated her spinal trouble, which had not been medically diagnosed, as being 'caused probably by worry about the children, and about husband's unemployment.'⁹⁷⁶ Jones notes that whilst those out of work were more likely to voice medical complaints, 'this may have been due to a deterioration in health or due to the fact that they had more time to dwell on their illness and, because they were depressed, to [also] be worse affected by their physical ill health.'⁹⁷⁷ Thus, even when the figures suggest that the health of the unemployed and their families could often be spared, the reality of these years was one of perceived ill health, and as Steven Thompson states, many experienced these years 'at least as a deterioration in the subjective quality of life.'⁹⁷⁸ It can be argued therefore, that this was the lived health *experience*; people genuinely believed that unemployment had played a part in undermining their

⁹⁷³ NAS, DD10/246/1, Unemployment: Notes on Proceeding at Meeting with Deputation from Unemployed Marches at 121a Princes Street, Edinburgh on 22nd February 1932 at 11.30am.

⁹⁷⁴ MacDougall, *Voices (1)*, p. 24.

⁹⁷⁵ MacDougall, *Voices (1)*, p. 201 (Footnote 27).

⁹⁷⁶ Spring Rice, *Working Class Wives*, p. 115; Similarly noted by Thompson, *Unemployment*, p. 5.

⁹⁷⁷ Jones, *Health and Society*, pp. 72-3.

⁹⁷⁸ Thompson, *Unemployment*, p. 248.

health. Hence, the effects of the recession in terms of public health were much more widespread and pronounced than mortality data and nutritional surveys could measure.

This further endorses the usefulness of analysing personal and public health perceptions to provide an additional layer of understanding to the statistics. Evans has claimed that 'it is invalid arbitrarily to separate quantifiable from unquantifiable elements in explanations of complex historical phenomenon, not least because to do so is often to imply (though rarely to assert openly) that evidence which can be counted is somehow more valuable than that which cannot.'⁹⁷⁹ Although Evans was discussing the nineteenth century standard of living debate, the point applies equally here. Therefore while evaluations of the diets and medical services experienced by the city's unemployed community can be somewhat used to endorse the view that their health was worse, this is complicated. The emphasis on calories in contemporary surveys actually tells us little about 'nutrition' and there is also the possibility that personal perceptions of unemployment affected the way in which health was experienced. However, there is no doubt that unemployment played an important role in determining the budgets, provisions and diets of those affected by unemployment and the ways in which they dealt with illness. The loss of work contributed significantly to shaping health experiences among this group. This was also apparent in relation to mental health.

⁹⁷⁹ E.J. Evans, *The Forging of the Modern State: Early Industrial Britain 1783-1870* (Harlow: Pearson, 2001), p. 190.

Mental Health

This indication of the personal rather than physical impact of unemployment is consistent with the view that mental health was more profoundly affected among the unemployed than physical wellbeing. This is another area of agreement between 'optimists' and 'pessimists'. Writers like Stevenson, who have typically written in relatively favourable terms of the interwar period, have recognised this was one conclusive health consequence of unemployment.⁹⁸⁰ There is renowned agreement among historians that unemployment adversely affected mental health.⁹⁸¹ Whilst extensive consideration of mental health falls out with the boundaries of this thesis, Whiteside notes that 'the stress caused by loss of waged work' has been found to manifest 'itself in a higher incidence of suicide and nervous breakdowns, mental depression and apathy, coronary heart disease and digestive disorders.'⁹⁸² Brenner also comments on the contribution of stress to mental and *physical* wellbeing.⁹⁸³ The psychological consequences of unemployment and the effects of this on the body are an important consideration for a study on physical wellbeing.

In the interwar period, the relationship between mental and physical health was becoming increasingly discussed.⁹⁸⁴ For example, one doctor was of the opinion that ailments such as ulcers and 'bad stomachs' were the 'reaction of strain and worry' and this could affect everyone from the working class housewife enduring the challenges of making ends meet to the

⁹⁸⁰ Stevenson, *British Society*, p. 285; Also see Gazeley, *Poverty*, p. 112.

⁹⁸¹ Constantine, *Unemployment*, p. 34; M.H. Brenner, *Mental Illness and the Economy* (Massachusetts: Harvard University Press, 1973).

⁹⁸² Whiteside, 'Counting the Cost', p. 228; Wilkinson and Pickett, *The Spirit Level*, pp. 75-6.

⁹⁸³ M.H. Brenner, 'Personal Stability and Economic Security', *Social Policy*, 3 (1977), p. 2.

⁹⁸⁴ Macgregor, *Public Health*, p. 150; D. Yellowlees, 'The Psychological Factor in Physical Disease', *GMJ*, 105 (1926), pp. 31-40; 'Preventative Medicine and Public Health', *GMJ*, 119 (1933), p. 186; 'Mental Mechanism: Elderpark Welfare Centre', *GP*, 3rd March 1933, p. 1; 'Health for Children: Sound in Body... Clear in Mind', *GP*, 11th February 1938, p. 6.

business man who has 'worried financially'.⁹⁸⁵ When holding a post at the University of Glasgow, E.P. Cathcart similarly asserted that: 'A healthy body is, without any manner of doubt, a priceless asset, but, unless that body contains not only a healthy but a contented mind, true health in the public health sense is not attained.'⁹⁸⁶ In some instances, observed increases in the incidence of mental ill health in Glasgow were attributed to the recession. Burnett warns however that with the 'vagueness with which such terms as "neurasthenia", "neurosis" and "strain" were used, the evidence of a direct link [between unemployment and mental health] is persuasive rather than conclusive.'⁹⁸⁷ Nonetheless, Whiteside notes that 'the loss of waged work is now recognised as a form of social and psychological deprivation in its own right quite distinct from the consequences of fall in income commonly experienced by the unemployed and their dependents.'⁹⁸⁸

Most contemporary commentators and medical observers agreed that unemployment had an adverse effect on the mental health of those out of work.⁹⁸⁹ In fact, it was believed by some that 'in dealing with unemployment, the effect on the mind is more important than the effect on the body'.⁹⁹⁰ In an article published in the *GH* it was similarly stated:

It is realised that at no time more than the present, when humanity is suffering from the effects of economic hardship and its consequent bodily and mental stress, in addition to the constant strain of civilised

⁹⁸⁵ NAS, HH76, Minutes of Evidence taken before the Committee on Scottish Health Services (Fourth Day), 19th January 1933, p. 9.

⁹⁸⁶ E.P. Cathcart, 'Preventative Medicine and Public Health', *GMJ*, 119 (1933), p. 185.

⁹⁸⁷ Burnett, *Idle Hands*, p. 230.

⁹⁸⁸ Whiteside, 'Counting the Cost', p. 228.

⁹⁸⁹ 'Unemployment Effect: No Increase in Morbidity: Professor E.P. Cathcart', *Scotsman*, 14th December 1933, p. 15; *Committee on Scottish Health Services Report*, p. 105; Macgregor, *Some Observations on Sickness Experience*, pp. 12, 14; *Disinherited Youth*, p. 8.

⁹⁹⁰ 'Psychoneurosis and Incapacity', *BMJ*, 16th March 1935, pp. 533-34.

existence, there is a need for every effort to be made to cope with the social and economic problems of mental illness.⁹⁹¹

The Scottish government also accepted that as a result of unemployment psychological health could be undermined. For instance, in 1921 officials remarked that 'with regard to acute illness, it became apparent as the year advanced that malnutrition and mental depression, arising out of the distress of the time, were having the effect, in a number of cases, of retarding recovery.'⁹⁹² In 1934 the *DHS* also stated that in the South Western division (which included Glasgow), 'no marked manifestations of ill health or actual physical disease that could be attributed to unemployment have yet appeared in the general population, but the Department's regional officers report an abnormal prevalence of nervous conditions among the unemployed men who come before them.'⁹⁹³ The MOH for Glasgow acknowledged the 'increasing demand for accommodation over a number of years' in the city's mental hospitals but he did not comment specifically on whether he thought that this was attributable to the recession.⁹⁹⁴ However, in one *BMJ* article detailing an increase in the number of admissions to the Glasgow Royal Asylum, it was said that this could be 'explained by the more difficult economic conditions, greater stress of life, and the fact that more confidence is now placed in institutions for this type of treatment.'⁹⁹⁵ In 1937 the higher incidence of male patients associated with the Landsdowne Clinic for Functional Nervous Disorders at Glasgow Royal Mental Hospital was also said to be 'due to unemployment.'⁹⁹⁶ Indeed, according to Whiteside, the increase in mental deterioration which occurred during the interwar years cannot be explained by changes in the way that this was diagnosed or by an

⁹⁹¹ 'Mental Disorders: Research Institute in West of Scotland: Modernised Laboratory in Glasgow', *GH*, 28th June 1933, p. 11; Also see 'Mental Illness: Influence of Social and Economic Conditions: Scottish Psychologists in Glasgow', *GH*, 6th March 1933, p. 8.

⁹⁹² *ARSBH 1921*, p. 290.

⁹⁹³ *ARDHS 1934*, p. 12; Also see pp. 20-21 for a more extensive passage on their acceptance of the impact of unemployment on mental rather than physical health.

⁹⁹⁴ *GGNHSBA*, HB19/2/2, 'Accommodation in Mental Hospitals: Report by the Medical Officer of Health Dr. A.S.M. Macgregor, Public Health Department, Glasgow, 14th February, 1931.' This was probably also affected by the increasing age of the population.

⁹⁹⁵ 'Scotland: Glasgow Royal Asylum', *BMJ*, 16th May 1931, p. 836.

⁹⁹⁶ 'Glasgow Royal Mental Hospital: Annual Meeting', *GMJ*, 127 (1937), p. 184.

overspill from the First World War since ‘over half of the “nervous” cases would have been below the age for military service at the time of the Armistice.’⁹⁹⁷

The relationship between the loss of work, mental health and physical wellbeing was reported in the public press. One article published in the *GH* stated ‘it is perhaps too much to expect that the people would come through this prolonged period of economic strain with no physical ill-effects. It is a common experience of the individual that a period of anxiety lowers resistance to disease, and this may be what is happening to the community now.’⁹⁹⁸ Hughes also found that the recession led to mental health issues in neighbouring Greenock:

The anxiety caused by unemployment, real or potential, the stress of poverty and the loss of traditional masculine identity linked to “breadwinning”, as well as the loss of status from earning power and “skill” led to pressures that caused some men to be admitted to mental asylums.⁹⁹⁹

This was also captured by contemporary literature and oral testimony. For instance, in the fictional novel *No Mean City*, the authors detail how Johnnie’s unemployed brother Peter threatens his wife that he would ‘do himself in’ if she took on a job and became the breadwinner, and they comment upon ‘that fearful sense of being “fed up” with life – that frustration of the spirit which comes at times to every healthy unemployed man’.¹⁰⁰⁰ Similarly, in an oral history interview, one man observed that the unemployed ‘were always down in my opinion’, ‘they always looked kinda lost, no happiness, no go, no nothing.’ Significantly, this man believed that ‘health got better because people were happier’ when conditions took a turn for the better ‘when the war

⁹⁹⁷ N. Whiteside, ‘The Social Consequences of Interwar Unemployment’, in S. Glynn and A. Booth, eds., *The Road to Full Employment* (London: Allen and Unwin, 1987), p. 24.

⁹⁹⁸ NAS, ED7/7/11, ‘DHS: Health and Unemployment’, *GH*, 17th June 1933.

⁹⁹⁹ Hughes, ‘Effects of Recession and Depression on Greenock between the Wars’, p. 302.

¹⁰⁰⁰ McArthur and Kingsley Long, *No Mean City*, pp. 282, 305.

started.¹⁰⁰¹ Another Glasgow woman, discussing when both her and her husband became unemployed in the early thirties, recalled 'it was terrible to see your man you know, well doing n' that, how he changed you know. It was dreadful.'¹⁰⁰² This also suggests that the impact of unemployment upon health experiences was more widespread than public health statistics reveal. Mental health could be clearly affected by the loss of work and this is where historians agree. Thus in this way the unemployed were less 'healthy' than those in work. Actually however the reality was much more complex and this interpretation can be complicated by the marked range of experience across the city in relation to a number of social variables.

Variables of Ill Health

The implications of unemployment for physical and mental health were in fact grossly unequal. Indeed, Stevenson notes that the effects of unemployment upon mental state 'varied enormously from individual to individual, depending very much upon age, sex, level of skill and personality, as well as family and social environment.'¹⁰⁰³ One contemporary survey which covered experiences in Glasgow also highlighted that 'not all reacted to unemployment in the same manner. Among the many important factors conditioning their reactions were those of locality of residence, social and economic background of home life, the nature of their work and what it had meant to them in their day-to-day lives.'¹⁰⁰⁴ The unemployed were not a homogeneous group, varying, not least, with regards to occupational skill and the financial status that this entailed.¹⁰⁰⁵ For example, a study by the Pilgrim

¹⁰⁰¹ SOHCA/038/002 (1927).

¹⁰⁰² *2000 Glasgow Lives*, Faye Doran (1907).

¹⁰⁰³ Stevenson, *British Society*, pp. 285-6.

¹⁰⁰⁴ *Disinherited Youth*, p. 66.

¹⁰⁰⁵ Also see Thompson, *Unemployment*, pp. 21-2.

Trust suggested that English skilled workers, who enjoyed high social status among the working class and a traditionally lower chance of unemployment, seemed to suffer most from the psychological impact of unemployment which was an affront to their pride, self-respect and work ethic.¹⁰⁰⁶ The survey *Disinherited Youth* similarly found that the impact of unemployment on those who were skilled or had been educated at secondary school was more severe and that 'it was noticeable that this sense of frustration and lowered personal value was keenest in the better type of young man who, by education, training and social class, felt he had a higher standard to maintain and who, in the beginning, had had ambitions for better things.'¹⁰⁰⁷ On the other hand, the semi-skilled and unskilled:

Did not expect so much from life, even when in employment. Consequently, their disillusionment and personal distress were not felt so keenly. The labourer, accustomed to casual or temporary employment and whose social life is lived within a community where most suffer the same fate, thinks less of the possibility that his unemployment may be due to personal failure.¹⁰⁰⁸

An article written by ex-Baillie Richard Williamson also claimed: 'Glasgow has the finest artisans in the world, and they are left workless, starving and depressed'.¹⁰⁰⁹ As Smout notes, 'the demoralisation of the Scottish work force in the interwar years was enormous, especially in the families of skilled workers with no previous tradition of being out of work for a long time.'¹⁰¹⁰

¹⁰⁰⁶ *Men Without Work* also cited in Burnett, *Idle Hands*, pp. 229-30.

¹⁰⁰⁷ Over one third (38.7 per cent) of those investigated were from Glasgow. The author also states in the introduction that his area of expertise was Glasgow and that he had made effort to ensure as far as possible that the report was not skewed too heavily from this perspective (*Disinherited Youth*, p. 67)

¹⁰⁰⁸ *Disinherited Youth*, p. 67; The statement 'most suffer the same fate' could also be important here in relation to these lower levels of psychological distress. For example, Brenner argues that when an *individual* is 'economically disadvantaged' and is a minority, this is more likely to be interpreted as personal failure due to incompetence – rather than a situation out with their control affecting many/the community (see Brenner, *Mental Illness and the Economy*, p. 236). Brenner's evidence is not specifically related to the interwar period but the point is relevant here.

¹⁰⁰⁹ NAS, DD6/1169, Ex-Baillie Richard Williamson writing, 'Article 3', Conditions in Glasgow.

¹⁰¹⁰ Smout, *Century*, p. 115.

The moral world and values of such workers meant that their spirits had further to fall when they lost their most prized asset – work.

Indeed occupational skill and its relevant financial status, alongside these conventional notions of respectability, could also have important consequences for the physical health of Glasgow's skilled unemployed. After examining the nutrition of working class and labouring class families affected by unemployment in 1921 and 1922 (as discussed), Tully then went on to publish on the diets of the Glaswegian artisan class in 1923. Chapter five has also commented on this study, which found that a lower energy value per penny was consumed by this group because 'fresh beef bought by these artisan families was much dearer than the corned mutton, sausages, and frozen meat purchased by the unemployed labouring classes previously studied.'¹⁰¹¹ This was explained as being due to the fact that the wives of artisan workers, used to superior incomes, were inexperienced and not forced by poverty to maximise spending power to provide an adequate diet – although there is the possibility that behavioural factors related to conventional notions of pride and respectability and the importance of 'keeping face' many have also played a role (See below, chapter 5 and chapter 7).¹⁰¹² Even so, it is likely that the mental strain of making ends meet when faced with unemployment was probably also more severe for this group compared to those used to living close to the poverty line. This study argued that during periods of unemployment the artisan class were able to expend savings to protect themselves from the adverse effects of job loss and that 'so far the trade depression of the country has not markedly affected the nutrition of these artisan families as it has that of the labouring classes, suffering the effects of unemployment and short time.'¹⁰¹³ However, for artisan workers who became unemployed, and when savings were

¹⁰¹¹ Tully, 'A Study of the Diets and Economic Conditions of Artisan Families in May, 1923', p. 6.

¹⁰¹² *Ibid.*, p. 6; Also see Thompson, *Unemployment*, p. 48.

¹⁰¹³ *Ibid.*, pp. 2, 11.

consequently exhausted, the evidence suggests that a period of prolonged unemployment was more detrimental for this group.

Thompson notes that the effective deployment of domestic survival techniques can make it difficult to 'find a conclusive correlation between unemployment and mortality in interwar Britain.'¹⁰¹⁴ However, essentially, when dealing with the same circumstances, experiences could vary down to the family level depending on the way the situation was 'managed' within the home.¹⁰¹⁵ Indeed, one woman recalled that while her father was unemployed 'for a few years', 'we didn't go without food' – 'we didn't have a lot but we didn't go without.'¹⁰¹⁶ There were certainly cases in Tully's study where the calorie intake of artisan families affected by unemployment mirrored that of the unemployed labouring classes, although this was inconsistent.¹⁰¹⁷ Nevertheless, Tully's survey and a host of other evidence suggests that in relative terms, the experience of unemployment could be more severe for the artisan group where the higher incomes of skilled workers outlined in chapter two, and resulting standards of health, had further to fall. For example, a *SBH* survey published in 1923 found that:

Relatively the effects of unemployment, as might have been supposed, have fallen much more heavily on the skilled and the artisan classes. There is always a greater reluctance amongst these classes to apply for poor relief. In a small majority the desire to avoid the 'taint of pauperism,' until compelled by sheer necessity to report to

¹⁰¹⁴ Thompson, *Unemployment*, p. 46.

¹⁰¹⁵ *Ibid.*, p. 46.

¹⁰¹⁶ *2000 Glasgow Lives*, Celia Cowan (1929).

¹⁰¹⁷ There were cases where families said to be in good financial circumstances could also record a calorie intake less than 3,000, while one artisan family affected by unemployment and short time still consumed 3,924 calories.

the poor law, must have caused at least some temporary deterioration in physical condition.¹⁰¹⁸

It must be emphasised that skilled workers and their families were likely to be wealthier and thus initially healthier than the unskilled and deteriorations may have only appeared so severe in contrast to the health that they previously enjoyed. Nonetheless, this still implies that lowering standards of health could be more pronounced and severe among the skilled unemployed.

On the other hand, chapter two has detailed that unemployment relief scales could be as much as the typical wages of those on low incomes.¹⁰¹⁹ Consequently, the *SBH* claimed that the diets of casual and unskilled workers could actually improve whilst unemployed because unemployment aid was more regular than their previous income. They wrote:

The medical evidence confirms the opinion formed by lay observers that public measures taken for the relief of unemployment have prevented any widespread physical distress. In this respect the position has been much more satisfactory than in previous severe trade depressions, when the unskilled and the casual worker, who become immediately affected by a falling off in trade, often suffered acute physical distress and privation because of the lack of coordinated efforts to provide relief. Even during times of normal trading activity, the casual worker, with his uncertain income and his generally improvident habits, experiences periods during which he is hardly able to obtain for his family the minimum nourishment necessary for the preservation of health. In the present depression the unemployed of this class have had available for them, in common with other classes of unemployed, a regular weekly income sufficient

¹⁰¹⁸ *ARSBH 1923*, pp. 193-94; Indeed Brenner argues that it is possible that the shame of accepting public relief could itself result in stress which would impact negatively upon health (Brenner, *Mental Illness and the Economy*, p. 237).

¹⁰¹⁹ Constantine, *Unemployment*, p. 29; Stevenson, *Social Conditions*, pp. 228-29.

to enable an adequate supply of necessaries to be procured. Nearly all the opinions obtained from medical sources refer, as an outstanding feature of the situation, to the improvement in physical condition resulting from this regularity of income.¹⁰²⁰

This was similar to the experiences of some in interwar south Wales, where Thompson notes that ‘despite the massive volume of unemployment and poverty that characterised interwar south Wales, a regular income could mean an adequate diet and even, as the period progressed, an increasing supply of nutritious food.’¹⁰²¹ Obviously, statements like this from official sources have to be treated carefully as they wanted to demonstrate that relief was adequate. However, there was an important distinction between the health experiences of the artisan and labouring class when the typically male breadwinner was out of work. Crowther maintains that ‘the long term unemployed were living on benefits which, even if they may sometimes have been higher than the earnings of poor families, were still at poverty level.’¹⁰²² Nevertheless, in the context of establishing public health trends, the physical condition of those in the lowest income bracket is unlikely to have been affected quite as severely, where the change in financial circumstances was less dramatic.

An important distinction also existed between the experiences of the long and short term unemployed in terms of both physical and mental health. Attempts to examine the health of the unemployed in this way is complex, in that it is complicated by the ‘healthy worker’ effect and the causal relationship between unemployment and illness – the extent to which unemployment results in ill health or whether ill health leads to unemployment. Constantine explains: ‘The poorer health record of the long term unemployed may have been caused as much by this process of selection as by the damaging effects of poverty and malnutrition to which many of the unemployed were

¹⁰²⁰ *ARSBH 1923*, p. 193.

¹⁰²¹ Thompson, *Unemployment*, p. 78.

¹⁰²² Crowther, *Social Policy*, p. 66.

undoubtedly also prone.¹⁰²³ Glasgow was an industrial city, and as one Glasgow hospital report pointed out, ‘in a large industrial area like this’, ‘accidents, unfortunately, are so common’, the result being that ‘deformities and disabilities are so often left behind’.¹⁰²⁴ Furthermore, many of those who survived the First World War incurred life changing physical disabilities making them less or unable to engage in physically demanding work. Thus, Glasgow had its fair share of physically damaged workers to pay off. Indeed, in 1929 the *GH* reported that ‘the least efficient people are always the first to go and the last to be re-engaged’ as employers favoured able bodied men.¹⁰²⁵ From figures based on the heights and weights of a sample of 100 unemployed Glaswegian youths (18-25) it was also noted that those classified as having had ‘least unemployment’ were 1.5 inches taller and 6 pounds heavier than ‘the average man with most unemployment.’ From this, the report concluded that ‘this means that, on average, a man from Group A (least unemployment) and one from Group E (most unemployment) standing alongside each other at the shipyard or factory gate and both competing for one job – and usually an unskilled one (67.8 per cent of the Glasgow [youth] sample were unskilled) – are noticeably different, particularly in height, to the foreman’s eye. The taller and heavier looks the fitter man.’¹⁰²⁶

The extent to which this was practiced is difficult to determine but it should be kept in mind. Indeed, Bellaby and Bellaby point out that actually, ‘where unemployment rates are high rather than low, the unemployed are likely to be healthier on average, for even the relatively fit may lose their

¹⁰²³ Constantine, *Unemployment*, p. 34.

¹⁰²⁴ Glasgow Royal Infirmary: Past, Present and Future: An Address Delivered by John Fergus, M.D., at the Annual Meeting of Delegates of Employee Contributions to the Glasgow Royal Infirmary, 1927; The experience of those with disabilities is one group which is absent from this thesis. However, a PhD on the Scottish experience of disabled ex-servicemen being conducted by Emily Rootham (Caledonian University) will shed some light on this in due course.

¹⁰²⁵ ‘Unemployment Insurance: IV. Physique and Employability’, *GH*, 2nd May 1929, p. 3; Hardy, *Health and Medicine*, p. 94.

¹⁰²⁶ *Disinherited Youth*, p. 30.

jobs.¹⁰²⁷ Therefore it is likely that in Glasgow, a region where at its worst one third of the population were out of work, the unemployed would have included a significant amount of healthy workers. Also, due to campaigns like the King's National Roll Scheme, which encouraged employment opportunities among the disabled community with significant success, Kowalsky points out that the percentage of unemployment among disabled ex-service men at least was actually lower than that for the able bodied unemployed.¹⁰²⁸ The figures published by Kowalsky refer to Britain as a whole but they are significant. Essentially, it is likely that a considerable proportion of the unemployed in Glasgow were able bodied workers and consequently, deteriorations in health which were observed may have often been more real than apparent.

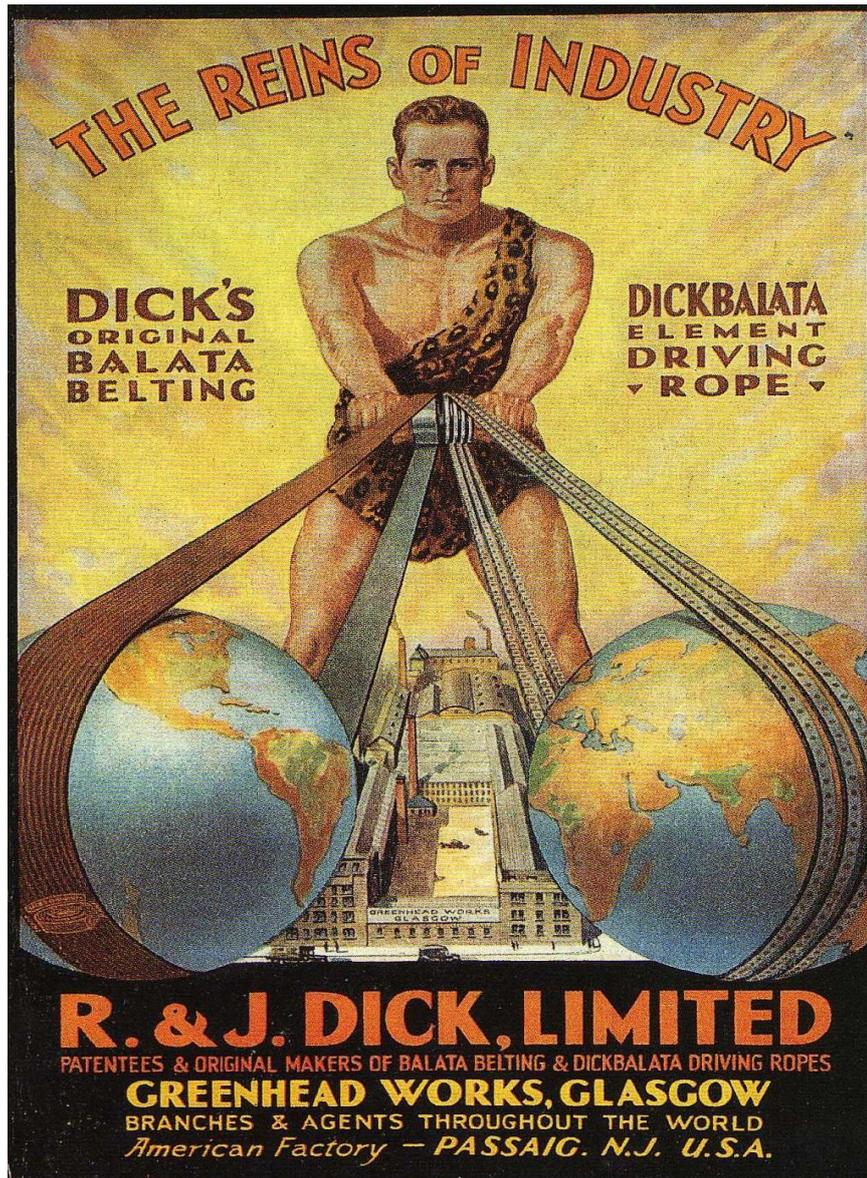
Evaluating the data in relation to duration of unemployment reveals how this could impact upon the body. Industrial workers have been traditionally associated with a 'hard man' image of physical and aggressive strength [Illustration 6.1].¹⁰²⁹

¹⁰²⁷ P. Bellaby and F. Bellaby, 'Unemployment and Ill Health: Local Labour Markets and Ill Health in Britain 1984-1991', *Work, Employment and Society*, 13 (3), (1993), p. 462.

¹⁰²⁸ M. Kowalsky, 'This Honourable Obligation': The King's National Roll Scheme for Disabled Ex-Servicemen 1915-1944', *The European Review of History*, 14 (4), 2007, p. 575.

¹⁰²⁹ Johnston and McIvor, 'Dangerous Work', pp. 135-52.

Illustration 6.1: 'The Reins of Industry'



SOURCE: R. Johnston and A. McIvor, 'Narratives from the Urban Workplace', p. 25.

One man recalling his childhood in Govan corroborated this view stating that:

A device long gone from internal combustion vehicles is the starting handle... In the thirties, however, they were a permanent fixture at the front, usually positioned behind the bumpers of cars... Cold starting heavy vehicles often involved two strong men, and the effort required

for the first start of the day in winter in sub-zero temperatures, conjures up the vision of a special breed of he-men.¹⁰³⁰

However, there is evidence that a decline in physical fitness occurred for the long term unemployed or young men who had never been employed who lost body strength necessary for industrial work, and this was agreed by the MOH for Glasgow.¹⁰³¹ The *SBH* also reported that ‘furnacemen restarting work after two years idleness found themselves so physically unfit for the heavy work that they required to be assisted in their tasks by their fellow workmen.’¹⁰³² The investigators found that in one Scottish district (frustratingly, it does not say which), that following only one month of unemployment and sole reliance on unemployment benefit, labourers’ efficiency dropped by 10 per cent.¹⁰³³ The extent to which this was solely due to the impairment of physical strength, however, should be kept in perspective. For example, in his novel *Scottish Journey* Edwin Muir comments on the loss of skill once performed by unemployed men, that their hands had ‘grown useless’ and that their skill had ‘dropped from them.’¹⁰³⁴ The *SBH* similarly reported that ‘loss of morale or technical efficiency manifestly adds to the numbers of people who become a public burden’.¹⁰³⁵ Nonetheless, there was clearly official concern regarding the dwindling industrial strength of the unemployed – a concern which manifest itself in the government’s fear that their physical state could undermine the recovery of the economy. The regional officer for Glasgow of the *UAB* stated, for example, that ‘when it is realised that in a Glasgow area about 30 per cent of the applicants have been idle for four years or more the need for [physical training courses] even to maintain industrial fitness is self evident.’¹⁰³⁶ This fear also underlined the government’s encouragement of the Keep Fit campaign discussed in the following chapter.

¹⁰³⁰ Rountree, *Govan*, p. 111.

¹⁰³¹ Macgregor, *Some Observations on Sickness Experience*, p. 12; Burnett, *Idle Hands*, p. 236.

¹⁰³² *ARSBH 1923*, p. 199.

¹⁰³³ *Ibid.*, p. 199.

¹⁰³⁴ Muir, *Scottish Journey*, p. 138.

¹⁰³⁵ *ARSBH 1923*, p. 15.

¹⁰³⁶ *RUAB 1936*, p. 123; ‘Social Life’, *Scotsman*, 3rd March 1936, p. 15.

The perceived decline in the physical condition of the long term unemployed was detailed by official documentation, in the public press and by contemporary literature. For example, in one letter to the editor of the *GH* it was stated that ‘anyone who comes into contact with [the unemployed] is impressed by their deterioration. The shrinkage of labour value will be reflected in the work done when resumption takes place.’¹⁰³⁷ Also, in *No Mean City* it was claimed that the character ‘Razor King took more kindly to the actual toil than might have been expected after his long period of idleness. The mere muscular effort of hefting heavy sacks gave him a sort of satisfaction. He had kept in semi-training all along, but he felt the need of hard work.’¹⁰³⁸ It was also claimed that this deterioration in strength could have additional implications for health. For example, it was said that ‘there can be no doubt that the decreased activity must lead not only to a lowered capacity for work, but also to a lowered resistance to infection and disease.’¹⁰³⁹ It was also reported that men’s hands could become soft, meaning that they were more susceptible to blisters, cuts, bruises and septic poisoning.¹⁰⁴⁰ Oral testimonies corroborate this point where one Glasgow man who was wholly unemployed between 1931 and 1936 explained:

I worked for three days, aye, three days. Oh, I was sore! Ma hands were ripped almost tae shreds wi’ carrying those wooden baskets, soaking wet, it was hard work, I wisnae accustomed to it, I was a weakling actually in regards to jobs.¹⁰⁴¹

Interestingly, the decline in physical capability was also observed by one Glaswegian female who was notably well-off during the interwar period. After commenting that the fathers of many of her school friends ‘never got jobs and, or they got jobs that they weren’t able to do’ she explained: ‘They

¹⁰³⁷ ‘Letter to the Editor: Unemployment’, *GH*, 11th September 1922, p. 7.

¹⁰³⁸ McArthur and Kingsley Long, *No Mean City*, p. 119.

¹⁰³⁹ Tully and Urie, ‘A Study of the Diets and Economic Conditions of Labouring-Class Families in Glasgow in June, 1922’, p. 366.

¹⁰⁴⁰ *ARSBH* 1923, p. 199; ‘Department of Health for Scotland: Report on the Physical Fitness of the Insured Population’, *GMJ*, 126 (1936), p. 238.

¹⁰⁴¹ MacDougall, *Voices* (1), p. 172.

weren't strong enough. I think they never got enough food, you know that kind of way.'¹⁰⁴²

The experience of men returning to work, and in work, is a grey area in the literature which tends to concentrate on the effects of the recession upon the health of the unemployed. Consideration of occupational health in interwar Glasgow could be a PhD thesis in itself. However, it is important to note that the trade depression could also have important consequences for those who kept their jobs. Writers such as Mclvor claim that 'workers' health was further undermined by the mental strain and anxiety of recurrent short-time working, underemployment and unemployment, and by the intensification of workload ('speeding-up') and increased monitoring and direct discipline that characterised the interwar period.'¹⁰⁴³ A report by the *SBH* in 1923 also noted that 'sub-normal out-put through want of practice is sometimes counterbalanced by a conscious speeding up by the men, who are anxious to prove their worth in the face of the competition for the few jobs available.'¹⁰⁴⁴ It was reported that workers returning to employment were more likely to display signs of physical fatigue and were more prone to accidents in the workplace.¹⁰⁴⁵ The *DHS* documented:

Much sickness is attributable directly or indirectly to general factors – housing, defective diet, poverty in the wide sense, and the deleterious aspects of occupational environment. Part of the high level of sickness can be attributed to the effects of unemployment and re-employment, which each act adversely, though in totally different

¹⁰⁴² SOHCA/038/001 (1912).

¹⁰⁴³ A.J. Mclvor, *A History of Work in Britain 1880-1950* (Hampshire: Palgrave, 2001), p. 137; Also see B. Supple (1987), *The History of the British Coal Industry, Vol. 4, 1913-1946*, cited in Mclvor, *History of Work*, p. 138 which details how occupational health standards deteriorated in some industries during the interwar period; Mclvor also notes that in Britain welfare services provided by employers could be cut meaning that 'the employment of works doctors, nurses and welfare officers was rare, and technological renewal and electrification quite sluggish in these industries.' This particularly applied to the traditional 'heavy' industries (Mclvor, *History of Work*, p. 137).

¹⁰⁴⁴ *ARSBH 1923*, pp. 198-99.

¹⁰⁴⁵ 'DHS: Report on the Physical Fitness of the Insured Population', p. 238.

directions; unemployment, especially when prolonged, leading to disabilities often of a psychoneurotic kind, re-employment producing sequelae as accidents, myalgias (muscle pain) and superficial sepsis.¹⁰⁴⁶

Similarly, the survey *Disinherited Youth* found:

If unemployment had been continuous, the return to normality was a much slower process. In the initial stages there was the nervousness associated with a fear of incompetence to hold on to the job. Some mothers mentioned that for the first two or three weeks at work the lad was very tired at nights and felt sickly and 'off his food.' This kind of tension shows itself, not only with the unemployed who have returned to work, but also with the employed who, at times of depression, fear the prospects of unemployment and exhibit similar manifestations of emotional instability.¹⁰⁴⁷

From this interpretation it can be argued that those affected and threatened by unemployment endured a poorer health experience, and that the effects of the recession were widespread – even if this is not conclusively reflected in the public health statistics. Indeed, one article published in the *GP* recognised that 'enforced idleness represents an incidence of temporary disablement of the workers by so-called trivial illnesses which, not being of a fatal character, do not influence the general death rate, and of which, except in specifically investigated records of the insurance doctors, there is no official record.'¹⁰⁴⁸ However, the inequalities in health standards and the diversity of experience between the unskilled and skilled, and the long and short term unemployed, further suggests that a more accurate understanding of the extent of ill health among this group can be achieved by unravelling and exploring the distinct health trends which existed according to a number of social variables.

¹⁰⁴⁶ *DHS, Report on Incapacitating Sickness in the Insured Population of Scotland, during the year 1st July 1934 to 30th June 1935*, p. 4.

¹⁰⁴⁷ *Disinherited Youth*, p. 69.

¹⁰⁴⁸ 'New Health Talks: The State of Public Health', *GP*, 17th September 1926, p. 6.

The long term unemployed were also thought to be more likely to experience deteriorations in psychological health. As mentioned, job insecurity also affected those in work. However, there is widespread agreement that lapses in psychological health could follow long spells of unemployment. For example, in *Shipbuilders*, Blake similarly says of one main character who suffers a period of long term unemployment, 'he knew himself to be going soft in the mind and body.'¹⁰⁴⁹ Again the notion of diversity can be reinforced, where it was claimed that it was 'prolonged unemployment' which 'led to disabilities of a psycho-neurotic kind.'¹⁰⁵⁰ This was illustrated by one local study in which Dr. J.L. Halliday¹⁰⁵¹ examined a sample of 1,000 sick insured people in Glasgow, found that one third of this number was ill due to psychological rather than organic symptoms, and he analysed this in relation to the incidence of unemployment among this group.

Table 6.1: Incidence of psychoneurotic disease among unemployed men in Glasgow

Duration of unemployment	Months			Years		
	0-3	3-6	6-12	1-2	2-3	3
Psychoneurosis as percentage of all causes	27	37	42	41	37	33

SOURCE: *Men Without Work: A Report made to the Pilgrim Trust* (Cambridge: Cambridge University Press, 1938), p. 136.

The table reveals that during the first year of unemployment the incidence of psychoneurotic symptoms increased alongside the period of unemployment, decreasing somewhat thereafter (Table 6.1). These findings were subsequently discussed in the report *Men Without Work* by the Pilgrim

¹⁰⁴⁹ Blake, *Shipbuilders*, p. 159.

¹⁰⁵⁰ 'DHS: Report on the Physical Fitness of the Insured Population', p. 238.

¹⁰⁵¹ J.L. Halliday was a regional medical officer for the DHS. He was also a teacher of G. Gladstone Robertson who later wrote *Gorbals Doctor*. In this Gladstone Robertson writes of Halliday that 'in the course of his work he noticed a close connection between the illness of groups of people and the stresses under which they worked or operated'. He also notes that he was criticised by doctors at home but 'American journals hailed his work as among the most fundamental contributions to psychosomatic medicine – body-mind relationships – of the time' (Gladstone Robertson, *Gorbals Doctor*, pp. 78-80).

Trust.¹⁰⁵² They argued that the Glasgow data was significant ‘not only because they show an increased incidence of psychoneurosis among unemployed men varying according to length of unemployment, but also because they may perhaps reasonably be taken to indicate the phases even of the normal man’s attitude during unemployment – the man who does not become a psychological state but is nevertheless worried and distressed.’¹⁰⁵³

The Pilgrim Trust claimed that Dr. Halliday’s figures actually provided a “time-table” showing approximately when the various stages are most usually reached; and that they show conclusively how unemployment may be a factor in mental illness’ – a phenomenon increasingly debated by interwar psychologists.¹⁰⁵⁴ Halliday himself pointed out that ‘gradually, anxiety and depression set in with loss of mental equilibrium; finally, after several years, adaption takes place to a new and debased level of life, lacking hope as well as fear for the future’ – a trend agreed by other contemporaries like Eisenberg and Lazarsfeld, and Beales and Lambert.¹⁰⁵⁵ The ‘stage theory’ was seemingly reflected by the data collated in Glasgow, and somewhat explains why the incidence of men suffering ‘psychoneurotic diseases’ declined between one and three years long term unemployment (Table 6.1). A host of disagreements on, for example, the exact number of stages, has resulted in the notion that the unemployed passed through an exact sequence of mental deterioration being largely discredited in the

¹⁰⁵² *Men Without Work: A Report made to the Pilgrim Trust* (Cambridge: Cambridge University Press, 1938), pp. 1-2; Stevenson and Cook, *The Slump*, p. 74.

¹⁰⁵³ *Men Without Work*, p. 136.

¹⁰⁵⁴ *Ibid.*, p. 137.

¹⁰⁵⁵ J.L. Halliday, ‘Psychoneurosis as a Cause of Incapacity among Insured Persons’, *SBMJ*, 16th March 1935, p. 100; E. Buchart, ‘Unemployment and Non-Employment in Interwar Britain’, *Discussion Papers in Economic and Social History* (16), May 1997 (Oxford: University of Oxford, 1997), p. 10; The Eisenberg and Lazarsfeld psychological study was based on the unemployed of an Austrian community. They also cited Israeli’s findings that the unemployed in Lancashire and Scotland displayed signs of neurosis, and were ‘more negative and depressed in that they expected greater failure in the future’ (See P. Eisenberg and P. Lazarsfeld, ‘The Psychological Effects of Unemployment’, *Psychological Bulletin*, 35 (1938), p. 378); L. Beales and R.S. Lambert, *Memoires of the Unemployed, 1933* (London: Garland, 1985).

literature.¹⁰⁵⁶ Nonetheless, the evidence indicates that psychological distress varied according to duration of employment, which was likely to be detrimental to health. Indeed, interestingly, Halliday also suggested that ‘the conscientious working man who is dismissed from his employment and takes ill with abdominal pains and vomiting (being hurt and sick with the treatment of his employers) contrives, though unconsciously, to furnish a more tolerable explanation for his dismissal – namely, he is not working because of ill health.’¹⁰⁵⁷ Thus, if health did not deteriorate, this reinforces the extent to which personal perceptions of health could contradict that measured by medical diagnosis. However, these studies clearly suggest that the term of unemployment could be significant in determining the health experiences of individuals in interwar Glasgow.

Furthermore, social investigators observed that psychological responses to unemployment differed between employed men and women, and this has been similarly found in more recent research.¹⁰⁵⁸ Indeed, this is an important point where, as Jones has remarked, ‘unemployed women were also in poor health, although their plight has gone largely unrecognised as contemporaries and historians have tended to focus on the ill-effects of unemployment on the unemployed man and his family.’¹⁰⁵⁹ The *Ministry of Labour* commented that centres for women aged between 35 and 45 years which were offered in Burnley, Glasgow, Leeds and Blackburn had ‘done valuable work for *the physical and mental welfare of the women*, and have definitely increased their chances of obtaining employment [my italics].’¹⁰⁶⁰ This suggests that some deterioration also occurred among unemployed women. Similarly, of the interwar Keep Fit campaign, discussed in more

¹⁰⁵⁶ For an introduction to this debate see R. McKibben, *The Ideologies of Class: Social Relations in Britain 1880-1950* (Oxford: Clarendon, 1994).

¹⁰⁵⁷ GUSC, MS GEN 1669, off print from the *SBMJ* titled, ‘Psychoneurosis as a Cause of Incapacity among Insured Persons’, J.L. Halliday, 9th and 16th March 1935, p. 8.

¹⁰⁵⁸ McKibben, *Ideologies of Class*, p. 256; N. Bailey, ‘Does Work Pay? Employment, Poverty and Exclusion’, in C. Pantazis, D. Gordon and R. Levitas, eds., *Poverty and Social Exclusion in Britain: The Millennium Survey* (Bristol: Policy Press, 2006), p. 165.

¹⁰⁵⁹ Jones, *Health and Society*, p. 73.

¹⁰⁶⁰ *Report of the Ministry of Labour for the Year 1931*, HMSO 1932 (4044), p. 42.

depth in the following chapter, it was also said that ‘the object of the scheme is to prove that physical wellbeing is absolutely essential toward fitting unemployed men and women for taking up work when called upon to do so and keeping them mentally and bodily alert.’¹⁰⁶¹ However, in psychological terms at least, Halliday found that ‘the effect of unemployment differs in the two sexes,’ whilst highlighting the often forgotten point that women also lost their jobs.¹⁰⁶² The investigation revealed that the percentage of employed males suffering from psychoneurotic disability was 28 per cent, compared to 37 per cent among unemployed men. On the other hand, the corresponding percentages for women were 37 per cent for those in employment and 32 per cent for those without work. The report concluded that ‘it seems that in the event of unemployment the male is more likely to break down than the female.’¹⁰⁶³ It should be noted that writers like Stephenson and Brown have highlighted the pride and esteem that women also attached to work, and that the assumptions and discourses in which Halliday was researching may have impacted upon his results.¹⁰⁶⁴ Nevertheless, if work identities were markedly different and shaped by gender in what was still an intensely patriarchal society the loss of employment may well have had different meanings for men and women.¹⁰⁶⁵ This evidence denotes the importance of paid work for males where failure to fulfil their traditional ‘bread-winner’ role could lead to erosions in psychological wellbeing.

¹⁰⁶¹ ‘Keep Fit Campaign’, *GH*, 28th June 1933, p. 9.

¹⁰⁶² ‘Psychoneurosis and Incapacity’, *BMJ*, 16th March 1935, p. 533.

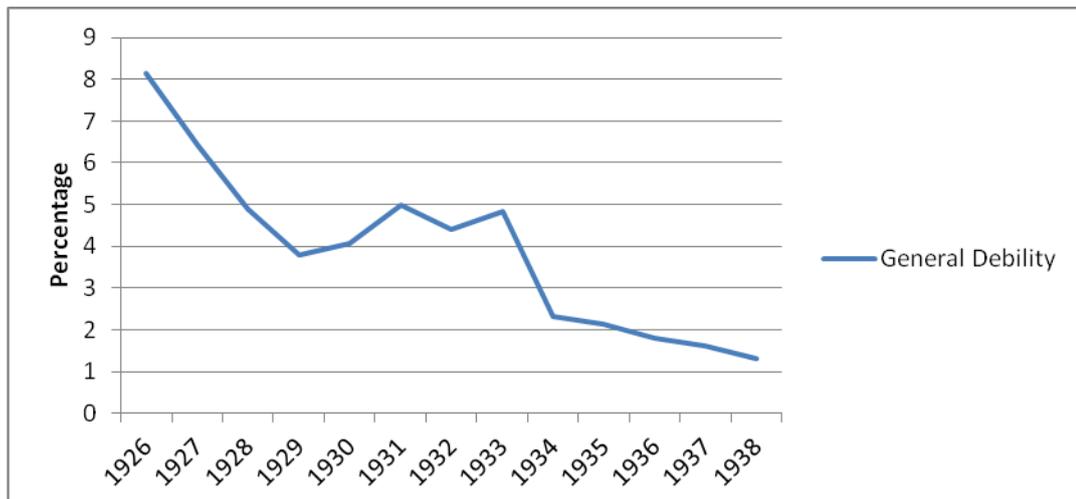
¹⁰⁶³ *Ibid.*, p. 533.

¹⁰⁶⁴ However, Stephenson and Brown drew on oral histories, and it may be the case that women remembered the workplace more fondly looking back on their lives after spending many years thereafter as housewives and mothers. At the time, the impact of unemployment upon women’s lives may have not been so severe (J.D. Stephenson and C.G. Brown, ‘The View from the Workplace: Women’s Memories of Work in Stirling, c.1910-c.1950’, in E. Gordon and E. Breitenbach eds., *The World is Ill Divided* (Edinburgh: Edinburgh University Press), p. 25.

¹⁰⁶⁵ E.P. Cathcart, ‘The Maintenance of Health’, *Medical Officer*, 12th November 1932, p. 202.

The health impact of job loss upon unemployed women themselves has not been examined in depth and is due research attention.¹⁰⁶⁶ Rather, the historiography has emphasised the indirect effects of unemployment upon the health of wives and mothers from families affected by loss of work (also see chapter 5). In Glasgow, statistics specific to the health of unemployed females or of women from households affected by unemployment, could not be located but was related to some available. For instance, in 1930 it was reported that “general debility” is largely contingent on the poverty and unemployment in the homes, and the size of the family. It is often synonymous with malnutrition due to underfeeding.¹⁰⁶⁷

Figure 6.3: Percentage of women attending ante-natal clinics in Glasgow found to be suffering from general debility, 1926-1938



SOURCE: RMOHG 1927-1938.¹⁰⁶⁸

The figures do not entirely correspond with unemployment rates since a small improvement in the percentage of women found to be suffering from general debility occurred during the nadir of the recession in 1931-32 (Figure 6.3). Also, the term ‘general debility’ is not particularly robust and may be

¹⁰⁶⁶ Jones, *Health and Society*, p. 58.

¹⁰⁶⁷ RMOHG 1930, p. 88.

¹⁰⁶⁸ Figures only published consistently from 1926.

more susceptible to changes in the way data was recorded, or diagnoses were made, compared to more statistically precise mortality data. Nonetheless, the continual decline between 1926 and 1938, except for the rise that took place over the worst years of the period, implies that this increase cannot be attributed to changes in the way the data was recorded. There is a clear increase in women suffering from general debility over the worst years of the Depression and a notable recovery thereafter. Health experiences associated with unemployment varied not only between those in and out of work, but between the skilled and unskilled, the long and short term unemployed, with important gender differences as well. It is evident that whilst there is relative agreement that the unemployed could experience lapses in physical and mental health, even the experiences of the group of the population most directly affected by loss of work were not universal. Consequently, it can be maintained that examining the unemployed community in isolation, and underlining the marked inequalities which existed, can provide a more detailed understanding of interwar public health trends.

Conclusion

The extent to which mass unemployment undermined standards of public health in Glasgow during the interwar years is difficult to measure, and it illustrates the ways in which the data, even within a distressed region, can be read and analysed to endorse contrasting interpretations. The IMR and tuberculosis mortality patterns – indices often utilised to analyse the effects of changing socio-economic conditions – were at times suggestive of a link between unemployment and poor health. However, the inconsistency of these trends in relation to unemployment makes it impossible to ascribe the fluctuating death rates to unemployment alone. The mortality pattern for regions notably depressed in Glasgow also confirmed this view, although

there was evidence to support the claims of historians like Burnett and Whiteside that the health of Glasgow, and more distressed regions within it, deteriorated in relative terms at least as their share of the overall health gains which were made was less.¹⁰⁶⁹ This also highlights that standards of health varied according to geographic region. The diets of those affected by unemployment were also somewhat inferior to those in work suggesting that this may have undermined their health, although issues with the way that this was recorded makes it difficult to be certain of the extent to which this was the case. However, this chapter has also reinforced the importance of examining the human details behind the numbers which reveal that the impact of 'unemployment', in terms of popular perceptions and what people believed to be the case, was much more widespread than public health statistics and medical literature implies. The era was one of perceived deteriorations in health as a direct result of unemployment, and this was often the lived health experience.

Examining the health of those affected by the loss of work in isolation reveals, for the most part, that they were a notably disadvantaged group who experienced both perceived and actual deteriorations in physical and mental health. However, even then, experiences were characterised by diversity, varying between and within individual groups of the unemployed itself. Discrepancies and divergences existed in relation to occupational status (along a spectrum from highly skilled to unskilled) and the period of unemployment (long term to short term), while this was also complicated by gender. The health trends of Glasgow's unemployed community mirrors Burnett's claim that their experiences 'followed no universal or simple pattern' and that they 'defy any single model' – a notion advanced throughout this thesis.¹⁰⁷⁰ The argument here is that unravelling and exploring these inequalities provides a more detailed picture of public health in the interwar years.

¹⁰⁶⁹ Burnett, *Idle Hands*, p. 254; Whiteside, 'Counting the Cost', p. 243.

¹⁰⁷⁰ Burnett, *Idle Hands*, p. 264.

Chapter 7 Culture, Agency and Health

Half of the folk [who] were no' well. No matter who was in government, it was themselves, you know... And I was wondering, I mean, it's only now, when you're older and you think on these things, I was wondering if that was maybe the cause, it wisnae the government or anything. I mean, people blame the government for this and the government for that. It's no' the government, I mean, it's how they act themselves, you know.¹⁰⁷¹

The previous chapter on the recession, unemployment and health examines the physical condition of those affected by the loss of work in isolation. However, in doing so, it could be argued that this paints a particularly depressing, and largely unrepresentative view of health in Glasgow between 1919 and 1939. In the interwar period, despite soaring rates of unemployment, the unemployed were a sizable minority. Also even within this group, it is important to note that, quite simply, everyday life went on. In spite of the socio-economic challenges of the era people engaged in daily leisure and lifestyle activities – pursuits which could have both important health enhancing and deleterious effects. Discussing the debate surrounding mortality decline, Kunitz summarises that those who could be called 'determinists' have adopted the view that disease was largely 'caused by society and citizens as victimised by that society' in that they were affected by structural factors including industrialisation, medical sources, unemployment, overcrowding and poverty, all of which were essentially out with personal control.¹⁰⁷² On the other hand, 'voluntarists' emphasise the role played by voluntary lifestyle factors and according to them of 'the major causes of mortality, the locus of control was internal; it had to do with the individual's will and moral responsibility.'¹⁰⁷³ It should be noted that culture

¹⁰⁷¹ SOHCA/009, Domestic Violence, Ms AB (1922).

¹⁰⁷² Kunitz, 'Explanations and Ideologies of Mortality Patterns', p. 390.

¹⁰⁷³ *Ibid.*, p. 391.

does not exist independently of the more structural factors impacting upon health, and there were obviously restrictions on the amount of choice a person had. Consequently, the debate has centred upon the extent to which ‘determined’ and ‘voluntary’ choices impacted upon mortality patterns and standards of health, and the balance of interaction between the two.

Nonetheless, historiographical literature on the interwar period is overwhelmingly concerned with the extent to which health improved or deteriorated in the context of economic instability. While the role of individual agency has been acknowledged by writers including Webster, Stevenson and Thompson,¹⁰⁷⁴ the impact of personal behaviour has tended to be overshadowed by debates on the social determinants of health including living standards, housing, falling mortality, morbidity and disease rates, improvements in medical care, and advances in diet and nutrition, essentially what could be described as ‘structuralist’ factors. However, the population were not passive to either the consequences of industrial recession or the official, interwar public health campaigns. This is acknowledged in the literature, but has not been examined in depth with reference to health. Thompson notes that ‘cultural factors led people to behave in specific ways which had consequences for their wellbeing’, and to a significant extent, people were responsible for their own physical condition – a notion realised from the personal testimony quoted above.¹⁰⁷⁵ The interwar Scottish authorities were also of the opinion that ‘the organised community could provide decent social conditions and services, but health remained very

¹⁰⁷⁴ Thompson is one of the few historians who have analysed agency in significant depth for this period (See Thompson, *Unemployment*); Webster, ‘Healthy or Hungry Thirties’, p.125; Stevenson, *Social Conditions*, p. 127; However, it is also important to note that there is widespread recognition of the apparent ‘ignorance’ of women, and this could be regarded as essentially a behavioural factor.

¹⁰⁷⁵ Thompson, *Unemployment*, p. 5.

largely a way of living, and in the end it was for the individual to lead the healthy life.¹⁰⁷⁶

In studying this role it is important to be wary of the political and medical discourses of the time, where many health professionals understood the ill health of communities in terms of 'ignorance' whilst obscuring socio-economic effects.¹⁰⁷⁷ However, Thompson claims that 'by taking a view "from below"', the active role of the individual becomes apparent and 'to some extent, the emphasis placed on human agency challenges the traditional historiography' which 'seems to view the working class people as victims of the powerful forces that acted upon their lives.'¹⁰⁷⁸ However, this was not specific to the working class, and in an era of increasing 'diseases of affluence' this also applied to those in superior socio-economic positions. This chapter will examine lifestyle choices, cultural factors and the 'voluntary' determinants which also impacted upon health experiences, by looking at the interwar physical culture and 'Keep Fit' campaign, dietary traditions and changing consumption patterns in terms of smoking, drinking and gambling, and behaviours resulting from interwar notions of respectable masculinity and femininity which could also affect health. This chapter argues that there were also important *cultural* factors which impacted upon health, and that these too varied according to geography, gender and class at least.

¹⁰⁷⁶ 'National Health Campaign: The Campaign in Scotland', *BMJ*, 9th October 1937, p. 720; Also see Chalmers, *Health of Glasgow 1818-1925*, p. ix; *Evidence to be Submitted to Committee on Scottish Health Services re The Medical Services*, p. 157.

¹⁰⁷⁷ Thompson, *Unemployment*, p. 6.

¹⁰⁷⁸ *Ibid.*, p. 7.

Healthy Living and Physical Culture

During the interwar period, the role of the individual was increasingly recognised by the public health authorities.¹⁰⁷⁹ Hardy notes that after the founding of the Ministry of Health in 1919 its 'first Chief Medical Officer, George Newman, came to office with a clear, holistic vision of the path the new Ministry should follow, a combination of the old environmental measures and a new emphasis on personal health and healthy living' – a view which filtered down through the Scottish health authorities.¹⁰⁸⁰ The 1936 *DHS* report conducted by the Committee on Scottish Health Services stated, for example, that:

All evidence goes to emphasise the point that health must be regarded as a way of living, and that it depends increasingly on the outlook and conduct of the individual. In our view no great improvement can be expected in the general health of the nation unless an organised attempt is made to convince each person of the necessity of observing fundamental rules and of developing such habits and attitudes and ideals as will promote physical, mental and emotional wellbeing. For these reasons we consider that health education should be placed in the forefront of national health policy.¹⁰⁸¹

Jones argues that 'the main thrust of the health education campaigns was to emphasise healthy behaviour and the overwhelming importance of cleanliness. Low incomes and social and economic factors which contributed to health were largely ignored.'¹⁰⁸² This new concept of health was implemented across society including, for example, an emphasis on physical education in schools and classes on the 'Laws of Health' – a principle which culminated in the Physical Training and Recreation Act 1937 which promoted

¹⁰⁷⁹ 'Health Week', *Medical Officer*, 1st July 1922, p. 3.

¹⁰⁸⁰ Hardy, *Health and Medicine*, p. 77.

¹⁰⁸¹ *Committee on Scottish Health Services Report*, p. 106.

¹⁰⁸² Jones, *Health and Society*, p. 77.

and encouraged personal health and fitness among the population.¹⁰⁸³ Arguably, this ideal was as much for the economic value of the State as it was for the health of the population, and Frederick Le Gros Clark and Richard Titmuss argued in 1939 that 'it is precisely because it costs more to keep a nation fed than it does to keep it partially exercised, that the Government had been tempted to the line of least resistance.'¹⁰⁸⁴ Zweiniger-Bargielowska has also argued that 'the promotion of exercise, healthy lifestyles, and greater use of existing health services provided a cheap alternative to more expensive and costly welfare reforms.'¹⁰⁸⁵

Nonetheless, in common with the rest of the UK, it is evident that there was increasing enthusiasm for active and healthy lifestyles among the people of Glasgow, and that it was a development affecting the more prosperous class as well as those of limited means. Hardy points out that 'medicine, in fact, received a great deal of publicity during the interwar period' through various media outlets including 'health columns in the new popular press and magazines.'¹⁰⁸⁶ In Glasgow newspapers, columns such as the 'Health of the People' in the *Glasgow Herald* (GH) and 'Dear Doctor' in the *Govan Press* (GP) featured regularly. The content, characteristics and marketing of these publications varied. The *GH* could be described as a 'middle class' paper and seems to have been favoured by and intended for a more prosperous audience. For example, in columns such as the 'Women's Section', articles commonly refer to the business class and the well-to-do in a way that the *GP* does not. The content of the literature, in terms of featured fashion styles and advertising for example, were clearly often out with working class

¹⁰⁸³ 'Laws of Health' included the 'instruction of simple personal hygiene' (GGNHSBA, HB38/1/3, *RMITSC 1929*), p. 19; See for example Zweiniger-Bargielowska, *Managing the Body*, p. 280; Zweiniger-Bargielowska, 'Raising a Nation of "Good Animals"', 73-90; Welshman, 'Physical Education and the School Medical Service in England and Wales', 31-48; SOHCA/038/001 (1912).

¹⁰⁸⁴ F. le Gors Clark and R. Titmuss, *Our Food Problem* (London: 1939), p. 101 cited in John Welshman, 'Physical Education and the School Medical Service in England and Wales', p. 43

¹⁰⁸⁵ Zweiniger-Bargielowska, *Managing the Body*, p. 329.

¹⁰⁸⁶ Hardy, *Health and Medicine*, p. 83; Also see Beier, *For Their Own Good*, p. 312.

budgets. The *GP* on the other hand was the local newspaper of working class area Govan and its surrounding regions.

Marketing campaigns in both however point to the enthusiasm with which people protected their health. Cleaning products and vacuum cleaners were advertised promising 'healthy' and 'hygienic' homes', coca was sold as a 'nourishing food', wool was promoted as a 'protector of bodily health', beef, chicken and mutton as 'invaluable as a preventative against influenza', Oxo, margarine, refrigerators, custard and sweets were all sold for their health enhancing properties.¹⁰⁸⁷ Advertising also bought into the 'Keep Fit' craze (as will be discussed) with one margarine brand promoting 'Keep Fit the Right Way! Guild Margarine'.¹⁰⁸⁸ Indeed, one woman remembered that the people of interwar Glasgow 'were quite careful about their health.'¹⁰⁸⁹ Some, however, were critical. For example, one columnist writing in the *GP* also acknowledged that everywhere, people were urged to behave in certain ways 'for health' and 'the mere fact that so many commercial interests think it is worthwhile to attach a "health" label is an indication that in the opinion of these shrewd observers Health has advertising value; it suggests that big business thinks we are really interested in Health.'¹⁰⁹⁰ The author of this article was unconvinced, claiming that it was only 'in a vague sort of way, we are – but not always to the point of making a conscious effort to live healthy, especially when that involves some disturbance of our ordinary way of doing things.'¹⁰⁹¹

¹⁰⁸⁷ 'Scrub Your Floor with Croftol', *GH*, 16th February 1920, p. 14; 'Bourneville Coca', *GH*, 16th February 1920, p. 14; 'Bourneville Coca', *GH*, 2nd February 1920, p. 11; 'Wool and Your Health: Pesco Underwear', *GH*, 19th October 1926, p. 6; 'Do You Know that Wool is Health! Braemar Underwear for Health', *GH*, 26th October 1938, p. 8; *GMJ*, July-Dec 1926, 106, p. 333; 'Oxo: For Health and Vitality', *GH*, 24th January 1936, p. 12; 'Guild Margarine', *GP*, 13th May 1938, p. 7; 'Read this Doctor: Food Safe, Money Saved with an Electrolux Gas Refrigerator', *Scotsman*, 26th May 1939, p. 12; 'Birds Custard', *GH*, 17th February 1920, p. 6.

¹⁰⁸⁸ 'Keep Fit the Right Way', *GP*, 16th September 1938, p. 7; The extensive marketing of items with reference to health is also discussed by Zweiniger-Bargielowska, *Managing the Body*, p. 182.

¹⁰⁸⁹ SOHCA/009, Domestic Violence, Ms AP (1919).

¹⁰⁹⁰ 'This Health Business', *GP*, 11th February 1938, p. 7.

¹⁰⁹¹ *Ibid.*, p. 7.

While this was undoubtedly true to an extent, it is evident that people actively and increasingly took up leisure pursuits with obvious benefits for health. Broadly, Stephen Jones claims that 'there was an expansion of all forms of leisure in the 1920s and 1930s' aided by 'rising real incomes and falling hours of work,' the demand for which was partly driven by trade union policy which included a campaign for increased leisure time, shorter hours, higher wages and paid holidays.¹⁰⁹² Stevenson also notes that 'enthusiasm for the outdoors was part of a general movement for physical culture which affected much of Europe during the interwar period and was reflected in Britain by the Keep Fit craze, which spilled over into cycling, hiking and rambling, physical training and naturism.'¹⁰⁹³ Hardy points out that 'the direct health impact of increased leisure time and an increasing variety of ways of using it cannot be measured'.¹⁰⁹⁴ Nonetheless, the *Committee on Scottish Health Services* claimed:

Many witnesses who submitted evidence to us called attention to the increased cleanliness of the people, their more hygienic ways of living and their greater readiness to adapt their ways deliberately to the attainment and preservation of health. The increase of sport and of open-air recreation, while doubtless in part due to other causes, is also partly attributable to the growing appreciation of the value of these activities as an aid to health... Many other witnesses, lay and medical, expressed much the same view with regard to the greater interest in health.¹⁰⁹⁵

¹⁰⁹² S.G. Jones, *Workers at Play: A Social and Economic History of Leisure 1918-1939* (London: Routledge and Keegan Paul), pp. 9, 22-33, 197; *Committee on Scottish Health Services Report*, p. 41.

¹⁰⁹³ Stevenson and Cook, *The Slump*, p. 26; Benson also describes the hiking 'mania' which existed in the interwar period (J. Benson, *The Working Class in Britain* (London: Longman, 1998), p. 42); Zweiniger-Bargielowska, *Managing the Body*, p. 295; Also acknowledged in J.T. Caldwell, *Severely Dealt With: Growing Up in Belfast and Glasgow* (Bradford: Northern Herald Books, 1993), p. 154.

¹⁰⁹⁴ Hardy, *Health and Medicine*, p. 108.

¹⁰⁹⁵ *Committee on Scottish Health Services Report*, pp. 43, 44; In the opening paragraph to the summary of this report it was also asserted that 'the people as a whole are more ready than formerly to take measures to safeguard and promote their health' (*Summary of Report of Committee on Scottish Health Services*, p. 5).

In Glasgow there was considerable voluntary participation in health enhancing leisure. Glasgow Corporation reported in 1934 that 'the demand for recreational facilities of an open-air kind has grown rapidly in recent years, and may be regarded as a permanent expression of a desire on the part of a great many people, on their own behalf and on behalf of their children, to attain by this means health and physical fitness and to pursue a more vigorous and active life.'¹⁰⁹⁶ Enthusiastic attendance at local gyms, such as that at Glasgow Green, was captured by both oral testimony and contemporary literary sources.¹⁰⁹⁷ Football was also popular and Devine cites one estimate that at its peak, one in four men in central Scotland aged 15-29 were members of a football team.¹⁰⁹⁸ One Glasgow man also recalled the extent to which football was popular among the unemployed and that 'every corner started trying to get their own football team.'¹⁰⁹⁹ This may be more an expression of male competitive culture, or simply a diversion activity used to occupy long periods of unemployment and enforced leisure (as is mentioned by one Glaswegian informant quoted in chapter 6).¹¹⁰⁰ However, whether intended or not, this would have been advantageous to health.

Furthermore, Finlay has said that with 159 dancehalls holding 30,000 people, Glasgow especially went 'dancin' daft' during the interwar period.¹¹⁰¹ Whilst this was, above all, a social activity, it could nevertheless produce

¹⁰⁹⁶ *Corporation of Glasgow: Evidence to be Submitted to Committee on Scottish Health Services re The Environmental Services* (Glasgow: Glasgow Corporation, 1934), p. 20.

¹⁰⁹⁷ Gladstone Robertson, *Gorbals Doctor*, p. 107; *No Mean City*, p. 27; *2000 Glasgow Lives*, Melvin (1924) and Carruthers (1929); SOHCA/009, Domestic Violence, Ms AM (1910).

¹⁰⁹⁸ It was noted that this was good for 'physical development' (*Disinherited Youth*, p. 106); Devine, *Scottish Nation*, p. 361; *2000 Glasgow Lives*, Betty Farmer (1914); GCA, 'Moving to Blackhill': Extracts from interviews with some of the first residents to Blackhill, conducted 1989 (Resource Book, Twentieth Century Glasgow).

¹⁰⁹⁹ *2000 Glasgow Lives*, Robert Young (1902).

¹¹⁰⁰ Interestingly, when one interviewee was asked whether the popularity of the People's Palace/Glasgow Green Gym among the unemployed was for them to 'fill in time', he disagreed that in fact 'they all kept on exercising in case they got a job, keep their muscles in trim' (M74, Gerald Michael Fisher, 1925). In this case, it seems that the informant is probably talking about the 1950s, although the point is telling nonetheless.

¹¹⁰¹ This was found to be particularly the case in Glasgow compared to Liverpool and Cardiff at least (*Disinherited Youth*, p. 105); Finlay, *Modern Scotland*, pp. 138-39; P. Dudgeon, *Our Glasgow: Memories of Life in Disappearing Britain* (London: Headline Review, 2010), pp. 169-74.

important benefits for health. For instance, one doctor who wrote weekly in the 'Women's Section' of the *GH* during the period under review claimed that the 'health value' of dancing was being overlooked and that it should be considered a form of exercise and cure for physical and mental ailments.¹¹⁰² Benson also notes that the enthusiasm for leisure pursuits like hiking and cycling were 'not without significant benefits to health', playing a 'vital part in the leisure time, often enforced, of many people in the thirties.'¹¹⁰³ Knox notes that 'cycling was also a popular pastime with employed and unemployed workers alike.'¹¹⁰⁴ Indeed it is noteworthy how many of the Hunger Marchers interviewed by MacDougall were active members of sports clubs which included swimming, cycling and walking. For example, one Glasgow man, a cooper before being paid off in 1931-32, recalled how he:

Used to do a lot o' pedalin', cyclin'... Nobody gave us a medical exam. But in those days you could tell if a man was fit, you know. I was young, a cyclist and a walker too. I think I was really fit... I was interested in physical fitness.¹¹⁰⁵

Certainly, income could influence the range of leisure and the facilities that could be afforded and enjoyed. For example, Glasser commented that during a hiking expedition, 'we looked with envy at the superior equipment of some of the people we met, from the better off parts of Glasgow like Kelvinside or Hillhead... Our boots were the single pair we possessed, perhaps with an extra sole hammered on at home.'¹¹⁰⁶ In addition, the Scottish health authorities admitted that 'in Glasgow in particular there are large areas occupied by working class people who have no ready access to

¹¹⁰² 'Women's Topics: Dancing: A New Health Measure: Where Doctor's Fail Dancing May Proceed', *GH*, 8th February 1922, p. 6; Molly Weir also notes that 'exercise was prescribed' as one remedy to cure her grief (probably what would be called depression today) following the death of her grandmother (Weir, *Best Foot Forward*, p. 12).

¹¹⁰³ Benson, *Working Class in Britain*, p. 44.

¹¹⁰⁴ Knox, *Industrial Nation*, p. 199.

¹¹⁰⁵ Archie McInnes (1908), MacDougall, *Voices (1)*, p. 43; Also see MacDougall, *Voices (1)*, pp. 44, 53, 245-8, 296.

¹¹⁰⁶ Glasser, *Growing Up*, p. 90.

any open spaces or play fields.¹¹⁰⁷ Therefore, class inequalities regarding the type and range of activities were important. Jones notes that 'the demand for leisure is determined by a number of economic and social variables. For instance, it is clear that real wages, hours of work, the price of recreation, the level of transport systems, and the general commitment of communities and governments to recreational provision will all have an impact on total leisure demand.'¹¹⁰⁸ One doctor from neighbouring Lanarkshire reported to the Committee on Scottish Health Services that:

People are far more health conscious than they used to be. In fact, in *the working classes as well as in the middle and upper classes* physical fitness is a distinct aim in life and this constitutes one of the greatest differences in medical work today as compared with that of thirty years ago [my italics].¹¹⁰⁹

Evidence from Glasgow clearly suggests that participation in healthy physical pursuits was enjoyed by those with both ample and limited means. This is also reflected by the sheer number of oral history informants from a range of backgrounds who recall being part of leisure clubs that would have been beneficial for health.¹¹¹⁰

Both men and women were active in the thriving physical culture of the interwar period. Whilst also taking part in pursuits like tennis, rambling, cycling and swimming, 'Keep Fit' classes were notably popular among

¹¹⁰⁷ ARSBH 1928, p. 17; Molly Weir stated that it took 20 minutes to get from her home to the nearest park (Weir, *Best Foot Forward*, p. 75).

¹¹⁰⁸ Jones, *Workers at Play*, p. 9.

¹¹⁰⁹ *Committee on Scottish Health Services Report*, p. 45.

¹¹¹⁰ *2000 Glasgow Lives*, James Phillips (1917); Glasser, *Growing Up*, pp. 82, 89-90; SOHCA/009, Domestic Violence, Ms AM (1910), Mr AK (1920), Ms AO (1916), Ms AA (1907); SOHCA/038/001 (1912); Howkins and Lowerson, *Trends in Leisure 1919-1939*, p. 21; Mowat, *Britain between the Wars*, p. 527; T.C. Smout, 'Patterns of Culture', in T. Dickson and J.H. Treble, *People and Society in Scotland* (3), pp. 273, 274; Zweiniger-Bargielowska, *Managing the Body*, p. 301; *M74*, Christina Wilson (1918); *M74*, Gerald Michael Fisher (1925).

women.¹¹¹¹ These were ‘conducted by the various branches [of the ‘Keep Fit’ movement] in connection with education authorities, among clubs and voluntary organisations, industrial centres, welfare clinics, hospitals and universities,’ and involved the completion of basic, physical exercise which promised a fit and healthy body.¹¹¹² These were consciously marketed towards the unemployed (men and women) amid concerns for their physical condition (see chapter 6).¹¹¹³ However, starting in Glasgow in 1934 with the establishment of the Glasgow Women’s Keep Fit Movement, ten classes were held between 1934-35 – by 1938 this had increased to 65 with a total membership of 3,000 women.¹¹¹⁴ Reflecting the new vision of the public health authorities, Keep Fit classes were introduced in the maternal and child welfare centres, suggesting that the movement was participated in by at least some working class women. Mrs Kay Brown, organiser of the Glasgow Women’s Keep Fit movement provided classes once a week and claimed that ‘the benefits mothers derive from this gentle exercise is such that childbirth dangers are reduced to a minimum.’¹¹¹⁵ Macgregor also wrote in his memoirs that ‘the Keep Fit movement was highly popular while it lasted; nearly every centre had its Keep Fit class’ and in 1936 he had recorded that ‘the popularity of these classes was surprisingly gratifying’.¹¹¹⁶ According to the *GP*, the Keep Fit movement was probably ‘the largest women’s recreational organisation in Scotland’ in 1938 – a craze with obvious benefits for health.¹¹¹⁷ While the movement aimed to embrace women of all social classes, it does seem that enthusiasm for and participation in the sessions

¹¹¹¹ Zweiniger-Bargielowska notes however that men took part in ‘Keep Fit’ classes in the late 1930s in London at least (Zweiniger-Bargielowska, *Managing the Body*, p. 205).

¹¹¹² ‘Women’s Keep Fit Clubs to Amalgamate’, *GP*, 16th December 1938, p. 7.

¹¹¹³ ‘“Keep Fit” Campaign in Glasgow’, *GH*, 28th June 1933, p. 9; ‘Keep Fit Week: Demonstrations by the Unemployed’, *Scotsman*, 8th September 1933, p. 11; ‘Keep Fit Classes: Scotland’s Drive’, *The Scotsman*, 24th February 1936, p. 14; ‘“Keep Fit” Week in Glasgow’, *GH*, 18th August 1933, p. 8.

¹¹¹⁴ ‘Women’s Keep Fit Clubs to Amalgamate’, *GP*, 16th December 1938, p. 7.

¹¹¹⁵ ‘Motherhood Without Fear: Inventors of Ante-Natal Fitness: Demonstration to B.M.A’, *GP*, 20th May 1938, p. 5; This is interesting, as it also implies that there was some lay fear among women themselves regarding the dangers of childbirth and maternal mortality – something which is difficult to establish from contemporary sources (see chapter 5); Also see ‘Fitness Campaign’s “New Deal for Women”’, *GP*, 3rd June 1938, p. 2.

¹¹¹⁶ Macgregor, *Public Health*, p. 118; *RMOHG 1936*, pp. 49-50; *RMOHG 1938*, p. 56.

¹¹¹⁷ ‘Women’s Keep Fit Clubs to Amalgamate’, *GP*, 16th December 1938, p. 7; ‘Inter Ways to Fitness: Demonstration in Glasgow’, *Scotsman*, 16th February 1938, p. 15.

was also somewhat class, or at least income specific. In an era of heightened poverty and unemployment for many, and in light of the task many women faced in making ends meet, it more likely that these meetings were attended by those financially able. Jones notes that even municipal leisure facilities could incur a cost and that purchasing power was essential: 'for without money individuals could not have participated.'¹¹¹⁸ However, in the absence of attendance figures, the official records of the Keep Fit movement having been destroyed, this is difficult to ascertain.¹¹¹⁹

The extent to which this enthusiasm represents active participation for the benefit of *health* also has to be kept in perspective. It undoubtedly had a positive impact upon physical, and probably mental, wellbeing. However, Macrae has claimed that it was often because a 'fit' and healthy body promised to exemplify beauty that women were enthusiastic about Keep Fit clubs and the Keep Fit campaign.¹¹²⁰ For example, at one demonstration during the 'Keep Fit' week in Glasgow in 1933, the 'winner' of a 'perfect figure' challenge was paraded 'for the benefit of women aspiring to a figure and carriage indicative of perfect fitness,' and it seems that for many women, participation was probably more about their physical appearance and an improved physique in terms of physical attraction, rather than maximum health per se.¹¹²¹ Furthermore, when detailing a visit by main character

¹¹¹⁸ Jones, *Workers at Play*, p. 10.

¹¹¹⁹ According to Eilidh Macrae, currently writing a PhD on the history of women's fitness in Scotland, the testimonies from interviews which she has conducted suggest that in the absence of a personal and disposable income, the classes were probably too expensive to be attended regularly by a number of women, and that they also became inconvenient when women started a family. Thus, the completion of this work is much anticipated in order to provide clarification.

¹¹²⁰ For example, Macrae quotes one article from the *Scotsman* which argued that 'beauty, if it is to last, must be built on a foundation of perfect health' (E.H.R. Macrae, "'Scotland for Fitness": The National Fitness Campaign and Scottish Women', *Women's History Magazine*, Spring 2010, pp. 26-36); Zweiniger-Bargielowska, *Managing the Body*, p. 242; 'Women's Topics: Caring for Teeth', *GH*, 4th August 1922, p. 4.

¹¹²¹ 'Keep Fit Week: Demonstrations by the Unemployed', *Scotsman*, 8th September 1933, p. 11; Similarly, one Glasgow professor reportedly stated that 'he had often heard it said that no beautiful woman ever developed any of the commoner forms of cancer of the skin. She was so sensitive of her beauty and of the necessity for keeping her skin in a healthy condition that even the slightest blemish or defect was attended to at once' ('Prevention of Cancer',

Johnnie Stark to the Glasgow Green open air gym, the author of *No Mean City* explained that 'vanity is as much a dominant motive in the slums as outside them, Johnnie had little to be proud of except his strong body and reckless spirit. He spent a lot of his leisure at the Green Gym and much of his money on clothes.'¹¹²² Indeed, according to Zweiniger-Bargielowska 'physical fitness was [also] indispensable to hegemonic masculinity,' and this is implied by the physically strong, 'hard man' image of Clydeside's industrial workers (see chapter 6).¹¹²³ Hence, important cultural factors also operated in the context of public health, independent of a desire to improve health per se. The popular physical culture of the interwar period is an important illustration of how men and women of all social classes in Glasgow engaged in health-affecting behaviours unrelated to the socio-economic, 'determined' conditions of the era, and the extent to which ordinary people could be active agents in shaping their own physical condition.

Diets and Dieting

The attainment of a 'perfect figure' also points to an important interwar phenomenon – increasing pressure to slim and anxiety about the overweight. Contemporary concerns with growing rates of obesity are an often unmentioned, stark contrast to simultaneous critiques that sections of the population were not only enduring poor diets, but were virtually starving.¹¹²⁴ Contemporary medics often wrote about 'diseases of affluence' which

Scotsman, 8th February 1933, p. 15); For an alternative interpretation see Szreter and Fisher (*Sex Before the Sexual Revolution*, pp. 311-12) who argue that good health rather than physical attractiveness was more important to interwar men and women.

¹¹²² McArthur and Kinsley Long, *No Mean City*, p. 27.

¹¹²³ Zweiniger-Bargielowska, *Managing the Body*, p. 222.

¹¹²⁴ For an exception see Zweiniger-Bargielowska, *Managing the Body*; 'Socialists and Viscountess Astor: Starvation Allegations Refuted', *GP*, 19th November 1926, p. 1.

included obesity and over eating.¹¹²⁵ Again, this was featured in the press media.¹¹²⁶ For example, in the year of the 1926 General Strike – an era which denotes connotations of poverty, poor diets and ill health – the *GP* was also reporting on ‘New Health Talks: Ominous Obesity – Shortner of Life,’ the article warning that ‘being fat is a more dangerous occupation than that of being a locomotive engineer’.¹¹²⁷ Others warned that ‘most people were ill either through over eating or consuming too much refined, soft, starchy food.’¹¹²⁸ Column articles such as ‘Women’s World: Fashion Tips for the “Not So Slim”’ also indicate that the era was not one of universal starvation.¹¹²⁹ Food stuffs could be marketed by reference to their slimming properties, and *Rivita* promised ‘Here’s the Way to Healthy Slimness, Makes You Fit and Keeps you Slim.’¹¹³⁰ The fact that the advertisement also promoted the health enhancing qualities of the product further implies that people were both concerned and actively involved in the maintenance of physical wellbeing, as well as a desire to lose weight.¹¹³¹

It is significant that in an era of concern over the impact of recession upon the population’s diet there was, ironically, a social pressure to slim. For instance, the free milk schemes of the interwar period were one of the most renowned public health campaigns and the authorities in Glasgow systematically researched and celebrated its success – in particular citing the increased height and weight of school children following the implementation of the programme.¹¹³² However, in 1938 the *DHS* reported that enthusiasm

¹¹²⁵ Zweiniger-Bargielowska, ‘Raising a Nation of “Good Animals”’, p. 75; ‘Reviews: Reduction and Dishes by E.E. Claxton, M.B., (London: William Heinemann (Medical Books) Limited, 1937)’, *GMJ*, 127 (1937), p. 243; ‘Women’s Topics: Food and Its Effects on Health’, *GH*, 5th December 1933, p. 6.

¹¹²⁶ Elizabeth Sloan Chesser, M.D., ‘On Keeping Slim’, *GH*, 24th March 1926, p. 9.

¹¹²⁷ ‘New Health Talks: Ominous Obesity – Shortner of Life’, *GP*, 10th September 1926, p. 6.

¹¹²⁸ ‘A Healthy Man a Rarity, Mr Dugald Semple, lecturing to the Glasgow Vegetarian Society’, *GH*, 17th December 1926, p. 9.

¹¹²⁹ ‘Women’s World: Fashion Tips for the “Not So Slim”’, *GP*, 30th August 1935, p. 2.

¹¹³⁰ ‘Ryvita’, *GH*, 17th June 1935, p. 11.

¹¹³¹ Another advertisement promoted ‘Recommended by Medical Men: A Delicious Change from Bread. Good For You. Unsweetened: McVita’, *GH*, 9th August 1935, p. 5.

¹¹³² *ARSBH 1928*, p. 18; *GGNHSBA*, HB38/1/7, *RMITSC 1935*, pp. 57-62; For extensive details on the milk experiments and milk scheme politics see Jenkinson, *Scotland’s Health*,

for the milk campaign was dwindling and only '51 per cent of the children in schools at which milk was supplied were taking the milk.'¹¹³³ A survey carried out to determine why this was the case¹¹³⁴ reveals a number of actively reasoned decisions consequently detrimental to health – notably that 'senior girls dread that the milk is fattening.'¹¹³⁵ It seems that pressure to be slim was probably more pronounced among women – a trend which medics claimed carried its own harmful effects but was embedded by contemporary fashion styles.¹¹³⁶ Offer claims that a social desire for slim women appears to have originated in the 1920s where bust-to-waist ratios in UK women's magazines like 'Ladies Home Journal and Vogue declined from the turn of the century to a minimum in the 1920s,' and as Zweiniger-Bargielowska points out, 'the irresponsible behaviour of the ultra-slim middle class woman paralleled that of her feckless working class counterpart.'¹¹³⁷ Cathcart and Tully similarly found that among female Glasgow college students only 2,035 calories on average were consumed. The reporters stated:

This may seem too low for healthy young women, who, in addition to their work in college, take, in the majority of instances, a fair amount of exercise. Of course, being perfectly normal young women, their physique is of acute interest to them, hence it is probable there may be some definite and voluntary limitation of food intake.¹¹³⁸

pp. 239-51, 268; Also see 'Milk Consumption and the Growth of School Children: Preliminary Report by the Scottish Board of Health', *Lancet*, 28th January 1928, pp. 202-3; G. Leighton and M.L. Clarke, 'Milk Consumption and the Growth of School Children', *BMJ*, 5th January 1929, pp. 23-5; 'Milk Consumption and the Growth of School Children: Second Parliamentary Report on Tests to the Scottish Board of Health', *Lancet*, 5th January 1929, pp. 40-3.

¹¹³³ *ARDHS 1938*, p. 57.

¹¹³⁴ Considered schools in Aberdeen, Angus, Kincardine, Clydebank, Lanark and Glasgow.

¹¹³⁵ Other reasons included the 'scornful attitude of older pupils who regarded the drinking of milk in school as a "childish" practice' and 'refusal to pay when others get milk free' (*ARDHS 1938*, p. 57); One newspaper article also claimed that this was the case in London ('Slimming Girls Refuse Milk', *GH*, 16th December 1935, p. 12).

¹¹³⁶ Zweiniger-Bargielowska, *Managing the Body*, p. 274.

¹¹³⁷ A. Offer, 'Body Weight and Self-Control in the United States and Britain since the 1950s', *Social History of Medicine*, 14 (1), (2001), p. 81; Zweiniger-Bargielowska, *Managing the Body*, pp. 223, 268.

¹¹³⁸ Cathcart and Tully, 'A Dietary Survey in Terms of the Actual Food Stuff Consumed', p. 47.

Not only does this add an interesting perspective on the existing historiography of interwar public health, it also illustrates how in both instances, these females were actively behaving in ways that could be harmful to health. Cathcart and Williams found that ‘women students showed individual variations [of calcium intake] ranging between the high figure of 1.974 grammes and the low one of 0.257’ and they noted that ‘curiosity is aroused as to how a woman whose diet provided less than one third of a gramme of calcium daily would react to the strain of pregnancy or of influenza.’¹¹³⁹ One article published in the *GH* also warned that some women had ‘slimmed themselves into tuberculosis’.¹¹⁴⁰ Zweiniger-Bargielowska has also commented on this contradiction, and while noting that the unequal allocation of resources in the home and the starvation of mothers to feed their families existed, in other cases ‘undereating was not necessarily due to poverty.’¹¹⁴¹

At the other extreme, over eating and excess weight was accompanied by its own health problems, contemporary health professionals associating being overweight with ailments including diabetes, cardiovascular and renal disease.¹¹⁴² For example, in one article Elizabeth Sloan Chesser, a doctor and regular health columnist in the *GH*, wrote about a journalist friend:¹¹⁴³

¹¹³⁹ ‘A Dietary Survey’, *BMJ*, 13th February 1937, p. 334.

¹¹⁴⁰ ‘Public Health Problems’, *GH*, 5th June 1935, p. 12.

¹¹⁴¹ Zweiniger-Bargielowska, *Managing the Body*, p. 267.

¹¹⁴² *Ibid.*, p. 218.

¹¹⁴³ Elizabeth Sloan Chesser was part of the People’s League of Health which, according to Zweiniger-Bargielowska, was an ‘elitist organisation’ which ‘aimed to “improve” the conditions of the “masses” by disseminating “knowledge on health” and the “CONTRIBUTING CAUSES OF MORAL AND PHYSICAL DISEASE [capitalised as in book],”’ advocating an ‘extensive programme of welfare reform and education focusing on diet, personal hygiene, physical education, tuberculosis, venereal disease, alcoholism and responsible parenting.’ She was also part of the New Health Society which endorsed a similar campaign and used the media to promote its aims. Zweiniger-Bargielowska notes that she published widely in both the popular press and women’s magazines (See Zweiniger-Bargielowska, *Managing the Body*, pp. 163, 169-72, 178, 180, 245).

I knew that she might have escaped [measles] if she had been in better condition at the time. Her resistance was poor – she had been eating too much of the rich foods of the continent, and had failed to counterbalance this with sufficient exercise... In her own case and in that of her husband of middle age let her recognise such danger signs of pre-obesity as lax abdominal muscles, increase in girth, or a tendency to slight breathlessness on exertion.¹¹⁴⁴

She also warned of the health dangers of overweight children stating: ‘Look at the fat, feverish youngsters whose mothers consider them beautiful because they are overweight and have pink cheeks. They are the product of excess of starchy diet, notably bread, rusks, and “milk puddings” and a succession of “colds”, bronchitis, and “tummy” upheavals are proof of the fact.’¹¹⁴⁵ However, again, in line with the argument advanced in this thesis – and as the quote above implies – it can be argued that in the period between the two World Wars this was a concern only for parts of the population, and was more specific to the wealthier middle class. It is well documented that a number of interwar researchers and nutritionists correlated food with income. For instance, the renowned studies by Boyd Orr found that diet correlated with financial status and the ‘consumption of milk, eggs, fruit, vegetables, meat, and fish rises with income.’¹¹⁴⁶

Among the middle class, Sloan Chesser claimed that ‘the average well-to-do person is usually over feeding,’ and that the ‘majority of women have four or five meals a day, sometimes six or seven: morning tea,

¹¹⁴⁴ ‘Women’s Topics: When Adults Catch a Child’s Ailment’, *GH*, 20th September 1938, p. 6.

¹¹⁴⁵ ‘Women’s Topics: Health and Looks: How Food Affects Them’, *GH*, 15th March 1922, p. 6.

¹¹⁴⁶ Boyd Orr, *Food, Health and Income* (1936), p. 49; Also see, Orr, *Food, Health and Income* (1937); J.E. Burnett, ‘Glasgow Corporation and the Food of the Poor, 1918-24’, in Fenton, *Order and Disorder*, p. 20; An investigation conducted by the *SBH* in Glasgow schools similarly found that among 5,028 families (30,275 persons) the consumption of milk increased alongside social position. Also see *GGNHSBA*, HB38/1/3, Report on the Work of the Education Committee, sessions 1929-31, and Report on the Medical Inspection and Treatment of School Children, pp. 59-61; Clark and Carnegie, *She Was Aye Working*, p. 97; Zweiniger-Bargielowska, *Managing the Body*, p. 275.

breakfast, snack at eleven, luncheon, tea, dinner, glass of milk at bed time. Yet they expect to sleep well, and never to be reproached by their overworked digestive apparatus.¹¹⁴⁷ Given the evidence aforementioned on the gendered nature of the unequal allocation of resources in the home, it is highly unlikely that this refers to the majority of women, and rather those of the 'well-to-do'. Sloan Chesser also directly commented on patients of the 'overfed and self indulgent class, and there is no doubt that many well-to-do women would look ten years younger, and feel it too, if they increased their daily allowance of work and cut down their food by one half.'¹¹⁴⁸ Sloan Chesser's articles were written in the 'Women's Section' of the *GH* and so it is unsurprising that they primarily concerned middle class women. Nevertheless, it can be maintained that obesity was primarily a middle class concern.

According to Zweiniger-Bargielowska, most national evidence suggests that in fact, men were more likely to overeat than women, but that 'the *businessman* suffering from middle-aged spread was a stock character in interwar reducing [dieting] manuals which urged obese men to lose weight in order to reclaim hegemonic masculinity [my italics].'¹¹⁴⁹ Indeed, one doctor claimed that smoking could be useful for middle aged men since it suppressed appetite.¹¹⁵⁰ The overweight middle class man has also regularly featured in caricatured form in the radical and Labour Press for example, to represent greedy wealthy capitalists, their unproductive lives and exploitation of workers. In general however E.P. Cathcart found that 'a direct relationship' existed between the consumption of fat and 'economic status', and 'the more money that was available to spend the greater amount of fat

¹¹⁴⁷ 'Women's Topics: When You Are Irritable', *GH*, 6th June 1933, p. 6.

¹¹⁴⁸ 'Women's Topics: Health and Looks: How Food Affects Them', *GH*, 15th March 1922, p. 6.

¹¹⁴⁹ According to Zweiniger-Bargielowska, the obese man 'subverted male beauty ideals and manly virtues such as self control [and] embodied an alternative counter type to emaciated unfit men in representations of the male body during the interwar years' (Zweiniger-Bargielowska, *Managing the Body*, pp. 214-15, 274).

¹¹⁵⁰ *GUSC*, MS GEN, 1669/25, Personal notebook of Dr. J.L. Halliday, includes numerous newspaper clippings, mostly from the *Evening Citizen*, 1920s.

there was consumed.¹¹⁵¹ Obesity was not specific to the middle class. For example, one Glasgow author from Calton who claimed to have lived in poverty, describes his mother as being of 'ample proportions', so much so, that she required two seats to sit comfortably when travelling by tram.¹¹⁵² Nevertheless, the national evidence which suggests that obesity was more common among middle class men also affirms this class dimension, and Zweiniger-Bargielowska claims that in Britain in general, it was not until the second half of the twentieth century that obesity became a concern for those lower down the social scale.¹¹⁵³ Modern research has also shown that 'in poor societies, food is scarce, the poor are thin, and the wealthy are fat' – a trend not reversed until the poorer society is 'exposed to food abundance' – as is the case today.¹¹⁵⁴ Hence, the health implications of over eating and dieting reinforce the importance of economic position to Glasgow's interwar health story, whilst revealing the extent to which class cultures and health related behaviours were implicit to public health experiences.

Food and Nutrition

Concerns regarding 'diseases of affluence' like obesity also reflect the important changes in consumption patterns which occurred throughout the period. Benson points out that 'the combination of (somewhat) easier work and a richer and more varied diet (that included growing amounts of salt, sugar and tobacco) increased the risk of obesity, diabetes, renal complaints, cancer, heart disease and high blood pressure.'¹¹⁵⁵ The issue of diet and nutrition flourished in the interwar period with Scottish experts including E.P.

¹¹⁵¹ 'Food Topics and Health', *The Times*, 20th May 1935, p. 8.

¹¹⁵² Robbie, *Privileged Boyhood*, p. 35.

¹¹⁵³ Zweiniger-Bargielowska, *Managing the Body*, pp. 340-41.

¹¹⁵⁴ Offer, 'Body Weight and Self-Control', p. 92; Razzell and Spence, 'The Hazards of Wealth'; Wilkinson and Pickett, *The Spirit Level*, p. 91.

¹¹⁵⁵ Benson, *Working Class in Britain*, p. 99.

Cathcart and John Boyd Orr as leaders in this field.¹¹⁵⁶ It was widely agreed that in the 1930s, the people of Britain as a whole were generally better fed than ever before. This trend was associated with falling disease rates, and contemporaries like Cathcart attributed the declining incidence of tuberculosis for example to improved nutrition.¹¹⁵⁷ Unfortunately, the most detailed reports on diets in Glasgow and Scotland compare interwar menus to those recorded before the war making it impossible to gauge whether these deteriorated during the recession. Nevertheless, the dietary surveys produced by nutritionists like Cathcart and Boyd Orr illustrate that improvements had occurred in terms of increased consumption of healthy foods including butter, eggs, brown bread, fruit, salad and vegetables.¹¹⁵⁸ Significantly, there were complaints in the early interwar period about the amount of orange and banana skins littering Glasgow's streets.¹¹⁵⁹ Stevenson points out that even the most outspoken critics including Boyd Orr could only admit that diets were better in the thirties at least when compared to 'what had gone before' and 'that compared with the period before 1914, there was significantly higher average consumption of the more nutritious foods.'¹¹⁶⁰

However, the extent to which the changing diets of the interwar period were beneficial to health should be kept in perspective. For example, the increase in sugar consumption alarmed the national and Glaswegian public health community – a matter also discussed in the historiography.¹¹⁶¹ Stevenson claims that:

¹¹⁵⁶ 'Edward Provan Cathcart 1877-1954', Reprinted without change of pagination from obituary notices of Fellows of the Royal Society, 9 (1954), p. 35.

¹¹⁵⁷ 'Food Topics and Health', *The Times*, 20th May 1935, p. 8.

¹¹⁵⁸ 'A Dietary Survey in terms of Actual Foodstuffs Consumed', p. 56; 'A Survey of Diets', *Lancet*, 30th January 1937, p. 293; Report of the MRC 1935-1936, pp. 19, 90; Boyd Orr, *Food, Health and Income* (1936), p. 18.

¹¹⁵⁹ 'Glasgow Street Dangers', *GH*, 15th January 1920, p. 5.

¹¹⁶⁰ Stevenson, *British Society*, p. 206.

¹¹⁶¹ A. Maitland Ramsay (Glasgow Royal Infirmary), 'Some Early Ocular Symptoms of Over-Indulgence in Sugar and Sweet Farinaceous Food', *BMJ*, 18th February 1933, p. 266; 'A Dietary Survey', *BMJ*, 13th February 1936, p. 334; Boyd Orr commented for example that

Much as concerned social investigators and nutritional experts might lament it, the British working class showed an almost irresistible urge to use part of their increased spending power on a plethora of sweets, snacks, savouries and processed foods. Cheaper foods, a rise in real incomes and a fall in average family size permitted a greater proportion of household incomes to be spent on non-essentials.¹¹⁶²

The movement towards an increasing consumption of sweets and treats occurred before the period under review, but is central to memories of interwar childhood and features consistently in autobiographies and personal testimonies.¹¹⁶³ For instance, Rountree recalls that as a child he enjoyed 'the usual fare of sour plumes, swizzles, sherbet fountains, liquorice sticks, and the figures of cheap chocolate, which could be bought with our ha' pennies,' and trips to Italian chip shops and ice cream parlours are also captured by Glaswegian folk songs and personal memory.¹¹⁶⁴ Interwar professionals expressed concern. One Glasgow doctor acknowledged for instance that 'a good housewife is also an economist. Money is not spent on fancy cakes, ice-creams and lemonade, but on fresh foods and fresh vegetables.'¹¹⁶⁵

The health implications of this were apparent in terms of increasing dental decay which was one of the key areas where the health authorities of Glasgow had limited success. The *DHS* also complained that despite the growing health consciousness of the public, and a steady amelioration of almost all other defective conditions found in school children, the incidence of

'from the nutritional standpoint this increase in the consumption of sugar is not so desirable as an increase in certain other food stuffs, such as milk, would have been' (Boyd Orr, *Food, Health and Income*, p. 17); J. Burnett, *The Scots in Sickness and in Health* (Edinburgh: NMS Publishing, 1997), p. 57.

¹¹⁶² Stevenson, *British Society*, pp. 125-6.

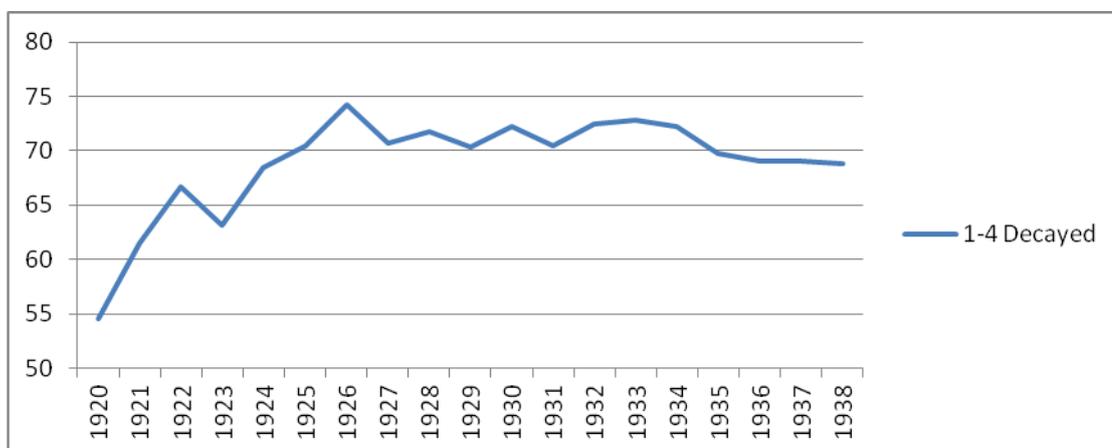
¹¹⁶³ Boyd, 'Thesis on the Prevalence of Tuberculosis in Certain Ayrshire Villages', p. 118; *2000 Glasgow Lives*, Joyce Booth (1912); SOHCA/038/001 (1912); *ESDS Qualidata*, 2000int440, Mrs Agnes Small (1902); Faley, *Up Oor Close*, p. 27; Bowie, *Penny Buff*, p. 104.

¹¹⁶⁴ Rountree, *Govan*, pp. 68, 218; Adam McNaughton, 'Where is the Glasgow that I Knew'; *2000 Glasgow Lives*, M. Cambull (1924), Frank White (1908); Devine, *Scottish Nation*, p. 513.

¹¹⁶⁵ *GUSC*, MS GEN, 1669/25, Personal notebook of Dr. J.L. Halliday, includes numerous newspaper clippings by a 'City Doctor', presumably Halliday.

dental defects displayed little sign of progress.¹¹⁶⁶ However, dental decay was particularly bad in Glasgow. Dr. J. Forbes Webster, Dean of the Incorporated Glasgow Dental Hospital, stated how ‘it had been said that Britons possessed the worst teeth on earth, and also that Glasgow citizens had the worst teeth in Britain.’¹¹⁶⁷ It seems that this can at least be partly explained by excessive sugar consumption north of the border – a notion endorsed by Smout.¹¹⁶⁸ A number of Scottish historians have recognised that in general, sugar consumption was disproportionately high in Scottish diets being 5.4 per cent compared with 4.9 per cent south of the border, that ‘by the 1930s, Scottish households tended to spend more on bread, cakes, cereals, butter, jam, eggs, sausages and biscuits than their southern counterparts and less on milk and vegetables’, and that Scots had an ‘aversion to fresh vegetables and fruit’ compared to their English neighbours.¹¹⁶⁹

Figure 7.1: Dental condition of school children examined by the school medical authorities, percentage of children with one to four decayed teeth



SOURCE: RMITSC 1920-1938.

¹¹⁶⁶ *ARDHS 1937*, p. 81.

¹¹⁶⁷ ‘Glasgow Dental Hospital’, *BMJ*, 5th June 1926, p. 964.

¹¹⁶⁸ Smout has associated the increasing percentage of children with unsound teeth in Glasgow to a ‘more sugary diet’ (Smout, *Century*, p. 124).

¹¹⁶⁹ Harvie, *No Gods*, p. 73; Macdonald, *Whaur Extremes Meet*, p. 132; Smout, *Century*, pp. 130-31.

The Glasgow statistics clearly reveal increasing tooth decay among school children at least, suggesting that lifestyle choices in terms of nutrition had important consequences for health (Figure 7.1).¹¹⁷⁰ The extent to which ordinary people can be criticised for failing to keep a healthy mouth, however, should be kept in perspective. For some, the prevention of tooth decay was not considered, as the removal of all teeth was accepted as the most effective means to stop the problems associated with bad teeth.¹¹⁷¹ There was also still debate even within the medical profession on whether brushing was beneficial or harmful to teeth, and while qualified health officials were discussing the detrimental effects of sweet treats, marketing advertisements were promoting their health enhancing qualities.¹¹⁷² For example, an advertisement for toffee claimed that ‘children’s love of sweets is not merely due to “a sweet tooth”, but to a natural craving – for sugar is an essential in early years.’¹¹⁷³

Smout agrees that for the most part, ‘bad teeth were not correlated with poverty, as rickets were’ and a Carnegie investigation on diets and nutrition in pre-war Britain illustrated ‘the obvious but sometimes forgotten point that some bad health is caused by individual choice and not by the blind impositions of poverty.’¹¹⁷⁴ One medical commentator did observe that ‘it was notorious that the teeth of the poorer classes were very bad, and that to maintain the general health of the community much needed to be done for

¹¹⁷⁰ However, it should also be noted that failure to obtain treatment was also blamed. Parents were criticised for not forcing their children into treatment, and it was claimed that ‘much dental disease in school children arises out of ignorance and neglect on the parent’s part prior to the child’s admission to school, and an increase of facilities for pre-school treatment is desirable’ (*ARDHS 1938*, p. 90). The latter point is important in that it reinforces the view that the pre-school population was one group in which a ‘pessimist’ interpretation applies.

¹¹⁷¹ *M74*, Thomas Wilson (1928).

¹¹⁷² ‘The School Child’s Teeth’, *BMJ*, 11th January 1936, p. 35; Stewart, ‘Health and Sickness’, p. 247.

¹¹⁷³ Advert for Mackintosh’s toffee, *GH*, 26th October 1920, p. 9.

¹¹⁷⁴ Smout, *Century*, p. 124; It is significant that the inhabitants of the Outer Hebrides were said to have excellent teeth until the spread of this more modern diet of sugar, tinned foods, shop bread, tea and sweets in the twentieth century (Smout, *Century*, p. 128).

their improvement.¹¹⁷⁵ Moreover, when walking through Sheffield, George Orwell had also been struck by the amount of bad teeth among the unemployed which he associated with malnutrition.¹¹⁷⁶ However the *BMJ* reported that ‘the Glasgow figures revealed a relatively trifling difference in the state of teeth among poor children in a notably depressed area and among those who went to a good school in non-depressed areas.’¹¹⁷⁷ It is likely that the inability to afford treatment, and possibly malnutrition, contributed to an inferior dental state among the poorer classes and unemployed of Glasgow in some cases. However, the *SBH* maintained that it was ‘well known’ that ‘defective teeth are extremely prevalent among all classes.’¹¹⁷⁸ Thus, the poor state of the city’s teeth may have been largely unrelated to socio-economic conditions, and instead reflect changing dietary choices which were detrimental to health.

The consumption of fresh milk also declined and the *DHS* found that its consumption was particularly inadequate in the industrial belt.¹¹⁷⁹ The percentage of families eating oatmeal also declined from 95 per cent to 58 per cent between 1911 and 1933.¹¹⁸⁰ The interwar survey *The People’s Food* still found that ‘porridge, as might be expected, has many more regular users in Glasgow than in any other of the towns visited,’ and the oral testimonies cited in books like *Up Oor Close* reveal that porridge was still a ‘mainstay of the daily meals’ of working class homes in Glasgow.¹¹⁸¹ However, public commentators observed the decline in its consumption.¹¹⁸² In terms of nutrition, this was an important dietary decision as the food had a

¹¹⁷⁵ ‘Glasgow Dental Hospital’, *BMJ*, 5th June 1926, p. 964.

¹¹⁷⁶ George Orwell, quoted in Constantine, *Unemployment Between the Wars*, p. 33.

¹¹⁷⁷ ‘Scotland: Preservation of Teeth’, *BMJ*, 28th March 1936, p. 658.

¹¹⁷⁸ *ARSBH* 1923, p. 59.

¹¹⁷⁹ *DHS: Milk Consumption in Scotland: An Inquiry into the Amount of Liquid Milk Consumed in Scottish Households*, pp. 3, 8, 26.

¹¹⁸⁰ Report of the Privy Council for Medical Research, Report of the MRC 1935-1936, p. 19.

¹¹⁸¹ ‘Food and Fitness’, *Scotsman*, 20th September 1938, p. 8; Faley, *Up Oor Close*, p. 50; W. Crawford, *The Peoples Food* (London: William Heinemann, 1938).

¹¹⁸² ‘Letter to the Editor’, *GH*, 16th January 1922, p. 7; ‘Effect of Diet Upon Health: Less Natural Food: Unfavourable System of Today’, *GH*, 1st November 1926, pp. 4, 9 – reporting on the sixth annual conference of the Scottish Council of Women Citizen’s Association.

distinctive Scottish tradition which was beneficial to health.¹¹⁸³ Cage and Foster also point out that in general, 'it is known that Glasgow's overall diet was more deficient in fruit and vegetables than Edinburgh's, although it is probable that this was more related to income, Edinburgh being historically more prosperous than Glasgow, rather than regional dietary cultures.'¹¹⁸⁴ Income was clearly important, and in the context of changing diets and nutrition the notion that class was implicit to health experiences can also be maintained. The concern of obesity within the middle class also indicates this point, and Zweiniger-Bargielowska argues that 'disparate food systems exemplify the economic inequality in interwar Britain, characterised by rising affluence within the middle class and persistent poverty among sections of the working class.'¹¹⁸⁵

It is widely agreed that economic status often determined the 'healthiness' of the diet consumed and foods were usually purchased in accordance with family budgets rather than its advantages to health. That the working classes and poorer sections of society ate an inferior diet of excessive carbohydrate is well documented.¹¹⁸⁶ Chalmers, the early interwar MOH, confirms that this was also the case in Glasgow observing the 'tendency of the poor households is towards an excess of carbohydrates in food.'¹¹⁸⁷ Similarly, in 1933 children of the poorest class were found to consume just 36 per cent of a pint of milk a week compared to 62 per cent in the highest classes.¹¹⁸⁸ Indeed, one middle class woman from Glasgow corroborated this claim when stating that she and her siblings always drank one glass of milk with their evening meal.¹¹⁸⁹ Contrastingly, one local man, who was less well off in the period recalled: 'Milk was well glorified as being

¹¹⁸³ Smout, *Century*, p. 123.

¹¹⁸⁴ Cage and Foster, 'A Tale of Two Cities', p. 139.

¹¹⁸⁵ Zweiniger-Bargielowska, *Managing the Body*, p. 293.

¹¹⁸⁶ For example, see Levitt, 'Scottish Poverty', p. 70.

¹¹⁸⁷ Reporting on statements made by MOH A.K. Chalmers, 'Glasgow Corporation Food Values', *GH*, 7th June 1922, p. 11; *NAS*, DD6/306, Report on Housing and Other Conditions in 50 Slum Houses in Glasgow' (Draft copy, p. 5, *NAS* p. 15).

¹¹⁸⁸ *GGNHSBA*, HB38/1/3, *RMITSC 1931*, pp. 59-62.

¹¹⁸⁹ *SOHCA/038/001* (1912).

good for you... [but] there wasn't a lot tae drink cause they could'nae afford to buy a lot of milk. If you got your milk at school you would'nae get any more.'¹¹⁹⁰ Working class diets were often said to be deficient in quantity and quality. For example, Hutt detailed that the unemployed ate a diet that not only excluded the foods most vital to health, but one that was actively harmful where their menu consisted of 'bacon, sausages, and mince that one sees everywhere in the cheap, and very nasty butcher's shops and on the barrows in the numerous poor markets,' with a 'high percentage of adulteration in sausage meat and the illegal use of sulphite as a preservative for mince.'¹¹⁹¹ Indeed, historian Burnett agrees that 'the use of sulphur dioxide to give the meat the appearance of freshness was common in Glasgow'.¹¹⁹² Thompson and Burnett support the view that 'the level of income was clearly the most important factor in determining the quality of diet experienced by a family', and Zweiniger-Bargielowska maintains that whilst improvements in the quantity and nutritional quality of diets were made, 'at the same time, consumption was unequal and an ample diet among the middle class coincided with undernutrition among the working class.'¹¹⁹³

It is important to note however that consumption patterns and dietary traditions also altered within the working class. Generally, the interwar period also witnessed an increase in artificially preserved, convenience foods and health correspondents warned that there was a 'growing tendency to use tinned meats in preference to fresh meats of home growth, which are more nutritious and digestible.'¹¹⁹⁴ Zweiniger-Bargielowska states that these years 'witnessed a transition in the British diet with the modernization of food production, expansion of chain stores, and rising consumption of processed

¹¹⁹⁰ SOHCA/038/002 (1927).

¹¹⁹¹ Hutt, *Condition*, pp. 111-12.

¹¹⁹² Burnett, 'Glasgow Corporation and the Food of the Poor', in Fenton, *Order and Disorder*, p. 24.

¹¹⁹³ Thompson, *Unemployment*, p. 84; Burnett, 'Glasgow Corporation and the Food of the Poor', p. 22; Zweiniger-Bargielowska, *Managing the Body*, p. 288.

¹¹⁹⁴ 'Health of the People: Health Correspondent, Errors of Feeding', *GH*, 21st April 1922, p. 6.

foods as well as fruit, vegetables, and eggs.¹¹⁹⁵ This was captured by oral testimony. For example, Rountree acknowledged the increasing popularity of tinned brands stating that ‘at this time tins of Heinz baked beans contained tiny pieces of pork, which made them a favourite.’¹¹⁹⁶ There was lay concern regarding the safety of tinned foods. One Glasgow woman recalled her mother’s suspicion of tinned products: ‘We had fresh food. My mother thought tins were poisonous.’¹¹⁹⁷ The tradition of frying was also condemned by one Glaswegian at least, where Molly Weir recalls her grandmother’s opinion that ‘fries’ were ‘dear to buy, hard on the stomach, and no’ nearly as nourishing as guid stews, cooked long and slowly to draw oot every bit of good from the meat.’¹¹⁹⁸ However, the evidence from Glasgow endorses Zweiniger-Bargielowska’s claim that ‘faced with unprecedented choice, consumers did not necessarily opt for the healthiest products.’¹¹⁹⁹

Consequently, in Glasgow sources it was widely argued that it was the types of foods chosen, as well as lack of income, which created a diet detrimental to health and the *DHS* argued that ‘the problem of malnutrition is not solely one of lack of food.’¹²⁰⁰ According to Glasgow Corporation, it was clear that improvements had been made, but individual choice remained an important element to those diets which were insufficient. They wrote:

As regards feeding, the practice of giving orange juice to infants is now very general. Fruit and vegetables are much more frequently included in the diet of families, an instance of more general appreciation of the importance of variety in foodstuffs. Feeding and cooking habits and customs vary in different parts of the city, as for

¹¹⁹⁵ Zweiniger-Bargielowska, *Managing the Body*, p. 185.

¹¹⁹⁶ Rountree, *Govan*, p. 214.

¹¹⁹⁷ Clark and Carnegie, *She Was Aye Working*, p. 105; Also repeated by one woman in Beier, *For Their Own Good*, p. 68; Although it should be noted that there was still disagreement among the medical profession on the extent to which foods became less ‘healthy’ after being tinned (‘Tinned Foods and Vitamins’, *Medical Officer*, 11th April 1925, p. 170).

¹¹⁹⁸ Weir, *Best Foot Forward*, p. 83.

¹¹⁹⁹ Zweiniger-Bargielowska, *Managing the Body*, p. 289.

¹²⁰⁰ *ARDHS 1935*, p. 20.

instance in the quantity of tinned foods consumed and in the kinds of articles preferred. On the other hand, diets which are ill-balanced from a nutritional point of view are common, are mainly due to ignorance, custom or indifference, and are not confined to the poorest classes.¹²⁰¹

E.P. Cathcart was especially outspoken about the inadequacies of diets even within high income families, stating that ‘the inferiority of many of the diets investigated is certainly not due solely to the lack of purchasing power, as it is not always those with the lowest incomes who are worst fed.’¹²⁰² Similarly, Sloan Chesser claimed that the ‘sugary and starchy sweets, these richly garnished beef and muttons, on which the average well-to-do families gorge especially at this season (winter), are nearly as bad as the inadequate vitaminless foods of the poor.’¹²⁰³ However, the trend towards convenience foods does seem to have been greater among the Glaswegian working class – illustrating that dietary choices, actively made within this group, ensured that their diets continued to be inferior. Kerr commented for example that ‘the articles for a suitable diet are easily obtained and inexpensive, but, unfortunately, large numbers of the industrial class favour an unsuitable diet consisting of tinned food, margarine, white bread – all deficient in essential ingredients’ – an observation endorsed by Sloan Chesser.¹²⁰⁴ This was also found in national studies. One *Ministry of Health* report published in 1937 highlighted that ‘the diet of many working class families appears to consist largely of food bought already cooked or at most requiring a frying pan; bread and butter or margarine, tea and tinned foods are largely used.’¹²⁰⁵

¹²⁰¹ *Evidence to be Submitted to Committee on Scottish Health Services re The Medical Services*, p. 123.

¹²⁰² ‘A National Food Policy’, *The Times*, 11th September 1935, p. 17; ‘Effect of Diet Upon Health: Less Natural Food: Unfavourable System of Today’, *GH*, 1st November 1926, pp. 4, 9; Cathcart and Tully, ‘A Dietary Survey in Terms of the Actual Foodstuffs Consumed’, p. 53.

¹²⁰³ Sloan Chesser also claimed that while the ‘poor especially eat too much carbohydrate – the diet of the rich is perhaps too well supplied with meat’ (Women’s Topics: What Every Woman Should Know: Health, Food, Vitamins’, *GH*, 10th February 1926, p. 8); ‘Women’s Topics: The Food of Tomorrow’, *GH*, 27th December 1938, p. 6.

¹²⁰⁴ Kerr, *Maternal Mortality and Morbidity*, p. 188; Also see ‘Women’s Topics: Food You Must Condemn: Give Up Starchy Foods’, *GH*, 8th December 1926, p. 8.

¹²⁰⁵ *Report on an Investigation into Maternal Mortality conducted by the Ministry of Health*, HMSO 1937 (5422), p. 116.

Zweiniger-Bargielowska argues that 'cheap luxuries such as tinned foods and chocolate may have averted revolution as Orwell has famously argued, but working class housewives' penchant for processed foods also provided a novel twist in the long-standing discourse which blamed their laziness and profligacy for the poor quality of the working class diet.'¹²⁰⁶

It is necessary to be wary that this criticism might in part reflect the official discourse of the time, which tended to blame working class women for their failures in diet, health care, and domestic management. For example, it was claimed that while there was:

No doubt that there are many cases where there are financial reasons for the lack of proper feeding, there are undoubtedly a large number of mothers who cannot be bothered to prepare a proper meal, and with whom a knowledge of how to fry and how to brew a pot of tea forms the bulk of their culinary equipment. In these unsatisfactory homes tinned milk, bread, and margarine and fried foods, with soups perhaps once a week, form the staple diet.¹²⁰⁷

However, whilst commentators frequently criticised women for the switch to convenience and tinned foods, this could, on the other hand, be interpreted as efficient domestic management – a dietary adjustment to maximise family resources on often meagre household budgets. For example, while used to some degree in the interwar period, refrigerators were still a luxury which, according to national estimates, was enjoyed by less than five per cent of the population in 1938.¹²⁰⁸ Rountree recalls that 'there being no fridges or freezers, leftovers were to be avoided and usually anything perishable not consumed by the following day had to be thrown out... Economy reasons meant that every scrap of what was set down in front of me had to be

¹²⁰⁶ Zweiniger-Bargielowska, *Managing the Body*, p. 289.

¹²⁰⁷ *ARDHS 1935*, p. 73; Also reported in 'Scottish Health and Wellbeing', *Scotsman*, 6th April 1936, p. 11.

¹²⁰⁸ Zweiniger-Bargielowska, *Managing the Body*, p. 184.

consumed'.¹²⁰⁹ As such it could be argued that the switch to tinned foods was rational, and whilst theoretically detrimental to health, this change can also be understood in terms of enhanced skills in domestic management. Indeed, there is evidence that working class wives and mothers understood the importance of, and actively attempted to provide families with a 'healthy diet'. Zweiniger-Bargielowska has claimed that:

It is doubtful that the nutrition advice did much to alter the habits of the main target group, poorer working class housewives. Eating was always more than simply imbibing calories and nutrients and working class resistance to nutritional advice from their social superiors has a long history... Among the housewives who 'confessed' an interest, few mentioned 'vitamins' or 'food values'.¹²¹⁰

However, Sloan Chesser argued in her *GH* column that women did actively respond to medical and nutritional advice. For example, in 1926 she wrote:

Dr Harry Campbell – perhaps the great authority in Europe on the food of the primitive man... is a little unhappy because he believes that the vast majority of women are not interested in providing the best food for their men and bairns. I do not quite agree with him. I think that women are seeking for knowledge and that they are realising how important to national health it is for the housewife to know how to feed their family.¹²¹¹

Admittedly, these articles are likely to have been written for and read by middle class women. However, local authority schemes which attempted to 'teach' and encourage wives and mothers to cook nutritious meals were also embraced. McGuckin notes that 'in general, working class mothers were criticised for their lack of a basic understanding of nutrition. They were seen as having little concern for 'balanced diets' and promoting "unhealthy eating

¹²⁰⁹ Rountree, *Govan*, p. 214.

¹²¹⁰ Zweiniger-Bargielowska, *Managing the Body*, p. 271.

¹²¹¹ 'Women's Topics: Food You Must Condemn', *GH*, 8th December 1926, p. 8.

habits” in their children’.¹²¹² Indeed, one Glasgow doctor quipped that ‘no woman should dare marry until she produces evidence that she can cook a meal to be consumed and declared satisfactory by the examiners appointed by the Ministry of Health.’¹²¹³ Medical professionals often spoke critically about the reluctance of working class mothers to amend their dietary and cooking habits. Nonetheless, by the end of the period at least, many women were actively participating in schemes intended to alter dietary traditions, including those among the working class. For example, in the Polmadie and McNeil Street Corporation housing schemes (in the South Western division of the city) it was said that attempts by the nurse inspector ‘to encourage the housewives to take more interest in the suitability and nourishing value of the foods they purchase for their families, and also in proper methods of cooking’ was appreciated – evidenced by the fact that ‘an offer to procure for them copies of the cookery book recently published by the British Medical Association, at a cost of three pence per copy (half price), was readily accepted by a large number of tenants (250, or 80 per cent in the rehousing schemes and 193, or 94 per cent, in the intermediate housing scheme).’¹²¹⁴

While nutritional terminology was not used, it is significant that the diets of working class families were often understood to be nutritious in spite of recognised class variations. For families lower down the social scale, the priority was first and foremost to provide a meal of sufficient quantity rather than quality. Nonetheless, it does seem that many women simultaneously tried to provide meals of nutritional value as well. The view that mothers provided their families with *nourishing* meals is a consistent theme of interwar oral testimonies.¹²¹⁵ For example, one woman recalled that her mother cooked food that was ‘economic but nourishing... Ma mother had to be economic, but we were never starved, ah’ll tell you that... If there was any

¹²¹² McGuckin, ‘Moving Stories’, p. 212.

¹²¹³ GUSC, MS GEN, 1669/25, Personal notebook of Dr. J.L. Halliday, includes numerous newspaper clippings by a ‘City Doctor’, 1922.

¹²¹⁴ RMOHG 1935, p. 275.

¹²¹⁵ Faley, *Up Oor Close*, pp. 61, 64-6.

economy to be used ma mother would use it, because eh - We were always well fed and as ah' say we were rarely ever ill.'¹²¹⁶ Another woman claimed that she had 'a very happy childhood. Eh, not exactly poor, not starving, but good nourishing food.'¹²¹⁷ This perception is likely to have been affected somewhat by hindsight, the possible 'romanticisation' of memories, and statements were regularly constructed and gauged with reference to the unhealthy lifestyles of the youth of today.¹²¹⁸ Nevertheless, these claims were substantiated by contemporary sources. Margery Spring Rice noted for example that a Glasgow working class female was 'one of the few people who say they make vegetable and bone soup as she believes this is much more nourishing than meat and is a good deal cheaper.'¹²¹⁹ As a result, while it can be argued that the diets of the working class were undoubtedly devoid of some of the healthier foods like milk and vegetables enjoyed more regularly by the middle class – reinforcing the view that diversity and inequality characterised health experiences – the *reality* of public health figures was more complex still. The experience of the numbers was contradictory, where working class women were active agents in both securing and undermining the health of their families, whilst creating a positive health framework understood in terms of sound physical wellbeing.

Masculine Vices

It is clear that throughout the interwar period, consumption patterns changed significantly. Optimists such as Stevenson have attributed this to overall improvements in living standards which occurred for many in spite of the

¹²¹⁶ SOHCA/009, Domestic Violence, Ms AQ (1908).

¹²¹⁷ *2000 Glasgow Lives*, Melvin (1924) and Carruthers (1929), Bert Cording (1925), Patricia Havelin (1929); SOHCA/009, Domestic Violence, Ms AI (1907).

¹²¹⁸ Also see Szreter and Fisher regarding the comparison of past experiences with views on the present (Szreter and Fisher, *Sex before the Sexual Revolution*, p. 11).

¹²¹⁹ Spring Rice, *Working Class Wives*, p. 165.

recession. It has been shown that in terms of diet, the irony was that this could have adverse consequences for health.¹²²⁰ This was also reflected in an increase in smoking – a trend fundamental to Glasgow’s poor health record even today. National figures show that smoking increased throughout the interwar period, except during the lowest point of the recession in 1931-33.¹²²¹ Figures specific to Glasgow could not be located. However, local studies indicate that even the poorest of families often reported two packets of “Woodbine” cigarettes among their domestic budgets.¹²²² Welshman points out that ‘there was little medical interest in smoking until the realisation of the links between smoking and lung cancer in the early 1950s,’ and while the slogan of one firm ‘for your throat’s sake smoke Craven A’ does suggest some recognition of the impact of smoking upon the body, its health consequences were not fully understood.¹²²³ For the most part, advertisements for cigarettes published in newspapers like the *GH*, featured ‘Hollywood’-like, physically attractive men, and significantly women, and they emphasised sociability.¹²²⁴ Although there was mounting recognition of scientific correlations between smoking and cancer in professional circles, Berridge points out that ‘in Britain in the interwar years, there was little

¹²²⁰ Stevenson, *British Society*, pp. 125-26.

¹²²¹ Mowat, *Britain between the Wars*, p. 304; Constantine, *Social Conditions*, p. 15.

¹²²² NAS, DD6/306, ‘Report on Housing and other Conditions in 50 Slum Regions of Glasgow’, pp. 121, 137.

¹²²³ J. Welshman, ‘Images of Youth: The Leisure of Juvenile Smoking, 1880-1914’, *Addiction*, 91 (9), 1996, p. 1380; Rountree, *Govan*, p. 215; Elliot, ‘Everybody Did It’, p. 303, Elizabeth (1926) and Anna (1925); One doctor asserted that excessive smoking was harmful to health ‘unless indulged in with moderation’, and caused soreness of the tongue and spit (*GUSC*, MS GEN, 1669/25, Personal notebook of Dr. J.L. Halliday, includes numerous newspaper clippings, see ‘Is Smoking Harmful?’). There is also evidence that some recognised the association between smoking and coughing/chest problems (see for example Robbie, *Privileged Boyhood*, p. 163); ‘Cigarettes’, *Medical Officer*, 10th September 1932, p. 107.

¹²²⁴ For example see advert ‘Help yourself to cigarettes. As a business woman and hostess I know that invitation to be a most useful conversation opening’ [attractive female holding cigarette] (*GH*, 29th March 1939, p. 6); Also, ‘No thanks, I’d rather have a Kensitas, Justifiably – Carol Goodner. They taste better and they’re easier on your throat’ [again, attractive woman in advert] (*GH*, 20th September 1935, p. 12); ‘Whatever the Pleasure Player’s Complete It: (Ironically) Had a good swim? Thanks, I always “round off” with a “Player” [Here, a ‘Hollywood’ looking, and young attractive couple are sitting aside a pool. Male offers female cigarette] (*GH*, 1st July 1935, p. 13); ‘Women’s Topics: Smoker’s Outfits’, *GH*, 12th February 1921, p. 4.

connection between formal public health and opposition to smoking.¹²²⁵ As late as 1939 some medical advice still recommended the smoking of herbs for ‘relief from asthmatic attacks.’¹²²⁶

Meanwhile, snuff – a dried tobacco product – was also widely used and thought to have medicinal properties. One article in the *GH* claimed that ‘snuff’ was the ‘best preventative of the common cold’, the *GP* repeating that ‘it is quite possible that a layer of this material lying in the mucus membrane of the nose would be more or less of an antiseptic towards the germs which constitute the nasal infection known as “cold”’.¹²²⁷ One Glasgow woman recalled of snuff that ‘it was an inhalant to clear the head, supposed to clear the head. But it really I think nearly blew their head off!’¹²²⁸ Belief in the use of tobacco as a preventative to infection and disease seems to have been relatively widespread. For example, Mclvor and Johnston have also found that some coal miners chose to chew tobacco, not only because smoking was forbidden in the mines, but because this was perceived to prevent dust inhalation and the occupational health hazards this entailed.¹²²⁹ The extent to which people were actively engaging in knowingly harmful behaviours does have to be kept in perspective, although these personal choices were undoubtedly deleterious to health.

While smoking among women was increasing, as is reflected by their prominent presence in advertising and marketing campaigns, Elliot maintains that ‘the amount of tobacco smoked by women was negligible compared to

¹²²⁵ V. Berridge, *Marketing Health: Smoking and the Discourse of Public Health in Britain* (Oxford: Oxford University Press, 2007), p. 13.

¹²²⁶ ‘Excessive Smoking’, *BMJ*, 29th July 1939, p. 264; ‘Cigarettes’, *Medical Officer*, 10th September 1932, p. 107.

¹²²⁷ ‘Take a Pinch of Snuff’, *GH*, 9th November 1935, p. 8; *GP*, 20th December 1935, p. 5.

¹²²⁸ SOHCA/038/001 (1912).

¹²²⁹ Mclvor and Johnston, *Miners’ Lung*, p. 245.

that smoked by men'.¹²³⁰ One Glasgow woman born in 1931 recalled how men coming out of the shipyard 'with their wee bunnets on, they all had cigarettes. The wives didn't have money for the cigarettes. The wives had to keep the children, but the men always seemed to get their cigarettes.'¹²³¹ Indeed, when asked whether the effects of the recession were worse for men or women, one woman commented: 'Oh I think it was worse for the men, cause they had cigarettes to buy and things like that.'¹²³² It was also found that unemployed male youths sacrificed the purchase of alcohol due to a preference for cigarettes.¹²³³ This masculine culture of consumption created distinctive mortality patterns according to gender.¹²³⁴ It is important to note that the incidence of cancer itself was seemingly higher among women. For example, in 1925 it was observed that in Glasgow 628 men and 720 females died from malignant diseases, 'this disparity being in greater ratio than the difference in the relative number of the sexes would account for.'¹²³⁵ However, the *site* of the cancer varied between men and women and it seems that gender-specific lifestyle practices may have played a role. For example, male deaths from cancer of the buccal cavity (mouth) were in excess of females – a variation which the MOH for Glasgow explained could be due to 'the greater use of substances which act as irritants to the mouth and throat' by adult males.¹²³⁶ In 1926, Beatson of the *Glasgow Royal Cancer Hospital* also noted that there was a significantly higher incidence of cancer of the tongue among men which could be associated with smoking – although he was unconvinced at the time that this was the cause.¹²³⁷ The MOH for Glasgow also reported:

¹²³⁰ 'Letter to the Editor: Smoking in Railway Carriages', *GH*, 24th June 1922, p. 7; Elliot, 'Everybody Did It', pp. 297, 298.

¹²³¹ Elliot, 'Everybody Did It', p. 305 (Joyce (1931)); Similarly recalled by *M74*, Thomas Wilson (1928).

¹²³² SOHCA/009, Domestic Violence, Ms AJ (unknown); This was not specific to the working class, one teacher describing male colleagues in secondary schools as 'tobacco-stained old misanthropes' (Bowie, *Penny Buff*, p. 180).

¹²³³ *Disinherited Youth*, p. 109.

¹²³⁴ GGNHSBA, HB11/4/21, *The Glasgow Royal Cancer Hospital Thirtieth Annual Report 1920*, p. 9.

¹²³⁵ *RMOHG 1925*, p. 31.

¹²³⁶ *RMOHG 1936*, p. 43.

¹²³⁷ GGNHSBA, HB11/4/27, *Report of the Glasgow Royal Cancer Hospital, 1926*, pp. 16-7.

If, as has been suggested, the disease can be caused by defective teeth, then the excess among males [deaths from cancer] may be explained as being due to the masculine habit of pipe smoking. The difference in habits of the sexes may, in the same way, be the cause of the heavier mortality among males from diseases of the pharynx, oesophagus, etc.¹²³⁸

Therefore, this evidence suggests that gendered health cultures also helped shape mortality patterns in Glasgow. People themselves operated as active agents in their own health experiences within the context, but irrespective of, the socio-economic conditions of the period.

This also applied to alcohol consumption. As Stewart notes, 'the relationship between the Scots and alcohol too has long troubled commentators.'¹²³⁹ Edwin Muir wrote for example that:

Scottish streets are given an atmosphere of their own simply by the number of drunk people that one encounters in them. Whether the Scottish people drink more than other peoples is difficult to say, but they certainly give the impression of doing so, because of the abundant signs of drunkenness that one finds in such towns as Edinburgh and Glasgow and even in small country towns on a Saturday night.¹²⁴⁰

Muir also commented upon the fact that Scottish people drank 'spasmodically and intensely' compared to their English counterparts and that 'there is no doubt, in any case, that the drinking habits of the Scots, like their dances, are far wilder than those of the English.'¹²⁴¹ However, others were of the opinion that this was even more pronounced in Glasgow. Historically, Glasgow has been particularly associated with 'rough culture' and excessive 'hard drinking'

¹²³⁸ *RMOHG 1929*, p. 46.

¹²³⁹ Stewart, 'Sickness and Health', p. 232.

¹²⁴⁰ Muir, *Scottish Journey*, p. 14.

¹²⁴¹ Muir, *Scottish Journey*, p. 14; Also see Finlay, *Modern Scotland*, p. 148.

– an image which according to Dudgeon has ‘etched itself in the minds of millions across the world.’¹²⁴² One local woman also recalled how Glasgow had ‘always been a drinking city,’ and contemporary visitors consistently commented upon the visibility of alcohol in Glasgow lives.¹²⁴³ Observers also claimed that it was ‘the most drunken city in the United Kingdom’, a statement tentatively indicating a more distinctive drinking culture in Glasgow and an important geographic variation.¹²⁴⁴ Despite this popular perception, however, most evidence suggests that the consumption of alcohol – or legal spirits at least – declined in the city during the recession, as with the UK. The *SBH* survey on the effects of unemployment in 1923 remarked for example, that ‘one well-marked feature’ of the recession was ‘the decrease in the amount of excessive drinking.’¹²⁴⁵ This decline was largely associated with the economic depression and was a phenomenon repeated throughout the contemporary press, business and medical sources.¹²⁴⁶ Indeed in contrast to popular perceptions of drunkenness, it is remarkable how many interviewees from oral history projects described themselves and their families as ‘teetotal’. Another interviewee from Blackhill also made the effort to point out that while ‘clabbers’ (get togethers) were common, ‘drink wasn’t the main thing, it was just a good party.’¹²⁴⁷

Declining rates of alcohol consumption were used to explain certain health gains made in the period. The extent to which people drank knowingly aware of its health effects in the first place, however, does also have to be

¹²⁴² One man recalled that his first impression of Glasgow after arriving from Largs was ‘Rough. Where I come from rough and ready. Rough’ (*2000 Glasgow Lives*, David Easson (1923)); When describing Glaswegians this phrase was repeated by a Stirling woman (*SOHCA*, Stirling Women’s Project, Mrs. Y3 (1901)); Dudgeon, *Our Glasgow*, p. 197.

¹²⁴³ *2000 Glasgow Lives*, wife of Frank White (1908).

¹²⁴⁴ ‘Drunkenness in Glasgow: Minister and Increase in Convictions’, *GH*, 21st March 1933, p. 7; ‘Glasgow Cross on Saturday Night’, *GH*, 22nd November 1920, p. 9.

¹²⁴⁵ *ARSBH 1923*, p. 201.

¹²⁴⁶ ‘The Whisky Market’, *GH*, 1st October 1926, p. 7; ‘Current Criticism’, *GP*, 31st January 1926, p. 5; ‘Less Liquor Consumed: Glasgow Association and Veto Polls’, *GH*, 24th February 1926, p. 9.

¹²⁴⁷ ‘Moving to Blackhill’ (Resource Book, Twentieth Century Glasgow). However, this respondent may have felt it necessary to assert this due to the poor reputation that Blackhill had.

kept in perspective, as moderate consumption of alcohol was actively encouraged for physical wellbeing. From medical journals to advertising posters, the health enhancing qualities of alcohol were emphasised. For example, one Glasgow physician claimed that alcohol ‘tends to fortify the body against diseases and tends to prolong life,’ while some were of the opinion that alcohol was good for the ‘stomach’s sake’, that alcoholic drinks could be considered ‘theoretically, as a kind of food,’ and domestic remedies such as ‘Toadies’ for colds (lemon, hot water, sugar and whisky) were both acknowledged as useful within medical circles and widely used, even by those describing themselves as teetotal.¹²⁴⁸ Indeed, an advert for ‘White Horse Whisky’ declared that it was for ‘For driving out cold. Handy flasks for your medicine chest for sale.’¹²⁴⁹ Other alcoholic brands such as *Guinness* beer and *Gordon’s* gin also promoted their health enhancing properties with bold adverts such as ‘Guinness is good for you’ and ‘if you value your health – insist on Gordon’s.’¹²⁵⁰ Nevertheless, Hardy notes how the *MRC* published in 1933 that ‘the post-war conversion from a culture of drunkenness was one of the main factors contributing to improved health’ and that ‘cirrhosis of the liver had become rare [and] a reduced expenditure on alcohol meant more in the family budget to spend on food and other items.’¹²⁵¹

Figures on deaths relating to alcohol are not robust due to a host of issues with diagnosis – not least when considering the moral discourse in which diagnosis occurred (see below). Nonetheless, the Glasgow MOH commented that after an initial increase in septic diseases in 1920 and 1921 – which was ‘probably due to the relaxation on the sale of liquor during the

¹²⁴⁸ ‘Letter to the Editor: On Alcohol’, *GH*, 1st November 1920, p. 9; The phrase ‘for the stomachs sake’ was also repeated in J. Ferguson, ‘Problems of Old Age’, *GMJ*, 112 (1929), p. 245; ‘Health of the People: From our Medical Correspondent’, *GH*, 13th January 1922, p. 5; ‘Now is the Time to Slim’, *GH*, 9th May 1935, p. 8; ‘Alcohol in Medicine: Dr. W.L. Reid, ex-President, Royal Faculty of Physicians and Surgeons’, *GH*, 24th March 1922, p. 7; Faley, *Up Oor Close*, p. 27; For example, one Glaswegian recalled that while neither her mother nor father drank, they would be ‘sent for a wee half’ when her mother took ill (*2000 Glasgow Lives*, Callaghan (1913)); Weir, *Best Foot Forward*, p. 42.

¹²⁴⁹ Advert for White Horse Whisky, *GH*, 31st January 1936, p. 6.

¹²⁵⁰ *GH*, 20th December 1935, p. 5; *GH*, 20th October 1938, p. 10.

¹²⁵¹ Hardy, *Health and Medicine*, p. 107.

war' – this began to fall by 1923.¹²⁵² In 1924 the MOH for Glasgow maintained that 'deaths from alcoholism remained remarkably few, and the reduction may be associated with the industrial depression. The death rate per million last year was 7, as against 6 in 1923, whereas the rate in 1921 was 21.'¹²⁵³ In 1930 the MOH repeated that 'cirrhosis of the liver was the cause of 36 deaths in 1930, compared with 44 in the preceding year, male deaths numbering 23, against 35. This is interesting in view of the recent considerable reduction which had taken place in the consumption of whisky, as indicated by the excise reports.'¹²⁵⁴ A table collated by Smout suggests that alcohol consumption in Scotland as a whole fell from 0.55 to 0.35 gallons per head of the population per year between 1921-29 and 1930-39, and that this was reflected in the death rate from 'alcoholic mortality' which fell from 47 to 37 deaths per million.¹²⁵⁵ Rates per million of death from cirrhosis of the liver in Scotland were also found to be 18 in 1920-24, 11 in 1925-29 and 6 in 1930-35.¹²⁵⁶ Nonetheless, while the decline in alcohol consumption is repeatedly documented in interwar historiography, Scottish historian Hughes is sceptical of the extent to which this occurred, arguing that illegal drinking dens were still very much in existence in areas of Glasgow like Budhill, Shettleston and:

In comparison to the nineteenth century this was the case, but in the 1920s the decline in the number of public houses in Scotland was marginal at best in Scotland. There were also attempts to regulate alcohol consumption through higher taxes on spirits, but this was mediated by working class men. Many men drank greater quantities

¹²⁵² *RMOHG 1920*, p. 22; *RMOHG 1921*, p. 29; *RMOHG 1923*, p. 33.

¹²⁵³ *RMOHG 1924*, p. 19.

¹²⁵⁴ *RMOHG 1930*, p. 66.

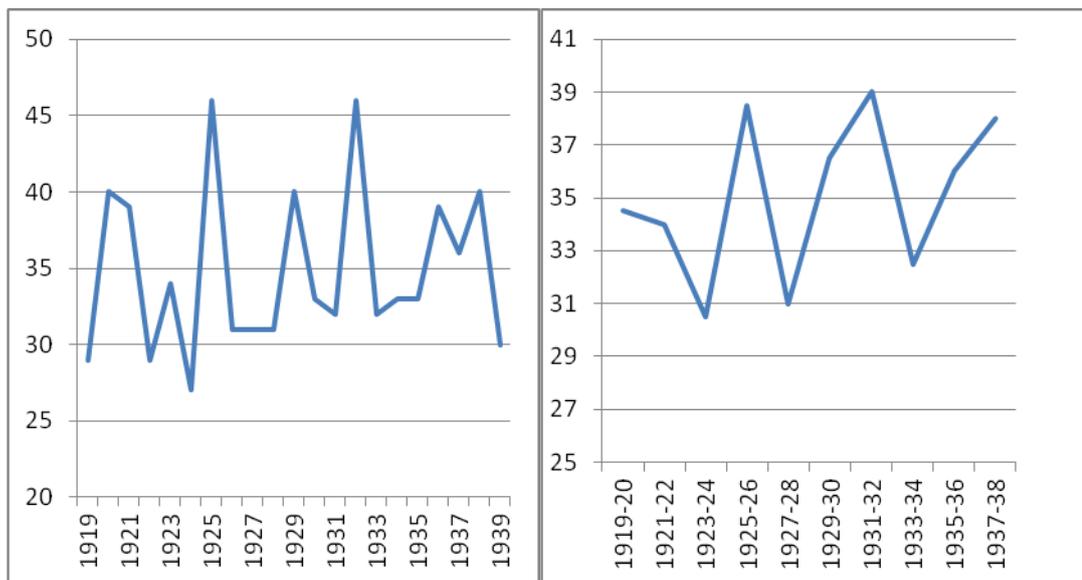
¹²⁵⁵ Largely collated using data from G.B. Wilson, *Alcohol and the Nation* (London, 1940), (Smout, *Century*, p. 135); Here it seems that Wilson's definition of 'alcoholic mortality' includes deaths from 'intemperance', 'delirium tremens', 'alcoholism' and 'cirrhosis of the liver', being what he describes as a 'useful method in comparing the increase or decrease of alcoholic excess, especially when taken in conjunction with statistics on liquor consumption and of drunkenness' (G.B. Wilson (PhD), *Alcohol and the Nation: A Contribution to the Study of the Liquor Problem in the United Kingdom from 1800-1935* (London: Nicholson and Watson, 1940) p. 278). Mortality data in this format is not available for Glasgow, only cirrhosis of the liver is consistently published.

¹²⁵⁶ Wilson, *Alcohol and the Nation*, p. 426.

of beer to supplement the more expensive spirits [and] the Amulree Report stressed that this was often at the expense of family necessities.¹²⁵⁷

One Glasgow woman commented on people actively trying to hide their drinking habits and possible dependency on alcohol, stating: 'I think it was between the wars that happened... people drinking and not realising they were becoming alcoholics.'¹²⁵⁸

Figure 7.2: Number of deaths from cirrhosis of the liver per million in Glasgow, 1919-1939



SOURCE: RMOHG 1919-39.

An analysis of the mortality data published by the MOH for Glasgow also reinforces the importance of considering regional variations. From 1919 deaths from 'alcoholism' declined and this ceased to be registered as an individual 'cause of death' category in the MOH annual reports from 1926. However, at the same time, mortality from cirrhosis of the liver in Glasgow, a disease associated with excessive alcohol consumption, is somewhat

¹²⁵⁷ Hughes, 'Representations and Counter-Representations', p. 175.

¹²⁵⁸ 2000 Glasgow Lives, wife of Frank White (1908).

contrary to the collective, national trend proposed by Wilson.¹²⁵⁹ Figure 7.2 suggests that in Glasgow deaths from cirrhosis of the liver increased (Figure 7.2).

Furthermore, the alleged decline in the consumption of whisky and spirits can to some extent be mediated by the increasing popularity of the much more physically harmful 'methylated spirit' – a trend also acknowledged by Hughes.¹²⁶⁰ Although this habit existed before the war, it increased in Glasgow throughout the interwar period. For instance, the Chief Constable of the city wrote to the Secretary of State for Scotland in 1932 that:

It is regrettable that though the convictions for drunkenness shew a decided decrease, drunkenness due to drinking methylated spirits is markedly increasing. This may be mainly attributed to the cheapness of methylated spirit and the ease with which it may be obtained, as compared with the prohibitive prices of spirits, wines and malt liquors and the strict interpretation of the laws governing their sale. Money is scarce owing to industrial depression and the means test has had its effect on unemployed persons in receipt of relief. Thus where the craving for stimulant exists recourse is had to methylated spirits, the cheapest intoxicant available.¹²⁶¹

In response to the growing popularity of the cocktail, the authorities had added the chemical pyridine in May 1924 to make the drink less palatable.¹²⁶² However, drinkers realised that adding a cheap red wine made the substance more agreeable and the Chief Constable observed that after an initial decline between 1924 and 1926, the drinking of methylated spirits

¹²⁵⁹ The rate of death from cirrhosis of the liver may have been affected by more deaths being recorded here rather than under alcoholism. However, the haphazard pattern of the cirrhosis trend makes this seem unlikely.

¹²⁶⁰ Hughes, 'Effects of Recession and Depression on Greenock between the Wars', p. 303.

¹²⁶¹ NAS, HH55/309, letter sent by the Chief Constable of Glasgow to the Under Secretary of State for Scotland, dated 8th December 1932; "'Red Biddy" Drinking', *Scotsman*, 12th April 1933, p. 14.

¹²⁶² NAS, HH55/309, Police Chronicle, 22nd April 1928; NAS, HH55/309, Letter to Blackloch dated 7th January 1931 from the Royal Commission of Licensing (Scotland), Edinburgh.

became 'more prevalent than ever forming a pernicious and increasing habit which has raised a great social problem in this city.'¹²⁶³ Other reports also reiterated that 'there was definitely an increase in red wine drinking in the city, which might have something to do with its low cost as compared with the price of whisky and other spirits.'¹²⁶⁴ An article in the *Scotsman* similarly noted that 'the drinking of methylated spirits had become more prevalent than ever... [and] the increase was mainly attributable to the cheapness of the spirits and the red wine, the effect of the industrial depression driving some people to that cheap form of drinking' – a craze acknowledged to be 'extremely injurious to health.'¹²⁶⁵

While the *SBH* acknowledged that this practice was increasing, they noted that it was '*particularly in Glasgow, Spanish red wine which was sold at the extremely low price of four pence per gill, was being used by methylated spirit drinkers to mitigate the unpleasantness of the spirits [my italics]*.'¹²⁶⁶ The drinking of this concoction and its impact upon the body was captured by both oral testimony and contemporary literature. For instance, in *No Mean City* the authors wrote:¹²⁶⁷

Often the common funds would not run to whisky and beer. Often the company fell back upon the iniquitous red wine, sour and poisonous and stunning, which all the public houses were beginning to sell at the time. A glass of red wine cost no more than a glass of beer, but it was twice as potent. Even if a man got sick on red wine, the fumes of it stayed in his head and he lived and moved and thought under its

¹²⁶³ It is interesting that the drinking of methylated spirits was referred to as a 'drug habit' ('Methylated Spirit', *Lancet*, 19th January 1935, p. 164); *NAS*, HH55/309, letter sent by the Chief Constable of Glasgow to the Under Secretary of State for Scotland, dated 8th December 1932 regarding the increasing consumption of methylated spirit in the city; Glasgow still has a negative reputation due to its preference among some for fortified red wine in the form of 'Buckfast', a notorious drink in Scotland (but perhaps particularly Glasgow) associated with a host of social problems including anti social behaviour.

¹²⁶⁴ 'Red Biddy', *Scotsman*, 12th April 1933, p. 14.

¹²⁶⁵ 'Prevalence of "Meth" Drinking', *Scotsman*, 13th December 1933, p. 15.

¹²⁶⁶ *ARSBH 1923*, pp. 89-90.

¹²⁶⁷ *SOHCA/009, Domestic Violence, Ms AC (1917)*.

influence long after he had outwardly thrown off its effects. Johnnie did not like the taste of red wine. Some days it made him want to vomit when he drained the first glass. But he liked the feeling it gave him; he liked the drugged irresponsibility it produced. Some of Johnnie's friends were already mixing their wine with methylated spirits, but Johnnie himself had only tried "Red Biddy" once. That was in a brothel in his own tenement, and, hours later, he woke to a kind of dim consciousness under the cold stream from the tap above the sink [to find] a girl holding him there with an arm under his shoulder... "By Cripes" she exclaimed, when he groaned and struggled under her grasp, "Ah thought you wis gaun tae die on me, Razor King!"¹²⁶⁸

Another Glasgow family claimed that their father was 'drinking himself to death with "red biddy,"' and in 1936 the *DHS* also commented that the habits of the 'habitual' drinker' but 'especially the methylated spirit addict' resulted in 'rapid physical and mental deterioration'.¹²⁶⁹ In his memoirs, MOH Macgregor commented upon this health hazard, stating that 'the methods employed to make it more palatable [included] mixing it with Spanish wine or even by shaking it up with plaster from the staircase wall', and that the 'delirium tremens was frequently fatal. "Cases where the symptoms were slow to develop were the worst; a young man dies as a fire would go out."¹²⁷⁰ It is true that the number of people drinking this cocktail, although increasing in the interwar period, was minimal. One report in 1928 had claimed that 'methylated spirit drinking in this city is mostly confined to beggars and the more debauched habitués of the common lodging houses. In pre-war days

¹²⁶⁸ McArthur and Kingsley Long, *No Mean City*, p. 213.

¹²⁶⁹ *NAS*, DD6/306, 'Report on Housing and other Conditions in 50 Slum Regions of Glasgow', p. 169; *NAS*, GD409/37/5, *DHS: Report of the Departmental Committee on Vagrancy in Scotland* (5194), 1936, p. 37.

¹²⁷⁰ Macgregor, *Public Health*, p. 20; Indeed, it is interesting that one man from Blackhill was imprisoned following the death of several people after drinking the industrial spirit he had obtained from his work. Although this took place in 1949, it was noted that the people had been drinking this for years, and it is significant that the residents of Blackhill felt that his sentence of 30 months was unfair – indicating that they were prepared for its most severe consequences for health (Damer, *Last Exit to Blackhill*, pp. 32-6).

these people drank whisky, the price of which is now prohibitive.¹²⁷¹ A Glasgow man similarly remembered:

There was a time that they had wine drinkers. They called them the mammy mimes, the red wine drinkers. But, eh, they were a nuisance, they were'nae drinkers, they were, when you were walking along the road you'd see them, you know, coming a mile off... lend me tuppence.¹²⁷²

Alexander Robbie also described his neighbours in Calton as the 'lowest of the low... real ragamuffins. The adults were always drunk, on the cheapest fortified wine, or methylated spirits, or worse, a deadly brew made from boot polish. Permanently on the dole, they were people who had lost all hope of ever getting out.'¹²⁷³ While it cannot be argued that this was the cause of Glasgow's stubbornly high alcohol related death rate, the habit did increase and was undoubtedly detrimental to health. This reinforces the degree to which people were active agents in their own health experiences, behaving in ways, often culturally rooted, that was detrimental to physical condition.

Access to alcohol was differentiated across the city. For example, in 1920 a map published in the *GH* showing the 'position of the wards in Glasgow which carried "Reduction" and "No License" under the Temperance Act' reveals clear distinctions in relation to geographic region (Illustration 7.1).¹²⁷⁴

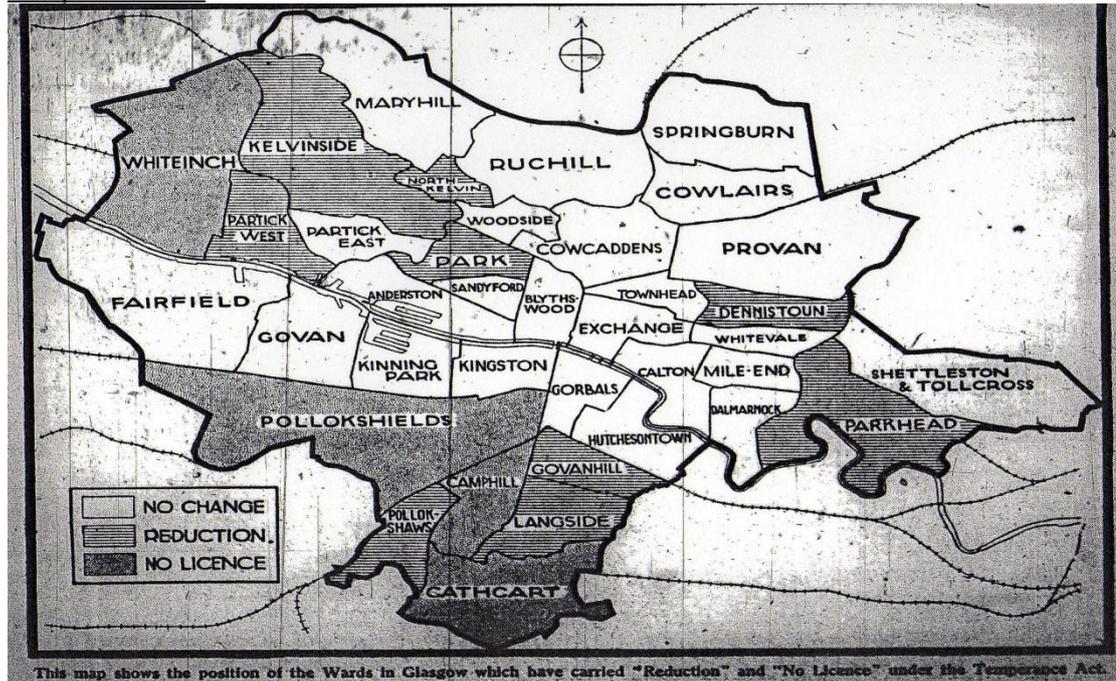
¹²⁷¹ NAS, HH55-309-1932-00063, Letter dated 23rd May 1928 to the Under Secretary of State for Scotland by the Chief Constable of Glasgow.

¹²⁷² *2000 Glasgow Lives*, Jimmy Conway (1914).

¹²⁷³ Robbie, *Privileged Boyhood*, p. 22; Also see Caldwell, *Severely Dealt With*, p. 94.

¹²⁷⁴ 'Glasgow After Temperance Poll', *GH*, 4th November 1920, p. 7; Pacione notes how 'national legislation to permit local veto polls on the licensing of public houses was passed in the Temperance (Scotland) Act of 1913, which came into operation in Glasgow in 1919 when the residents of middle class areas like Cathcart, Pollokshields and Kelvinside voted to be "dry". The areas of greatest concern, however, remained unchanged' (Pacione, *Glasgow*, p. 245); 'Local Veto: Results in Glasgow Poll', *GH*, 4th November 1920, p. 3; However, it is interesting that Parkhead, conventionally regarded as a 'working class'/industrial area (see chapter 3), voted 'reduction.' Indeed, one interviewee recalled that in neighbouring Tollcross live miners who 'all stayed in the one wee street... a wee mining street' (*2000 Glasgow Lives*,

Illustration 7.1: Map showing voting behaviour according to geographic region regarding the Temperance Act



SOURCE: GH, 4th November 1920, p. 7.

However, there is the suggestion that this reflects different drinking cultures associated with 'class'. Glasgow itself is commonly perceived as a working class city, although as chapter three indicates, working class identity was actually more specific to individual districts within the city itself.¹²⁷⁵ It is these regions which were associated with 'hard drinking'. This was reflected in voting behaviour regarding the Temperance Act. In short, the 'No License' vote was passed in 'middle class' regions of the city like Camphill, Cathcart, Pollokshields and Whiteinch, with 'No Change' agreed in 'working class' regions like Calton, Cowcaddens, Dalmarnock, Gorbals, Govan, Hutchesontown and Mile-End.¹²⁷⁶ Gorbals, for example, was described as a 'congested licensed area' with the highest number of licenses in 1935 at

Jean Lennie (1919)), suggesting that a skilled population may have lived here and bought into 'respectable' culture. However, this merits further investigation.

¹²⁷⁵ A. Durie, 'No Holiday this Year', p. 3 (sent personally by author but also featured in *Journal of Tourism History*); Macdonald, *Whaur Extremes Meet*, p. 103.

¹²⁷⁶ 'Local Veto: Results in Glasgow Poll', GH, 4th November 1920, p. 3.

least.¹²⁷⁷ One man also recalled that in 'Plantation, there was a pub and fish shop on nearly every corner' and that 'there was hunners of corners.'¹²⁷⁸ Another recalled that in Anderston there was 'sometimes three in the one street.'¹²⁷⁹ Although the intensity of licensed premises was clearly associated with the regions in Glasgow associated with the working class, it is important to note that drinking alcohol was not confined to working class culture.¹²⁸⁰ While relating to Britain in general, Bourke points out that in their lifetimes, members of the middle class could consume four times as much wine and spirits.¹²⁸¹ Indeed, observers became concerned about the increasing popularity of 'cocktails' among middle class females.¹²⁸² Figures on alcohol related deaths according to class or region could not be located for this time period. However, even then, mortality and disease rates tended to be higher among working class areas anyway and therefore it would have been difficult from area-specific death rates to confirm whether the working class drank more.

Indeed, while writers such as Damer argue that 'the pub' is central to working class history in Glasgow, it might be more accurate to associate excessive alcohol consumption and 'the pub' with Glasgow's *masculine* culture, which itself operated within the working class culture of the city.¹²⁸³ Johnston and McIvor point out that 'hard drinking and heavy smoking have for a long time been 'strong symbols of male virility and *machismo* in Scottish

¹²⁷⁷ 'Fewer Glasgow Licences: Gorbals Loses 17 Certificates', *GH*, 10th April 1935, p. 13; Gladstone Robertson, *Gorbals Doctor*, p. 56; Also see McArthur and Kingsley Long, *No Mean City*.

¹²⁷⁸ *2000 Glasgow Lives*, M. Cambull (1924).

¹²⁷⁹ *2000 Glasgow Lives*, Robert Young (1902).

¹²⁸⁰ Advertisement, 'Persuasive Pussyfoot', *GH*, 22nd October, 1920.

¹²⁸¹ D. Sears, *Changes in the Cost of Living and Distribution of Income Since 1938* (Oxford, 1938), cited in Bourke, *Working Class Cultures*, p. 6.

¹²⁸² 'The Drinking of Cocktails: Increasing Among Girls in Scotland: Should Be Stamped Out,' *GH*, 13th February 1926, p. 7.

¹²⁸³ S. Damer, 'Review: Dear Auld Glasgow Toon', *Scottish Affairs*, 56 (2006), p. 152; Clark and Carnegie, *She Was Aye Working*, p. 59; Howkins and Lowerson, *Trends in Leisure 1919-1939*, p. 21.

culture'.¹²⁸⁴ For instance, one Bridgeton man claimed of his shipyard working grandfather, who also participated as a boxer in the 1920 Olympics, 'he was a man's man, you know. A 1920s man's man. He smoked, he drank, there was a lot of back slapping.'¹²⁸⁵ Finlay also notes that 'manliness was associated with consumption, and holding one's drink was an essential part of male self-respect' and thus hegemonic masculinity.¹²⁸⁶ For example, in Glasgow, male dominated leisure arenas like Saturday football was often as much a day of drinking as it was a day of sport, and one woman from neighbouring Port Glasgow explained that 'the men all took a drink in them days.'¹²⁸⁷ Another informant stated that 'a man's territory was the pub.'¹²⁸⁸ Drink was also associated with the physically draining male-only 'heavy' industries, for example iron and steel works, where bringing beer to the workplace was a common occurrence before the Second World War. Oral testimonies reveal the extent to which it was shameful for women to be visibly drunk or enter a pub.¹²⁸⁹ This does not mean that women did not drink, and both the MOH's annual reports and oral testimonies reveal that women (presumably working class women) often purchased jugs of beer from the local pub to be consumed at home.¹²⁹⁰ However, according to writers such as Muir 'drinking is in Scotland a secret mainly confined to the masculine sex', and the gendered nature of excessive alcohol consumption was reflected in the health statistics published by the MOH for Glasgow.¹²⁹¹

¹²⁸⁴ Quoting from K. Mullen, *A Healthy Balance: Glaswegian Men Talk about Health, Tobacco and Alcohol* (Avebury: Aldershot, 1993, p. 177), cited in Johnston and McIvor, 'Dangerous Work', p. 141; Hughes, 'Representations and Counter-Representations', p. 175.

¹²⁸⁵ Quoted in Dudgeon, *Our Glasgow*, p. 189.

¹²⁸⁶ Finlay, *Modern Scotland*, p. 151; Dudgeon, *Our Glasgow*, p. 51; Knox, *Industrial Nation*, p. 197.

¹²⁸⁷ H. Hagan, "'It's my job to work, it's yours to make it go round": The Experience of Shipyard Workers' Wives in Port Glasgow between the Wars', *International Journal of Maritime History*, 18 (1), (2006), p. 319.

¹²⁸⁸ M74, Gerald Michael Fisher (1925).

¹²⁸⁹ *2000 Glasgow Lives*, Patricia Havelin (1929); SOHCA/009, Domestic Violence, Ms AM (1910) and Ms AO (1916).

¹²⁹⁰ *2000 Glasgow Lives*, Robert Young (1902); SOHCA/009, Domestic Violence, Mr AK (1920), Ms AN (1907), Ms AQ (1908); Clark and Carnegie, *She Was Aye Working*, p. 134; *RMOHG 1929*, p. 212.

¹²⁹¹ Muir, *Scottish Journey*, p. 37.

Helman notes that even today 'several aspects of male culture can be said to contribute to men's ill health, or the risk of such ill health developing. For example, in comparison with women, men are encouraged to drink more alcohol, smoke more cigarettes, to be more competitive and to take more risks in their daily lives.'¹²⁹² Indeed, writers Kruger and Nesse have claimed that this kind of behaviour is probably a significant factor as to why life expectancy is lower today among men than women.¹²⁹³ Risk taking behaviour among Glaswegian men was certainly reflected in the health experiences and mortality patterns of the interwar period. For instance, one female doctor was of the opinion that 'men often run health risks because they are afraid of being accused of molly-coddling if they take reasonable care of themselves.'¹²⁹⁴ In 1926, deaths from what the MOH labelled violence¹²⁹⁵ were also 'twice as common among males, especially at ages over 25 years.'¹²⁹⁶ Similarly, an overriding image of Glaswegian working class culture is gang warfare, grounded in the publication of works like *No Mean City*.¹²⁹⁷ Whilst this did not only involve males, or indeed the majority of males, it was notably confined to working class masculine culture. The problem was regularly captured by oral history interviews and qualitative literature (including fictional works and newspaper reports), detailing the use of weapons including knives, held in 'specially prepared pockets', hammers and hatchets.¹²⁹⁸ Davies has found that gangs like the Billy Boys of

¹²⁹² C.G. Helman, *Culture, Health and Illness* (London: Huddersfield University Press, 2000), p. 117.

¹²⁹³ D.J. Kruger and R.M. Nesse, 'An Evolutionary Life-History Framework for Understanding Sex Differences in Human Mortality Rates', *Human Nature*, 17 (1), (2006), 74-97.

¹²⁹⁴ 'The Husband's Health', *GH*, 22nd June 1922, p. 6.

¹²⁹⁵ Also included deaths due to incidents such as motor traffic accidents.

¹²⁹⁶ *RMOHG 1926*, p. 29.

¹²⁹⁷ Rountree, *Govan*, p. 75; Dudgeon, *Our Glasgow*, p. 184; Infamous Glasgow gangs include the Norman Conks and Billy Boys who were affiliated with religious sectarianism ('Glasgow Gangs: Serious Situation in the East End', *GH*, 22nd September 1926, p. 7); Also see *2000 Glasgow Lives Collection* oral history project, question by interviewer James McKenna regarding Glasgow's 'No Mean City' image. However, there are also indications that gang warfare in 'notorious' areas like the Gorbals was not as widespread as its image suggests. For example, one oral history informant has claimed the area was actually quite peaceful and claims that when gang warfare occurred, it was confined to a Saturday night (*M74*, Gerald Michael Fisher (1925)).

¹²⁹⁸ 'Glasgow Gangs', *GH*, 22nd September 1926, p. 7; 'Razor Slashing: Alleged Assaults in Glasgow', *GH*, 20th August 1926, p. 10; 'Alleged Knife Attack on Glasgow Moulder', *GH*, 2nd January 1922; Gang culture is also discussed quite extensively in Blake's, *The Shipbuilders*,

Bridgeton Cross amounted to 200 by 1927 and 'even boasted a junior wing, the Derry Boys, for youths aged fourteen to twenty one.'¹²⁹⁹ Davies asserts that gang membership afforded men 'cultural capital' and 'as unemployment increasingly undermined traditional, work-based masculine identities, it became more common for men in their twenties and thirties to play active roles in street gangs.'¹³⁰⁰ Therefore, it is clear that conventional notions of masculinity and its associated behaviours were often dangerous for health.

In 1920 the MOH also stated that 'deaths from alcoholism are usually greater among males,' and in 1923 it was similarly reported that 'cirrhosis of the liver and violence were responsible for nearly twice the number of male deaths as compared with females.'¹³⁰¹ Other conditions associated with excessive alcohol consumption like ulcers of the stomach were also more common among men. The MOH for Glasgow reported in 1929 that this was 'always more prevalent among males, the deaths this year amongst them being in the ratio of three to one among females. The mortality begins apparently about 25-35 years of age,' and 'the same disparity is evident with regard to cirrhosis of the liver, 35 deaths occurring among males to nine among females.'¹³⁰² In 1931, cirrhosis among males was also found to be 50 per cent in excess of females.¹³⁰³ Johnston and McIvor have claimed that it has become increasingly understood that masculinity can be associated with 'an excess of life-threatening illnesses and premature death' – a trend illustrated by these figures.¹³⁰⁴

where one main characters' son is involved and consequently tried in court over the death of a male in relation to gang fighting.

¹²⁹⁹ Quoted from Macdonald, *Whaur Extremes Meet*, p. 141.

¹³⁰⁰ A. Davies, 'Street Gangs, Crime and Policing in Glasgow during the 1930s', p. 266; Also see J.A. Mack, 'Crime', in J. Cunnison and J.B.S. Gilfillan, eds., *Glasgow: The Third Statistical Account of Scotland* (Glasgow: Collins, 1958), pp. 644-45.

¹³⁰¹ *RMOHG 1920*, pp. 22-3; *RMOHG 1923*, p. 35.

¹³⁰² *RMOHG 1929*, pp. 45, 46.

¹³⁰³ *RMOHG 1931*, p. 43.

¹³⁰⁴ Johnston and McIvor, 'Dangerous Work', p. 136.

However, statements such as the 'shipyard built up a lot of that image. You know, the hardman, the hard drinker, and the tough guy and things,' still denotes the association between excessive alcohol consumption and working class masculine culture, rather than masculine culture per se. Related mortality data specific to working class males from Glasgow does not exist, and in the absence of these figures it is difficult to confirm the extent to which this was reflected in the health statistics. Nonetheless, it can be argued that the health consequences of masculine culture in relation to alcohol consumption were certainly more severe, both directly and indirectly, for those lower down the social scale in nutritional terms at least. The machismo culture of the city had important health consequences, not only for the drinker, but their immediate family as well – particularly in relation to its burden on domestic budgets. One professor of the West of Scotland Agricultural College reportedly stated that 'official returns for the year 1924 showed that for every £1 spent on milk there was expended £2 14s on beer alone. Last year the nation spent four times as much on alcoholic liquors as on milk.'¹³⁰⁵ Indeed, the interwar survey by Paton and Findlay found that in the Scottish cities in general, among the poorer men they surveyed 'there was a good deal of drinking and betting, and nearly all were heavy smokers.'¹³⁰⁶ The consequences of expenditure on alcohol were also embroiled in the gendered distribution, and unequal allocation of resources within the home, where its cost created an additional burden upon the provisions available for dependants. For example, Paton and Findlay observed that:

Apart from drunkenness, a moderate indulgence in alcohol makes a serious demand on such small incomes as those of the families which have been studied. Even a glass of whisky a day, costing 1s 4d. will make a material difference on an income of, say, 35s per week...

Despite the poverty of the Glasgow slums, drinking is much more

¹³⁰⁵ Report on an address given by Professor Benwick H. Leitch of the West of Scotland Agricultural College, Kilmarnock to members of the City Business Club, Glasgow ('Drink More Milk', *GH*, 12th November 1926, p. 4).

¹³⁰⁶ Paton and Findlay, 'Poverty, Nutrition and Growth', p. 283.

prevalent than in the mining districts. In fact, when one considered the exorbitant rents of some of these 'hovels' (averaging 7s a week) and the average amount of money spent on drink, it is difficult to know how the mothers meet and manage to feed their children at all [my italics].¹³⁰⁷

Firstly, this quote reinforces the view that geographically, health cultures and consequences could vary, where these writers again indicate that this was more pronounced in Glasgow than other Scottish regions. However, it also illustrates how this machismo drinking culture was indirectly and acutely felt by wives and dependants, particularly those living in households of limited means. Clark and Carnegie maintain that 'it was [a woman's] sacrifices which kept families fed, when men could seem selfishly ready to indulge themselves at the pub.'¹³⁰⁸ Hughes also notes that drinking could contribute to 'poor health and family and community conflict' and this was also captured by oral testimony.¹³⁰⁹ One woman explained that she never saw her mother eat, reasoning 'if you think about it with a family of eleven children – well twelve, as one died – you needed a dozen eggs just to give everyone one egg. My father wasn't a bad man but he did sometimes leave her short and he did tend to drink.'¹³¹⁰ Both oral testimonies and medical observers acknowledged that consequent arguments between man and wife often led to domestic violence (see chapter 5), and at a meeting of the Glasgow district branch of the *Scottish National Society for the Prevention of Cruelty to Children* in 1920, it was also said that 'it was not poverty alone that was responsible for cases of cruelty to children. The income of many of the people concerned were ample to provide for their dependents. It was

¹³⁰⁷ Paton and Findlay, 'Poverty, Nutrition and Growth', p. 251; The cost of drinking was reiterated in one letter to the Editor of the *GH* ('Letter to Editor: Why Be a Moderate Drinker?', *GH*, 1st November 1920, p. 9).

¹³⁰⁸ Clark and Carnegie, *She Was Aye Working*, p. 133; 'Letter to the Editor: Medical Opinion on Prohibition', *GH*, 30th October 1920, p. 5.

¹³⁰⁹ Hughes, 'Effects of Recession and Depression on Greenock', p. 303.

¹³¹⁰ Clark and Carnegie, *She Was Aye Working*, p. 133.

undeniable that a large proportion of cases of cruelty was due to drunkenness.¹³¹¹

The moral discourse in which this was written, and the condemnation of drinking to any degree among families of limited means in particular, has to be kept in mind. However, it is clear that the demands of masculine culture and leisure could help drain working class family budgets. Gambling did limit the spending of some income on drink. Nevertheless, Smout also notes that this was 'to no better purpose from the perspective of the spender's wife and family.'¹³¹² For instance, Scottish nutritionist E.P. Cathcart was of the opinion that 'leisure increased the demands on the family purse, and gambling today was a greater tax than alcohol.'¹³¹³ Hughes has argued that 'street gambling [also] escalated phenomenally between the wars in Scotland, particularly in *working class communities* where it was associated with sport [my italics],' and although not specifically reserved as a male pastime, gambling was also bound up in working class masculine culture.¹³¹⁴ Whilst commenting favourably on the declining consumption of spirits, the Scottish health authorities were simultaneously condemning a coincident rise in regular gambling – a tendency which occurred throughout the UK.¹³¹⁵ Commentators also acknowledged that this pastime was still

¹³¹¹ SOHCA/009, Domestic Violence, Ms AM (1910) and Mr AK (1920); Gladstone Robertson, *Gorbals Doctor*, p. 62; Although it is important to note that men could also be subject to domestic violence within the home. For example, Weir recalled 'at that moment his daughter came down to recover the missile (a mat), which she had thrown at her father in fury because all they had to eat for their tea was bread and margarine, and her father had come staggering home from work drunk' (Weir, *Best Foot Forward*, p. 28). Also see Hughes, 'Representations and Counter-Representations'; 'Drink and the Child: Publicans as Temperance Reformers', *GH*, 14th April 1920, p. 11.

¹³¹² Smout, *Century*, p. 155.

¹³¹³ 'Rules of Food', *Scotsman*, 11th September 1935, p. 12.

¹³¹⁴ Indeed, the *GP* reported that on one occasion, a raid on a Govan bookmaker in 1926 unearthed 6,000 betting lines as well as football coupons (Hughes, 'Representations and Counter-Representations', pp. 176-77).

¹³¹⁵ Constantine, *Social Conditions*, p. 15; *ARSBH 1923*, p. 201; 'The Increase in Gambling', *GH*, 28th April 1920, p. 7; Cathcart and Tully, 'A Dietary Survey in Terms of the Actual Food Stuffs Consumed', p. 54.

enjoyed by the unemployed – an occurrence recalled decades later.¹³¹⁶ This had important consequences for health and a report by Cathcart and Murray, which surveyed diets in Glasgow, Cardiff, Reading and St. Andrew's, 'suggested that cheap, unhealthy food was being purchased by many families so as to allow bets to be laid on horse or dog races.'¹³¹⁷ This was reinforced by oral testimony where one Glasgow woman recalled that gambling 'was just the done thing. Ah' mean they would do without food to keep the money for gambling.'¹³¹⁸

Glasser has also detailed the consequences of living with a father with an addiction to gambling, noting instances where 'there was not a scrap of food in the house', that on one occasion 'the only item of food left was some coca in the bottom of a tin – no milk, no bread, no sugar, no nothing', and that the family often endured 'lean times, even whole days without food'.¹³¹⁹ Hence, household budgets were depleted at the expense of health enhancing resources – an outcome more severe for women and children given the already unequal allocation of resources within the home. Others commented upon the mental strain caused by 'losses due to gambling', and that this also contributed to psychoneurosis and consequent incapacity.¹³²⁰ Hughes maintains that 'behaviour such as this caused immense misery because while men used income to shore up their sense of masculinity, many women were left trying to maintain their families on what was left.'¹³²¹

¹³¹⁶ *Disinherited Youth*, p. 108; Rountree, *Govan*, p. 245; Stevenson and Cook, *The Slump*, pp. 91-3; *No Mean City*, pp. 5, 6; *Ministry of Labour: Reports of Investigations into the Industrial Conditions in Certain Depressed Areas*, HMSO 1934, (4728), pp. 221, 233; D. Allan, *Hunger March* (Glasgow: The Association for British Literary Studies, University of Glasgow, 2010), p. 370 – first published in 1934.

¹³¹⁷ Thompson, *Unemployment*, p. 71; They wrote 'if the income is limited and if the natural cravings of the appetite can be met by the purchase of certain relatively cheap articles of diet, why spend more, when such a diet leaves some free cash for the cinema or to "put on" a horse or the dogs' (Cathcart and Tully, 'A Dietary Survey in Terms of the Actual Food Stuffs Consumed', p. 54).

¹³¹⁸ SOHCA/009, Domestic Violence, Ms AO (1916).

¹³¹⁹ Glasser, *Growing Up*, pp. 143, 168, 174.

¹³²⁰ GUSC, MS GEN 1669, off print from the *SBMJ*, J.L. Halliday, 'Psychoneurosis as a Cause of Incapacity among Insured Persons', 9th and 16th March 1935, p. 4.

¹³²¹ Hughes, 'Representations and Counter-Representations', p. 176.

Thus, here the interaction between ‘determinist’ and ‘voluntarist’ factors in impacting upon health is evident, where the financial and health consequences of low wages and unemployment for example, could also be affected by voluntary cultural choices. It is clear that working class male culture, in terms of its direct and indirect effects, could be particularly detrimental to physical and psychological wellbeing, and it illustrates the extent to which social, economic and *cultural* factors contributed to health experiences in interwar Glasgow.

Femininity, Respectability and Resistance

Chapter five has detailed how it remained a women’s responsibility, in spite of what proportion husbands spent of their wage on leisure pursuits like the ‘pub’, to ensure that ends were met and a sufficient supply of provisions were secured. Interestingly, within this context, the relocation of the population to new housing estates intended to benefit health could be unfavourable. It was not uncommon for women to wait at factory gates to collect men’s wages before he could spend them in the public house or to the local bookmakers. Clark and Carnegie point out that following relocation ‘women found it much harder to get into town to chase the wages, bundling the children into prams and having to change buses en route’ – in the tenements the close proximity of work and home made men easier to find.¹³²² Also, Finlay points out that temperance ‘received most vocal support from women, who recognised that they were the section of society which suffered most from alcohol abuse’ as well.¹³²³ Indeed, historically, women in Glasgow have often taken direct

¹³²² Clark and Carnegie, *She Was Aye Working*, p. 134.

¹³²³ Finlay, *Modern Scotland*, p. 151.

steps to secure and improve conditions for the benefit of health.¹³²⁴ For example, Glaswegian females were active agents in improving housing in the city, and this was often campaigned for with reference to health. The political action of women was apparent before the period under review where they were key campaigners in the Clydeside rent strikes and pivotal to the securing of the Rent Restriction Act in 1915.¹³²⁵ This activity extended into the interwar period where, for instance, the *GH* reported in 1920 that:

A deputation of working class women from Shettleston district attended in support of a protest by the tenants of dwelling houses against the proposed erection of a factory on open space near Shettleston Cross. It was urged by the spokeswoman, who like the majority of the deputation, wore a shawl over her shoulders, that the proposal was objectionable, because it would rob the children of a playground and add to the congestion in a congested district.¹³²⁶

Similarly, at the National Conference of Labour Women the *GH* reported that 'Scots women were [again] much in evidence in the housing discussion, and attacked the subject from the economic standpoint. Housing in Glasgow, one of them claimed, was worse than in any other city, and they were threatened with a smallpox outbreak owing to overcrowding.'¹³²⁷

¹³²⁴ 'An Important Question: Fairfield Fight: Cause of Govan Mothers', *GP*, 24th January 1936, p. 5; Well-known Glasgow politician Patrick Dollan has claimed that it was his mother who 'prompted me to agitate for better housing' (Quoted in Dudgeon, *Our Glasgow*, p. 84).

¹³²⁵ W. Kenefick and A. McIvor, eds., *Roots of Red Clydeside, 1900-1914? Labour Unrest and Industrial Relations in West Scotland* (Edinburgh: J. Donald, 1996); H. Corr, 'Introduction', in J. Melling, ed., *Rent Strikes: People's Struggle for Housing in West Scotland, 1860-1916* (Edinburgh: Polygin, 1983); J.J. Smyth, 'Rents, Peace, Votes: Working Class Women and Political Activity in World War 1', in E. Breitenbach and E. Gordon, eds., *Out of Bounds: Women in Scottish Society 1880-1945* (Edinburgh: Edinburgh University Press, 1992).

¹³²⁶ 'A Shettleston Protest', *GH*, 14th May 1920, p. 7.

¹³²⁷ 'Women Labourists: Scots Women and Housing', *GH*, 23rd April 1920, p. 6; It was also remarked in the 'Women's Section' of the *GH* that 'in the writers opinion, the best educated politically are the working class women in industrial districts. In many instances they evince a keen interest in the questions of the moment, and are remarkably well informed on legislative and social questions concerning their own and husband's welfare, and seem to realise the importance of citizenship. Many middle class women look upon politics as "dry" and would far prefer going to dance or to the theatre to the most interesting lecture on economic or social subjects' ('Women's Section: In Working Class Areas', *GH*, 3rd November 1922, p. 6); Also see *Medical Officer*, 24th June 1922, p. 264.

It is also well known that within the home, cultural norms ensured that women were responsible for the nutrition and health of their families. However, in the way that men behaved in ways to accentuate their masculine status, this was also the case among women, and pride and respectability were important feminine ideals which could have consequences for health. As Beier notes, 'it is difficult to exaggerate the importance of respectability in early- and mid-twentieth-century working-class neighbourhoods. [This] was the key to the social and mutual aid that was particularly important for women and children, who lived in streets where everyone knew everyone else's business.'¹³²⁸ On the one hand, this could be beneficial due to the association of hygiene with respectability. For instance, the desire to avoid the social stigma associated with female tenants who failed to contribute to the cleanliness of the communal tenement close was obviously advantageous to health (as is discussed in more detail below). For example, one interviewee recalled that 'there was a communal idea that to keep your self-respect you have to keep the close tidy.'¹³²⁹ On the other hand, contemporary notions of respectability could be detrimental. For example, for Davidson, the marked variation between male and female attendance at centres treating venereal disease could partly be explained by the lack of anonymous out-patient medical services for women, the view by women that vaginal discharge was simply 'part of their natural lot', but also 'from a real fear of provoking domestic strife and violence and of being stigmatised by family and neighbours in the event of their disease becoming public knowledge; all too probable within the constricted and inquisitive social world of most working class women.'¹³³⁰ This contributed to a significant disparity between men and women, Davidson stating that 'while health standards for the mass of the population were steadily improving, this "dark figure" of unreported and untreated infection represented a lasting and significant threat to the health and fertility of Scottish women.'¹³³¹ Likewise, Cathcart

¹³²⁸ Beier, *For Their Own Good*, p. 233.

¹³²⁹ *M74*, Thomas Wilson (1928).

¹³³⁰ Davidson, *Dangerous Liaisons*, p. 86.

¹³³¹ *Ibid.*, p. 170.

and Tully claimed that they did not believe that the problem with nutrition was 'solely one of an economic nature':

The problem is far more complicated than we fear some would be reformers imagine. Even if perfect knowledge were available, which it certainly is not, concerning the necessary composition of the optimum diet, it would not suffice merely to recommend its adoption... They are bound up by tradition, full of prejudices and a curious false pride, which often prevents them from purchasing excellent food stuffs like skim milk, either because they imagine it to have no food value, or else because they are afraid that their neighbours will despise them for buying a reportedly inferior article. The public opinion of the immediate neighbours is one of the most powerful forces for good or evil, especially where more households are crowded together. The quite laudable desire to 'keep up appearances' has a bad side, as it may lead to an excessive expenditure on house rent to the detriment of food supply.¹³³²

This was not class specific and in contrast to criticisms of 'ignorance' typically levelled at working class women, it is evident that middle class women also behaved in ways which were knowingly detrimental to health. In the *GH*, for example, female doctor Sloan Chesser discussed the increasing use of cosmetics among women and their alleged health dangers due to their chemical nature – properties which were said could lead to conditions from rashes to intestinal complications.¹³³³ However she wrote:

About one in three in well-to-do circles indulge in powders, an occasional touch of rouge, and certainly a lipstick... The fact is that women are hardened to these terrible warnings from males. Was

¹³³² Tully and Cathcart, 'A Dietary Survey in Terms of the Actual Foodstuffs Consumed', pp. 53-4; "What will the neighbours think?" was the criterion of budgeting; they could see what the children wore but not what they ate' (*Disinherited Youth*, p. 60); Also see Thompson, *Unemployment*, pp. 72, 74.

¹³³³ It should be noted that cosmetics were not the preserve of the middle class being used among the working class as well. National figures suggest that they were applied by two thirds of women in the 1930s (Zweiniger-Bargielowska, *Managing the Body*, p. 239).

there ever a time when we were not warned! Stiff corsets, high heels, long skirts, hoops, bustles, thin stockings, low necks, fur collars, have all in their time been condemned as ruinous to our health and wellbeing. Terrible things are predicted for a generation of shingled women in the way of baldness, and the effort to keep thin and boyish in figure is going to send many of us to an early grave. And still we all flourish. The pretty healthy looking girls' one sees coming out of shops and theatres, in restaurants, at dances, on the golf course and the tennis court seem none the worse for a little corrosive sublimate and arsenic and mercury in the powder and rouge they have obviously used. Indeed, they look healthier, and are healthier, than girls have ever been before, and any anti cosmetic league will have to use subtler methods than these to persuade women to give up using good powders, rouges and lipsticks.¹³³⁴

This does not represent the 'ignorance' which many medical professionals claimed that women could usually be blamed, but rather a conscious, informed decision knowingly contrary to medical advice – in this instance, a way of seemingly defying the constraints set by medical men.

Similarly, chapter five has also detailed the Scottish health authorities' dismay that women continued to utilise community 'handy women' to assist in their labours, rather than turn to qualified medical advice – a choice which the *SBH* deemed dangerous and a contributing factor to the maternal death rate.¹³³⁵ The testimonies of working class women from the Blackhill area of Glasgow also testify to this point. The tenants living here were relocated as part of the interwar slum clearance campaign. In this particular estate the inhabitants were working class, predominantly Catholic, unskilled and notably poor. These women often spoke critically of the invasive procedure carried

¹³³⁴ 'Women's Topics: Digging Their Own Graves with Powder Puffs', *GH*, 19th July 1926, p. 5.

¹³³⁵ See Douglas and McKinlay, *Report on Maternal Morbidity and Mortality in Scotland*, p. 22.

out by typically female nurse visitors who were given the task of ensuring that those relocated to new houses kept them clean. Some commented on the embarrassment endured by the assessment, the affront to their pride and the dread of the nurse inspector's arrival. One woman remarked how the visit left her feeling 'dirty'.¹³³⁶ Similarly, when discussing why she had not called upon medical supervision during her labour one woman stated:

You couldn't have a nurse in if you didn't have proper underthings and towels and the like. Not that we were dirty you know... everybody was the same. I know the nurses were used to seeing it [poverty] but I didnae want anyone talking about what we had or didnae have – nobody was going tae talk about me!¹³³⁷

Notions of respectability were important and dutifully practiced among working class women, to the extent that in this instance, keeping up appearances was more important than ensuring the safety of mother and unborn child during labour. One interviewee commented on the 'whispers' and complaints by neighbours when the Sanitary Department fumigated her home, and another woman explained that she actively withheld her ringworm afflicted children from attending school when the nurse visited through fear that the authorities would 'spray the place' and shave her children's heads.¹³³⁸

Rather than reflecting the ignorance of these women, McGuckin has argued that this refusal can be interpreted as resistance, and an attempt by women to maintain control over their own and their families' bodies.¹³³⁹ For example, one contemporary article had claimed that the failure to get children inoculated was due to wanting to 'save medical fees, and partly to escape the trouble of nursing a child in any sickness that may affect it following

¹³³⁶ McGuckin, 'Moving Stories', p. 208.

¹³³⁷ *Ibid.*, p. 216.

¹³³⁸ Dudgeon, *Our Glasgow*, p. 70; McGuckin, 'Moving Stories', p. 216.

¹³³⁹ Also see Beier, *For Their Own Good*, p. 149.

inoculation.¹³⁴⁰ One woman from Blackhill did admit that she deliberately ensured that her children did not come into contact with the school medical inspectors and their immunisation campaigns. However, although the programme was intended to be advantageous to health, she explained ‘they put you in these houses and they think that they can do anything to you. But they can’t.’¹³⁴¹ Indeed, the language used in the MOH reports suggests that control may have been an underlying intention of housing policy and relocation programmes (see chapter 4). For example, in 1925 it was said that ‘small housing schemes [were] preferable to large schemes, the tenants being more easily *handled*, advised, and raised to a higher level in their appreciation of cleanliness [my italics].’¹³⁴² Similarly, in 1927 Mr. John Bryce, director of housing for Glasgow reportedly stated that ‘in every scheme for rehousing disposed tenants a caretaker was on duty who took an interest in the moral and physical welfare of the tenants, and saw that they kept their houses in order and obeyed the rules and regulations.’¹³⁴³ However, this further illustrates the extent to which ordinary Glaswegians were active agents in their own health experiences, that they were not passive victims to the socio-economic conditions of the era or official health campaigns, and how feminine notions of respectability helped to shape health experiences in interwar Glasgow. This also reinforces the view introduced in chapter four that within new rehousing estates, people continued to *behave* in the same way that they had done in the slums. This not only undermines the extent to which housing policies were successful in the context of public health, but also the fact that ‘voluntary’ cultural norms and customs continued to be powerful determinants in shaping public health experiences, out with the important ‘structural’ and ‘determined’ socio-economic conditions of the period.

¹³⁴⁰ *Scotsman*, 26th April 1920, p. 6.

¹³⁴¹ McGuckin, ‘Moving Stories’, p. 216; Similarly, one woman recalled: ‘Oh aye. It was a terrible thing the Parish. If you got boots ma mother would’nae let us put them on. She would say your daddy’ll work for what you get. No she would’nae put them on and clothes-pants and your underwear, ye know, and some [days you] never had pants on you had to go without them’ (SOHCA/009, Domestic Violence, Ms AH (1902)).

¹³⁴² *RMOHG 1925*, p. 245.

¹³⁴³ ‘Slum Clearance in Scotland’, *BMJ*, 14th May 1927, p. 895.

Furthermore, these allegations of negligence can be qualified by clear evidence that contemporary notions of femininity could impact favourably upon health. A host of domestic skills were exercised to maintain health and hygiene where women in Glasgow upheld a high standard of cleanliness within the home. The personal memories of writers like Molly Weir detail the importance of cleanliness and hygiene as an outward display of respectability.¹³⁴⁴ This was not always devotedly practiced and a female inspector of slum accommodation in Glasgow comically remarked that one wife was 'a bright woman of 42 who looks ten years younger, possibly because she never does any work in the house, which is filthy.'¹³⁴⁵ Nonetheless, for the most part Glasgow women were praised for the cleanliness of their homes. The MOH observed that 'despite unemployment and illness the cleaning period was hailed with enthusiasm' in the central division of Glasgow (Yorkhill scheme) at least.¹³⁴⁶ However, it was repeatedly said that unemployment presented a 'serious handicap' to this task.¹³⁴⁷ Another contemporary similarly observed that in one new rehousing estate, 'twelve of these houses are occupied in every case by unemployed people, only three of whom keep their houses clean. There is a downward tendency, as the mothers complain of losing heart because of the struggle to make ends meet.'¹³⁴⁸ The *DHS* expressed some sympathy towards these women and about the slum domestic manager in her 'constant struggle against the conditions that surround her', they reasoned that it was 'not to be wondered at that sometimes the struggle is abandoned.'¹³⁴⁹ Nevertheless, a host of evidence suggests that women exercised a marked resilience during tough times. For instance, the SI of the Eastern Division observed that 'despite the depressing times as the result of unemployment, the majority of

¹³⁴⁴ Weir, *Best Foot Forward*, p. 204.

¹³⁴⁵ *NAS*, DD6/306, 'Report on Housing and Other Conditions in 50 Slum Houses in Glasgow', p. 201.

¹³⁴⁶ *RMOHG 1932*, p. 227.

¹³⁴⁷ *Ibid.*, p. 227.

¹³⁴⁸ *RMOHG 1930*, p. 232; Also see Paton and Findlay, 'Poverty, Nutrition and Growth', p. 283.

¹³⁴⁹ *ARDHS 1929*, p. 22.

tenants have kept their houses very satisfactorily.¹³⁵⁰ It was also realised that 'the industrial depression ha[d] stimulated the home manufacture of certain commodities such as bleaching or cleansing liquids by the unemployed [and] it would appear that these are readily sold, and quite a few people have taken to their manufacture within their dwelling-houses.'¹³⁵¹ This reveals not only the techniques employed within Glaswegian homes to ward off the effects of poverty, but also the extent to which wives and mothers were active agents in maintaining a healthy, hygienic environment. Indeed, it is revealing in itself, and arguably testament to the dependability of this fictional novel, that a review of *No Mean City* was published in the *GMJ* alongside reviews of typical medical texts, the author advising that the 'book should be read by all social workers.'¹³⁵² This appraisal criticised the novel's overly pessimist portrayal of conditions within working class homes. When discussing the slum conditions prevailing in the city, J.E. Highton, Secretary to the *SBH* had stated that the book, while in many respects was 'disgusting', it did 'strike that particular nail forcibly on the head.'¹³⁵³ However, the *GMJ* review claimed:

While everyone will condemn the structure of these houses, and in particular the communal water-closets and stairs, anyone who had visited these dwellings must have been struck by the presence of houses which have been kept scrupulously clean by persons who have maintained their individual identity and respectability amidst their squalid surroundings.¹³⁵⁴

It is apparent that despite direct attempts to maintain a clean and respectable household, unemployment was a significant hindrance, reinforcing the view that those affected by job loss were a notably disadvantaged group to which a pessimist interpretation could apply. Still, the weight of the evidence suggests that cultural norms ensured that women were active agents in

¹³⁵⁰ *RMOHG* 1932, p. 238.

¹³⁵¹ *RMOHG* 1933, pp. 248-9.

¹³⁵² 'Reviews: No Mean City – A Story of the Glasgow Slums', *GMJ*, 125 (1936), p. 82.

¹³⁵³ 'Health and Housing: Scottish Official's Advice', *Scotsman*, 18th January 1936, p. 14.

¹³⁵⁴ 'Reviews: No Mean City', p. 82.

determining health experiences, that this could have important health enhancing as well as deleterious effects, and that conventional notions of respectability and femininity contributed to health trends.

Conclusion

It is evident that within the context of industrial recession and its socio-economic effects, the behaviour of communities and individuals could impact in ways that were both beneficial and detrimental to physical wellbeing. There is ample evidence that people were actively concerned with protecting their health, and whilst there is debate regarding the *extent* to which this was the case, the myriad of marketing campaigns emphasising the health enhancing value of products, leisure pursuits like 'the dancing', and the thriving physical culture and 'Keep Fit' campaign, all illustrate that voluntary lifestyle choices constituted important health enhancing behaviours. However, coinciding with the increasing 'health consciousness' of the population were important changes in consumption and leisure patterns notably detrimental to health, including a rise in the use of tobacco products among men and women, the movement away from fresh to convenient and artificially preserved foods, and greater expenditure on luxury items – reflected by the increase in sugar consumption, growing rates of dental decay and mounting concern over obesity. Nevertheless, it can be maintained that these trends did not apply equally to the population at large and important cultures and behaviours existed between and within individual groups which could impact upon health. In line with the argument advanced in this thesis, health cultures in Glasgow reinforce the view that interwar health experiences were a complex lattice of a *number* of interacting variables. In the context of overall improvements in nutrition, growing concern over obesity and overeating – a phenomenon in stark contrast to

conventional literature on interwar public health – was related to class, being more pronounced among the middle, and wealthier class than the population per se. Moreover, whilst it is well documented that diets were worse lower down the social scale, it is important to note that within this group, dietary traditions actually changed, and the switch from traditional menus of fresh to convenience foods was more pronounced. Nonetheless, low incomes continued to shape inferior diets, reinforcing the important interaction between the ‘determined’ and ‘voluntary’ factors described by Kunitz in determining standards of health.¹³⁵⁵

There are also indications that the drinking culture of Glasgow – a phenomenon itself which reinforces the importance of geographic region to interwar health experiences – was bound up in the machismo culture of the city, manifest by higher rates of diseases associated with excessive smoking and alcohol related deaths. However, this was also complicated by economic position where the health implications of this machismo culture – which involved unnecessary expenditure on drink, tobacco and gambling – was both directly and indirectly more severe for those lower down the socio-economic scale, in terms of its demand on domestic budgets and the provision of health enhancing resources available within the home. Similarly the feminine culture of pride and respectability, important for working and middle class women, could also be detrimental to health, and this is evidenced by their deliberate disregard and unreserved resistance to accept medical advice in certain situations. However, it is also clear that women were actively involved in the maintenance and improvement of their family’s health, not least with regards to the upkeep of a ‘respectably’ clean and hygienic home. Thus, this chapter illustrates the extent to which people were active agents in their own health experiences, how the often contradictory health trends mapped throughout this thesis were shaped by important voluntary health related behaviours and decisions, and how socio-economic

¹³⁵⁵ Kunitz, ‘Explanations and Ideologies of Mortality Patterns’, pp. 390-91.

and cultural factors were implicated in the diverse public health experiences of interwar Glasgow.

Chapter 8 Conclusion

This thesis started from the question of whether health improved or declined in Glasgow between 1919 and 1939. The conclusion reached is that health improved for some and not others but that establishing who benefited and who lost out is a complex business. It is difficult in part because of the intricacies of the statistical data and ways of reading these, as they render unsatisfactory such straightforward notions as improvement or decline in matters related to population health. The project of establishing where health improved or deteriorated is additionally complicated as the impacts of structural determinants of health were varied and interactions between them had diverse outcomes. A final level of complexity is added when the agency of individuals is factored in, as the evidence here suggests that personal choices, behaviour and attitudes could mediate or mitigate the force of structural determinants of health. The rest of this final chapter will discuss how these levels of complexity can provide a more nuanced view of public health in the interwar period.

Using a range of key health indicators, this project began by mapping Glasgow's public health profile through an analysis of the extent and characteristics of ill health in the period. This demonstrated that in spite of the economic vicissitudes of the era improvements in infant mortality, life expectancy, crude and standardised death rates, and the heights, weights and nutrition of the school population were made. There is no doubt that 'health' was generally better in 1939 than it had been in 1919 based on these figures. In this way Glasgow's public health statistics can be used to support the more optimistic views of writers like Winter and Stevenson that people were healthier on the eve of the Second World War than they had ever been before.¹³⁵⁶ However, the conclusions which can be derived from these data

¹³⁵⁶ Stevenson, *British Society*; Winter, 'Infant Mortality'.

sets are contradictory. They also reveal that there was a clear stagnation in the pace of improvement in terms of infant deaths, that regional inequalities intensified, and that the city's health position deteriorated in relation to Scotland as a whole. The heights and weights of school children worsened when the recession was most severe and the marked increase in chronic ailments as a result of the epidemiological transition can undermine the extent to which the city was 'healthier' by 1939. Reductions in spending on local health provisions, concern over the growing incidence of psychological illness, and the worsening of conditions at certain points between 1919 and 1939 complicate the interpretation that the era was one of progress. It is easy to manipulate the statistics to provide evidence to support the interpretations of writers like Aldcroft and Winter on the one hand, and Webster and Mitchell on the other. Examining the popular perceptions and health experiences behind the statistics complicates this story further. Personal testimonies indicate that often the health 'gains' of the period were not realised at the ground level and the era continued to be perceived as one of ill health.¹³⁵⁷ Depending on what aspect of this complex picture is highlighted affects the overall conclusion which is reached. Burnett has commented that establishing the impact of unemployment itself upon health is difficult 'partly because the statistics of mortality and morbidity are capable of differing interpretations.'¹³⁵⁸ Laybourn maintains that the 'debate has been fuelled by the contradictory nature of the evidence.'¹³⁵⁹ This is aptly demonstrated by the Glasgow evidence.

It seems, therefore, that adopting a one-dimensional approach and attempting to establish the extent to which health improved or deteriorated in the interwar period is unhelpful. This is corroborated by the wide range of experience throughout the city. For example, while improvements in public

¹³⁵⁷ As Thompson found was similarly the case in interwar south Wales (Thompson, *Unemployment*, pp. 247, 248).

¹³⁵⁸ Burnett, *Idle Hands*, p. 252.

¹³⁵⁹ Laybourn, *Britain on the Breadline*, p. 43.

health data like IMR and heights and weights suggest that the health of infants and school children got better, this was not the case for the pre-school child and youths aged 14-16 years after leaving school. Here health could actually be worse – a disparity largely explained by voids in the health care system for the purposeful care of these groups. In the context of broad improvements, there were marked *divergences* according to age. Similarly, the most outstanding feature of health in the interwar period is the extent to which socio-economic conditions shaped mortality and morbidity patterns. Death rates, standards of diets and nutrition, access to and the affordability of medical services, and housing conditions, overcrowding and material environments were grossly unequal in relation to ‘class’. Aggregate public health statistics reveal distinct experiences according to geographic region – a characteristic which also had an important relationship with social status. The health records from districts associated with Glasgow’s ‘working class’ were consistently poorer than those returned from ‘middle class’ residential areas. However, a broad and complex spectrum of ‘class’ was also reflected in these statistics where inequalities existed within the working class itself, and to the community and street level.

Class inequalities had always existed and within the debate on health in the interwar years it is the extent to which differentials narrowed which is contested.¹³⁶⁰ Adopting Szreter’s views on the ‘dynamic interactions between class and “place”’, the city’s region-specific mortality statistics tentatively imply that inequalities eroded.¹³⁶¹ However, the importance of considering the demographic make-up of local populations as well as socio-economic circumstances as emphasised by Thompson was also clearly endorsed by this research.¹³⁶² In Glasgow, the reduction in the discrepancy between ‘working’ and ‘middle class’ areas was influenced by alterations in

¹³⁶⁰ Webster, ‘Healthy or Hungry Thirties’, p. 116; Stevenson and Cook, *Slump*, p. 81; Winter, ‘Infant Mortality’, p. 451.

¹³⁶¹ Szreter, *Health and Wealth*, p. 13.

¹³⁶² Thompson, *Unemployment*, pp. 180-90.

the spatial arrangement of the city's population, and the extent to which these inequalities were reduced was exaggerated by the influx of unhealthier 'slum dwellers' into conventionally middle class communities. As Gazeley states, 'the extent of the disparity in improvement by socio-economic class during the interwar years is dependent on the choice of mortality statistics.'¹³⁶³ Yet the overwhelming conclusion attained from this thesis was that inequality in relation to factors such as class consistently defined health trends regardless of the statistics used.¹³⁶⁴ When mortality data can be treated and arranged to support conflicting interpretations, in the final analysis what always stands out is that socio-economic status was a key determinant of public health experiences. A youngster born in a Glasgow working class district in 1939 continued to be twice as likely to die before reaching their first birthday compared to one born in a 'middle class' area. This was a variance reflective of the rate in 1919 and one which was mirrored by other analytical approaches to examining health inequalities in relation to class.¹³⁶⁵ Gross inequalities persisted in the context of general improvements.¹³⁶⁶ Indeed, the continuity of the poorer health of the working classes is widely recognised by historians. However often this is where the analysis ends. The health of the middle class is noticeably neglected in the literature and minimal attention has been given to the experiences of this group. However, by examining these inequalities further, this research has shown that the middle class and wealthy also endured significant challenges to health in the interwar years despite their generally superior health status. Increasing concern over 'diseases of affluence' like obesity and cancer, which rose considerably throughout the period, were primarily concerns of those higher up the socio-economic scale. This was also somewhat true of the rising maternal death rate which is discussed in more depth below. As such, this research argues that it is more telling to investigate these differences further, and to unravel

¹³⁶³ Gazeley, *Poverty*, p. 118.

¹³⁶⁴ This is also agreed by Gazeley (Gazeley, *Poverty*, p. 118).

¹³⁶⁵ For example see J. Agnew, 'Mortality-Rates in Glasgow Families: An Analysis of the Various Kinds of Wastage of Child Life in Well-To-Do and in Poor Families of Varying Size', *GMJ*, 3 (1922), 145-71.

¹³⁶⁶ Laybourn, *Britain on the Breadline*, p. 58.

and explore the wide range of experiences across the population, to provide an alternative, detailed and more nuanced picture of interwar public health.

Between 1919 and 1939 health experiences were influenced significantly by socio-economic position. However, this interacted with a range of other 'structural' determinants. Perhaps the most obvious contribution to the city's poor health record was its housing. Living conditions and levels of overcrowding in Glasgow were notoriously bad and they compared unfavourably to the other Scottish cities and English urban regions of a similar industrial character. There is broad agreement that this impacted adversely upon the population's health, and it has been demonstrated statistically that indices like IMR and respiratory disease were directly affected by Glasgow's inferior housing conditions.¹³⁶⁷ However, this was unequally felt. The distinct regional inequalities throughout the city were shaped by their housing standards. As a result, certain districts were recognised health hazards. Unsurprisingly these were the regions associated with the working class and their poorer survival rates. Ambitious legislation in the interwar period meant that some of the city's worst housing was destroyed as part of building and slum clearance campaigns. This thesis addressed how far these developments were successful in improving public health.

Undoubtedly, the houses built by Glasgow Corporation between the wars were structurally superior. Important environmental gains were made and census data reveals some improvement in terms of overcrowding. However, the local authority housing built in Glasgow had the effect of *accentuating* inequalities due to the nature of the homes constructed. The experience of improvement was uneven and the chief beneficiaries were the middle and 'respectable' tier of the working classes (e.g. 'artisans') able to

¹³⁶⁷ Cage, 'A Tale of Two Cities'.

afford the superior 'ordinary' category of house, compared to poorer working class residents relocated to inferior 'rehousing' homes. These inequalities were reflected in the health statistics returned from these homes with higher levels of IMR and infectious and respiratory disease being recorded in the 'rehousing' schemes. On the other hand, for others, particularly the unemployed, health experiences could deteriorate where the struggle to meet higher local authority rents, for example, meant that less could be spent on food. Housing conditions among those affected by the loss of work were consistently and considerably worse, overcrowding was significantly higher, and the improvements which local authority housing could offer were often beyond their means. Given the relationship between overcrowding, housing and physical condition, there can be little doubt that the housing conditions of the unemployed impacted adversely upon their health.

As the diverse range of experience in relation to housing demonstrates, health in Glasgow was the outcome of a number of interacting variables. Similarly, whilst the relationship between income and housing was clearly important, experiences also varied according to gender. In Glasgow there is clear evidence that it was women's health which suffered the most when housing was inadequate due to the more prolonged periods of time they spent within the home. Indeed, the gendered nature of health in the interwar period is widely recognised. A key feature of the historiography, this primarily relates to discussions of the era's soaring maternal mortality rate and on how the female domestic role could impact adversely upon health.¹³⁶⁸ The rising level of maternal deaths represented an important obstacle for women's wellbeing and the public health authorities. Here, a number of state campaigns were also introduced – although it seems that this mortality rate was only halted by the introduction of the sulphonamides in the mid-1930s.¹³⁶⁹ This research has demonstrated that the women of Glasgow as a group experienced significant challenges to health. However, in an attempt

¹³⁶⁸ Whiteside, 'Counting the Cost', p. 242.

¹³⁶⁹ Mitchell, 'Unemployment', pp. 105-26.

to provide a more holistic view it has been emphasised that the experiences of 'women' were varied. For example, while levels of maternal death and IMR were consistently higher for illegitimate births, the discrepancy in relation to infant mortality at least had decreased considerably by the end of the period. On the other hand, the experience of Glasgow's married women, particularly those from households distressed by the loss of work, was often affected by their biological role as mothers, and by their cultural position within the home and family. The mental stresses of making ends meet and household incomes stretch was also more pronounced, and was a burden reflected by the growing incidence of dangerous self induced abortions. This combined with the experience of domestic violence within the home, aggravated by masculine insecurities when male breadwinners lost their jobs during the recession, suggest that working class married women was one section of the population where standards of health could decline.¹³⁷⁰ The health experiences of 'women' in Glasgow were not homogenous, varying with regards to age, marital status and the employment position of the household at least.

Mitchell is one historian who also argues that the maternal mortality rate in the interwar period 'simply reflects the deepening economic crisis and of its accentuated effect upon women' due to the high incidence in areas like Glasgow notably affected by the Depression.¹³⁷¹ Here the value of disentangling the experience of different social groups to provide a more accurate understanding of the statistics is apparent. While writers such as Winter and Mitchell claim that this questions the 'optimist' interpretation this has to be treated carefully. Whilst offering support to the view that the health of women was undermined between the wars, the evidence from Glasgow suggests that often maternal mortality had little to do with the economic situation. Undoubtedly, the challenges brought about by the recession

¹³⁷⁰ Hughes, 'Representations and Counter-Representations'; Mitchell, 'Unemployment', p. 119.

¹³⁷¹ Mitchell, 'Unemployment', p. 111.

impacted to some extent upon the maternal death rate, where poverty and its aggravation of illnesses like tuberculosis could have an adverse effect on pregnancy. Given the evidence of increasing mortality from tuberculosis among younger women of childbearing age in Glasgow this seems plausible. Nonetheless, maternal mortality did not obviously correlate with poverty. In fact, in contrast with most other health indices, the risk of death during childbirth was as, if not more, pronounced for middle class women – a trend acknowledged by Loudon, Jones and Hardy.¹³⁷² Ironically, this was affected by what usually secured their better health – the ability to pay for private treatment – where unnecessary interference in the labour process by professional medical practitioners impacted adversely upon their maternal health. Middle class women could also feel neglected by maternity services, where the efforts of public health authorities and the health facilities offered were overwhelmingly promoted to improve the health of the poorer classes. This is an interesting contrast to the typically favourable health records associated with those of a higher financial position, and it reiterates the value of considering the unique health experiences of individual groups to provide a more detailed understanding of what was going on in the interwar years.

Considering the health of Glasgow's unemployed community in isolation confirms this view. Examining the direct impact of unemployment upon health is essentially impossible as it is so intrinsically linked with a host of other social, economic and environmental factors. Burnett also notes that 'although there are many illustrations in the literature of severe hunger, mental and physical debility, harder evidence of the direct effects of unemployment upon health is difficult' to find.¹³⁷³ Indeed, to some extent this was also true in Glasgow. Claims of malnourishment among the unemployed and their families, for example, were abundant. However, this was harder to pin down from contemporary surveys which revealed that the diets of the

¹³⁷² Loudon, *Tragedy*, pp. 189, 204; Jones, *Health and Society*, p. 65; Hardy, *Health and Medicine*, p. 95.

¹³⁷³ Burnett, *Idle Hands*, p. 252.

unemployed were less in terms of calories but not necessarily insufficient. Nevertheless, a host of evidence suggests that unemployment played an important role in determining health experiences. Certainly, public relief offered some protection and it seems that this was fairly successful in ensuring that the health of distressed communities did not strikingly deteriorate.¹³⁷⁴ However, in common with working class areas per se, the health of districts in Glasgow notably affected by unemployment failed to share equally in the overall gains of the population. The physical condition of the unemployed also weakened, regularly alongside psychological state, and the Glasgow evidence supports Laybourn's contention that 'unemployment conditioned many aspects of working class life, made decisions for working people about the housing which they could afford [and] determined their physical health', even if this is difficult to determine from aggregate statistics.¹³⁷⁵ In Glasgow the unemployed undoubtedly experienced deteriorations in physical and mental wellbeing. However, in line with the argument advanced in this thesis experiences were not universal. The duration of unemployment was significant. The physical and mental health of the long term unemployed was particularly affected – although occupational skill and the financial status this entailed meant that for skilled families less familiar and effective in dealing with poverty, deteriorations in health could be more severe and their perceived loss also deeper.¹³⁷⁶ When faced with unemployment the degree of impact varied for different members of the population.

However, it should be emphasised that out with the socio-economic effects of the recession, personal perceptions were also important. Examining the human dimension of statistics and the realities behind them is crucial to providing a more nuanced view of interwar public health. For

¹³⁷⁴ Constantine, *Unemployment*, p. 36.

¹³⁷⁵ Laybourn, *Britain on the Breadline*, p. 2.

¹³⁷⁶ Also see Constantine, *Unemployment*, pp. 25, 29 and Stevenson, *British Society*, pp. 288, 348.

instance, while the inferior physical and mental state of the unemployed was captured by both contemporary observers and oral testimonies, it is significant that illnesses and ailments were personally understood to be the result of unemployment without any conclusive relationship or medical certification. As Hardy notes, 'difficulties of interpretation arise in this period partly because of a significant difference in the experience of the nation and of different individual localities, as measured by standardised death rates, but also because perceptions of health and ill health were often confused by individual memory and experience.'¹³⁷⁷ It is widely recognised that the effects of unemployment may not have been so severe as to result in death, and therefore may be inadequately accounted for by public health statistics. Nevertheless, it is also likely that because unemployment was such a prominent aspect of life for many, and restrictions on medical provisions, the tightening of domestic budgets affecting the supply of necessities within the home, and the greater length of time in which the unemployed had the opportunity to reflect on their illnesses, probably meant that periods of ill health were more acutely felt. Thus, while medical evidence of the consequences of job loss is difficult to establish, the impact of unemployment upon health experiences was far more general than accounted for by numerical data and clinical exams. As Thompson states, 'analyses of mortality in the 1920s and 1930s must be anchored in the realities of lived experience.'¹³⁷⁸

Examining the daily lives of Glaswegians was essential to understanding their health. Individuals were active agents in defining their own health experiences and standards of physical and mental wellbeing. It is clear that the people of Glasgow often made direct attempts to improve their health or behaved in ways which were beneficial. This is evidenced by the marketing of products featured in Glasgow newspapers which promised better health and the participation of men and women in the flourishing

¹³⁷⁷ Hardy, *Health and Medicine*, p. 92.

¹³⁷⁸ Thompson, *Unemployment*, pp. 245-46.

physical culture and Keep Fit campaign. In contrast, changing consumption patterns and unnecessary expenditure on leisure pursuits like smoking, drinking and gambling were often deleterious to health. This research has shown that lifestyles and behaviours were often culturally rooted. These similarly varied according to region, gender and class at least and they contributed to defining the health inequalities experienced across the city. Nevertheless, ultimately, the role of the individual complicates any generalisations which can be gleaned from the statistics. For example, the subletting of rooms to additional families, and the crowding into one room for sleeping purposes when relocated to houses with extra space, could undermine the expected improvements of superior housing conditions. The practice of domestic medicine within the home and the deliberate resistance of some to public health campaigns could also have harmful effects. At the same time, adherence to cultural notions of respectability which ensured that homes were kept healthy, hygienic and clean, the range of survival strategies employed within the home to stave off the harmful effects of poverty, and the drive of some mothers to provide families with adequate and *nourishing* meals could have positive impacts. Within the historiography, this kind of behaviour has been discussed most extensively with regards to women. However, a closer look at the realities of everyday life reveals that some fathers also refused food to protect their children, could reject medical treatment in favour of working to provide a family wage, and often they too played a significant role in health experiences within the home. Indeed, when faced with the same circumstances, like unemployment, reactions to it and the extent and effectiveness in which survival strategies were employed, varied within different social groups and within individual families. As Thompson points out, 'each week, families were forced to make decisions as to the most effective way of apportioning their income to meet the various costs they faced. Different families prioritized their requirements in vastly different ways.'¹³⁷⁹ This also applied in Glasgow with diverse outcomes.

¹³⁷⁹ Thompson, *Unemployment*, p. 46.

In the interwar period soaring rates of unemployment, increasing levels of poverty and financial austerity in the provision of medical services created a challenging backdrop for public health – particularly in industrial regions like Glasgow where the effects of the recession were severe. Conditions were worse in terms of poverty, unemployment and health when compared to Scottish national averages, the other Scottish cities Dundee, Aberdeen and Edinburgh, and industrial heartlands with similar industrial profiles like Liverpool and Manchester. An ‘unhealthy city’ label features regularly in the historiography defining Glasgow as a place where the social problems of the Depression were pronounced and where ill health was acute. As such, it might have been expected that a ‘pessimist’ interpretation of ill health, premature death and inadequate diets would apply. In fact, this research has shown that the public health profile of interwar Glasgow was far more complex. Its health experience was contradictory and the statistics can be used to endorse both ‘optimist’ and ‘pessimist’ readings. Laybourn has argued that ‘there is no contradiction in improving living standards occurring alongside acute poverty, and even worsening standards of life for a substantial minority of the nation.’¹³⁸⁰ This also applied to local economies like Glasgow and its interwar health experience demonstrates the ‘paradox’ highlighted by writers like Glynn and Oxborrow.¹³⁸¹ For them, arbitrating between ‘optimist’ and ‘pessimist’ perspectives was unhelpful. They argued that the period was one of ‘two faces’ – progress on the one hand and unemployment and poverty on the other; both were ‘real and both should have their place in any history of the interwar period.’¹³⁸²

In terms of public health, the experience of Glasgow confirms this view. Health improved for some but not others. However, demonstrating where this was the case is complex. This thesis argues that disentangling the diverse range of experience across the population goes some way to

¹³⁸⁰ Laybourn, *Britain on the Breadline*, p. 53.

¹³⁸¹ Also see Hardy, *Health and Medicine*, p. 109.

¹³⁸² Glynn and Oxborrow, *Interwar Britain*, p. 13; Thompson, *Unemployment*, p. 14.

providing a more accurate understanding of health in the interwar years. Adopting a multi-dimensional approach reveals that diversity and *inequalities* in health in relation to a number of social, economic, demographic and cultural factors characterised the city's mortality and morbidity patterns more conclusively than improvements or deteriorations. Indeed, it is important not to over simplify the historiographical debate on health in interwar Britain. Often those holding opposing views on the extent to which gains were made accept the broad groups where improvements occurred and often fell short, and all agree that experiences varied between and within individual sections of the population.¹³⁸³ The argument here is that it is more useful to emphasise and *explore* these divergences to provide an alternative interpretation of the records. By answering Mitchell's plea to unravel and reassess the wide range of experience which existed, a more detailed and nuanced understanding of public health can transpire.¹³⁸⁴

The picture which emerges in Glasgow is one of health inequalities and individual experiences of the extent to which this was the case. Indeed, Webster states that 'the persistence of gross disparities between the sexes, or between social and occupational groups constitute the dominant features of the interwar pattern of health.'¹³⁸⁵ The conclusions drawn from this research suggest that a comparative approach is a useful method for comprehending the intricacies of the period.¹³⁸⁶ Szreter claims that 'in any field of investigation, there needs to be a preparedness to modify and revise pre-formed, overly neat analytical categories and models in recognition of the diversity of different contexts and of empirical findings.'¹³⁸⁷ This thesis similarly argues that eschewing the 'optimist-pessimist' debate, and

¹³⁸³ For example see Jones, *Health and Society*, pp. 72, 76; Hardy, *Health and Medicine*, p. 95; Winter, 'Infant Mortality', p. 462; Constantine, *Unemployment*, p. 36; Stevenson, *British Society*, pp. 283, 285; Gazeley, *Poverty*, p. 112.

¹³⁸⁴ Mitchell, 'Effects of Unemployment', p. 120.

¹³⁸⁵ Webster, 'Healthy or Hungry Thirties', p. 125.

¹³⁸⁶ An argument also advanced by S. Pooley, 'All We Parents Want is that Our Children's Health and Lives Should be Regarded': Child Health and Parental Concern in England, c.1860–1910', *Social History of Medicine*, 23 (3), (2010), p. 546.

¹³⁸⁷ Szreter, *Fertility, Class and Gender*, p. 594.

emphasising the wide range of experience across the population, can provide a more holistic view of health in the twenties and thirties. It seems unhelpful to try to assert a broad generalisation on standards of health when experiences were so varied. As Webster notes, 'such persisting sex, class, occupational and regional inequalities are quite as valid a representation of reality, and as important historically, as the decline in average rates of mortality.'¹³⁸⁸

Emphasising, engaging with and evaluating these divergences provides an alternative interpretive framework and a more detailed understanding of interwar health trends, whilst accounting for the realities behind the statistics and actual health experiences. Between 1919 and 1939 Glasgow was an 'unhealthy city' in relation to other Scottish cities and English urban areas of a similar industrial profile. However, the physical and mental condition of the population, both perceived and actual, was characterised by diversity and it is more precise to understand public health in terms of inequalities. This thesis suggests that health in Glasgow in the interwar years was a complex and intricate lattice, characterised by marked variations in experience influenced by a wide range of interacting social, cultural and economic factors. Clearly some individuals and some groups fared better than others. As the nation's health is again challenged by the social consequences of recession it may be the case that these issues will resurface. Glasgow still retains its unenviable record of being an 'unhealthy city'. Macdonald points out that even by the end of the twentieth century 'six parliamentary constituencies recording the highest levels of premature mortality in the UK were all located in Glasgow.'¹³⁸⁹ Stewart has similarly discussed how in 2008 the Scottish Government recognised:

¹³⁸⁸ Webster, 'Healthy or Hungry Thirties', p. 124.

¹³⁸⁹ Macdonald, *Whaur Extremes Meet*, pp. 114-15.

That while taken as a whole the country's health was improving, 'the fact is that some (health) inequalities are *widening*' [my italics]. These derived from various sources, including personal lifestyle issues such as smoking as well as broader socio-cultural and environmental factors. There thus remained 'many challenges to overcome to tackle the country's poor health record.'¹³⁹⁰

In light of the research findings promoted in *The Spirit Level* by Wilkinson and Pickett – that not only health, but a range of other performance indicators were significantly better in societies where relative inequalities were less – this is important.¹³⁹¹ As recently as 2011, the influential report by the *Commission on the Future Delivery of Public Services* in Scotland described the country as 'a paradoxical tapestry of rich resources, inventive humanity, gross inequalities, and persistent levels of poor health and deprivation.'¹³⁹² The similarities are striking and it seems that the health inequalities of the interwar period have an important historical legacy. One local woman recalled of growing up, 'Glasgow was always a city of contrasts.'¹³⁹³ This was true of public health in interwar Glasgow, 1919-1939, and it is still true today.

¹³⁹⁰ Stewart, 'Sickness and Health', p. 231.

¹³⁹¹ Includes crime, violence, addiction, education and teenage pregnancies (among a range of other social indicators) (Wilkinson and Pickett, *The Spirit Level*).

¹³⁹² *Commission on the Future Delivery of Public Services* chaired by Dr Campbell Christie (published 29th June 2011), <http://www.scotland.gov.uk/Publications/2011/06/27154527/18>, viewed 14th February 2012.

¹³⁹³ *2000 Glasgow Lives*, Joyce Booth (1912).

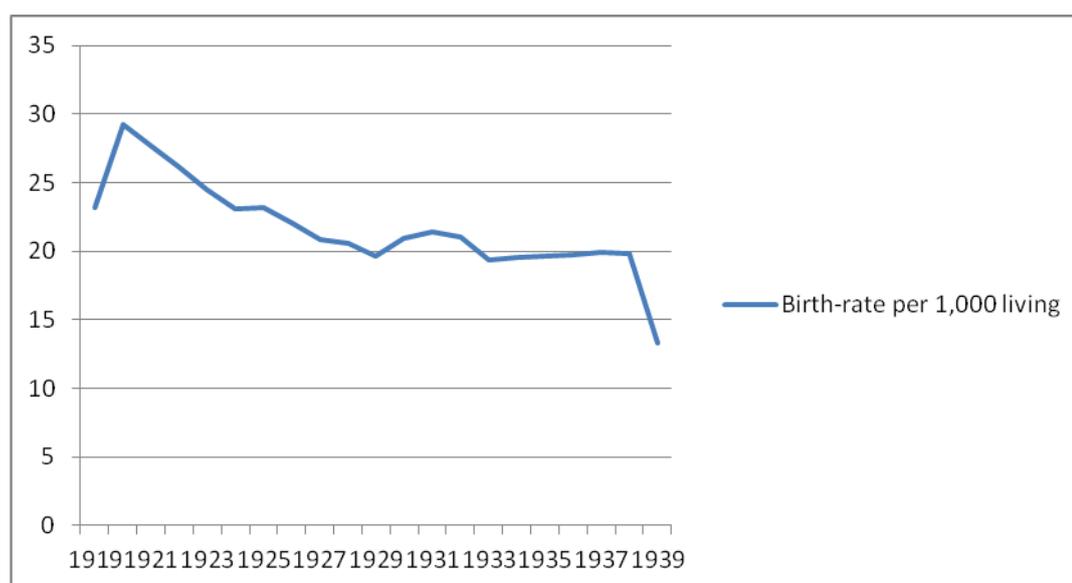
Appendices

Appendix 3.1: Age composition of Glasgow as a percentage of the population

	Population 1921	Percentage	Population 1931	Percentage
0-4 years	101573	9.8	98977	9.1
5-9 years	100337	9.7	104136	9.6
10 -14 years	101576	9.8	94483	8.7
15-19 years	100934	9.8	100006	9.2
20-24 years	96090	9.3	98667	9.1
25-34 years	163220	15.8	173995	16
35-44 years	140665	13.6	143038	13.1
45-54 years	115391	11.2	123896	11.4
55-64 years	70694	6.8	90673	8.3
65-74 years	33338	3.2	46347	4.3
75+ years	10208	1	14170	1.3
Total	1034026	100	1088388	100

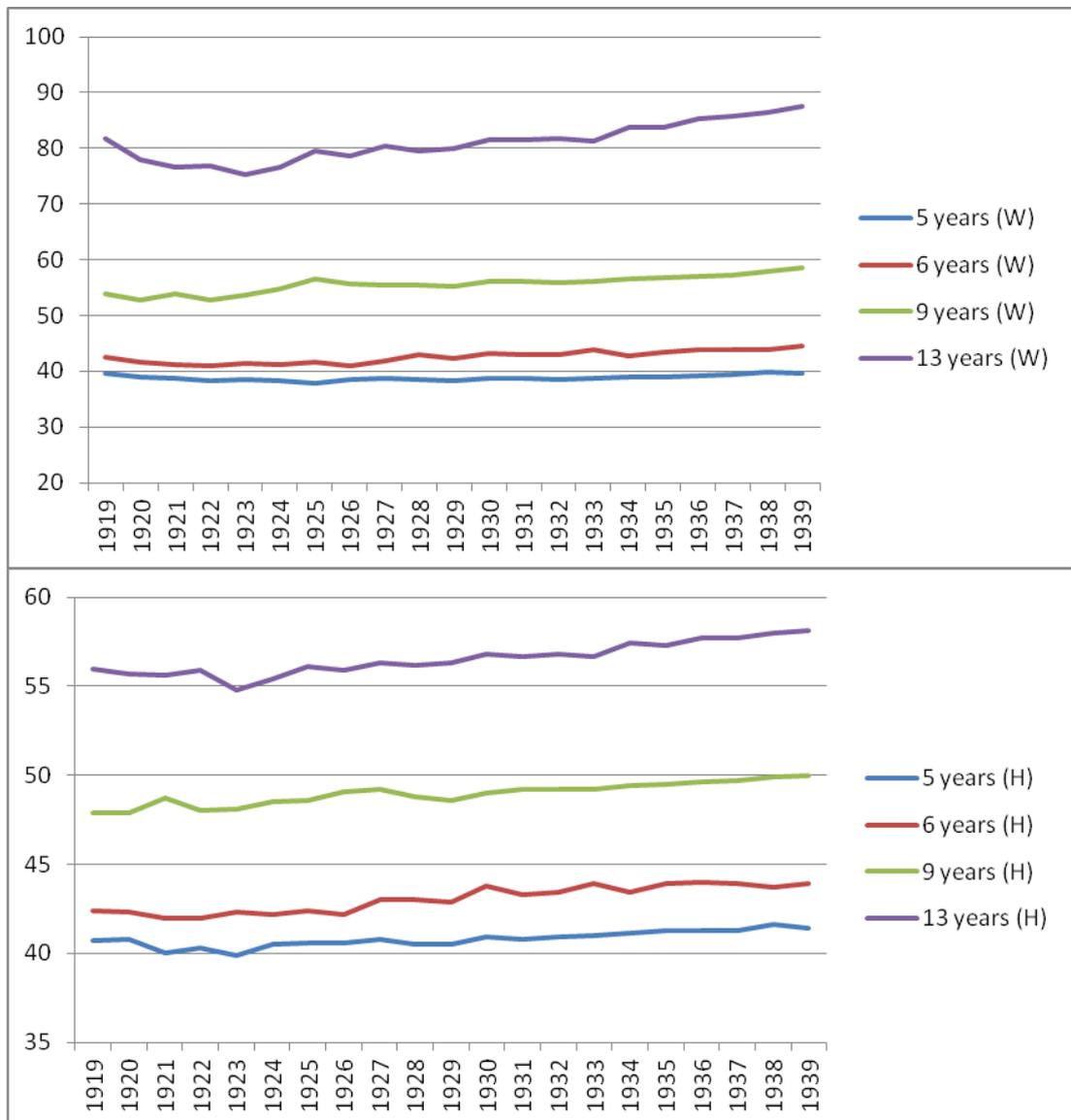
SOURCE: *Census Report, Glasgow, 1921 and 1931*; Jones, *Life Expectancy*, p. 32.

Appendix 3.2: Birth rate per 1,000 living in Glasgow, 1919-39



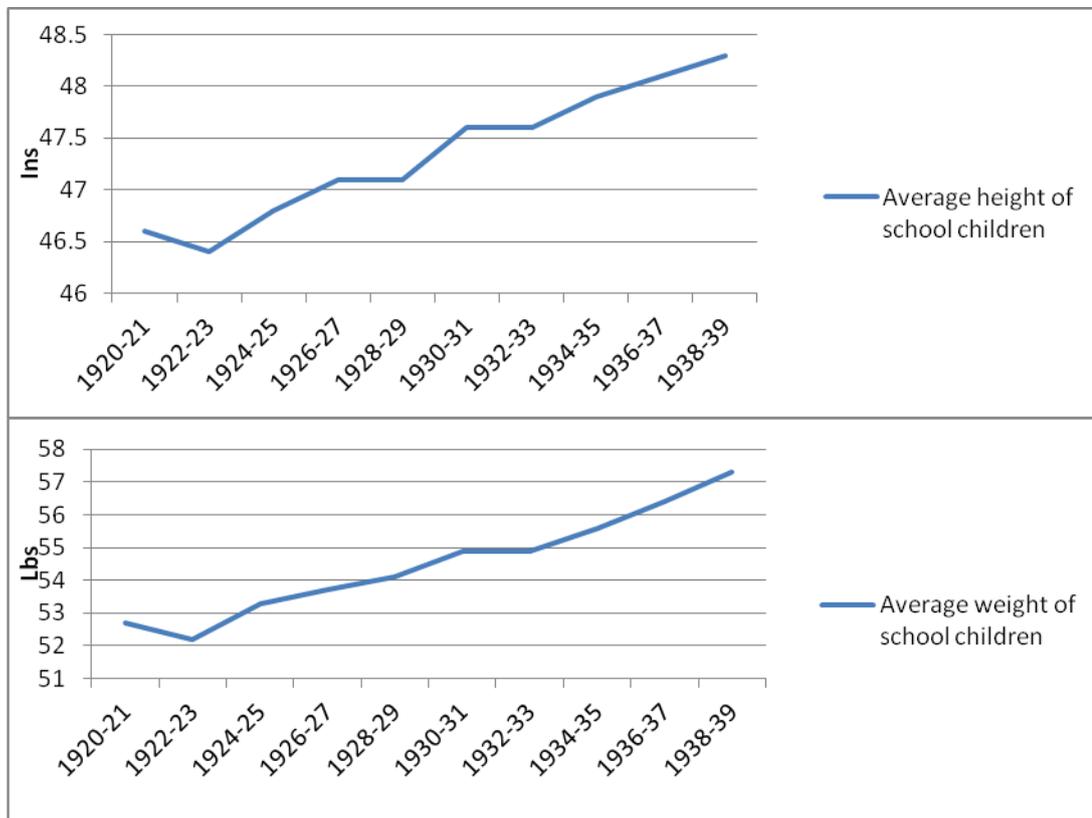
SOURCE: *RMOHG 1919-39*.

Appendix 3.3: Height (H) and weight (W) of Glasgow school children, 1919-39 (pounds and inches)



SOURCE: RMITSC 1919-39.

Appendix 3.4: Average height and weight of Glasgow school children in two year intervals, 1920-39



SOURCE: RMITSC 1920-39.

Appendix 3.5: Methodology used to calculate the death rate of the school and pre-school population

According to the corrected population figures published by Glasgow Corporation, the death rate for children of school age decreased from 3.5 to 3.2 per thousand, or by 8.6 per cent¹³⁹⁴ (or 3.7 to 3.2 per 1,000 based on the 1921 census data, 13.5 per cent) between 1921 and 1931. The death rate for children of pre-school age fell from 18.8 to 17.2, or by 8.5 per cent (or 19.5 to 17.2 per 1,000, 11.8 per cent) in the same period. Age-specific mortality data was published annually in the MOH annual reports. However, an age-specific death rate for the pre and school age population could only be calculated for 1921 and 1931 since age-specific population data was only available in census years. The age-group 5-9 years was considered children of school age. This was consistent with the population breakdown provided by the census. The school age death rate was calculated from the mortality data of children aged 5 years to less than 10 years. This was considered alongside the population data for children aged 5-9 years, based on the corrected population data published by Glasgow Corporation *and* as per the figures published in the actual census reports (see chapter 3).

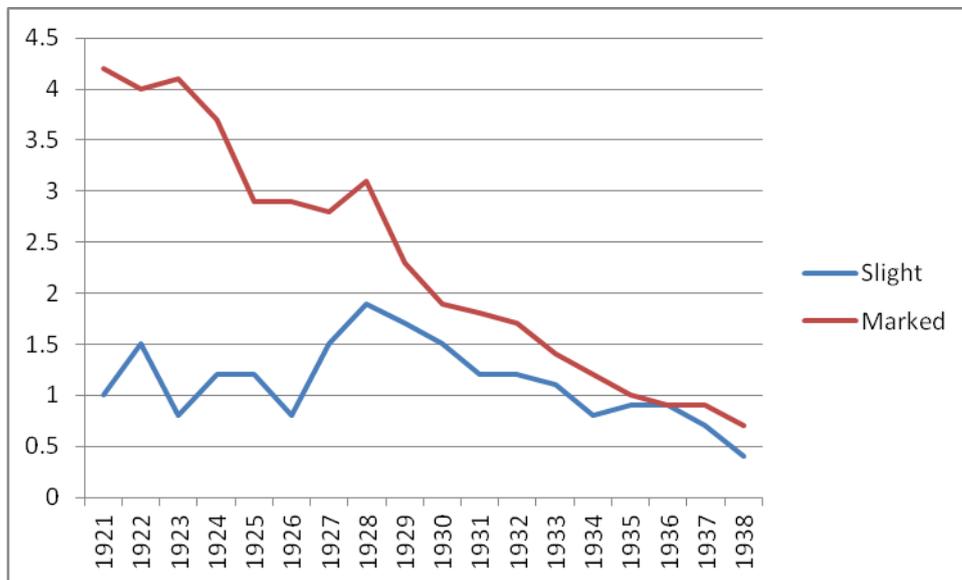
Children aged 1-4 years were defined as being 'pre-school age'. To calculate the pre-school age death rate, the mortality figures for children less than two years (i.e. 1 year or more but less than 2 years) and less than five years (i.e. 2 years or more but less than 5 years) were added and used alongside the population rates for children aged 1-4 years. The infant death rate i.e. deaths among children under one year old was excluded from this analysis on the grounds that one of the primary concerns at both the local and national level was to control and improve the infant death rate. Contrastingly, a gap in the health care system existed where children of pre-school age were neglected from any particular public health focus. However,

¹³⁹⁴ This was 9.6 per cent if mortality data was not rounded to one decimal place before the percentage was calculated.

the 1-4 year age group proved to be statistically awkward. The 1921 census report, and Glasgow Corporation's adjusted figures, publishes the population data for children aged 0-4 years only, compared to the 1931 census report which publishes the 0 years and 1-4 years population figures separately. The 1931 census report does publish the preceding census data i.e. the 1921 population data in the format 0 years and 1-4 years. However, the 1931 census report publishes the 1921 population figures *inclusive* of population changes which took place due to the 1925 Glasgow Boundaries Act. Therefore the 1-4 year population data for 1921 published in the 1931 census report is not strictly comparable with the mortality figures published by the MOH in 1921, which obviously fail to account for the deaths which occurred in the areas now included as Glasgow under the Act.

Consequently, the percentage of the 0-4 population which was 0 in 1921 (based on the figures published in the 1931 census report including the new boundary) was calculated. This was found to be approximately 25 per cent, and was applied to the actual figures published for 1921 in the census report, and to those published by Glasgow Corporation. Regardless of what population data was used, the rate of mortality decline was faster among the school age group (see above). Even when using the age-specific populations published for 1921 in the 1931 report inclusive of the new boundaries, the same discrepancy was observed. The numerical shortcomings of this calculation and comparison should be kept in mind. However, the poorer health record of the pre-school population was also observed and accepted in official reports suggesting that there is some truth behind this flawed analysis.

Appendix 3.6: Percentage of school children with marked and slight rickets in Glasgow, 1921-1938



SOURCE: RMITSC 1921-38.

Appendix 3.7: Person per acre figures for residential and working class areas of Glasgow, 1921-25 and 1935-39

Working Class	Cowcaddens	Dalmarnock	Hutchesontown	Gorbals	Govan
1921	91	143	108	207	69
1922	89	147	109	212	72
1923	88	146	146	212	72
1924	86	146	110	210	72
1925	85	146	110	208	72
1926	84	146	110	207	72
1927	84	146	107	204	72
1928	83	145	109	202	74
1929	80	138	109	199	74
1930	73	128	100	180	68
1931	73	124	100	186	68
1932	73	124	99	182	68
1933	72	124	99	180	67
1934	72	123	100	178	67
1935	71	118	97	173	70
1936	71	113	96	174	73
1937	69	109	95	170	72
1938	67	109	95	168	71
1939	67	109	94	169	71

Working Class	Cowlairs	Parkhead	Shettleston and Tollcross	Provan	Maryhill	Springburn ¹³⁹⁵
1921	62	42	35	29	37	22
1922	58	43	37	33	29	25
1923	58	43	37	35	30	25
1924	58	43	39	36	30	26
1925	58	44	38	36	29	26
1926	59	44	39	36	30	27
1927	59	45	35	29	19	10
1928	58	47	38	29	19	11
1929	58	47	40	32	19	12
1930	52	43	38	32	19	11
1931	49	45	39	33	18	11
1932	50	44	39	33	19	9
1933	50	44	39	32	19	9
1934	50	46	43	33	19	9
1935	49	46	45	33	20	9
1936	48	48	46	35	21	10
1937	50	47	46	35	20	9
1938	52	47	33	16	13	6
1939	52	47	33	16	13	6

Residential	Cathcart	Langside	Pollokshields	Kelvinside	Camphill	Pollokshaws
1921	21	44	12	21	62	54
1922	20	44	11	19	45	55
1923	20	44	13	20	57	55
1924	21	44	16	20	57	56
1925	21	45	16	20	57	56
1926	22	45	16	21	57	56
1927	14	35	7	21	58	12
1928	15	35	7	22	59	13
1929	19	35	7	22	59	13
1930	20	32	6	21	54	12
1931	20	32	6	21	52	11
1932	23	33	6	22	53	13
1933	24	33	7	23	52	13
1934	24	33	8	25	52	13
1935	24	34	9	23	51	14
1936	24	35	9	23	52	14
1937	24	34	9	23	51	13
1938	11	34	9	24	51	8
1939	11	34	9	24	51	8

SOURCE: *RMOHG* 1921-39.

¹³⁹⁵ Note that where density decreases alongside a simultaneous increase in population (like in Pollokshields and Pollokshaws) this can be explained by the extension of city boundaries (see *RMOHG* 1926, pp. 11-4, 251 for details on the impact of the extension in 1926, and *RMOHG* 1938, p. 256 for that in 1938).

Appendix 3.8: Map showing housing construction in Glasgow according to region, housing act, and 'ordinary', 'intermediate' and 'rehousing' classification, 1919-1939

[PLEASE FIND OVERLEAF]

Appendix 3.9: Average population in selected residential and working class areas of Glasgow, 1921-25 and 1935-39¹³⁹⁶

	Residential	Working Class
1921	19379.8	44639
1922	18446	45049.8
1923	19350	45001.5
1924	20486.8	44607.8
1925	20604.8	44447.3
1935	27377	37453.3
1936	27810.3	37040
1937	27828.8	36179
1938	28281.5	35728
1939	28512.5	35737.3

SOURCE: RMOHG 1921-39.

¹³⁹⁶ Average based on Cathcart, Langside, Pollokshields and Camphill for residential, and Cowcaddens, Dalmarnock, Hutchesontown and Gorbals for working class (as per classification explanation in chapter 3).

Appendix 3.10: Average birth rate per million in selected residential and working class areas of Glasgow, 1921-25 and 1935-39

	Residential	Working Class
1921	13951.5	34927.8
1922	13636.3	33413
1923	13653.8	31554
1924	13632	29357.3
1925	12584.8	29105
1935	10598	27101.8
1936	10727.8	27250
1937	11949.5	26640.5
1938	10836.8	27099
1939	10848	26781

SOURCE: RMOHG 1921-39.

Appendix 4.1: Vital statistics of typical clearance and improvement areas which have been carried out

	1923	1923	1923	1923	1926	1926
Area	Clyde & Piccadilly St.	Richard St. (Southside)	Richard St. (Northside)	Muse Lane	Water St.	Rose St.
Death rate all causes	30.9	31.65	24.82	22.1	25.7	32.2
Resp. Disease	6.3	7.39	6.6	5.7	5.2	10.1
Pulmonary tuberculosis	2.5	2.65	2.21	2.3	1.84	1.6
IMR	191.4	166.02	136.1	147.8	148	190
	1927	1927	1928	1928	1929	1933
Area	Coalhill St.	Rumford St.	Possil Rd.	Whitelaw St.	Calton	Garngad
Death rate all causes	24.57	24.45	24.93	20.26	22.48	28.99
Resp. Disease	6.14	6.08	5.80	4.14	4.63	7.25
Pulmonary tuberculosis	1.87	2.83	0.87	1.74	1.69	1.96
IMR	174	138	191	193	141	178

SOURCE: RMOHG 1933, p. 151.

Appendix 5.1: Age-sex distribution of mortality in Glasgow, 1921-25 and 1931-35¹³⁹⁷

	1921		1922		1923	
	Male	Female	Male	Female	Male	Female
0-4 Years	48.0 ¹³⁹⁸ (49.9)	39.6 (41.2)	62.3 (64.7)	51.5 (53.5)	42.2 (43.8)	34.4 (35.7)
5-9 Years	3.7 (3.9)	3.3 (3.4)	3.3 (3.4)	3.1 (3.3)	3.3 (3.4)	2.8 (2.9)
10-14 years	2.3 (2.4)	2.1 (2.1)	2.3 (2.4)	2.3 (2.3)	1.8 (1.8)	2.0 (2.1)
15-19 years	3.7 (3.8)	3.1 (3.2)	3.2 (3.4)	3.5 (3.6)	2.9 (3.1)	3.0 (3.1)
20-24 years	3.5 (3.6)	3.9 (4.0)	4.3 (4.5)	4.7 (4.9)	4.3 (4.5)	3.4 (3.5)
25-34 years	4.9 (5.1)	5.2 (5.4)	6.0 (6.2)	5.9 (6.1)	4.3 (4.4)	4.6 (4.8)
35-44 years	8.3 (8.6)	7.6 (7.9)	8.5 (8.8)	8.1 (8.4)	8.1 (8.4)	6.3 (6.6)
45-54 years	15.4 (16.0)	12.1 (12.6)	15.5 (16.2)	12.6 (13.1)	14.5 (15.1)	11.7 (12.2)
55-64 years	32.7 (34.0)	25.3 (26.3)	34.7 (36.1)	27.9 (29.0)	31.6 (32.8)	26.6 (27.6)
65-75 years	73.6 (76.5)	55.8 (58.0)	78.7 (81.8)	61.5 (64.0)	77.7 (80.8)	62.7 (65.1)
75+ years	172.2 (178.9)	145.0 (152.1)	186.6 (193.9)	166.0 (174.2)	165.4 (171.9)	154.4 (162.0)

	1924		1925	
	Male	Female	Male	Female
0-4 Years	54.1 (56.2)	44.7 (46.5)	42.8 (44.5)	33.5 (34.8)
5-9 Years	2.8 (2.9)	2.8 (2.9)	2.7 (2.8)	2.7 (2.8)
10-14 years	2.2 (2.3)	2.0 (2.0)	2.1 (2.2)	2.3 (2.4)
15-19 years	3.1 (3.2)	3.4 (3.5)	2.8 (2.9)	3.1 (3.2)
20-24 years	4.4 (4.5)	3.5 (3.6)	4.5 (4.7)	4.0 (4.1)
25-34 years	4.6 (4.8)	5.2 (5.4)	4.4 (4.6)	4.7 (4.9)
35-44 years	8.0 (8.3)	7.4 (7.7)	8.1 (8.4)	6.7 (7.0)
45-54 years	15.4 (16.0)	13.3 (13.8)	14.0 (14.5)	11.6 (12.1)
55-64 years	33.9 (35.2)	27.5 (28.6)	34.1 (35.5)	29.0 (30.1)
65-75 years	80.4 (83.5)	67.0 (69.7)	82.6 (85.9)	65.6 (68.2)
75+ years	199.0 (206.8)	172.4 (181.0)	192.5 (200.1)	156.7 (164.4)

¹³⁹⁷ Bold print represents instances when the age-specific death rate was greater among females.

¹³⁹⁸ These figures are based on the corrected population data published by Glasgow Corporation. The figures in brackets are based on the population data published in the 1921 census report (see chapter 3 for explanation).

	1931		1932		1933	
	Male	Female	Male	Female	Male	Female
0-4 Years	41.8	33.9	39.9	32.8	51.9	24.1
5-9 Years	3.5	2.8	3.2	2.6	2.8	2.3
10-14 years	2.1	2.1	2.3	2.2	2.3	2.0
15-19 years	3.5	3.2	3.4	3.5	3.6	2.6
20-24 years	4.1	3.6	4.0	4.0	3.6	3.6
25-34 years	4.2	4.2	4.8	5.1	4.5	4.1
35-44 years	7.8	5.8	8.2	6.5	7.4	5.6
45-54 years	13.9	10.3	14.5	10.9	14.5	9.6
55-64 years	28.2	23.0	29.3	25.4	30.3	22.9
65-75 years	72.2	53.7	71.0	55.0	73.7	55.3
75+ years	155.2	147.6	185.5	157.4	177.9	153.0

	1934		1935	
	Male	Female	Male	Female
0-4 years	37.3	28.8	32.4	25.1
5-9 years	3.1	2.6	2.1	2.3
10-14 years	2.1	2.1	1.9	2.1
15-19 years	2.3	2.7	2.8	3.0
20-24 years	3.6	3.7	3.3	3.7
25-34 years	4.6	4.0	4.4	4.4
35-44 years	7.5	5.6	7.8	6.2
45-54 years	14.2	10.4	15.0	10.8
55-64 years	29.3	23.5	30.1	25.0
65-75 years	73.8	53.5	81.2	57.5
75+ years	184.8	154.6	205.1	173.7

SOURCE: *RMOHG 1921-1935*; Census Report, City of Glasgow, 1921 and 1931; Jones, *Expectation of Life*, p. 32.

Appendix 5.2: Case rate of puerperal fever per 1,000 births in all regions mentioned by the MOH for Glasgow as working class and residential¹³⁹⁹

Working class	1927	1929	1930	1933	1934	1935	1936	1937	1938
Parkhead	*	*	*	10	*	*	*	29	*
Hutchesontown	*	*	25.5	*	18.8 (20)	*	*	*	22.9 (21)
Gorbals	*	*	17.6	17.6 (20)	22.8 (27)	27	29	25	16 (20)
Springburn	*	*	*	*	*	*	9	*	*
Whitevale	*	*	*	*	*	*	32	*	*
Calton	9.9	8.7	5	5	27	28	*	23	*
Mile-end	7.8	*	*	*	*	*	*	*	27.6
Provan	*	*	5	18 (17)	25.87 (23)	25	*	*	26.8 (28)
Shettleston and Tollcross	*	*	*	24 (20)	*	*	*	*	*
Govan	*	*	*	19.3 (17)	*	*	*	*	*
Cowcaddens	*	*	*	10	*	*	*	22	*
Dalmarnock	*	*	*	16.8 (16)	*	*	*	23	
Anderston	*	*	28.9	*	*	*	*	*	*
Yoker	*	*	*	2.4	*	*	*	*	*
Exchange	*	*	*	(1)	(4)	*	*	*	*
Residential									
Pollokshields	8.8	2.9	0	0	*	*	*	*	*
Kelvinside	*	*	5.4	6.6 (1)	30	*	30	5	*
Pollokshaws	*	*	5.9	*	10.1 (4)	*	*	5	*
Camphill	*	*	9.9	10.8 (2)	20.4 (4)	10	9	*	*
Park	*	*	37.8	*	*	*	4	*	*
Langside	9.7	*	*	0	12.5 (2)	*	*	*	0
Cathcart	*	*	*	5.2 (2)	*	8	8	5	*
Blythswood	*	*	*	47	14	*	*	22	*

SOURCE: RMOHG 1928-39.

¹³⁹⁹ Number of cases in brackets.

Appendix 5.3: Mortality rate per 1,000 births from puerperal fever in all regions mentioned by the MOH for Glasgow as working class and residential¹⁴⁰⁰

Working class	1927	1928	1929	1930	1933	1934	1935	1936	1937
Hutchesontown	*	*	*	1.8	*	3.8	*	*	*
Gorbals	*	*	*	*	*	*	6.21(7)	5.1 (6)	0
Cowcaddens	*	*	*	*	6	*	*	*	0
Dalmarnock	*	*	*	*	*	*	*	*	6.3 (5)
Springburn	*	*	*	7.8	0	*	*	*	*
Townhead	*	*	*	7.5	0	*	*	*	*
Whitevale	*	*	*	0		0	*	*	*
Exchange	*	*	*	0	6	*	*	0	*
Maryhill	*	*	*	1.7	0	0	0	*	5.3 (3)
Calton	*	4.9	1.1	1.09	1	*	*	*	*
Mile-end	*	1.3	*	1.5	*	*	0	*	0
Provan	*	*	*	1.5	*	*	*	*	3.6 (4)
Shettleston and Tollcross	*	*	*	*	*	4.3 (4)	5.8 (6)	*	(3)
Govan	*	*	*	*	0	*	*	(3)	*
Parkhead	*	*	*	*	8	(4)	*	(4)	*
Anderston	*	*	*	4.8	0	*	*	*	0
Yoker	*	*	*	*	*	0	0	*	0
Residential									
Pollokshields	2.9	*	2.9	0	0	*	8	4	0
Pollokshaws	*	*	*	*	*	*	*	*	*
Camphill	*	*	*	0	*	10	0	4	0
Langside	0	*	*	12.2	0	12	*	0	*
Park	*	*	*	10.8	10	*	0	0	11 (3)
Kelvinside	*	*	*	*	7	*	12	0	*
Cathcart	*	*	*	0	0	0	*	0	*
Blythswood	*	*	*	0	5	*	*	*	*

SOURCE: RMOHG 1928-39.

¹⁴⁰⁰ Number of cases in brackets.

Appendix 5.4: Case rate of puerperal fever per 1,000 births in residential and working class regions, 1924, 1928 and 1939

Case rate of puerperal fever per 1,000 births		1924	1928	1939
Residential	Pollokshields	18.5	8.5	15.6
	Camphill	3.4	33.2	10.6
	Langside	4.1	0	10.7
	Cathcart	5.4	4.7	14.6
	Average	7.8	11.6	12.9
Working Class	Dalmarnock	4.2	14.5	21.4
	Cowcaddens	8.5	20.4	22.1
	Hutchesontown	5.8	9.3	36.4
	Gorbals	8.9	14.8	31.0
	Average	6.9	14.7	27.7

This is a sample of weekly returns collated by the MOH for the annual reports on health in Glasgow. 1924 was chosen simply because it was the earliest date made available; 1928 because this was the year in which the case rate of puerperal fever was highest in the city; and 1939 the end of the period under review. It is noticeable in 1924 that the average rate is higher in residential areas due to an outbreak in Pollokshields, and that the individual case rates in each ward do not strikingly illustrate social inequalities in the way that other mortality data (like the death rate and IMR) do.

In 1928, the average case rate was higher among working class compared to residential areas. However, it is significant that the overwhelmingly highest rate recorded that year was in residential Camphill and that the average rate has been affected by no cases occurring in the Langside district that year. By 1939 it seems that typical class inequalities had been reinstated.

Without further examination, it is impossible to state with any accuracy conclusions regarding the class composition of the incidence of puerperal fever. Given that the two (significantly) highest case rates in 1924 and 1928 were in residential regions does certainly suggest that the relation between this disease and class is ambiguous, and that the disease was as much of a threat in residential areas as working class ones.

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Mrs. H3 (1902), Mrs. Y3 (1901)

SOHCA/009, Domestic Violence, 1995-97:¹⁴⁰¹

Ms AA (1907)	Mr AK (1920)
Ms AB (1922)	Ms AL (1907)
Ms AC (1917)	Ms AM (1910)
Ms AD (1907)	Ms AN (1907)
Mr AE (1900)	Ms AO (1916)
Ms AF (1915)	Ms AP (1919)
Ms AG (1910)	Ms AQ (1908)
Ms AH (1902)	Ms AR (1909)
Ms AI (1907)	Ms AS (1907)
Ms AJ (unknown)	Ms AT (1907)

Glasgow Museums: M74 Dig Oral History Project:
Fisher, Gerald Michael (1925)
Wilson, Christina (1918)
Wilson, Thomas (1928)

¹⁴⁰¹ The interviews detailed here are not currently catalogued although the collection number is correct. Therefore these interview codes may follow a different format when cataloguing is completed.

Glasgow Museums: 2000 Glasgow Lives Collection:

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Armstrong, William (1924)	Ellis, Mary (1917)
Baker, James (1924)	Farmer, Betty (1914)
Barden, Isa (1916)	Farmer, Marshall (1916)
Barden, Mary (1919)	Faulkner, Elsie (1922)
Black, Gertude (1912)	Gilmore, Stan (1929)
Booth, Joyce (1912)	Glen, Jean (1920)
Brown, John (1901)	Graham, Robert (1921)
Brown, Mary (1915)	Hammon, Jean (1916)
Buchanan, Jean (1909)	Havelin, Patricia (1929)
Callaghan, Margaret (1913)	Heaney, Mary (1916)
Campbell, Edmund (1924)	Hodge, Betty (1927)
Carlin, Gerald (1926)	Hodge, Robin (1926)
Carruthers, Janet (1929)	J.G. (1917)
Carwood, Mattie (1916)	Kerr, Agnes (1915)
Conroy, Helen (1918)	Lang, Katy (1913)
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