THE IMAGINED HEALTH COMMUNITY: NARRATIVES OF SCOTTISH HEALTH AND INDEPENDENCE

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INNOGEN WORKING PAPER NO. 112

AUGUST 2014

PART OF THE ESRC FUTURE OF THE UK AND SCOTLAND PROGRAMME

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1. Introduction

The goal of this paper is to situate Scotland's on-going goals in health and health research, and the current Scottish movement for independence, within the conceptual framework of imagined communities as originally theorised by Anderson (1991). The rise of Scottish nationalism is closely linked to the view that Scotland holds more communitarian attitudes to social policy than England, and that Westminster does not understand the needs and expectations of the Scottish population. The paper asks the questions: "does Scottish health and healthcare form a part of Scottish identity *vis a vis* the rest of Britain?", "how do Scots perceive health and healthcare?", and "what implications might this have on health related research?" Answers to these questions are provided based on analysis of grey literature from before, and leading up to, the foundation of Scotland's Parliament.

The imagined community of Scotland is expressed in a series of statements that indicate a "have not" status or a "have-but-denied" (i.e. not able to take advantage of) status (Beland and Lecours, 2008; Scott and Wright, 2012; Bond et al, 2013). For example, Scottish White Papers and strategic plans addressing health policy consistently indicate that Scottish health is below that of the rest of the UK, and that the challenges facing Scotland need to be addressed in a more direct manner. The health issues that have been outlined for Scotland over time have included cardiovascular and other diseases caused or exacerbated by lifestyle decisions, and research has increasingly been highlighted as part of the solution.

In government documents and White Papers regarding Scotland's health policy, research has been framed as a contributor to increased health, with NHS Scotland being the object of restructuring plans that would better capture the benefits of new health innovations. The rhetoric in the documents, however, also calls for efforts to use epidemiological and population health research to provide better data and evidence-based policy making to improve healthcare in Scotland. The emphasis of this rhetoric has been to better tailor policy and practice to match the specific needs of the Scottish population (whether policies or changes did better match these needs is beyond the scope of this paper). The emphasis on Scottish health needs since the early 1990s (and earlier) raises the question of whether these view are much different than those being expressed currently in the run-up to the independence referendum.

The remainder of this paper is divided into 5 sections. Section 2 introduces the concept of imagined communities, and how it might apply to the case of Scotland. It discusses how health, health policy and health research has been a major component of the imagining of Scotland. Section 3 reviews the grey literature, evidence from public sector white papers and strategy documents, as well as the media. Section 4 briefly discusses the implications of the societal image of Scotland, its health system and goals, and how it may be impacted by separation from the rest of the United Kingdom. Section 5 summarises the discussion and the main points of the paper.

2. Imagined Communities

Benedict Anderson introduced the concept of Imagined Communities in an "anthropological" spirit to try to explain the apparent universality of the concept of nationalism (Anderson, 1991). Anderson describes nations as *imagined* "because the

members of even the smallest nation will never know most of their fellow-members, meet them, or even hear them, yet in the minds of each lives the image of their communion," (pg. 6); *limited* "because even the largest of them, encompassing perhaps a billion human beings, has finite, if elastic, boundaries, beyond which lie other nations," (pg. 7); and as a *community* "because, regardless of the actual inequality and exploitation that may prevail in each, the nation is always conceived as a deep, horizontal comradeship" (pg. 7).

The formation of imagined communities is based on mechanisms, such as print and other media to bind the whole group (seen and unseen; comrades known or unknown) in a horizontal manner through expressions of mutual experience, which lead to a common identity. For many emerging nations, particularly in the former colonies (e.g. in the Americas) part of the common experience was a sense of being kept out of power or privilege by the central metropole (e.g. Britain or Spain) that prompted a sense of "other". In regards to Scotland, Anderson argues that although "Scotland" can be described historically in a geographic sense and through a description of its people, the internal cohesion of nationalism in Scotland was later to develop than places like the Americas. Barriers to power for Scots *vis a vis* England were not as pernicious; i.e. "Scottish politicians came south to legislate, and Scottish businessmen had open access to London's markets. In effect, in complete contrast to the Thirteen colonies (and to a lesser extent Ireland), *there were no barricades* on all these pilgrims' paths towards the centre," (Anderson, 1991; pg. 90).

The concept of imagined community regarding Scotland has been taken up explicitly by some scholars looking at the development of nationalism in Scotland. Macleod (1998) states that regions in the UK are not simply administrative units but reflect the cultural and historical experience that make up a cultural image; an image-based an economic and social processes that reflect a common history and "infused the everyday lives of its inhabitants (pg. 836)." While not using the term "nation", Macleod argues that there was an early retention of Scottish cultural autonomy and representative symbols since the 1707 union through the legal, religious and educational institutions. Macleod also notes that there were different images of Scotland and they depend on the area discussed and the economic and/or cultural emphasis of the discussants, and that these images may not always gel together. It was only more recently in the post-war era and during economic crisis that a modern Scottish image began to grow based on differences and inequalities with other regions in the UK, the discovery of oil, and increased devolution.

Just as Anderson (1991) argued that the printing press and newspaper helped to create a horizontal sense of imagined community amongst people that made up a nation, McCrone (2005) echoes this by noting the importance of media in forming a Scottish identity as it allows for a focus of the local industrial and economic news and reporting, and "helped make Scotland 'real' during the 1950s and 60s" (pg. 68). He also concludes that a large part of the Scottish identity is linked to economic factors, and arguments regarding how resources should be divided.

Beland and Lecours (2008) state that a very important factor in modern Scottish nationalism is Thatcher neoliberal policies, which were perceived as an attack on institutions important to Scotland, as well as demonstrating the inability of Scotland to stop them. They state that the Scottish national identity became associated with notions of egalitarianism and social policy preferences; for Scotland social policy is an even

more important factor than for other national identities because other identifying factors, such as language, are not as strong.

Scott and Wright (2012) argue that social justice is a crucial part of Scottish life. In the political sense, social policy can be framed as discussions of core values and fit into the language of nationalism; the Scottish National Party (SNP) uses the language of social justice to state that it can be increased through independence. Interestingly, Bond *et al* (2013) state a similar argument that nationalists saw social policy as a key part of Scotland's identity; yet they contrast this with Thatcherism, which they describe as a sort of nationalism in the sense that it was meant to recapture "the spirit of enterprise" of the British people which had been diluted by social democracy (pg. 373).

2.1. Scotland's Health and the Imagined Community

Health policy, and policy related to health research, offers an illustrative case in terms of Scotland's Imagined Community. Scott and Wright (2012) explain how this area offers an example of devolution and divergence, in that Scottish health policy has differed from that of NHS England by resisting marketisation and consumerisation; furthermore, health is an area where Scotland lags behind other European regions and has called for differences in approach to reflect Scottish needs. Busby and Martin (2006) use the case of biobanks in the British case to illustrate how such institutions, and related health policy, are impacted by how an imagined community may be perceived. Their study shows that in British cases, biobank contributions may be driven by feelings of loyalty to a *region.* Furthermore, if framed in terms of the NHS, then there are notions of insiders and outsiders, and expectations of resources to be used only for those within the "imagined community" the NHS is provided for (therefore, consider that Scotland has a devolved NHS).

This paper looks at discussions of the Scottish health system, policy and related research and how it shapes and is shaped by images of Scotland in society. To do this the paper analyses grey literature and media (i.e. newspapers). The analysis of grey literature and media reports in relation to Scottish health and health research was conducted in two stages. The first stage involved an analysis of government documents from 1993 to just after the formation of the Scottish Parliament. The documents were read in order to determine the health goals and priorities expressed by the government at the time. Explicit statements regarding research, and implications for research by references to innovation or change were also documented. Media analysis was conducted by searching for convergence of health policy, references to research and clinical trials in Scotland. The Scotsman, Glasgow Herald and Daily Record were selected over the period 1993-2005. The search terms used were Scotland, drug trials, clinical trials, sick man of Europe, devolution, health, wealth, research, NHS, attitudes. The articles that were found were compiled chronologically and then compiled according to categories based on common narratives that emerged.

The following section illustrates the different perceptions of an Imagined Scottish community and the development of health and health research to cater to the unique needs of that community, in contrast to the rest of the UK and Europe.

3. Policy Statements and Media Perceptions

3.1. Policy White Papers and Official Statements

The imagining of Scotland as a unique community in terms of healthcare and health research has not been the sole projection of the Scottish National Party's vision of an independent Scotland, or related strictly to a separatist agenda; rather it has been put forward by different governments through the Scottish Office in Westminster.

The 1991 Framework for Action by NHS Scotland sets out the need for health improvement in Scotland and a framework to address it. It notes that the level of health in Scotland is quite low relative to other European communities, and that raising awareness in the Scottish population and improving satisfaction with local health services are amongst the priorities. Some of the priorities are framed as particularly Scottish (e.g. people's behaviours and attitudes towards smoking and alcohol and diet), and the main aim seems to be structuring NHS Scotland in a way to better address its priorities without reference to the NHS in the rest of Britain. The Framework does not directly call for an explicitly Scottish Health Research agenda. The emphasis on monitoring and evaluation of health services, however, and the use of the evidence gathered in this regard to improve the Scottish health service, opens up the space for evidence-based change and the use of research (beyond the life sciences or technological realm) to create benefits for Scottish health. It also opens up a base of justification for epidemiological and public health studies.

The call for evidence upon which to build policy and public health priorities, such as healthcare in community, disability, alcohol and drug abuse, appears in the Research and Development Strategy for the NHS Scotland (1993) released by the Scottish Office. The call is for links between health and practices to be improved, and R&D investment to be justified by results. As implied in the Framework for Action, the emphasis is not on technological research alone but includes to a significant degree research that can improve policy and processes to better the health. The research base in Scotland's universities is seen as crucial, and the number of researchers operating within the medical hospital setting is seen as an advantage because of their position to better link research with medical relevance. The strategy also calls for increasing the involvement of economics, business students/scholars, and health policy researchers. The Strategy does note, however, a lack of awareness in the Scottish system of the research that exists; it states that the transfer of research to practice is problematic, implying this as another focus of change for the Scottish NHS.

In *Designed to Care: Renewing the National Health Service in Scotland* (1997), the first page notes the goal of structuring the NHS based on Scottish needs, and the Labour government's claims to have been partially elected on that basis. It also states that building an NHS on individual regional needs has been in keeping with traditions of the past, and that the current renewal would help absorb the rapid change in scientific knowledge and training available, and increase NHS Scotland's ability and resources to meet the specific needs of its community. It specifically mentions an awareness of the differences in health status between Scotland and the rest of Europe, and that a Green Paper would outline how to link NHS Scotland with other Scottish organisations in unemployment, poverty and related areas to address these factors in a more systematic manner. Again, an emphasis is placed on research methods to gauge the needs and wants of the Scottish population to shape the structures and policies of the NHS.

Towards a Healthier Scotland (1999) echoes the same tone appearing in these documents since 1993, that regardless of the research strengths that Scotland has in its universities, the key part of a health strategy and related research is for knowledge transfer and research that can better improve the actual policy and mechanisms for delivering health services. The document again emphasises not technological research but rather a more effective use of resources, and a call for the Chief Scientist Office to work with research partner to develop a public health component of research.

In *Partnership for Care* (2003), the White Paper from the Scottish Government states that health is not just a matter for the Health Department to worry about. Rather, improved health for Scotland involves addressing overall issues tied to health, community and economic well-being. Once again, *Partnership for Care* calls for evidence-based care, encouraging research and evaluation of successful healthcare practices and public health. The White Paper also explicitly calls for innovation; the call, while including facilitating the entry of new technologies, also emphasises innovation in *how* care is provided and delivered.

The grey literature, from the decade before devolution to just after the establishment of the Scottish Parliament, shows a continuing emphasis on Scotland requiring a differentiated solution to improved health and healthcare delivery. The White Papers and documents were produced by different governments in power, but they show a continuing call for attention to lifestyle diseases, such as cardiovascular disease and cancer, and the physical and mental health concerns that are related to socio-economic imbalance. In regards to research and knowledge use in health, there is a clear call for public health research, epidemiology and evidence gathering regarding healthcare delivery. The emphasis was not on looking for new drugs or therapies/technologies, but rather on areas of improvement and mechanisms to share knowledge of them.

The narratives that emerge in media coverage of Scotland's health reflect the priorities expressed in the grey literature, but go further in linking issues to particularities and peculiarities of Scotland.

3.2. Media Narrative 1: Extreme Health and Wealth Disparities Impacting Scotland's Health and Health Standing (1995 – 2001)

As put forth in the grey literature summarised above, in Scotland, poor health has been linked to inequality, with mortality and sickness rates higher among poorer sections of society. While the grey literature, policy documents and white papers reflect this to a certain extent, the discussion in the Scottish media goes further. Labelled the "sick man of Europe" (Scotsman, 2001), it has been claimed that Scotland is looking at a "survival of the richest" due to links between poverty and ill-health, and public profiles of every constituency in Scotland have painted a stark contrast of a country divided between haves and have-nots. For example, cancer rates are not consistent throughout Scotland, but reflect the wealth of an area so precisely that postcodes are used to indicate the likelihood of any individual falling ill.

Poverty and geographical location are also factors in life-expectancy – for example, young people living in poor areas of Glasgow are 2½ times more likely to die before the ages of 65 as those living in affluent areas. Despite receiving identical treatment to those in affluent areas, more than half of all women with breast cancer living in poor areas will

die. "A new-born baby leaving hospital today to go home to Drumchapel might expect to die around 7-10 years sooner than the baby in the next cot who is going home to Bearsden" (Herald, 1995). Finally, a study of 4000 men and 1551 women living north of the Clyde showed that men in the most deprived socioeconomic quarter of the population were 70% more likely to have a heart attack to men in the least deprived. In women, it was 240% more (Herald, 1999).

Tackling the problems of Scotland's health is seen to be an enormous and pressing challenge for the Scottish Parliament, with calls for a more "holistic government" following devolution that would take into account individual health, genetic inheritance, physical circumstances, social environment, person behaviour, access to money and resources. The calls for greater government attention to health and regulation have been featured in Scottish media. "Good health in individuals and communities emerges from interactions between genetic inheritance, the physical circumstances in which we grow up and then live, our social environment, personal behaviour, and, crucially, our access to money and other resources that give us control over our lives," (Glasgow Herald, 1999). Too often, policy debates have centred on one or two of these in isolation, according to commentators in the article. A more strongly "Scottish" position was put forward that states the relative decline in health in areas of deprivation and the absolute rise in death rates of younger men – date from the influence of global economic change and politically-driven social experiments that affected Scotland severely during the 1980s. At that time, many Scots blamed a physically distant and politically alien government in Westminster for many of our ills (Glasgow Herald, 1999).

The figures and evidence being highlighted in the media, included "appallingly" high death rates from lung cancer, stroke and heart disease, and Scotland being "cancer capital of the world" (Scotsman, 2001), making the link between poverty in Scotland and its health.

3.3. Media Narrative 2: Scotland is Disproportionately Sick and Unhealthy Compared to the Rest of the UK and Europe (1997 – 2005)

As the declared 'sick man of Europe', Scotland is the 'sickest place in the UK'. Cancer and heart disease are big killers in Scotland; cancer accounts for 25% of deaths, and heart disease accounts for 20% (Herald, 1997). The death rate was 11.8 per 1000 of population, putting Scotland behind Eastern European nations, such as Czech Republic, Slovakia and Poland, and on a near footing with Romania, Russia and Hungary. Birth rates fell to the lowest since the 1850s and were outnumbered by deaths by almost 5000 in 1999 (Herald, 1999).

Media highlighting Glasgow's health woes was particularly notable, citing it as 114 out of 120 authorities on the "sick list", which was based on death rates from cancer and heart disease, hospital waiting lists, hip operations and deaths from avoidable diseases, such as tuberculosis. Scotland as a whole also came out badly. The negative performance of Scotland on health indicators is noted despite the fact that it received 20% more health funding than England, based on the Barnett Formula.

Following devolution, the government launched high profile campaigns to help address Scotland's poor health record. Health promoters in Scotland ranked among the top ten advertisers in the country, spending nearly £5 million of taxpayers' money on anti-

smoking, diet, alcohol abuse, heart disease prevention and safe-sex media campaigns in 2002. The Scottish Executive spent the equivalent of double the amount of its English counterpart, equating to £1 per person in Scotland, compared to £0.50 in England. Even with some reports in 2000 that the disease rates in Scotland were falling, as people became more likely to survive heart disease and cancer, this was met with an increase in the numbers of reported drug use, stress, depression and anxiety (Daily Record, 2000).

Interestingly, the low health figures were used as arguments that criticized devolution; critics say the fight against bad diet and obesity was put back years because of devolution and the subsequent political upheaval, which caused the issues to be side-tracked (Herald, 2005). In seeming contrast, others saw these figures as a reason to offer criticism of "London Rule" (Herald, 2000).

The media coverage of Scotland's health also began highlighting possible economic side effects for the region. For example, the Daily Record (2001) reported that 100,000 Scots would "flee" by 2020 to find better health and job opportunities. While such a statement likely involved an oversimplification, it does help introduce an interesting twist on Scotland's 'have not' status. While the article predicts economic loss partially based on low health, others turn the low health status of Scotland into an opportunity.

3.4. Media Narrative 3: Scotland's Lifestyle Diseases Give it a Legacy in Clinical Trials (1995 – 2005)

According to the media, Scotland's reputation as the "cholesterol capital of the world" (the Scottish population has the highest overall cholesterol levels in the western world), the "global heart attack capital" (heart disease kills 15,000 Scots a year and 1 in 3 men) (Daily Record, 1998), and the "cancer capital of the world", meant that pharmaceutical companies are coming to Scotland to undertake drug trials "where there is no shortage of guinea pigs," (Scotsman, 1995). This has led to concerted efforts by politicians and government to use this reputation as "sick man of Europe" for economic gain by actively pursuing bids to turn Scottish cities (like Glasgow) into drug-testing centres, which would streamline previously fragmented capability. The Scotsman (2005) quoted Dr Allan Gaw, Director of Clinical Trials unit at Glasgow Royal Infirmary, in saying that:

> "What we want to do is to go to pharmaceutical companies around the world and market this expertise and bring these trials here, instead of waiting for it to come. It will bring a lot of money to the city, while also bringing improved medical care to people... We do have a high concentration of people with cancer and diabetes living in this area, but we also have doctors with a lot of practical experience of these conditions and they are working at the forefront of treatment, which is of great value to the wider world."

It also quoted Andy Kerr, member of Scottish Parliament, in stating that "an expansion of our clinical trials in Scotland will not only help improve the health of our population, but will also enhance the economic standing of our country."

Conversely, reports at this time also claimed that drug firms were 'more interested in wealth than health', (Herald, 2003) with charges that the government was putting large amounts of money into the pharmaceutical industry - which focused on creating drugs

that generate huge profits, such as statins to lower cholesterol - while neglecting the health of large groups of people (Herald, 2003). Media statements also implied that perhaps high participation in drug trials could also be contributed to factors beyond just large unhealthy populations, including lack of governmental funding for ovarian and breast cancer drugs. It was also reported that consultants in Scotland's major cancer centres – Edinburgh, Glasgow, Dundee, Aberdeen – were forced to put patients through clinical trials to gain access to new drugs, as drug firms provide free drugs to hospitals carrying out clinical trials and wherever possible patients are included (Daily Record, 2000).

3.5. Media Narrative 4: Scotland's Strong Medical Research Attracts Clinical Trials and Biotechnology Investment (1993 – 2000)

The "sick man of Europe" image of Scotland coincides with another image Scotland has held, that of a strong research centre. Media accounts describe how Scotland is specifically a leader in the biotechnology field, particularly in the detection of heart disease, drug delivery systems, cancer therapies and appetite suppressants, and cancer and human tissue therapeutics. Due to an appropriately skilled labour force in plentiful supply (with just 9% of the UK population, Scotland produces 18% of its life sciences graduates and PhDs), a breadth and depth of relevant research (all four Scottish medical schools are involved in long-term research programmes into the use of lipid based drugs), and an existing bio-medical community with a strong pharmaceutical support structure and a positive social environment (Herald, 1997). The narrative is, therefore, that Scotland offers an ideal "formula" that is fuelling investment and job creation (Herald, 1993).

As such, during the early millennium Scotland was seen as one of the most important and fastest growing clusters of companies, researchers, support services and organisations in European biotechnology. Devolution was not seen as a hindrance in the continuing success of Scotland's health related biotechnology sector, as foreign firms continued to invest in Scotland and base their companies in Scotland during this time period (Daily Record, 2000; Scotsman, 2000).

The combination of 'sick man' and strong site for research led to expressed expectations of both increased health and wealth through the attraction of industry and research to Scotland.

4. Discussion

From the 1990s to early millennium, health and healthcare have been proclaimed as policy priorities for Scotland and Scottish policymakers. In the grey literature, media coverage, and academic literature the emphasis is on *Scottish* health regardless of party or government in power. Furthermore, the emphasis is on the low health and 'lifestyle' diseases that characterise Scotland, such as cancer and cardio-vascular disease. Scottish health problems have been linked with wealth disparities in society and the need for overall health (in contrast to simply improved healthcare).

Health and healthcare are a key part of the social policy that forms part of the egalitarian image of Scotland put forward from the time of Thatcher's administration onward. The nationalist agenda, and the accepted image of Scotland as a more egalitarian society

than England was cemented during this time period as policy leaders and the electorate reacted to the Thatcher and Major government efforts that would limit the region's ability to tailor policy to its needs (Beland and Lecours, 2008). The lower level of health in Scotland was used by some to argue that Westminster-based policy was neglecting the needs of Scotland. Yet the contrary emphasis – in the grey literature analysed, its emphasis on Scotland's needs, public health and research-based policy – raises the question of whether more success would have occurred under an independent Scotland.

Jervis and Plowden (2003), for example, argue that very little changed under devolution in substantive terms. They offer a somewhat dissenting view in that they note the claim offered by Scottish nationalists of having differing community values. According to Jervis and Plowden, a lot of the evidence supports more a change in *how* policy is decided rather than substantive changes to health and healthcare policy (though they do note the greater emphasis on public health). Greer (2004) notes that both after and before devolution, Scottish health policy was determined by health and healthcare "elites" who had strong connections to research institutes and the 'ancient universities'. While these elites gained greater direct contact with policymakers after devolution, and had to work through London in the past, the substance of their role did not change. This of course raises the question of how such a role and their influence would change with greater independence.

Interestingly, within the Scottish community, social policy and the meaning of an egalitarian society has changed while remaining distinct from that of England. Beland and Lecours (2008) note, for example, that the "Scottish myth" of it being a more egalitarian society was rooted in a more hierarchical society, which in the 19th century was more liberal rather than socialist. Such a vision rested on Scotland offering an equality of *opportunity*, rather than redistribution. They cite the application of the Poor Laws in Scotland and England (enacted in 1845):

> "Scotland... had been the birthplace of the formulation of the principles of laissez-faire and a minimal state presence. These concepts had been enthusiastically sustained through the nineteenth century, notably in Scotland's fervent espousal of economic liberalism and free trade, and in a harsher application of social policy as embodied in Poor Law. In Scotland, the conditions for receipt of poor relief were *less generous than in England*, most notably in the denial of benefits to able-bodied unemployed men," (pg. 102).

One implication of this, given the contrasting views and national image put forth during the Thatcher years, is that change to the image of Scottish egalitarian society is possible, but would have to be endogenously driven. It also means that the image of Scotland put forth by the SNP may change if other parties (which may or may not exist presently) take an independent Scottish government's reins.

5. Conclusion

This paper has framed Scottish goals for improved health and health research within the context of a Scottish imagined community. After examining government grey literature, as well as media coverage regarding Scottish health from the 1990s to 2005 we see both a common theme of Scotland being a "sick man" of Europe, having unique

healthcare needs, and common policy goals to meet those needs expressed by different governments both before and after devolution.

We noted that the Labour government before devolution saw the importance of treating each region's healthcare needs as separate, recognising that a common policy may not meet the differing communities' needs adequately. We also see that the same priorities were repeated over time, and the same general concerns before and after devolution, regardless of the party in power. It is difficult to foresee whether such priorities would change under independence. The question is more why such priorities have remained, whether policy has resulted in any change in quality of health over time, whether and/how health research has contributed to change, and what changes in health policy are necessary, regardless of whether independence is achieved or not.

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