

PUSHED INTO SOCIAL EXCLUSION: ASBESTOS-RELATED DISABILITY AND RELATIVE POVERTY ON CLYDESIDE

Ronald Johnston and Arthur McIvor

This article utilises the concepts of relative poverty and social exclusion to explore industrial disability on Clydeside using oral testimony. Since the publication of Townsend's **Poverty in the UK** in 1979 there has been an on-going debate surrounding the issue of poverty in Great Britain (Townsend 1979; Pichaud 1987; Alcock 1993; Hutton in Baldwin et al 1990). Townsend's rediscovery of the existence of relative poverty in the late 20th century was achieved by surveying 2000 households and ascertaining details of amenities, fuel and light, diet, family support, etc. From this he arrived at a benchmark of 60 indicators against which deprivation could be measured. His main findings were that, despite the existence of a welfare state, the resources of a significant number of individuals fell so far below the average that they were 'excluded from ordinary living patterns, customs and activities' (in Hutton 1990; see also Mack and Lansley 1989). More recently it has been argued that poverty should incorporate factors other than just material deprivation, and Townsend's (1987) London study makes a distinction between material and social deprivation. The merits of such a methodology were quite convincingly demonstrated by the Breadline Britain research in 1983 and 1990 (Gordon and Patanzi 1997). However, poverty still remains a difficult concept to pin down. Indeed, the present-day DSS takes the view

Dr. Ronald Johnston is a Research Fellow in the Department of History, University of Strathclyde. Dr. Arthur McIvor is a Senior Lecturer in the department. This article reports upon a project, funded by the Nuffield Foundation and the Thriplow Trust, which examines the social impact of asbestos-related disease on Clydeside using oral history testimony. The authors would like to thank the two funding bodies and the University of Strathclyde for their financial support, the staff at Clydeside Action on Asbestos for their assistance, and to the anonymous referee for her/his comments on an earlier draft of this article. Most importantly, though, their sincere thanks go out to all those who volunteered to take part in the study.

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that poverty cannot be measured objectively, while the difficulty of determining 'quality of life' with any degree of accuracy - in both the medical and social spheres - has been written about at length (Fallowfield 1993; Kind 1994).

Recently, the term 'social exclusion' has been used more and more frequently to imply a depth of poverty beyond that caused by material deprivation, and is a much more useful concept. The government has recently launched an assault on social exclusion, and the initiation of the Scottish Parliament with its participatory mandate should see more focus on this important issue north of the border. Scotland's Social Exclusion Network was set up in December 1997, and there are currently 47 Social Inclusion Partnerships in place across Scotland to tackle the problem at the local level - for example the Govan Partnership has a budget of £1.375 million over three years - and a Scottish Poverty Information Unit has been initiated, funded by the Nuffield and Joseph Rowntree Foundations, which clearly distinguishes between poverty and social exclusion. There is still a problem of definition, though, and at a recent meeting of the Social Exclusion Network the question arose as to whether indicators of social exclusion should be chosen by government - in effect 'imposed' from above - or derived from the views of individuals or communities (Social Inclusion Strategy Action Team 1999). It will be argued here that only self-perception-based indicators can reveal the extent and nature of social exclusion. For the purpose of our research, then, individuals will be considered to be in social exclusion if their own testimonies reveal they are no longer able to enjoy a previously accepted living standard, or they feel isolated from the accepted social norms of their own communities.

Our prime concern is with the social effects of industrial disability, as a major omission from the poverty and social exclusion debate has been an investigation into the degree to which industrial illness was and is a causal factor. It has recently been estimated that one-in-ten British workers are incapacitated as a result of employment-related illness at a cost to the economy of £15 billion a year (Tolley 1998). Despite this, researchers have so far failed to examine this major cause of medical and social disability. For example, Alcock's **Understanding Poverty** (1993) offers a comprehensive account of the various factors underlying the problem of poverty. However, little attention is given to the fact that a significant degree of exclusion from the labour market is caused by unsafe working practices within the labour market itself. A recent publication by the Child Poverty Action Group also concedes that disability and sickness are major causes of poverty, but fails to acknowledge the importance of the workplace as a causal factor (Oppenheim and Harker 1996). Research by Hills (1995) has shown the extent to which

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low incomes shape patterns of social exclusion. A significant degree of low income across Britain, though, is caused by industrial disability, and this is especially relevant in the Scottish context where it has been argued that the working environment is more hazardous to workers' health than elsewhere in the UK (Woolfson and Beck 1999).

ASBESTOS

Our study focused upon the social effects of asbestos-related illness in the west of Scotland. Due to the heavy concentration of shipbuilding and engineering, the Clydeside region has had a long association with the use of asbestos - between 1920 and 1967 imports of the 'magic mineral' increased 30-fold, and asbestos was used across a wide swathe of Clydeside industries, such as in the building trade, shipbuilding, locomotive manufacture, and heavy engineering. As a direct consequence of this high exposure level, the Clydeside area now has one of the highest rates of asbestos-related disease in the world (Lenaghan 1991). Important research has been undertaken on the asbestos problem on Clydeside and beyond. However, there has been no attempt so far to systematically examine victims' testimony (Wikelly 1997; Gorman 1992). Only by taking such a 'bottom up' approach can the social impact of asbestos-related ill-health be accurately understood. Moreover, to make a more general point, only by using such an approach can the changing nature and extent of social exclusion in Scotland be determined with any degree of success.

The main illnesses caused by asbestos exposure are asbestosis, pleural plaques, pleural thickening, lung cancer, and mesothelioma. Asbestosis is scarring of the lungs by asbestos fibres and may take 15-30 years before any symptoms are experienced. The disease is progressive and incurable, causes pain and disablement, and may lead to heart or lung failure. Thickening of the pleura - the membrane between the lungs and the rib cage - is also caused by inhalation of asbestos dust and causes progressive breathlessness. Pleural plaques are isolated thickened areas on the pleura and can be painful and debilitating, especially where another asbestos-related disease is present. Mesothelioma was, until fairly recently, a rare form of cancer, and is almost wholly related to asbestos - 85% of sufferers having been exposed to asbestos. Mesothelioma can present up to 40 years after the victim's first exposure to asbestos, results in a high degree of pain, and normally kills the sufferer within a year of diagnosis. Between 1968 and 1991, 1020 Scots have died of this condition. Finally, lung cancer caused through exposure to asbestos is now thought to be the most significant work-related cancer in the

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world. The main difficulty, of course, is differentiating between cancer caused through cigarette smoking, and that due to asbestos. This is compounded by the fact that Scottish workers are 79% more likely to take time off work for bad health than those in the rest of the UK, and that fatalities due to cancer are currently running 10% above the UK average. Moreover, it has been estimated that cigarette smokers who have also been exposed to asbestos have 92 times more likelihood of contracting lung cancer than non-smokers (De Vos Irvine 1999).

Public awareness of the dangers of asbestos on the Clyde was first raised in the 1960s when insulating engineers - known as ladders - went on strike over fears for their safety. By 1957, six workers employed by Newall's Insulation company spraying asbestos insulation had contracted asbestosis. Ten years later the number had jumped to 53, and 14 men had died. In the early 1980s the Health and Safety Executive's (HSE) mortality study - of workers whom the HSE thought were most risk from asbestos exposure - had revealed that 183 people in the survey group had died of mesothelioma since the 1970s. However, over the same period, the NHS had given 11,000 people palliative care for this type of cancer. The focus, then, had been far too narrow, and the HSE had failed to pick up the wider health implications of industrial exposure to asbestos - amongst such diverse trades as plumbers, electricians, plasterers, welders, and insulation engineers. The interface between the occupational health service and the NHS had proved to be inadequate, to the detriment of workers' safety.

RESEARCH METHODS AND QUESTIONNAIRE RESULTS

With the assistance of the principal support group for asbestos (Clydeside Action on Asbestos) 115 individuals were targeted who had suffered industrial disability. Most of our respondents fell into two broad categories: those exposed between 1945 and 1960, and those exposed between 1960 to present. The research method comprised the initial dissemination of a short questionnaire that inquired into the extent to which industrial disability had impacted upon the lives of the respondents. The response was encouraging, and clearly illustrates the utility of a more comprehensive future study. Of the 115 questionnaires sent out, 47 were returned completed, 30 respondents agreed to be interviewed, and 23 interviews were subsequently conducted.

The first point to be made is that surprisingly few victims received adequate state benefits or succeeded in attaining any civil compensation. Only 8 of the 47 respondents (17%) stated that they were in receipt of Industrial

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Disablement Benefit - currently £104 a week; 10 (21%) received Motobility Allowance; 7 received Constant Attendance Allowance; and 22 were on Retirement Pension. Therefore, although 76% of the respondents were either retired or unemployed through ill health, only a minority of them had been compensated by Disablement Benefit. This ties in with an earlier survey conducted by Clydesde Action on Asbestos which found that only 41% of those with an asbestos-related disease were in receipt of Industrial Disablement Benefit (Lenaghan 1991). Moreover, it has been estimated that across the UK only 25% of applications for this form of benefit are successful. The principal reason for this lies in the stringency of the DSS's authorisation procedure, in which the claimant is required to undergo a chest X-ray - as opposed to the much more effective CT scan - to prove the presence of asbestosis, and ascertain the degree of pleural thickening. As a consequence of this, only 50 to 80 awards are made every year. Additionally, 35 (74%) of our respondents had made a civil claim for damages against their previous employer or employers. However, the time taken to deal with such claims is illustrated by the fact that only 4 (11%) of the survey group have been successful in their litigation, and that 30 (86%) were still awaiting court action.

Our questionnaires incorporated a section where respondents were encouraged to give additional information regarding their circumstances, and several individuals provided graphic evidence of how the economic and the social consequences of disability prohibited them from taking part in their accustomed social roles. For example, a 56 year-old lagger stated that he had to sell his house in Oxford and move back to Glasgow. He is now deeply in debt to credit card companies and his bank and cannot afford to socialise as much as he previously could¹. Another case is that of a lagger's widow who is living in a house for which the DSS is paying the interest on the mortgage while she and her mother struggle to pay the remainder (Res. A25). And the 74 year-old widow of a ship's plater was forced to move in with her daughter when her husband's illness became serious. She continues to live there at her daughter's expense now that her husband has died (Res. A26).

A common thread running through the replies to the questionnaires - and in the interviews - was that the economic and social consequences of industrial disability frequently merge to compound the problem. A 64 year-old

¹ Respondent A16. Henceforth Res. All the interviews and questionnaires are anonymous and are deposited in the Scottish Oral History Centre Archive, Strathclyde University. Reference SOHCA/016

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electrician wrote in his questionnaire: 'Up until now I thought trauma was a fad imported from America and reserved for the middle classes. I am now wiser' (Res. A13). A 69 year-old retired insurance salesman - exposed to asbestos while an apprentice fitter in the shipyards - said 'I cannot climb the smallest hill ... life has got to be lived in the slow lane with no exertions of any kind' (Res. A15). Similarly a one-time brickwork labourer wrote: 'I am unable to socialise since I have to avoid smoky atmospheres, and, in any case, I become very tired in the evenings' (Res. A7). Similar sentiments were expressed by a 67 year-old retired labourer who said: 'I am unable to decorate or do very little around the house due to a lack of puff. Also I cannot do sport, which I liked, for the same reason. I sometimes become irritable and frustrated because of this. I have also put on weight due to lack of exercise' (Res. A48). And an ex-heating engineer commented that he can no longer afford to go for a social drink and a game of snooker with his contemporaries (Res. A46).

These volunteered comments illustrate how perceptions of social exclusion vary - from being 'irritable and frustrated' over not being able to take part in sporting activities, to being unable to go for a drink with members of one's peer group. They also indicate that there is much more to the problem of industrial disability than economic hardship alone. Both these points were substantiated by the oral history interviews, and it is to this element of our study that we now turn.

ORAL HISTORY EVIDENCE: COHORT 1 1945-1960

With one exception all the interviews were conducted in the respondents' homes. A loose questionnaire format was used to ensure a uniform structure and coverage of main themes, and to avoid leading questions. However, where possible the interviewer allowed the respondents themselves to set the agenda. The principal evidence to emerge from the interviews was that the social consequences of industrial illness were as pertinent as the financial effects, and that one factor compounded the other to restrict individuals from following their accustomed lifestyles.

Several of the interviewees reported that their reduced income had no significant effect on their lives. All of these respondents, though, had passed retirement age when their industrial disability was diagnosed. A 68 year-old ships' plumber - who had first been exposed to asbestos when an apprentice in 1947 - stated that his industrial disability had not brought with it severe economic consequences. This, he maintained, was largely due to the fact that

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his wife still worked, that they had been prudent with their savings, that he had two pensions - superannuation and an old age pension - that he was in receipt of Industrial Injury Benefit, and that he had been recently granted £7000 in civil compensation (Res. A14). In the same manner, a 68 year-old retired marine engineer who recently received a £10,000 out-of-court settlement for lung damage caused by asbestos exposure over the course of his working life feels his disability does not adversely affect his life to any great extent - although he does tend to suffer more from colds and chest infections. A retired engineer also indicated that the financial effects of his asbestos-related disability were negligible (Res. A11).

These, though, were the exceptions. The majority of our sample group - indeed over 80% - have been less successful in attaining compensation for work-induced disability and complained bitterly at the treatment they had received from the DSS. A 74 year-old logger's claim for Industrial Disability Benefit was turned down by the DSS, and he had this to say:

They didnae think pleural plaque was an incapacitating disease. So the brother-in-law, he phoned up and says ... no an incapacitating disease? You want tae see this brother-in-law of mine, sitting here without a bloody breath tae draw. He gave them a few choice words ... They turn around and tell you 'Aye, you're fit enough, fit tae work.' 'Oh Jesus Christ', I said, 'I wish tae God I was.' I wish their diagnosis was correct.
(Res. A1)

Struggling to make ends meet, a 71 year-old sheet metal worker, like many damaged by the working environment, was more concerned about the impact upon his social life:

I've had no social life since about 1980. Eh, people unfortunately don't want to know you when you're, you're ill like, you know? And people stopped coming. I was very disappointed. They made the excuse that we were too far away and what have you. And we've been more or less on our own since then. Couldn't go to pubs or clubs, cinemas, anywhere where they might smoke. ... And we're more or less hermits. ... As long as I can keep that car I can get out. ... We can get down to the esplanade, or we can get down tae Arrochar or something like that. If the ground is flat I can walk. As long as it's not too cold or too warm, or the wind's not going, I can walk a reasonable, maybe a couple of hundred yards.
(Res. A9)

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For this individual, then, the degree of social exclusion is reduced by having a partner, and by the fact that they have managed to retain the means of escaping from the house for a while.

The retired ships' plumber mentioned above stated that, although his finances had not been too severely hit, his social life had changed for the worse:

See, my wife and I were great dancers. We used to love going to the dancing. Now if I dae one turn round the hall I'm bugged.

Similarly, when a 73 year-old boilermaker plater with pleural plaques was asked to describe the effect his bad health had had on his social life, one of his first reactions was to refer to the dance floor:

Well I was no a bad dancer. I liked dancing, but you cannae dae that now. I'm breathless. Even bowls ... you're puffing and panting just walking up and down. Even doing the garden. ... Even getting out of bed in the morning you're breathless. Even walking down for the papers you're breathless.

(Res. A3)

At the age of 62, three years before he was due to retire, this man had been fit enough - and competent enough at his job - to compete in the labour market and change employers. He was, therefore, looking forward to a long and active retirement. The realisation that his long working life has damaged his health adds another layer of stress to his situation.

The wife of a 73 year-old joiner who has pleural plaques elaborated on the impact that her husband's industrial disability has had on their lives:

Well, he cannae go out. He's all right sitting here. ... But if he goes somewhere he's got tae take a taxi, and he's got tae take a taxi back. ... If we're going shopping, if we go tae Asda, we've got tae take a taxi and we've got tae take a taxi back.

(Res. A8)

The constant need for taxi fares, then, was becoming a significant financial burden on the couple. However, notwithstanding this, it was the effect which his disability had had upon his and his wife's social life that caused the couple the most concern. Like the boilermaker plater above, this joiner had looked forward to a long, healthy, and active retirement. He was a life-time non-smoker and sportsman - indeed, he was fit enough at the age of 68 to restrain a hapless burglar in a double leg lock until the arrival of the police.

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However, whereas before his illness he and his wife had been 'out every night' at various clubs and functions - at which he was frequently called upon to sing - he was now practically confined to the house. Once again, then, it is the isolation from a peer group that is the main causal factor of social exclusion.

Looking beyond our own survey, at least a third of pensioners in Scotland depend solely on state pensions for their income (Scottish Local Government Information Unit 1999). Many of these individuals would have worked in occupations that have damaged their health in some way. These individuals, then, must endure social deprivation as well as economic hardship. Recent government initiatives to tackle this problem focus upon the creation of 'inclusive communities' and the breaking down of 'barriers to inclusion' (Scottish Social Inclusion Network 1999.) Our study suggests that only through interview-based research will the multi-faceted nature of these barriers be properly realised, and comprehensive inclusive strategies be initiated.

ORAL HISTORY TESTIMONY: COHORT 2, 1960-PRESENT

So far we have highlighted how those diagnosed as having an industrial disease after retirement age coped with their disability; and it would appear from their responses that the economic consequences are important, but are not the paramount concern. This is likely to be at least partly the product of reduced financial expectations. The interview evidence suggests, though, that when industrial disability strikes during working life, there is more likelihood of palpable financial disruption, as well as a severe curtailment of social activities.

For example, a 60 year-old logger's earnings suddenly dropped from £300 a week to just £65 a week; on this income he says he could no longer afford new clothes or buy household goods as often as he would like (Res. A14). A 59-year-old marine engineer had worked his way up to a consultative position when the effects of his exposure to asbestos - some 20 years earlier in the shipyards - became serious. He gave a graphic description of events when asked to describe the financial effects:

Devastating Ronnie, devastating. As I said I lived in a beautiful detached bungalow in Crookston very comfortably. My wife and I lived ... company cars, steaks all the time, used to the good life, used to a good comfortable life. From that ... I had to sell my house, get rid of my car,

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give up my job obviously because of my ill health. My wife went to stay with her parents and there was no room for me there. I had to live out of the car for several days. ... Then fortunately I found a pal who had room to put me up for three months. Financially we are up to our ears in debt. ... We now owe, and I'll say the figure, we now owe about £12,000 to the bank. ... Financially I'm crippled. ... We rob Peter to pay Paul.

When asked to comment upon the social consequences he had this to say:

Again devastating, and I'll use the word devastating. Ronnie I have gone from one extreme to another. ... I went out regularly with my mates ... used to go to parties, used to have friends round to the house. I no longer do that. I have shut myself off from life completely.

(Res. A12)

This was the same story with a 64-year-old electrician who had recently undergone a large operation for mesothelioma. He too lamented on the changes to his living patterns that his illness had brought about:

Saturday night we had two couples, we went tae the Tavern across the road, had a meal out and three, three drinks each, and a wind up.

(Res. A13)

His wife took up the story:

And we had a meal and a talk. And then they'd come back here and have a coffee and had a blether. That was fae July and we've never been out fae July. Never been out the house. We've had no social life. Nothing ... It's just been one thing after the other for 6 months ... Everything has just been crying every day. Every day. 'Cause I keep thinking back, all my thoughts are negative. I cannae see a future.

(Res. A13)

Another 60 year-old who had worked in Turner and Newall's asbestos factory in Dalmuir in the 1960s, also related how the sudden shock of his marked drop in earnings compounded the physical effects of his disability. What makes things worse for this particular family is that both husband and wife now suffer from an asbestos-related disease - she having sustained lung damage by washing her husband's overalls on a regular basis in the late 1960s:

We used to live in reasonable comfort. We're living just sort of on the poverty line I would say. It's difficult. [My wife] is very very good at

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making ends meet. We get three different lots of money. This is absolute lunacy but this is the way it goes. We get Supplementary Benefit. The second one is Industrial Injuries, and then the wee monthly pension. So the Industrial Injuries and my work's pension get taken off the Supplementary Benefit. So I've got three lots of money coming in, but it all amounts to the same as though I'm getting Supplementary Benefit.

At this point the interviewee expressed his anger at what he saw as the unfairness of the system:

And I feel a wee bit annoyed at that. 'Cause I feel I got the way I am through working for an employer; working damn hard tae earn a living. That employer did something wrong tae me and [my wife], and because I'm living below a certain limit I can only get Supplementary Benefit, so they take that off of me rather than let me have it. Now the government colluded in me getting in tae that bloody state, why should they not be paying for it?

Like the previous interviewee, this asbestos factory worker then went on to relate how his social life had been drastically curtailed by his illness:

Well the health aspect has had more impact than the financial aspect actually. The health aspect has stopped us going anywhere and daein things. We used to be running about all over Scotland. Everywhere we went we made friends. We could still dae that even though we're skint; but we cannae dae it because of the ill health.

(Res. A19)

Clearly, then, a significant degree of social exclusion, as well as economic hardship, results from industrial ill health, and this was a common problem amongst those whose working life had been curtailed by asbestos exposure. Even when in receipt of full state benefits for industrial disability - and as stated earlier this applies to only a minority of our survey group - several respondents indicated that they felt isolated and dejected through being suddenly cut off from what they view as mainstream life.

A 60 year-old heating engineer told his story:

I can go back tae 1990, I could clear, I was doing seven days, 12 hour shifts. I was working away fae home, we were taking in the region of £400 to £500 a week. And then when I was off you were taking about £48 a week. A normal year up until I stopped was maybe £17000 to

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£20000 a year. I was on £48 for six months then they put me up tae £57.
But off of the £57 they wanted rent.

As a consequence of this the respondent's living pattern had suddenly changed. Again, though, this was a result of interacting economic and social factors, as this short extract illustrates:

I cannae go any holidays, that's finished you know... You can live but you cannae go over the score ... You don't socialise with a freedom, you socialise with strings on the purse. Everything's different. When I get up in the morning I can be full of energy for a couple of hours, but in the afternoon I'm tired you know.

(Res. A6)

Similarly, a 54-year-old joiner told us that only because his wife had a part-time job were the couple able to afford some sort of social life (Res. A17). The sudden shock of having to adjust to a drop in income was also noted by a 68-year-old logger who suffered from pleural plaques (Res. A14). And the logger who had to sell his house in Oxford and move to a small flat in East Kilbride told us that his drop in income was compounded by the fact that the DSS suddenly stopped paying him the Mobility Allowance and Care Allowance upon which his severely curtailed social life had come to depend (Res. A16).

This disillusionment with the benefit system was echoed by many of our respondents. For example, a 53 year-old labourer who had been exposed to asbestos while working in the demolition industry - and is now suffering from diffuse pleural thickening - related his struggle to secure state welfare for his disability while, at the same time, trying to come to terms with its devastating medical effects. One of the most difficult aspects, he said, was the constant pressure of having to prove that his disability was severe enough to get state allowances - he had 'fought' for five years to get Motobility Allowance. He maintained that a general disagreement among health professionals over the severity of his disability seriously affected his benefit entitlement and had added significantly to the stress levels he was already having to endure:

One [doctor] will no agree with this, and then one will no agree with that, then back tae another, then another year tae wait. During that time the wife got put off on the sick ... 19 months. So all we got then was £84 for the two of us, plus our £20 pension ... It's the doctors that does it. You go tae the doctor at the Southern and they give you all the tests, and put you

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on this walking thing ... You've got tae be crippled before you can get that Mobility money you know.

(Res. A4)

Interestingly, one of our respondents, who had been diagnosed with pleural plaques, had worked with the DSS for 32 years. He was, therefore, in a position to reflect upon the system from the other side of the desk:

I think first of all the rates are ludicrous, ludicrously low. If you suffer an industrial accident and contracted a prescribed disease as they call it ... they'll examine you and say 'right, your disability is 20%.' So in 1986 you'd get £19.86 a week. If they say its 40% you'd get about £40. So I'd say its ludicrously low.

His strongest recollection, though, was of the complexities of the claim system:

I mean, I worked in there for 32 years and I'd like to I think I've got enough malum. After the first time I was knocked back by the medical appeal tribunal I was finished - and I consider myself quite a strong character. I gave up. So I'm just trying to figure out how many poor people who are probably not that *au fait* with paper work get on.

(Res. A7)

CONCLUSIONS

Several conclusions can be drawn from this oral history study of industrial disability and social exclusion in the Clydeside region. Firstly, it is clear that the unexplored correlation between industrial disability and relative poverty deserves more detailed investigation. None of our respondents had been plunged into absolute poverty by their experiences. However, the general consensus has been that the sudden drop in income has placed severe limitations on their lifestyles. Therefore, within their own frame of reference, the changed social and economic status of these individuals pushes them into Townsend's criteria of being 'excluded from ordinary living patterns, customs and activities' (Hutton, in Baldwin et al 1990).

The concept of 'social exclusion' is more useful in relation to our survey group than that of poverty or relative poverty, as it more accurately sums up the accumulative effect - and constant interplay - of the financial, physical, and emotional, factors that lie behind work-induced disability. However, the difficulty still lies in determining when and to what extent individuals and

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groups are socially excluded, as individual perceptions, family and community support networks, and coping strategies, differ widely. The recent plan by the Social Exclusion Network, then, to conduct 2700 household interviews on an annual basis is along the right lines, as such longitudinal research should make us more aware of these different perceptions - as well as giving us more information on how the workplace impacts upon health. There has also been a suggestion that a more direct experience of social exclusion would be achieved by policy-makers if selected individuals were encouraged to keep a diary and take photographs (Social Exclusion Action Team 1999). This self-perception-based 'bottom up' style of social investigation should also be encouraged. In general, though, we can conclude that based upon our definition of social exclusion - characterised by an inability to pursue previously accepted living standards; and a feeling of isolation from community and peer group - the majority of our interviewees were experiencing social exclusion. Therefore - and bearing in mind the limitations of the pilot study - we could also tentatively conclude that industrial disability is a neglected factor of social exclusion in Scotland.

The evidence provided by this study also suggests that DSS industrial compensation procedures regarding asbestos-related disease - in which the onus falls on the claimants to prove they have been affected to a significant degree by asbestos exposure - need to be re-appraised. Most respondents praised the tenacity of the pressure group Clydeside Action on Asbestos in pursuing their DSS claims. However, the fact that there is a fairly low success rate, even among Clydeside Action's own members, indicates that the system is in need of serious re-appraisal. Unfortunately, such a re-appraisal cannot be undertaken by the Scottish Parliament as the powers of the DSS and the Employment Service still remain with Westminster. This is also the case with occupational health and safety, and it is to be lamented that Scotland's new holistic approach to government has not as yet encompassed these important areas.

We would suggest that research should be done on the role of support groups in helping individuals tackle social exclusion. Our own cohort of interviewees was drawn from the membership of Clydeside Action on Asbestos, and all praised this organisation for providing invaluable assistance in dealing with the bureaucracy surrounding disability claims. This suggests, then, that similar community-based support groups could be useful in preventing economic-related social exclusion. However, there would still appear to be a need for support agencies oriented towards tackling the social isolation which sudden removal from the labour markets brings about.

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Finally, all our respondents took part in the taped interviews with great enthusiasm, and several told us that they were anxious that their testimony should be made immediately available to policy-makers. They were all very forthcoming regarding their work history, their illness, and the effect this has had upon their finances, their family lives, and their social lives. This enthusiasm on the part of the respondents to participate, and the evidence generated by our pilot study, suggests the utility of a larger project that investigates the degree to which industrial disability in general causes social exclusion within communities. More importantly, this study illustrates the worth of an oral history research method as a tool for investigating crucial contemporary social issues.

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