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Research Paper

Framing health inequalities to tell political stories: Devolution makes the difference

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Progress on health inequalities in England following the New Labour era has been undone by austerity policies, COVID-19, and the cost-of-living crisis. Meanwhile, New Labour's devolution agenda, which led to the creation of Scottish, Welsh and Northern Irish legislatures, has been followed by a longer-term focus on city-regional devolution. These devolutionary processes have provided opportunities for political actors to compare newly empowered places in various ways. By analysing policy texts and policymaker interview data from Greater Manchester Combined Authority (GMCA) and the Scottish Government (SG), this paper explores the intersection between place-based health inequalities and the place-making processes of devolution. In GMCA, health inequalities were used to emphasise difference with the nation, to 'justify devolution' and to make the case for further powers. Similar 'poor us' comparisons were prominent in Scottish policy texts shortly after devolution, but are now almost entirely absent. Instead, Scottish policy texts focus on within-Scotland inequalities: the 'poor among us'. GMCA also appears to be moving towards this focus, suggesting a pattern of health inequality policy framings closely related to broader devolutionary aims. By highlighting political incentives for attention to particular axes of health inequality, this paper provides new ways to consider policy approaches to inequality in the context of increasing devolution.

Introduction

Recent data suggest that the UK New Labour government's national health inequalities strategy for England between 1999 and 2010 was at least partially successful (Holdroyd et al. 2022). However, health inequalities in the UK have worsened since then due to economic austerity, the COVID-19 pandemic, and the cost-of-living crisis (Bambra & Marmot 2023, Walsh & McCartney 2025). In the absence of new strategies aimed directly at health inequality, recent scholarship has suggested that 'inclusive' or 'wellbeing'-based economic agendas might also achieve such aims (Shipton et al. 2021, McCartney et al. 2025).

Commonly, health inequalities are framed as comparisons to imply a distributive injustice between different groups of people: this structure has been described as a 'social comparison' framing (Bigman 2014). For example, from the statement that 'average life expectancy in Place A is 80, and in Place B is 84', the implication is that 84 is achievable, so people in Place A are unjustly losing out on four years of

life. Rather than focusing on why people in Place A are so affected, this article addresses the strategic use of this social comparison framing: why might an author choose to compare Places A and B, among the vast range of ways to group and compare people?

Liu and Niederdeppe's (2024) review of studies on social comparison framings of health disparities in the US finds that they can have negative emotional impacts on disadvantaged groups, while weakening support for policies favouring those groups. Other research has described how countries have tended to conceptualise health inequalities differently: comparing places in France, but comparing social class groups in the UK, Netherlands and Belgium, and racialised groups in the United States (Freeman 2006, Lynch 2016, Lynch & Perera 2017). These approaches necessarily mean less attention is paid to other group comparisons, such as class-based inequalities in the US, for example. This article builds on this literature of approaches to framing health inequality to consider the interaction of place-based health inequality comparisons with the place-making processes of devolution.

Successful referenda shortly after New Labour's election victory in 1997 devolved power to three centuries-old places: a Parliament with competence for health and much of social policy was granted to Scotland, and Assemblies were created for Wales and London. But a failed referendum for the vaguer notion of 'North-East England' in 2004 led to a rethink of plans for further English devolution. Eventually, Greater Manchester Combined Authority (GMCA) was created in 2011, with further 'soft devolution' arrangements over health and social care granted to the Greater Manchester Health & Social Care Partnership (GMHSCP) in 2015 (Walshe et al. 2018, p. 34). Devolution in England has broadened and deepened since then without resort to referenda: several further devolved authorities have been created, and further 'trailblazer' deals for GMCA and West Midlands Combined Authority were agreed in 2023 (Sandford 2024).

This may be considered part of a broader 'paradigm shift' within policy towards focusing on places rather than on individuals (Bentley & Pugalis 2014). Originally an urban design concept focused on the built environment, 'place-making' has come to take on multiple broader meanings, in recognition of the social, cultural and historical characteristics of communities who cherish or use particular spaces (Friedmann 2010, Lipsitz 2011). Places like Scotland, England and Wales have been shaped by centuries of ideas about culture, identity and history; partly in terms of how they differ from each other. But newer places, such as Greater Manchester (Ward et al. 2015), are contingent and changeable. As Hoole and Hincks (2020) describe, policy actors in Yorkshire competed to frame spatial-economic 'imaginaries' to align with UK central government criteria for devolution: 'South Yorkshire Mayoral Combined Authority' was born out of a competition between 'Sheffield City Region' and the Doncaster-led 'One Yorkshire'.

In this way, devolution can be seen to drive spatial differentiation; and health inequalities often describe spatial differences. This article surfaces this interplay to 'de-naturalise' presentations of policy interest in health inequality, in this UK context of place-making in response to devolution.

Materials and Methods

This research is based on case studies of two devolved sub-state polities – the Greater Manchester Combined Authority (GMCA), and the Scottish Government (SG). Further analysis at this level is important for two main reasons. First, more than 20 years ago, health inequality researchers were warning about the difficulties of navigating a 'congested state' for cross-sectoral policy challenges (Exworthy & Powell 2004) . Since then, more than twenty areas of England have agreed devolution deals, and some continue to negotiate deeper 'trailblazer' arrangements: including GMCA, on both counts. Therefore, as devolution continues apace, analysis of the interplay between devolution processes and other policy goals is increasingly important. Second, with initial data suggesting New Labour's national strategy to tackle health inequalities in England had failed, and the election of successive Conservative-led governments,

health inequality ceased to be a priority at the national level. Therefore, devolved polities with health policy competence became the main settings for policy attempts to reduce health inequalities. As these polities proliferate and gain further powers, analysis of their efforts within their own particular political and cultural contexts is essential to understanding the future prospects of the health inequality agenda.

Case Study Selection

Greater Manchester Combined Authority (GMCA) was selected as the first polity to research, alongside the Greater Manchester Health and Social Care Partnership (GMHSCP). GMCA is a combined authority comprising one elected councillor from each of the ten local authorities of Greater Manchester, and an elected mayor. It has policy authority in several social and economic policy areas of importance to health and to inequalities, such as transport, housing, and planning. A series of reports commissioned from external actors - including *The Greater Manchester Independent Inequalities Commission* (Pickett et al. 2021), and *Building Back Fairer in Greater Manchester: Health Equity and Dignified Lives* (Marmot et al 2021) – demonstrated a polity with active interest in exploring social, economic and health inequality issues. GMHSCP provided the GM-based health policy texts and actors for this research (GMHSCP became the GM Integrated Care Partnership in July 2022).

Second, the Scottish Government (SG) was chosen as a polity to research, alongside Public Health Scotland. The Scottish Government has extensive policy authority within Scotland on issues of importance to health and to inequalities, including education, transport, housing, healthcare, and some taxation powers. In 2018, it was a co-founder of the 'Wellbeing Economy Governments' group (WEGo), as it sought to understand how to incorporate wellbeing into economic policymaking. Public Health Scotland is an arms-length public health agency established in 2020 to support the Scottish Government and local authorities with public health evidence and advice.

Analysing Policy Texts

The websites of both polities were thoroughly searched for plausibly relevant policy strategy texts published in the five years between GMCA's first and second overall strategy texts (*Our People, Our Place*, and *Good Lives for All*). This period was chosen for both polities so that interviews in 2022-23 could reflect on simultaneous policy development. Initially, all texts which explicitly referred to inclusive or wellbeing economic agendas, and to health or wellbeing, at least once, were shortlisted. Sixteen GMCA and twenty-three SG texts met that criteria. To manage workload, texts making very few such references were deprioritised, such as the GM *Infrastructure Framework 2040*, and SG's *National Islands Plan*. Where multiple texts on the same policy area were available, one was prioritised on a similar basis; and only the most recent of SG's annual Programme for Government texts was selected. Ultimately, twelve GMCA and eighteen SG policy texts were chosen for analysis (see Tables 1 and 2, below).

All policy texts were read closely at least twice. Analysing framing involves critically assessing the particularities of a presented conceptualisation of an issue in its socio-political context (Chong & Druckman 2007). Frames influence beliefs and behaviours (Benford & Snow 2000, Bridger et al. 2024); so what is communicated, what is left unsaid, and what may be the strategic motivations behind preferred presentations?

Following Lynch's (2020) five key elements of a policy frame – problems, causal stories, moral judgements, attributions of responsibility, or solutions – all such descriptions related to health or wellbeing or to inequality were coded, analysed, and synthesised. For the purposes of this paper, specific descriptions of unequal health outcomes were captured in an MS Excel spreadsheet, and categorised according to the portrayed axis of inequality: who is unequal with who?

Document	Year
Our People, Our Place: The GM Strategy	2017
Children & Young People's Health and Wellbeing Framework	2018
Taking Charge: The Next 5 Years	2019
Local Industrial Strategy	2019
Housing Strategy	2019
Children and Young People's Plan	2019
GM Model for Public Services	2019
Transforming the Health of our Population	2019
Transport Strategy 2040	2021
Local Skills Report & Labour Market Plan	2021
AGMA Places for Everyone	2021
Good Lives for All: GM Strategy 2021-2031	2022

Table 1: Greater Manchester Combined Authority texts analysed

Document	Year
Mental Health Strategy 2017-2027	2017
Every Child, Every Chance: Tackling Child Poverty Delivery Plan 2018-2022	2018
No One Left Behind: Next Steps for Employability Support	2018
Public Health Priorities for Scotland	2018
National Transport Strategy	2020
Economic Recovery Implementation Plan: SG Response to Advisory Group on Economic Recovery	2020
Public Health Scotland's Strategic Plan 2020-2023	2020
Updated Climate Change Plan 2018-2032	2020
A Fairer, Greener Scotland: Programme for Government 2021-22 (Non-Health Chapters)	2021
A Fairer, Greener Scotland: Programme for Government 2021-22 (Health Chapter)	2021
Scottish Government Vision For Trade	2021
Fair Work Action Plan	2021
Social Enterprise Action Plan	2021
Public Health Scotland Delivery Plan 2021-24	2021
Housing to 2040	2021
Covid Recovery Strategy: for a fairer future	2021
Scotland 2045: Our Fourth National Planning Framework Draft	2021
Delivering Economic Prosperity: National Strategy for Economic Transformation (NSET)	2022

Table 2: Scottish Government texts analysed

Interviewing Policy Actors

Initial findings from text analysis were presented at a conference in Manchester in March 2022. Attendees with contacts within GMCA and SG then suggested potential participants to contact. Priority participants were identified based on their professional roles and interests, and snowball sampling followed from the first contacts made. Potential participants repeatedly suggested by colleagues were prioritised, as was a range of representation from relevant policy areas. Twelve interviewees in GMCA (two in health policy

teams), and twenty-two in SG (seven in health policy teams), were recruited for interview. The twenty-four social and economic policy participants worked in various teams working on equalities, economic development, skills and employment, housing, transport, spatial planning, public services, climate, and devolution teams; two participants worked in policy research. Ethical approval for interviews was granted by the University of Strathclyde's Research Ethics Committee in May 2022.

Interviews were semi-structured around a set of questions focused on conceptualisations and framing, policy text development, and policy processes. All interviews were conducted via Microsoft Teams, following participant preferences, and lasted between 45 and 88 minutes. Anonymised transcripts of interviews were analysed both deductively and inductively using NVivo. High-level categories were created to code data in relation to analysed policy texts and key themes from health inequalities literature. These were merged and modified into a final coding structure (which included the summary themes in Table 3). Extracts from interviews are tagged with site (Greater Manchester [GM] or Scotland [SCO]), participant number, and sector.

Findings

First, this section describes the axes of health inequality identified in the corpus of policy texts, how often each was used, and why this might be meaningful. Then, interview data from policymakers in GM and in Scotland is used to elaborate the reasons why some axes of health inequality are used more often than others.

Identified Axes of Health Inequality

Table 3 shows seven specific axes of health inequality found in the texts, with an illustrative example of each. This shows the various ways groups are differentiated in framings of health inequality: by socio-economic disadvantage; by place-based comparisons; by other social disadvantage; by medical vulnerability; by distant, global disadvantage; or, rarely, by local advantage.

Axis of health inequality	**Example**
General social-economic disadvantage	*Poverty and differences in income across our communities underpin the unfair differences in Scotland's health and wellbeing* (PHS Delivery Plan, p. 39)
Place-based GM/Scottish disadvantage	*Compared to the UK average we know that: Children growing up in Greater Manchester have a lower life expectancy than the national average* (GM: Children & Young People Plan, p. 4)
Place-based within GM/Scotland disadvantage	*The most deprived areas of Scotland have twice the density of shops selling cigarettes and twice the density of off-licences per person as the least deprived.* (PHS Strategic Plan, p. 31)
Social group disadvantage	*Covid has affected people's health in different ways, with higher levels of morbidity and mortality in certain groups including older people, men, disabled people, minority ethnic groups […]* (SG: Covid Recovery Strategy, p. 6)
Medical disadvantage	*The disproportionate harm caused to […] people with obesity, diabetes and respiratory disease has highlighted vulnerabilities and widened existing inequalities.* (SG: Programme for Government 21-22 (Health Chapter) p. 32)
Globalised disadvantage	*We will […] continue to support our African partner countries with their response to COVID-19 through additional supplies of medical equipment and products this year* (SG: Programme for Government 21-22 (Other Chapters) p. 14)

GM/Scotland advantage	*Overall, our cancer survival rates of 69.9% compare well nationally.* (GM: Transforming the Health of our Population, p. 28)

Table 3: Axes of health inequality found in the analysed texts

Which Axes of Health Inequality Were Most Commonly Used?

Across the GMCA corpus, the relative health disadvantage of Greater Manchester residents compared to an external other (the 'national', 'English' or 'UK' average) was conceptualised 48 times, from a total of 76 GM conceptualisations (see Figure 1, blue bars). This GM-disadvantage axis was by far the most common axis of health inequality conceptualised by GMCA.

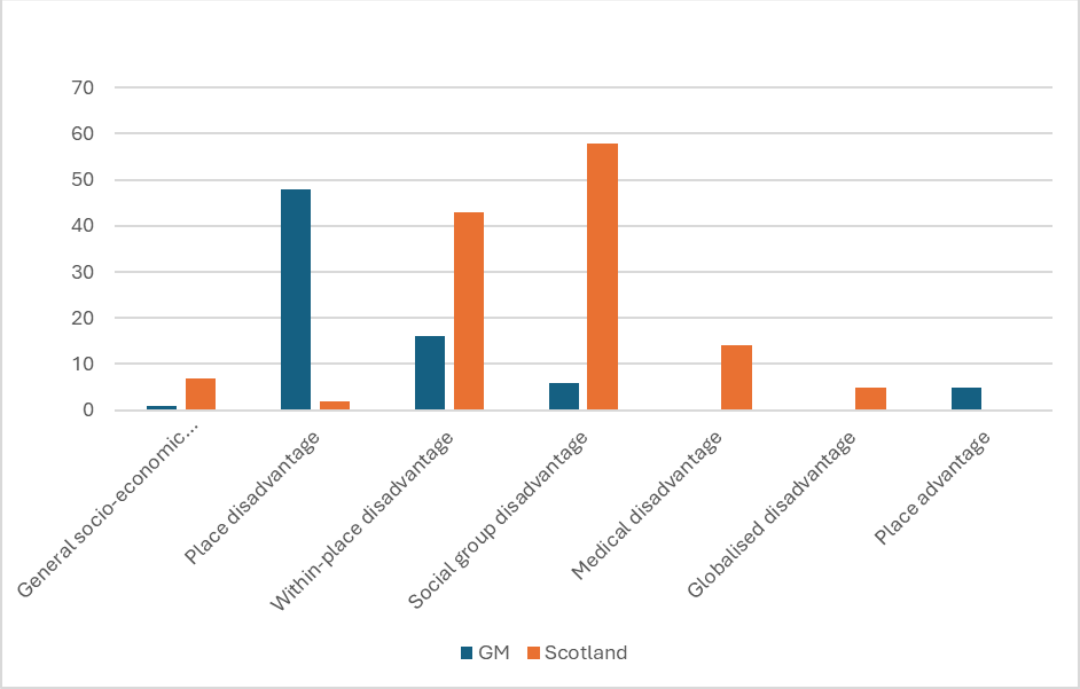

Figure 1: Axes of health inequality identified in policy texts
Notes: Y axis: Number of times each axis of health inequality identified in policy texts. Total N for GM = 76; total N for SG =129

This is potentially important because a focus on Greater Manchester health averages compared to national averages allows a policy focus on improving average health outcomes in Greater Manchester to reduce that inequality. This may appear to be a solution to the 'dual aims' dilemma: the policy strategy habit of aiming for both overall health improvements, and reductions in health inequality, despite the difficulty of achieving both within the same population (Mackenbach 2015). But this 'solution' only works to the extent that inequalities within the group are neglected: improving overall health in Greater Manchester to reduce a disadvantage compared to England nationally risks simultaneously widening inequalities between places or groups within Greater Manchester, because population-wide approaches tend to benefit more advantaged sub-groups more (McLaren et al. 2010, Adams et al. 2016).

In comparison, the health disadvantage of Scotland's residents compared to an external other is almost completely absent as a category (Figure 1, orange bars). It was found only twice, from a total of 129 specific conceptualisations of health inequality. These conceptualisations were both contained in a single sentence in Public Health Priorities for Scotland (2018) which compares Scotland's average life expectancy unfavourably with that of 'Western Europe' and 'other UK countries'. This single sentence reflects an important and well-known population health reality of excess ill-health suffering and death for Scots (Walsh et al. 2016). But no other sentence in the Scottish corpus makes such a comparison. Instead, social groups within Scotland were identified as disadvantaged 58 times, and within-Scotland place-based inequalities were conceptualised 43 times.

Greater Manchester Combined Authority: 'The Story That Gets Told Is How as a Place We Differ'

Policy documents serve as the focal point for the social process of constructing problems and proposing feasible solutions (Freeman 2006). For constructivists, exploring policy processes of 'framing' (Lynch 2020) or 'problematization' (Kriznik et al. 2018) highlights the social, cultural and political forces that shape our beliefs about societal issues such as health inequality. But places also must be framed: they must be named; they need boundaries to distinguish them; and they need logics to connect the spaces and people within those boundaries. These actions are also deeply shaped by social, cultural and political forces (Lorne & Lambert 2026). Interviews with policymakers involved in document construction help us to understand the processes behind health inequality and place framings.

In Greater Manchester, the availability of data was suggested by some participants to be an important factor in the selection of particular axes of inequality:

> When it gets down to district level, the confidence intervals are so wide that the data aren't available, and even if they were, we really wouldn't be able to use them because they wouldn't tell us anything much. So I guess that's in part why we have gone with the GM versus England thing [GMP03, Social Policy]

However, almost all social and economic policy participants offered a political reason for highlighting this axis of inequality. This suggests a widely known, cross-organisational approach that may also have applied to other framings of inequality, as well as health inequality:

> A lot of documents that we write, one of their primary purposes is persuasion of national government. So you're talking to people who don't understand, arguably don't care that much about the subtleties of the places within Greater Manchester. [GMP02, Social Policy]

> Often when we are making proposals, requests to government, it's about saying 'Greater Manchester needs greater support because we lag behind the UK average on this metric and we need to catch up'. So the story that gets told is how as a place we differ from the UK and it's often a story of, how can we contribute more to UK plc, how can we catch up? [GMP06, Social Policy]

> But I think at times and by some parties in GM it [inequalities] might be framed that way because it's a way of trying to extract more from central government [GMP08, Economic Policy]

For Hincks et al. (2017) policy actors collaborating to seek further resources is part of the process of embedding a new place. These interviewees and others each offered a similar political reason for this framing of Greater Manchester's health disadvantage: to 'persuade' or tell a 'story' vertically to the national government in London that they 'need greater support' or to 'extract' more' resources. These comparisons showing 'how as a place we differ' can be seen as forming one strand of GMCA Mayor

Andy Burnham's 'political narrative of difference' (Taylor 2020, p. 3), which included the campaign slogan 'This is Manchester, we do things differently here'. But rather than 'doing' things differently, these GMCA policy texts framed Greater Manchester as different from England in terms of poorer health in order to appeal for more resources.

Interviewees also highlighted a risk about this GM-disadvantage approach:

> So it's a different narrative from the one that I think was more dominant in Greater Manchester 10 or 15 years ago, which was more of: talk up Greater Manchester because you want investors, you want more people to come. If you give out an external message of 'this place is terrible' then why is anyone going to invest? [GMP08, Economic Policy]

This comment reports a prior approach of 'boosterism' (McCann 2013) that implies social problems such as inequality be excluded from promotional framings so as not to deter investment. A health policy interviewee discussed positively framing healthcare outcomes, which similarly appeared to be motivated by a desire to prevent the withdrawal of investment:

> I suppose it's a really fine balance […] we were four years post- signing the [devolution] deal. And there was definitely conversations about a fine line between evidencing that we'd done some stuff in that time and to justify remaining devolved because there was always the understanding it could be taken away from us at any point […] it was definitely a conscious decision around needing to showcase the wins but equally […] not wanting to say we'd fixed it all. [GMP11, Health Policy]

In this comment, the participant articulates the power dynamic between the devolved administrations of Greater Manchester and central government in Westminster that necessitates they 'showcase the wins' to reinforce support for the previous decisions of central government; and to 'justify remaining devolved' while also asking for more resources. This creates a tension between portraying statistical variations as inequalities that need further attention, or as evidence of good performance. This provides an explanation for the handful of 'GM-advantage' variations observed in the texts, such as 'our cancer survival rates of 69.9% compare well nationally':

> I think there was definitely a strategic decision made about how many wins we were going to showcase versus how much we were going to keep spinning a sob story almost about how bad it is in Greater Manchester. [GMP11, Health Policy]

Further, several social and economic policy participants claimed that GMCA's focus had moved towards more within-GM inequalities more recently. For the economic policy participant who above described the boosterism of the previous approach, the visible investment and regeneration of Manchester's city centre then provided a stark contrast to other parts of Greater Manchester.

Another economic policy participant attributed the high public profile of Burnham over several years as a facilitator of that new approach to inequalities, connecting this high profile to an increasing confidence within the organisation that its long-term future would be secure. This increasing confidence, they guessed, would manifest in an increasing focus on within-Greater Manchester inequalities later in the GMCA corpus:

> It's harder to churn an actual organisation with a political head who's got their own mandate […] you can't abolish the Scottish Government now because it's got its own independent civic identity […] My guess would be if you looked at the dates of when those [GMCA] documents were produced, you'd see a pivot over time to looking more at intra-Greater Manchester differences. I think that earlier in the last decade as you're still making the devolution case, there's quite a lot

> of 'look, Greater Manchester is different to England, we need a different set of arrangements'. And then over time the local political conversation has changed. [GMP07, Economic Policy]

This change – although perhaps not a 'pivot' – is indeed visible in the social and economic policy texts of the GMCA corpus. Across five such texts released between 2017-19, within-Greater Manchester health disadvantage is only described twice, while GM health disadvantage is described ten times; but in four texts released between 2021 and 2022, within-GM health disadvantage is found four times, compared to six occurrences of GM health disadvantage. Therefore, the health disadvantage of Greater Manchester residents compared to external others remained the more common framing, but only slightly, as its use decreased while the use of within-GM health disadvantage increased.

A social policy participant also described the change in 'local political conversation':

> Those variations within GM resonate much more strongly with the ten leaders of the districts, the people that live here, you know, 'I don't care how we're doing against London, how am I doing against my neighbour?', is much more relevant […] I think there is that movement in terms of how we're using information to tell a story because we're talking to different people and we're trying to tell a slightly different story. [GMP01, Social Policy]

Therefore, according to these accounts, the increasing visibility of local economic inequality, and growing confidence in the long-term establishment of the organisation, led to changes in the people talked to, the conversations had, and the story to be told in Greater Manchester: from a focus on 'poor us', to an additional interest in the 'poor among us'.

Scottish Government: No Longer Checking the 'Health League Table'

The almost complete absence of Scotland-disadvantage from the corpus of policy texts is interesting because of the long-term reputation of Scotland as 'the sick man of Europe' (McCartney et al. 2012) and the persistence of multiple poor health outcomes in comparison to the rest of the UK (Finch et al. 2023). Scotland-disadvantage framings are very prominent in policy texts from early in the post-devolution period: for example, the third sentence of New Labour's first green paper on health in Scotland (Scottish Office & Department of Health 1998) says 'It is about respect, self-confidence and the firm belief that Scotland need not remain trapped at the foot of the health league'; and a large pull-quote on page one of the subsequent white paper (Scottish Office & Department of Health 1999) says 'Our position at or near the top of the international "league tables" of the major diseases of the developed world […] is unacceptable and largely preventable'. Therefore, in the early years of political devolution, this framing appeared to be a key part of the scene-setting of Scottish health policy strategy texts.

Therefore, in contrast to Greater Manchester, the well-known inequality of Scotland compared to external others no longer appears to be serving as a motivator for the Scottish Government to focus on improving Scotland's overall health. Participants in Scotland offered no reasons for this difference. Instead, several spoke about a new cross-departmental focus on place-based disadvantage within the country. This was the most common single axis of health inequality identified across the Scottish texts – with 43 health inequalities conceptualised in this way – while 58 disadvantages were identified for different types of social group.

A variety of reasons were given for this focus. As in GM, one participant highlighted data availability as a reason for the place-based focus. Another participant associated a new focus on places with Brexit and the subsequent 'Levelling Up' agenda at UK national level, which they linked to the particular issue of depopulation in Scottish rural areas:

> So I think that sort of population issue also has that geographical element in terms of rural areas, and rural economies or islands are really significant parts of the Scottish economy. [SCOP04, Economic Policy]

Participants involved in Scotland's 'Tackling Child Poverty' agenda were particularly interested in a place-based approach, and had created a 'Place-Based Social Justice' team to lead small-scale community-based pilot projects to improve access to services and mitigate some of the impacts of poverty. For three more participants, place was the new focus because it represented how people experienced inequality, through local services and their physical and social environments:

> At the end of the day, you and me interact with our public services through our neighbourhoods and communities and the places we live… our whole experience is through the places in which we live and that's where we need to think about. [SCOP17, Health Policy]

To follow the logic of GM participant GMP07 quoted above, the lack of coverage of Scottish disadvantage may reflect that the Scottish Government no longer has to 'make the devolution case', and very much has its own civic identity, so it should have more confidence to focus on internal inequalities, rather than those in comparison to England or European countries.

While the Scottish Government no longer has to advocate for devolution, the Scottish National Party's (SNP) long-term leadership, and its ambition for Scottish independence, may impact on the extent to which it wishes to highlight Scotland's poor health. This may be what a senior Scottish civil servant in Blackman et al. (2009) implied by explaining that comparing health gaps with the UK or England 'would not be acceptable to a Scottish government'. Similarly, policy text analysis and interviews in Belgium led Lynch (2016) to conclude that emphasising the health disadvantage of Wallonia residents compared to those of Flanders risked highlighting failures of regional devolution. This may be transferable to the Scottish context: highlighting the health disadvantage of Scottish residents compared to those of England may strengthen perceptions of failure around the SNP and of devolution more generally.

Discussion

In this paper, I have described contrasting representations of health inequality by two devolved UK polities. On one hand, the newly devolved Greater Manchester Combined Authority emphasised its poorer health outcomes compared to the English national average. According to Lui and Niederdeppe's (2024) review of social comparison framings, these 'upward' comparisons may have risked creating negative emotional impacts among Greater Manchester residents. On the other hand, the long-devolved Scottish Government almost entirely ignored Scotland's poorer health outcomes compared to England. This may have been to avoid such negative emotional impacts, and their political weaponisation. This paper shows how social comparison framings of health inequality which imply a distributive social injustice are also deeply linked to broader political aims regarding institutional power and place-making.

Devolution Makes the Difference in Greater Manchester: 'From the Bottom-Up'

The process of distinction between Greater Manchester and England, the identity-building of the 'mental construct called Greater Manchester', has emerged over fewer than 40 years (Harding & Peake-Jones 2023, p. 12). Following decades of stable leadership and collaboration among neighbouring local authorities, 'Greater Manchester' appears to have stable footing as it moves towards hegemony (Haughton et al. 2016, Kenealy 2016).

Therefore, the question is whether the deepening establishment of Greater Manchester as a spatial-economic imaginary, and of GMCA as its corollary political institution, will lead to a long-term focus on

GM-disadvantage to embed the differentiation with England; or to within-GM inequalities, to maintain the support of local policy actors, particularly those representing more deprived areas. There is reason to suspect both axes of health inequality shall remain important for the foreseeable future, and a balance shall have to be sought as new narratives and conversations develop to shape political agendas.

In this context, the commissioning of both a health inequality strategy in *Building Back Fairer in Greater Manchester* (Marmot et al. 2021) and an Independent Inequalities Commission report (Pickett et al. 2021) signals a strong interest in tackling inequality to the largely pro-Labour Greater Manchester electorate, despite GMCA's highly limited levers. It also fits with Mayor Burnham's narrative of difference with national government. An important part of that narrative is that national government is siloed and out-of-touch, while Burnham's GMCA is unified and collaborative, as he explained in a speech after commissioning Marmot's Greater Manchester work:

> Back in February 2010, I received the Marmot Review into health inequalities. Even if I had remained Health Secretary long enough to agree to full implementation, I wouldn't have been able to do it. As the review itself acknowledged, many of the policies that would determine people's health were not in the control of the Department of Health. Implementing the review's recommendations[…] would have required the full buy-in of the entire Whitehall machine. Knowing that world as I do, I am confident in saying that it would never have come. Whitehall departments like nothing more than fighting turf wars. Instead, we have a much better chance of implementing the Marmot Review from the bottom-up rather than top-down. (Burnham 2018)

Early evidence suggests that GMCA's approach is both reducing GM's life expectancy disadvantage compared to England, and increasing life expectancy faster in more deprived areas, driven by improvements to healthcare services and to social determinants of health (Britteon et al. 2024). These studies compare a range of outcomes before and following devolution but before the COVID-19 pandemic and the Marmot and Pickett reviews. Burnham's promotion of a 'bottom-up' approach is supported by Britteon et al.'s observation that 'Changes in life expectancy [suggest] that devolution may have had a redistributive effect at the regional level, potentially enabled by greater collaboration through a bottom-up system wide approach (2024, p. 12). Such findings could be used to make a case for other devolved city-regions to take similar approaches to health inequalities, particularly if they wish to both differentiate themselves from national government, and coalesce support for their new spatial-economic imaginaries (Ayres et al. 2025).

Devolution Makes the Difference in Scotland: 'Don't Say We Have Got a Problem'

In contrast to Greater Manchester, processes of distinction between Scotland and England have extended through hundreds of years of debate, several battles or wars, different languages, a separate legal system and more. Distinctions between Scotland and England remain key to Scotland's national identity (McCrone 2002). Indeed, Mitchell (2005, p. 23) describes Scottish devolution as the outcome of a mobilisation against the 'other' of Thatcherism; and Reicher et al. (2009) found experimentally that Scots minimise racism in comparison to England, but not in comparison to Scandinavian countries: 'When measured against the English, the attitude seems to be "they have got a problem, don't say we have got a problem"' (2009, p. 31). For Spence (2024), media representations of Scotland's long-term health disadvantage compared to England – sometimes known as the 'Scottish effect', or more specifically 'the Glasgow effect' – show a tendency to link Scotland's excess ill-health suffering and death to stereotypes about national character or culture.

In this context, the near-total lack of reference to Scotland's long-term health disadvantage in the policy texts analysed constitutes a significant negative result, especially in comparison to its prominent role in early devolution-era texts. Then, Scotland's uniquely poor health was part of the argument for the additional powers of a Scottish Parliament, just as Greater Manchester's poor health was used as an

argument for additional powers in GMCA's earlier texts. Now, twenty years after Scottish devolution, highlighting this reality could function as an argument against taking the further step of independence. To borrow Reicher et al.'s (2009) characterisation of the in-group attitude to unflattering comparisons to the out-group: 'don't say we have got a problem'.

One form of Scottish health disadvantage was subtly present in a particular and distinct form: the health chapter of the *Programme for Government 21-22* conveys a sense of urgency and priority in its description of the 'national disgrace' of the 'drugs death emergency' (p28). Scotland's drug death rate has long been significantly worse than that of many other countries, including England's (EMCDDA 2021). One Scottish Government health participant described 'Scotland's drug death crisis' in reference to whole population statistics: 'where that inequality comes through at catastrophic levels, levels that are so bad amongst a very small cohort, that they impact on our life expectancy and healthy life expectancy statistics' [SCOP07, Health Policy]. But no other interviewee connected drug deaths with health inequality.

Why might the 'drug deaths emergency' have taken on such political prioritisation, while the nationwide health disadvantage is ignored in the policy texts analysed? Part of the reason may be that drug policy is not entirely devolved to the Scottish Government, while health policy is devolved. Therefore, highlighting an 'emergency' involving inadequate Westminster drug policy helps make a case for independence (e.g., Garavelli 2020, Harrison 2023). On the other hand, highlighting a 'health' emergency may encourage an argument for Scottish Government incompetence or the failure of devolution itself (e.g., McLaren 2023). In this way, the 'emergency' or 'crisis' narrative is able to overshadow the narrative of longstanding inequality (Lauber et al. 2025).

A further, pragmatic explanation may also apply. One Scottish participant closely involved in policy approaches to health inequality said: 'I think that there's been a realisation that certain communities are disproportionately affected, so the efforts need to be focused or skewed towards that'. While not specifically identifying drug users, it is arguable that this community may be the worst affected by social injustice. More than 200,000 Scots have experienced two of the three severe and multiple disadvantages – substance dependence (including drug use), homelessness, or offending – and report very high levels of traumatic or disruptive childhood experiences (Bramley et al. 2019). More specifically, drug-related deaths are eighteen-times higher in the most deprived areas of Scotland than the least deprived (Finch et al. 2023). Their health does not represent Scotland's health overall; their health is among the poorest of the population. Therefore, a policy focus on drug deaths arguably focuses on the individuals who have suffered the most severe social, economic and health disadvantages of all.

Seen in this way, Scotland and Greater Manchester may be following similar post-devolution paths in their framings of health inequality: from the early days of 'poor us' stories which serve to differentiate the new place, justify its creation, and argue for more resources; to an additional focus on the 'poor among us', after devolution is embedded and attention turns to internal political imperatives.

Conclusion

This research has surfaced a function of health inequality framings beyond that of describing a straightforward measurement of social injustice. There are many ways in which individuals may be grouped and then compared with other groups; these choices may often be politically meaningful. In GM, health inequalities were framed to 'justify remaining devolved' and to appeal for further resources. GMCA Mayor Andy Burnham had campaigned for devolution as a means of 'doing things differently'; but this emphasis of differentiation related to poorer health across Greater Manchester. GMCA participants suggested – with support from text analysis – that increasing confidence in devolution was allowing attention to turn to within-GM inequalities: a framing shift from 'poor us' to the 'poor among us'.

In contrast, the longstanding excess illness and death in Scotland compared to external others was almost completely ignored in policy texts, and not explained by participants in this research. This appeared markedly different from the early days of Scottish devolution, when Scotland's particularly poor health was prominently discussed in policy texts. Exceptionally, the Scottish Government has prioritised one specific health disadvantage compared to England: the 'drug deaths emergency'. This analysis suggests that, as a 'drugs' issue, it can be mobilised in support of claims for national independence, while a 'health' comparison with England appears to remain politically dangerous.

There are two main implications of this paper. First, it invites further analysis of the interplay between devolutionary processes and policy approaches to health inequality, given the evidence of improving outcomes in Greater Manchester, and the continuing expansion of devolution to regions across England. Can policy lessons be learned from GMCA's approach and applied to newer city-regions, or to the broader national project in Scotland? Second, by highlighting the political incentives to emphasise or downplay particular axes of health inequality, this paper challenges persistent assumptions about the evidence-led basis of public health policy. Place-based health inequalities reflect place-based inequalities more generally, and are therefore profoundly political. Surfacing the political stories shaped by these health inequality framings helps us to think deeper about how best to target and reduce systematic and avoidable suffering.

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