



03 Looking back:

findings and recommendations from the *Health in London* report series 2002–2005

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In this section . . .

Key findings from previous *Health in London* reports are summarised in relation to:

- geographical inequalities
- disabled people
- black and minority ethnic communities
- children and young people

Implications for action identified in previous *Health in London* reports are summarised:

- Improving data and information on diverse and disadvantaged communities
- Evidence-based policy and practice
- Specific recommended research
- Supporting action to achieve change
- Community involvement

Summary of findings from previous *Health in London* reports

The following section reviews key findings against each of the ten high-level indicators that *Health in London* reports have focused on since 2002. All reports in the 2002 to 2005 series highlighted that in relation to these indicators, London as a whole does not stand out as significantly different from other UK regions, but that the overall picture masks significant inequalities within London. Looking at patterns across the indicators, as well as performance on each individual measure, shows that there continue to be:

- significant health inequalities affecting different geographical communities
- significant health inequalities affecting different groups in London; priority groups identified by LHC partners are disabled people (*Health in London*, 2003), black, Asian and minority ethnic communities (*Health in London*, 2004), and children and young people (*Health in London*, 2005)
- a number of important areas where there are gaps in data and information.

Findings on these aspects of health inequality in London are summarised below, with reference (by date) back to the specific *Health in London* report where each finding was reported in more detail. Gaps in information relating to different groups are referred to in the text below, and, in addition, previous reports highlighted gaps related to the individual indicators, including the limited availability of:

- research into the effects of air quality on different communities
- information on road injury or death related to disability or ethnicity
- information on self-reported good health for specific population groups

- borough-level data on several health issues.

Geographical inequalities

On standardised good health ratios from the 2001 Census, London fared better than England as a whole, with approximately 3% more people reporting their health as good (2004). The proportion of people in London aged 15 to 19 years; who reported their health as good, was slightly higher than the proportion in England. For the younger age group (10 to 14 years), the proportion reporting good health in London was similar to but slightly lower than the proportion nationally.

All indicators showed substantial variations in current levels and rates between London boroughs, and those that fared badly on one indicator also tended to fare badly on others (2003). Teenage conception rates in London boroughs ranged from the lowest in England to the highest, and the rates varied both between and within boroughs (2005).

Previous reports demonstrated an ongoing divide between inner and outer London on many issues. For example, the 2005 report showed that children's risks of being in a workless household were far greater in inner London, and the proportions of children living in overcrowded housing were significantly higher in inner London than in outer London. The proportion of young people not in full-time education or employment tended to be lower in outer London boroughs (2005).

Disabled people

The 2003 report focused on the experience of disabled Londoners in relation to the determinants of health, and found that

they fared worse on all the *Health in London* indicators for which relevant information was available. However, the report identified several areas in which data sources did not include reference to impairment or illness, and a trawl of wider sources was included in this report, which reinforced the impression that disabled people tended to fare worse than other Londoners on a range of issues related to health.

The 2003 report highlighted that disabled Londoners had an unemployment rate nearly twice as high as that of non-disabled people, and that the position of disabled people in the labour market had deteriorated between 1979 and 1997. Rates varied widely for people with different types of impairment or illness, with unemployment being especially high among people with learning impairments and mental health issues. Twenty-eight per cent of disabled Londoners wanted to work but did not have a job, compared with 11 % of non-disabled Londoners. Those disabled people in employment were more likely to be in part-time employment and to earn considerably less than equivalent non-disabled workers at each level of educational attainment.

There was a lack of relevant information on many of the other high-level indicators, but consideration of information from a range of sources highlighted the following:

- despite the lack of routine information about the educational experience and achievements of disabled children, one survey showed that 40% of disabled people felt that teachers had underestimated their ability
- about one in five children in London's schools had been assessed as having

special educational needs, and there was wide variation between boroughs in the extent to which they placed these children in mainstream or so-called special schools

- despite limited information about disabled people's housing needs and access to appropriate housing options, some surveys showed that many disabled people were living in unsuitable housing and experienced dissatisfaction with their accommodation
- there had been little research on disabled people's experience of crime, but those studies that had been done highlighted the impact that fear of crime has on some disabled people
- records of household crimes do not include information about disabled people, but information on personal crime showed that twice as many disabled people as non-disabled people experienced violent crime in London during 2001/02.

Black, Asian and minority ethnic communities

All previous *Health in London* reports demonstrated the occurrence of inequalities between ethnic groups across the high-level indicators, and the 2004 report had a more detailed focus on black and minority ethnic communities. The previous reports showed that most black and minority ethnic groups fared worse on all the indicators for which data are available: unemployment; education; burglary; unfit housing; and road casualties (2002, 2003, 2004); domestic burglary; road casualties; and self-assessed health status (2004). In particular, ethnic inequalities in the unemployment rate were very persistent.

Past reports also highlighted exceptions to this general picture of health inequalities in black and minority ethnic communities. For example, some Asian groups had the best educational attainment outcomes (2003). There was evidence that British-born people from ethnic minorities had made progress in terms of earnings and access to professional/managerial jobs, and there had been a steady rise in the employment rate of women in non-white groups (2004).

Past reports also found wide variations across different black and minority ethnic groups on the individual indicators including:

- self-assessed health: the percentage who reported their health as not good (in the 2001 Census) was highest in the Asian British, Bangladeshi and Pakistani groups and high in the Indian and Black Caribbean groups; while White British, Black African and Chinese groups had some of the lowest percentages of people who reported their health was not good (2005)
- self-assessed health reported by young people also varied, with Black Africans the most positive about their health followed by Indians, and Black Caribbean and Black Other young people less positive about their health (2005)
- the risk of crime in Britain was highest for Pakistanis who were also the group most susceptible to racially motivated crime, and all ethnic minorities were at substantially increased risk of burglary, vehicle crime and street crime (2004)
- children from ethnic minority backgrounds were at substantially greater risk of pedestrian road casualties – for example, the pedestrian casualty rate for African-Caribbean

children in London was more than double that of the next highest ethnic group (2004)

- indicators measuring employment showed that 11% of Indian children lived in ‘workless’ households, compared with 20% of white children and 49% of children of mixed white and black backgrounds (2005)
- some ethnic groups were more likely to experience overcrowding in housing than others, with Bangladeshi households more than five times more likely than White British households to be overcrowded and over half of Black African households, two-fifths of Other Black households, and 38% of Pakistani households living in overcrowded conditions (2005)
- there were major differences in the educational attainment of different ethnic groups, and GCSE attainment was below average for most non-white minorities, especially Black Caribbeans, with Pakistanis, Bangladeshis and Black Africans having ‘intermediate results’, and Indian and Chinese children performing well above average.

Children and young people

The 2005 *Health in London* report focused on children and young people’s health and related issues, and found that:

- the proportion of people aged 15 to 19 years who reported their health as good was slightly higher in London than in England, but for the younger age group (10 to 14 years) the proportion reporting good health in London was slightly lower than the proportion nationally
- children in London aged 5 to 10 years had similar levels of mental health problems to children elsewhere in the country. However, overall rates of mental disorder among children aged

5 to 15 years were higher in inner London than elsewhere in the UK, and were particularly high for boys aged 11 to 15 years. Rates of mental health disorders were higher among boys than girls in London, with rates among 11 to 15 year-olds more than twice as high

- in relation to broader determinants of health, the 2005 report showed that 28.5% of all dependent children in London were living in overcrowded conditions in 2001, compared with the England and Wales average of 12.3%. About 24% of dependent children in London lived in households where no adults were in employment, compared with 18% nationally
- when it came to individual health behaviour, the picture in London was variable. Children and young people in London had the highest fruit and vegetable consumption of any English region in 2002. Young Londoners reported lower levels of alcohol consumption than young people in other regions, and were considerably more likely to report that they never drink. However, rates of illicit drug use in London remain consistently higher than in other regions in England and Wales, and diagnoses of sexually transmitted infections in London were continuing to rise, with rates for several infections being significantly higher than elsewhere in England.

Implications for action identified in previous Health in London reports

The last four *Health in London* reports (2002–2005) presented key information on health outcomes, health inequalities and their wider determinants in London. They offered recommendations for how LHC partners and other regional or local agencies could work, both individually and together, to increase their impact on health inequalities. The recommendations are summarised on the next two pages .

Improving data and information on diverse and disadvantaged communities

- Continue to monitor trends related to the health of Londoners.
- Use, and promote the use of, high-level indicators to provide an overview of health and health inequalities, and to monitor health outcomes at regional and local levels.
- More detailed profiling of health inequalities at local level.
- Take measures to increase the use of comparable data sources and formats by a range of organisations across London – including boroughs, PCTs and other local agencies.
- Make better use of existing information on ethnicity, disability and other dimensions of inequality.
- Improve collection of data and information on the determinants of health and health outcomes for ethnicity and for disabled people.
- Ethnic categories should be refined as much as possible by those collecting information for research and service planning. The new educational statistics have demonstrated the inadequacy of broad categories like 'black' and 'Asian'. Further refinement is needed at local level, to establish the needs, for example, of the Turkish Cypriot and Somali communities in London.
- Information about service users should be routinely recorded, shared and used in order to increase understanding of local people's health, along with their access to services that impact on health, and to plan for improved services.
- Better links need to be established between qualitative and statistical information, at Londonwide and local level.
- Better use should be made of community intelligence.
- Identify the barriers that prevent people in the voluntary and statutory sectors from accessing and using these data when planning work on health inequalities.
- Quantify the need for, and availability of, housing that meets the needs of disabled Londoners.

Evidence-based policy and practice

- Promote/undertake research to increase our understanding of how different factors, such as socio-economic standing, gender, ethnicity, faith and disability, interact to determine the health status of groups within wider communities.
- Monitor and evaluate the effectiveness of interventions.
- Support work to identify what works in improving determinants of health, and why the experience of some groups and/or certain areas seems better or worse than others' experience in London.
- Promote and facilitate sharing of learning across London.
- Ensure that good use is made of the expertise and commitment to be found in London.

Specific recommended research

- Examine further – perhaps initially through small-area research – self-assessed health and individuals' perceptions of quality of life.
- The health needs of more recently arrived communities, whose needs were not

identified in earlier studies (such as some African communities).

- The effects of parental background and generation on the labour market achievement of ethnic minorities; generation (1st, 2nd etc) and age should be considered together.
- The effects of economic disadvantage on the educational attainment of ethnic minorities.
- Interventions to reduce road injuries and deaths.

Supporting action to achieve change

- Increase awareness of the impact of the various determinants on health across relevant audiences.
- Increase awareness of the role of different organisations and sectors in improving health and reducing health inequalities.
- Promote a more systematic approach to understanding and tackling health inequalities.
- Promote/take action to tackle health inequalities, which takes into account a range of determinants, rather than attempting to deal with individual factors in isolation, or focusing too narrowly on individual lifestyle factors.
- Contribute to the development and delivery of regional and national programmes to reduce health inequalities and improve health and wellbeing.
- Joint planning and partnership working between organisations and sectors.
- Secure/facilitate targeted support for some of London's most deprived communities, including supporting area-based initiatives.
- Use race equality schemes (a requirement placed upon many public sector organisations by the Race Relations (Amendment) Act 2000) as a driver to underpin the new 'duty to promote racial equality'.
- Use the Disability Discrimination Act (2005) at all levels as a driver to focus on health inequalities and disability, and to address the needs of disabled people more effectively.
- Promote the social model of disability so it becomes more widely known and used to challenge policies and practice that discriminate against disabled Londoners.
- Improve access to and quality of language support services.
- Identify and promote understanding of the barriers to employment for disadvantaged communities.
- Use of new and existing tools and national, regional and local planning mechanisms, including health scrutiny, HIA, Health Equity Audit (HEA) and Best Value Reviews (BVRs), *Every Child Matters: change for children* (HM Government, 2004), *National Service Framework for Children, Young People and Maternity Services* (Department of Health and Department for Education and Skills, 2004) etc, and their use of equalities information.

Community involvement

- Work with London's diverse and disadvantaged communities to identify priorities for action, using their own experience and expertise in dealing with health issues.
- Community involvement.
- Listen effectively to children, young people and parents.

