

Section 1

Key findings and recommendations

In this section ...

- ▶ key messages are identified
- ▶ recommendations are made.

Overview

- ▶ What factors affect people's health, and how?
- ▶ Are these factors changing? – and for better or worse?
- ▶ Do the factors affect everyone in the same way?

This report sets out to answer questions of this kind for London in the period from spring 2000 until the winter of 2001.

It takes as its focus ten high-level indicators developed as part of the London Health Strategy (see page 6). Listed below, the indicators are used to:

- ▶ measure changes over time
- ▶ highlight inequalities among different areas and groups in London, and between London and elsewhere.

London Health Strategy – high-level indicators

- ▶ Unemployment rate
- ▶ Unemployment rate among black and minority ethnic people
- ▶ Percentage of pupils achieving five GCSE grades A*–C
- ▶ Proportion of homes judged unfit to live in
- ▶ Burglary rate per 1000 resident population
- ▶ Air quality indicators – NO₂ and PM₁₀
- ▶ Road traffic casualty rate per 1000 resident population
- ▶ Life expectancy at birth
- ▶ Infant mortality rate
- ▶ Proportion of people with self-assessed fair, poor or bad health

Key findings

The report contains detailed findings for each of the ten indicators. These are described in Section 3.

This section summarises key messages about factors affecting health in London – and, in particular, those factors that relate to inequalities in health. See Section 4 for more detailed discussion of the issues involved.

Ethnicity

- ▶ Non-white groups fare worse on all the indicators for which data are available – unemployment, education, burglary, unfit housing and road casualties – although Indian and ‘other Asian’ pupils have the highest educational attainment.
- ▶ In several ways, Bangladeshi people are the most deprived of all the ethnic groups, with very high levels of unemployment, the worst housing conditions and (along with Pakistani people) the least educational success. This has been a persistent issue throughout the last decade.

Age

- ▶ Age is a major element in health inequality for two reasons:
 - Physical and mental factors: certain age groups are particularly vulnerable to diseases or accidents. For example, old people and young children suffer most from the effects of poor air quality.
 - Socioeconomic factors: people’s living conditions change as they move through the life cycle. Deprivation is not a static phenomenon; people move in and out of it. The most vulnerable groups are elderly people and young adults.
- ▶ The effects of age may be compounded by those of ethnicity and social class. An example is the high unemployment rate of young black and Asian people. The health of elderly people in the minority ethnic groups is a phenomenon of growing importance, as the number of ethnic minority pensioners rises. This will be an important issue for Bangladeshi people, who currently have a relatively young age profile.

Social class

- ▶ The high unemployment and low educational attainment of young working-class men, especially in social classes IV and V, may have health implications.

Geographical area

- ▶ The indicators show substantial variations in current levels and rates for the determinants of health between London boroughs. A characteristic of the capital is that although it has some of the most affluent areas in the country, it also has some of the most deprived.
- ▶ Variations in infant mortality and life expectancy by borough have been shown to be related to the level of deprivation in the area, with more deprived areas generally showing the poorest health. This was more marked for life expectancy than for infant mortality.

Other dimensions of inequality

- ▶ A range of other features separate people on the indicators. Single parent status is a significant disadvantage in some respects; for example, it is associated with higher infant mortality, a higher risk of burglary and (in international research) with higher road casualty rates among children. Also important is the quality of the area; graffiti, rubbish etc. are associated with crime and unfit housing.

Recommendations

The recommendations below are drawn from discussion and analysis of the key findings and messages found in the report.

The **London Health Commission** sees these recommendations as an important part of its ongoing work to tackle health inequalities through partnership work in London. The Commission is committed to considering the recommendations when developing its future work programme.

The **Greater London Authority** intends to consider these messages in planning work in relevant policy areas, and will exercise all its powers in continuing to work to promote the health of Londoners.

The authors of the report encourage **other local and regional partnerships** to consider actively ways in which they can contribute to, or lead on, work to implement the recommendations.

Increasing knowledge about what works

- 1 Continue to monitor trends related to the health of Londoners.

Why?

- ▶ To ensure that current regional initiatives are collectively having a positive effect over time.
- ▶ To identify priorities for future regional activity.

- 2 Keep under active review at regional level the choice of high-level indicators used to provide an overview of health and health inequalities.

Why?

- ▶ New indicators are constantly being developed.
- ▶ There needs to be an assessment process to ensure use of the most suitable indicators (i.e. those likely to provide the most accurate picture possible).
- ▶ Support local partnerships in actively considering the use of high-level indicators to monitor health outcomes, access to services, and life chances that impact on health.

Why?

- ▶ To enable them to track their own progress towards improving quality of life locally – and to share this information with interested parties.

- 4 Support further work to identify learning about what works in tackling some of the issues that impact on health – and to share this learning across boroughs.

Why?

- ▶ In-depth knowledge about good practice in this field is scarce – it would be useful to find out how some boroughs are able to perform better than others in a variety of relevant areas, such as improving the quality of their housing stock.
- ▶ Ensure that good use is made of the expertise and commitment to be found in London and in other cities.

Why?

- ▶ To maximise opportunities to learn from each other about how to tackle health inequalities and to build on the learning from earlier initiatives, such as Megapoles.

Improving access to information

- 6 Explore ways of collecting further data on ethnicity and health outcomes, and on ethnicity and the determinants of health, such as educational attainment.

Why?

- ▶ Present procedures for capturing data of this kind are inadequate – for example, the recording of ethnicity on birth and death registrations.

- 7 Explore ways of collecting further data on disabled people in relation to both the determinants of health and health outcomes.

Why?

- ▶ Present procedures for capturing data of this kind are inadequate.

- 8 Take measures to facilitate better use of existing information on ethnicity, disability and other dimensions of inequality – and to make informed plans for the future collection and use of information of this kind.

Why?

- ▶ Present and future work to improve the range of information available to policy and decision makers needs to be based on a clear understanding of data deficits and information needs.

- 9 Examine further – perhaps initially through small area research – self-assessed health and individuals’ perceptions of quality of life.

Why?

- ▶ We know that individuals’ perceptions of their own health and quality of life have an important effect on their well-being.

- 10 Take measures to increase the use of comparable data sources and formats by a range of organisations across London – including boroughs, primary care trusts and other local agencies.

Why?

- ▶ To facilitate the collation and comparison of information from a range of sources.

- 11 Take measures to increase awareness of the impact various issues have on health – and to disseminate information about this to relevant audiences.

Why?

- ▶ To make sure that a wide range of agencies understand how their mainstream roles/ responsibilities impact on health.

Supporting action to achieve change

- 12 Promote a more systematic approach to understanding and tackling health inequalities.

Why?

- ▶ To ensure that relevant issues are actively considered in mainstream planning and funding as well as through specific initiatives.

- 13 Use high-level indicators and other comparative data to raise questions about why the experience of some groups and/or certain areas seems worse than others’ experience in London.

Why?

- ▶ To find ways to better understand the issues and to plan action to address them.

- 14 Secure/facilitate provision of targeted support for some of London’s most deprived communities.

Why?

- ▶ To ensure that all communities in London have access to relevant services and life opportunities.

- 15 Work with communities known to be experiencing multiple deprivation and/or disadvantage, such as the Bangladeshi community, in order to identify priorities for action.

Why?

- ▶ To develop a shared agenda about how partnership work might make a real difference to communities’ experience of living in London.

- 16 Give continuing support to selected area-based initiatives.

Why?

- ▶ To tackle the range of issues affecting some geographical areas living with the effects of a particularly poor environment and/or pockets of deprivation.