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Annex 1 Sources and resources

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Resources

Useful websites

www.dtlr.gov.uk
(for national road casualty figures)

www.homeoffice.gov.uk
(for national police statistics and
British Crime Survey)

www.lho.gov.uk
(for the London Health Observatory)

www.londonshealth.gov.uk
(for the London Health Commission and
London Health Strategy)

www.met.police.uk
(for Metropolitan Police statistics)

www.doh.gov.uk/healthinequalities/
(Department of Health – Health
Inequalties)

www.odpm.gov.uk/sustainability/
(Office of the Deputy Prime Minister –
Sustainable Development)

Abbreviations

CO	Carbon monoxide
DEFRA	Department for Environment, Food and Rural Affairs
DETR	(former) Department for the Environment, Transport and the Regions
DfEE	(former) Department for Education and Employment
DfES	Department for Education and Skills
DfT	Department for Transport
DOH	Department of Health
DTLR	Department for Transport, Local Government and the Regions
EHCS	English House Condition Survey
GLA	Greater London Authority
HIP	Housing Investment Programme
ILO	International Labour Organisation
LFS	Labour Force Survey
LHC	London Health Commission
LHO	London Health Observatory
LRC	(former) London Research Centre
NO_2	Nitrogen dioxide
NO_X	Oxides of nitrogen
NS-SEC	National Statistics Socio-economic Classification
NVQ	National Vocational Qualification
O_3	Ozone
OFSTED	Office for Standards in Education
ODPM	Office of the Deputy Prime Minister
ONS	Office for National Statistics
OPCS	(former) Office of Population Censuses and Surveys
PM_{10}	Fine particles (less than 10 microns in diameter)
SEN	Special Educational Need
SO_2	Sulphur dioxide
SOC	Standard Occupational Classification
TfL	Transport for London
TRL	Transport Research Laboratory

Glossary

Exceedances
When an air quality objective is not achieved (definition in Greater London Authority Air Quality Strategy). The measurement has to be based on the time period of the objective, e.g. a daily or annual average, and on a particular site or sites.

Disability
Disability is the loss or limitation of opportunities to take part in the normal life of the community on an equal level with others due to physical and social barriers. (Source: Barnes, 1991).

Economically active
This includes all those in employment, students who have paid employment, those in HM forces and those who are unemployed and seeking work.

Economically inactive
Full time students without paid employment and others not seeking work, for example, permanently sick, housewives and retired people.

Impairment
Impairment is a physical, mental or sensory functional limitation within the individual. (Source: Barnes, 1991) Disabled people in Britain and discrimination. Third edition, London: Hurst and Company.

Older boroughs
Characterised by the older private housing and modern social housing, predominantly flats, that is found in the urban core of London.

Personal crime
Crime committed against the individual, such as assault or robbery, as opposed to crime against the household, such as burglary or vandalism.

Running annual average
An average which is calculated on an hourly basis, yielding one running annual average per hour. The running annual average for a particular substance at a particular location for a particular hour is the average of the hourly levels for that substance at that location for that hour and the preceding 8,759 hours (there being 8,760 hours in a 365 day year). The 'average' here is used in its every day sense and is also known as the 'mean', i.e. the sum of all the measurements divided by the number of measurements.

Social class
Social class (based on occupation) groups occupations together in terms of occupational skill.

Until recently this fivefold hierarchical classification has been used in government statistics and is the basis of the social class statistics in this report. The classification is shown below.

Non-manual

I Professional occupations, e.g. accountants, doctors, engineers

II Managerial and technical occupations, e.g. marketing and sales managers, teachers

IIIN Skilled occupations – non-manual, e.g. clerks, cashiers

Manual

IIIM Skilled occupations – manual, e.g. carpenters, joiners

IV Partly skilled occupations, e.g. security guards, warehousemen

V Unskilled occupations, e.g. labourers, cleaners

In 2001, the government introduced the new National Statistics Socio-economic Classification (NS-SEC). This takes account of social changes, and is based

not on skill levels but on employment relations and conditions. The new NS-SEC classification is shown below:

1 Higher managerial and professional occupations
2 Lower managerial and professional occupations
3 Intermediate occupations, e.g. mid-level sales and technical occupations
4 Small employers and own account workers
5 Lower supervisory and technical occupations
6 Semi-routine occupations
7 Routine occupations
8 Never worked and long-term unemployed

Suburban boroughs

Include most of Outer London and some larger towns in the South-East.

Annex 2

About the indicators

The following material explains what the indicators are for, some of their current limitations, and current progress to develop more sensitive measures for health inequalities. Each of the ten indicators is then defined and briefly discussed. For further background information on the indicators, please consult last year's (2002) report.

What are the indicators for?

The indicators are designed to provide information on, and to monitor, trends in key determinants of health – and in particular, trends in inequalities in health and in the determinants of health. These trends can help to identify areas for action. Some trends, such as pedestrian casualties, have a direct relationship to health and service provision – for example, road-calming measures may be introduced in areas where there are high levels of accidents involving pedestrians. Others, like unemployment, are more general. Some trends may take longer than one year to emerge and this update report provides some information on trends where this is considered appropriate and useful. Probably the most useful way to look at the overall results and new information is in combination, as a backdrop to area provision, regeneration and health programmes, at local and London-wide level.

The indicators are not designed to be used for monitoring the effects of a specific project or strategy. That is why they are referred to as 'high level indicators'. Many different factors affect each of the indicators and it would not be possible to attribute a change in one of them to a specific activity. Several of the indicators will change as result of national and global factors, in addition to local and regional ones.

Limitations of the indicators

The indicators are by definition limited and selective. They cannot capture the qualitative experiences of individuals experiencing material disadvantage. Nor can they capture the compounding effects of multiple deprivation. For example, they fail to capture the disadvantages experienced by women, or important lifestyle factors, such as smoking.

In addition, care must be taken with local area analysis. A borough may have high unemployment and high infant mortality. It does not necessarily follow that all individuals in the area have a high risk of unemployment and infant mortality or that unemployed individuals have infants with high mortality. Some completely different factors may be at work that affect people who are employed just as much as those who are unemployed – poor housing stock, for example.

A similarity in the distribution of, say, life expectancy and burglary, does not show that the two are causally related; at most, it raises questions for further investigation.

The limitations of the indicators were recognised in the London Health Strategy, which also emphasised that they need to be developed and combined with other data.

It was considered important that the indicators should be selected from those in current use, and should cover a range of factors known to impact on health as well as providing some measure of health outcomes. The indicators were largely derived from the Government's

sustainable development strategy, *A Better Quality of Life* (DETR, 1999). They were amended and added to on the basis of consultation and further research, and are described in the Statistical Supplement to the London Health Strategy published in March 2000 (Dawson and Hamm). They were considered to be the best available at the time; but it was acknowledged that some of the indicators were less than ideal for the purpose.

Developing better ways to measure health inequalities

Progress is being made in both regional and national initiatives to develop better approaches to measuring health inequalities and quality of life, and it is likely that, over time, some improved measures will be developed. For example, work is progressing within the Greater London Authority to identify a set of high-level indicators for monitoring Quality of Life in London, with attention being paid to making the proposed indicators consistent with other indicators in use where possible. In addition, work is being progressed to identify a 'basket of indicators' to be used to measure health inequalities nationally, and to monitor progress towards achieving the Health Inequalities targets identified by the Government.

Work is also underway on Project LION (London Information on Net), a joint initiative which includes the following agencies: the Greater London Authority, Metropolitan Police, London Health Observatory, London Boroughs, London Ambulance Service and London Fire Brigade. Project LION has been first run in the London Borough of Lewisham, with the next candidates being Southwark, Wandsworth, Merton, Enfield and Waltham Forest. The project supports agencies in sharing information for the purpose of crime prevention – with the particular aim of identifying local areas where action is necessary or best targeted. Once the analysis has been carried out on several boroughs, indicators may be developed that would highlight particular areas of concern or suggested activity.

Indicator 1 – Unemployment

Definition

For a definition of social class, see Glossary (Annex 1).

There are several ways of measuring unemployment, the most important for this review being the International Labour Organisation (ILO) definition and the claimant count. The ILO definition is widely accepted and is the measure for these annual reports.

- The ILO definition states that unemployed people are either without a job, want a job, have actively sought work in the last four weeks and are available to start work in the next two weeks or are out of work, have found a job and are waiting to start it in the next two weeks. The Labour Force Survey (LFS) measures ILO unemployment.

- The claimant count records the number of people claiming unemployment-related benefits. Claimants must be available and actively seeking work in the week in which their claim is made. This definition leaves out many jobless people who are seeking work but do not qualify for the Jobseeker's Allowance, such as 16- and 17-year-olds; it therefore produces lower figures for unemployment. Its main advantage is that it gives a

full count of those on the register, whereas the LFS is based on a sample. The claimant count is more useful in local areas, such as boroughs and wards, where the LFS samples are too small for reliability.

Unemployment is a significant risk factor for health. It is associated with morbidity, injuries, poisoning and premature mortality, especially coronary heart disease. It is also related to depression, anxiety, self-harm and suicide.

Unemployment rates are calculated only as a percentage of the economically active population (see Glossary) – that is, those of working age, in work or available for work. The standard measure for these reports is the International Labour Organisation (ILO) definition of unemployment, used by the Labour Force Survey. For boroughs and smaller areas, the claimant count is more useful, since it is based on a full count and not a sample.

The government will revise the mid-year population estimates in the light of the 2001 Census results. This in turn will lead to revised estimates of unemployment rates by the Labour Force Survey, later in 2003. Meanwhile, this report uses figures based on the old (1991-based) population estimates, both for the ILO and for the claimant count percentages. According to the Office for National Statistics, the 2001 Census is likely to make only minor differences to the percentages of unemployed. (ONS Guidance 2002. Although a revised estimate for 2001 is already available, it has not yet been incorporated into the Labour Force Survey)

Indicator 2 – Ethnicity and unemployment

Definition

The International Labour Organisation (ILO) definition of unemployment (see Indicator 1 above) is the basis for this indicator, combined with 1991 Census ethnic categories. This indicator draws on Labour Force Survey data only; there are no ethnic group data in the claimant count. Sometimes the ILO and census ethnic categories are combined in the Labour Force Survey, to boost the sample size.

Unemployment is particularly high in some ethnic minorities, which has implications for the health of the people involved.

The indicator draws on Labour Force Survey data only; there are no ethnic group data in the claimant count. Sometimes the employment and ethnic group categories are combined in the Labour Force Survey, to boost the sample size.

In spring 2001, the Labour Force Survey brought in a new classification of ethnic groups. It is based on main headings (e.g. 'Black or Black British') and subgroups (e.g. 'Black African'). The main heading 'Mixed' is entirely new and is itself divided into four sub-groups. The sub-group 'Other White' is also new. These changes brought the Labour Force Survey into line with the 2001 Census but the latter has an extra subgroup – 'White Irish'. These classificatory changes are designed to reflect social change, for instance, the growing number of people who regard themselves as 'Mixed' or 'Black British'.

The new Labour Force Survey ethnic categories in the Labour Force Survey cannot be directly compared to the old ones; the 'Other' categories are quite different (for example, they no longer include mixed groups). Even categories like 'Black Caribbean' are no longer the same; for example, it is now more likely to include people who also regard themselves as 'Black British', but who would previously have been classified as 'Black Other'. Broad groups, like white/non-white, are also affected. The result of these changes is that data from earlier years have to be revised in retrospect for comparability with recent figures. These 'back-cast data' are estimates and not exact (see gender section, below). According to Labour Market Trends (December 2002), the broad messages of approximately equivalent groups are not changed greatly.

Indicator 3 – Educational attainment

Definition

The selected indicator is the percentage of pupils aged 15 achieving five GCSEs at grades A*– C or equivalent. This is one of the National Learning Targets. The aim was to reach 50 per cent in 2002. (To be included in this target, pupils must be aged 15 on 31 August of the year before they took the exams). The figures are based on the education authority, not on the pupils' home addresses.

Education has a bearing on health-related behaviour, such as smoking, drinking, drugs, exercise, diet and safe play areas for children. It also reduces the chances of unemployment and poverty, which have a negative effect on health.

The selected indicator is the percentage of pupils aged 15 achieving 5 GCSEs at grades A*– C or equivalent. This is one of the National Learning Targets: The aim is to reach 50 per cent in 2002. For the purposes of borough and regional comparisons, this report uses results from maintained schools only, although the national target includes independent schools as well. The figures are based on the education authority, not on the pupils' home address.

Indicator 4 – Proportion of homes judged unfit to live in

Definition

A property is unfit for human habitation if it fails to meet any one of nine criteria, as defined by Section 604 of the Local Government and Housing Act 1989. These include, structural stability, freedom from serious disrepair and from dampness prejudicial to health, adequate provision for lighting, heating and ventilation, satisfactory cooking, water and drainage facilities, bath or shower and suitably located WC. There is also a separate fitness standard for houses in multiple occupation, which includes adequate fire precautions; this is especially relevant in London.

Unfitness, as defined in the statutes, may be too narrow as an indicator of housing standards. The Department for Transport, Local Government and the Regions is developing the use of the concept of 'decent homes', which includes unfitness among other matters. The new Housing Health and Safety Rating System will replace the current fitness standard in a few years' time, and this will contain a better spread of the factors that make housing unsatisfactory, such as pest infestation and noise problems, which are not in the current standard.

London and national trends

Poor housing can cause or contribute to ill-health or exacerbate existing conditions, for example through damp, cold, bad lighting or design.

A property is unfit for human habitation if it fails to meet the criteria set out in the Local Government and Housing Act 1989. The current fitness standard will be replaced some time after 2004. Fitness itself now forms part of a wider concept, 'decent homes', which is the target for all social housing by 2010. The other aspects of a decent homes policy are a reasonable state of repair, reasonably modern facilities and services and a reasonable degree of thermal comfort.

Local authorities produce estimates of fitness levels each year as part of the Housing Investment Programme (HIP) bidding process. In most years, data are missing from a few boroughs but the government provides an estimate for the missing figures and hence, for the total number of unfit dwellings in London.

Further data are provided by the English House Condition Surveys. The last published one took place in 1996 (DETR 1998). The EHCS 2000, due to be published in 2003, will contain much relevant new information.

Indicator 5 – Domestic burglary rate

Definition

Domestic burglary has been selected as an indicator because it is more likely to be reported to the police than other crimes (with the exception of vehicle theft, which affects only vehicle owners). There are two main sources of information about crime rates – police records and the British Crime Survey.

- The police records show all reported crimes in an area. They are available at borough level.
- The British Crime Survey (Home Office) is based on a sample, which is reliable at London but not at borough level. Its main advantage is that it covers the large number of crimes which are not reported to or recorded by the police. It also covers a wider range of topics, like ethnic group and fear of crime.

To give an example of the difference between the two sources, the police recorded 35 per cent of all domestic burglaries in 1999 in England and Wales, as estimated by the British Crime Survey (this was a high rate, compared to most other crimes). For good results, both sources should be used and compared.

Crime has been chosen as a health determinant for two broad reasons: First, it serves as an area indicator - the same factors that affect the local crime rate also seem to affect health. Second, crime can affect health directly.

Domestic burglary has been selected because it is more likely to be reported to the police than other crimes (with the exception of vehicle theft, which only affects vehicle owners).

According to the British Crime Survey 2001/02, 34 per cent of victims of burglary with entry are very much emotionally affected and another 28 per cent "quite a lot". The most common reaction is anger, but shock affects more than a third. This and other studies suggest that burglary may have an effect on health.

The standard indicator for the annual report is the police recorded burglary rate per 1000 residents. Police records are available at borough level.

The other main source of information about crime rates is the British Crime Survey. Being based on a sample, it is reliable for London but not for boroughs. Its covers the large number of crimes which are not reported to or recorded by the police and also deals with a wide range of topics, like ethnicity and disability.

Street crime is also discussed in this section because it particularly affects London, and the figures provide some insight into how opportunity affects the crime rate.

Indicator 6 – Air Quality indicators: NO_2 and PM_{10}

Definition

The two types of pollution tend to occur under different conditions and roughly complement each other. London is likely to meet the national targets for the other five pollutants but will exceed the limits for NO_2 and PM_{10} unless extra measures are taken. This report will therefore use both as indicators. It should be noted that both pollutants are affected by weather, so in a 'bad-weather' year for pollution, the pollution can increase while the sources of pollution have been reduced, and that a longer-term trend should be borne in mind as well as the annual indicators.

Pollutant objectives are expressed in averaging periods or 'exposure durations'), e.g. short term (one hour) and long term (annual). For NO_2, there is an annual and an hourly objective; for the latter, the level is set much higher, because it is measure of acute pollution. In 1999, the hourly limit was exceeded at only one site in London. The objective is to be met in 2005.

For PM_{10}, there are daily and annual average objectives. The former are exceeded at more sites and may be more of a problem in London. The present objective is to be met in 2004. It should be noted that tightening of the PM_{10} objectives for 2010 is in preparation.

Air pollution levels depend on two factors: emissions and the weather.

Polluted air can damage health, especially that of the most vulnerable - the very young and the old. Short-term exposure to air pollution may have accelerated the deaths of up to 24,000 vulnerable people in Great Britain in 1996, and may also have precipitated a similar number of hospital admissions (COMEAP 2001).

The Greater London Authority's Air Quality Strategy, published in September 2002, covers seven major pollutants, in line with national and European policy. London boroughs must take into account these same pollutants, and must have regard to the Mayor's Air Quality Strategy in exercising their air quality functions.

For the purposes of the annual Health in London reports, the recommended indicators are exceedances (see Glossary) of the air quality standards for nitrogen dioxide (NO_2) and fine particles (PM_{10}). London is likely to meet the national targets for the other five pollutants but will exceed the limits for these two unless extra measures are taken; the main problems are the annual average

for NO_2 and daily average for PM_{10}.

Ozone comes within the national air strategy but is not the subject of local or regional targets. However, ozone will be discussed here, because it sometimes exceeds the provisional national limits in the outer London boroughs, and the levels have risen since 1996.

Indicator 7 – Road traffic accidents

Definition

Although the accident rate was selected in the London Health Strategy as an indicator, the Statistical Supplement concentrated on casualties. The latter are more directly relevant and are the main subject of national and London targets. Casualties can be monitored in different ways.

1. Casualties per 100 million passenger kilometres. This relates casualties to the amount of traffic; it is therefore closely related to policy and is probably the best indicator. However, this is not easy to measure and comprehensive data are not currently available.

2. Casualties per 1000 residents. This was the indicator used in the London Health Strategy Statistical Supplement and it is used again here, for the purposes of comparison. It is also sometimes used by Transport for London (TfL) and has the advantage of relating casualties to population. Its disadvantage is that many casualties do not involve local residents but people from outside, especially commuters; this is a major factor in central London, especially the City.

3. The number of casualties is the simplest measure and the most widely used. TfL figures are quoted in this report. The disadvantage of this indicator is that it is not related to population or traffic flow. However, it can be combined with information about vehicle licensing and population trends, as necessary.

Total casualties provide a broad indicator of safety. However, it is also useful to separate slight casualties from serious/fatal, because they have different significance and also follow different trends.

Road traffic accidents are a major avoidable hazard to health. In 2001, 6,101 people were killed or seriously injured on London's roads. A further 38,393 people were slightly injured.

For the purposes of this report, the standard indicator is casualties per 1000 residents. Its limitation is that many casualties involve non-residents, especially in the centre. Another widely used measure, employed by Transport for London (TfL), is the number of casualties.

The standard source, used here, is the national police database ("Stats19"). Comparison with hospital statistics shows that there is a high level of under-reporting, especially of serious injuries, and casualties involving children, cyclists and "other vehicles". (Radical Statistics Group 2000; TRL 1996). Nevertheless, these figures are the best available, and serve to demonstrate trends for different kinds of road user.

There is also evidence that some groups, like children, old people and potential cyclists, avoid roads because they are dangerous, which can reduce casualties but lower the quality of life (Radical

Statistics Group 2000). Ideally, casualty data need to be combined with other information. For example, a rise in journeys on foot and bicycle combined with a fall in accidents would indicate real progress.

The context for this section is provided by Transport for London's Road Safety Plan, published in November 2001. The plan incorporates national and London targets. These targets are set for 2010, and are to be compared with the average for 1994-1998.

Indicator 8 – Life expectancy at birth

Definition

> Average life expectancy for an area is an estimate of how long a baby would be expected to live if current age-specific mortality rates for that area remain constant. It is not a forecast of how long individual babies born now will actually be expected to survive. Therefore, it is best interpreted as a summary measure of mortality like any other. More details on the interpretation and the calculation of average life expectancy can be found on the London Health Observatory web site www.lho.org.uk in the report *Calculating life expectancy and infant mortality rates* (LHO 2001).

Average life expectancy is determined by mortality at all ages. Therefore, the range of influences on life expectancy is vast and includes all those influences on health at each age. In addition, all of the previous seven indicators, as wider determinants of health, will have an impact on life expectancy. Average life expectancy is therefore a good summary indicator of the health status of the population.

Average life expectancy is an estimate of how long a baby would be expected to live if current age specific mortality rates remain constant. It is not a forecast of how long babies born will actually be expected to survive, as it is unlikely that age specific mortality rates will remain constant for an extended length of time. Therefore, it is best interpreted as a summary measure of mortality at a point in time like any other. More details on the interpretation and the calculation of average life expectancy can be found on the London Health Observatory website http://www.lho.org.uk/pubs/p_pubs.htm#lho in the report '*Calculating life expectancy and infant mortality rates*'.

Life expectancy is also a national health inequalities target (Department of Health 2001):

'Starting with health authorities, by 2010 to reduce by at least 10% the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole'

Indicator 9 – Infant mortality rate

Definition

> The infant mortality rate is defined in this report as the number of infant deaths (deaths in the first year of life) among those born in a particular year per 1000 live births in that year.

Infant mortality rates are a commonly used indicator of the health status of the population. The level of infant mortality is influenced by a range of factors including the health of mothers during pregnancy including smoking and nutrition, health care services during delivery and postnatal care. These in turn are influenced by socio-economic factors.

Infant mortality is also a national health inequalities target (Department of Health 2001):

'Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between manual groups and the population as a whole'.

Indicator ⑩ – Proportion of people with self-assessed good health

Definition

Many health surveys include a question asking people to describe their own health status. These self-assessments are a very simple way to describe health and have been found to be associated with other health indicators. They are also useful because they tell us how people are feeling generally and not just whether they have any specific health conditions. There is strong evidence that people's own assessment of their health is a good indicator of their health status and among older people a good predictor of future mortality.

A number of surveys currently include a question asking people to describe their own health status. These include:

- The 2001 Census of population.
- The Health Survey for England.
- The General Household Survey.
- The Association of London Government's London Residents Survey.
- The Greater London Authority's London Household Survey.

The actual wording of the question in these surveys is not always comparable and the categories by which the answers are grouped are not always the same.

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