Section 1

Key findings and implications for action

In this section…

- Last year's key findings are updated.
- New findings relating to disabled people in London are added.
- Implications for action are explored.

SECTION 1

Overview

This publication follows on from the first *Health in London* report, which appeared in March, 2002. The intention is not to replace the earlier publication, but to supplement it and to provide significant new information where that is available. The 2002 report is available at: www.londonshealth.gov.uk/hinl.htm

The report takes as its focus ten high-level indicators developed as part of the London Health Strategy (see page 10). These indicators shed light on what are known as the 'determinants of health' – factors, like employment and education, which have been shown to have a significant influence on people's health. The indicators are used to:

- measure changes over time
- highlight inequalities among different areas and groups in London, and between London and elsewhere – a particular focus for 2003, the European Year of Disabled People, is the experience of disabled Londoners.

The question might well be asked: 'What are the implications for action of these findings?' The section ends with a summary of suggestions for constructive work at pan-London and borough level.

Update on findings

The report contains an update of findings for each of the ten indicators. Some indicators have produced new findings. With others, the emerging picture is broadly similar to last year's. Details of findings, as well as gaps in current knowledge, are described in Section 4. The main findings are summarised below, indicator by indicator.

Taken together, the findings on the indicators can be used to contribute to a picture of inequalities in health across London's population. Different groups and categories of people have very different experiences of the determinants of health. These different experiences can have an effect on health. Inequalities in health and of health outcomes can become entrenched when categories overlap – for example, ethnic group, age, area. The report shows that some inroads have been made, but inequalities persist, for a range of reasons discussed in Section 4. Again, these are summarised below.

Key findings across the indicators

- *Ethnicity.* Most black and minority ethnic groups continue to fare worse on all the indicators for which data is available – unemployment, education, burglary, unfit housing and road casualties. In particular, ethnic inequalities in the unemployment rate are very persistent. But there are exceptions. For example, some Asian groups have the best educational attainment outcomes.
- *Geographical area.* All indicators still show substantial variations in current levels and rates between London boroughs. Compared with the last year, the gaps are wider for burglary, unfit housing and road casualties. Only in education has there been a narrowing of the range of any note. Boroughs that fare badly on one indicator also tend to fare badly on others.
- *Social class and age.* There are no significant new findings on social class and age since last year's report. However, both continue to be major factors in health inequality. High unemployment and low education attainment of young working-class men, especially social classes IV and V, continue to have health implications. The effects of age continue to be compounded by those of *ethnicity* and *social class*.
- *Disability* (additional factor 2003). Disabled Londoners fare worse on all the indicators for which relevant information is available; and a trawl of other, wider data sets indicates that they fare worse across other dimensions too.

Key findings on the indicators

1 Unemployment

- In 2002, the unemployment rate in both London and the UK increased for the first time since 1993, and it remains higher in London than for the rest of the country. In addition, the rate of long-term unemployment is higher in London than the country as a whole.
- There is considerable variation in the unemployment rates in different London boroughs, with a range from two per cent in Havering to twelve per cent in Tower Hamlets.
- There has been a slight increase in unemployment among 16 to 24 year olds, and over one-quarter of male teenagers in London continue to be unemployed.
- Disabled Londoners have an unemployment rate nearly twice as high as non-disabled people, and the position of disabled people in the labour market deteriorated between 1979 and 1997.
- Twenty-eight per cent of disabled Londoners want to work but do not have a job, compared to eleven per cent of non-disabled Londoners.
- Unemployment rates vary widely for people with different types of impairment or illness, with unemployment being especially high among people with learning impairments and mental health issues.
- Disabled Londoners are more likely to be in part-time employment and earn considerably less than equivalent non-disabled workers at each level of educational attainment.

2 Ethnicity and unemployment

- Ethnic inequalities in unemployment rates persist, and the gap between white and minority ethnic unemployment is wider now than it was 15 years ago and shows no sign of decreasing.
- The experience of different ethnic minority communities varies, with 'other white' people experiencing high unemployment and Bangladeshis continuing to have the highest rate of unemployment which is five times that of white British people.

3 Educational attainment

- Performance and achievement rates have continued to show a further rise, particularly in inner London, and national targets were surpassed in 2002.
- Differences in these rates continue between London boroughs, with a range of 31 (Hackney) to 65% (Sutton) for achievement rates.
- Patterns of underachievement in some ethnic groups show some signs of changing, but limited availability of information on ethnicity and education currently affect the extent to which trends can be accurately assessed and understood.
- There is a lack of information on the educational achievements of disabled children and limited information about the experience of disabled children in education, although one survey showed that 40 per cent of disabled people felt that teachers had underestimated their ability.
- About one in five children in London's schools have been assessed as having 'special educational needs', and there is wide variation between boroughs in the extent to which they place these children in mainstream or "special" schools.

4 Proportion of homes judged unfit to live in

- The estimated proportion of unfit dwellings in London has been falling and now stands at 7%. However, there is significant variation between boroughs and some (e.g. Tower Hamlets, Barnet) have shown rising levels in levels of unfit housing in their area. Others, including some in boroughs with high deprivation (e.g. Lewisham), have achieved steep falls in the proportion of local housing that is unfit.
- There is limited information about disabled people's housing needs and their access to appropriate housing options, but some surveys highlight that many disabled people are living in unsuitable housing and experience dissatisfaction with their accommodation.

5 Domestic burglary rate

- In London the burglary rate has been fairly stable over the last year, after a long-term decline, but the burglary rate per household remains higher than average in London.
- The risk of burglary varies more than fourfold between London boroughs (Kingston-upon-Thames at 4.4 per thousand to Lambeth at 20.3), and continues to be higher in the inner city and in west London.
- Although there are some differences in recorded crime experienced by

different ethnic groups, it does not appear that ethnicity is a major risk factor. However, there are large numbers of racially motivated crimes which are now monitored, as well as many racially motivated incidents which are not recorded as crimes.

- Records of household crimes do not include information about disabled people, but information on personal crime shows that twice as many disabled people than non-disabled people experienced violent crime in London during 2001/02.
- There has been little research on disabled people's experience of crime, but those studies that have been done highlight the impact that fear of crime has on some disabled people.

6 Air quality

- Levels of some pollutants, including nitrous dioxide (NO_2) and fine particles (PM_{10}), in London have stabilised or declined slightly while levels of ozone have increased.
- London's air quality continues to be the worst in the UK and among the worst in Europe.
- There has been little research into the effects of air quality on different communities.

7 Road traffic accidents

- London's road casualty rate in 2001 improved over the previous year, mainly due to a fall in the rate of slight injuries.
- Fatalities have risen for the third year running and are now 20 per cent above the 1994–98 average.
- Information in relation to road injury or death is not routinely collected about disabled Londoners or Londoners from black and minority ethnic communities.

8 Life expectancy at birth

- Life expectancy is generally increasing in London as a whole and nationally; London as a whole has similar life expectancy as England.
- The relative position of some of the boroughs in expectation of life has changed, but this is likely to be due to changes in the population size from the 2001 census rather than due to real changes in life expectancy.
- Kensington and Chelsea replaces Westminster as having the longest life expectancy in London for both males and females. Newham continues to have the lowest life expectancy in London for males, and along with Islington, Newham also has the lowest life expectancy in London among females.
- At borough level average life expectancy is closely related to the level of deprivation, with a stronger association between life expectancy and deprivation for males than for females.

9 Infant mortality rate

- Data for the period 1996–2001 shows that infant mortality is decreasing in London as a whole and nationally, and the overall infant mortality rate in London continues to be very similar to infant mortality in the rest of the country.
- There continue to be large differences in infant mortality rates between

London boroughs, ranging from 3.4 (Kingston-upon-Thames) to 8.6 (Lewisham) infant deaths per 1000 live births.

- Between 1993-99 approximately 8% of births were registered by the mother alone, and these sole registered births had by far the highest mortality rate of 9.5 per 1000 live births.

⑩ Proportion of people with self-assessed good health

(*Note:* the wording of the title of Indicator 10 has been modified to take account of terminology used in the 2001 Census.)

- New information from the 2001 Census shows that 70.8% of Londoners assess their own health as good compared to 68.7% of the population of England.

- Levels of self-assessed good health vary between boroughs, and not all the variation is related to deprivation. Boroughs that had the lowest percentages that reported good health are Barking and Dagenham, Tower Hamlets and Newham. Richmond, Kingston-upon-Thames and Wandsworth had the highest percentages that reported good health.

- There is currently little information for specific population groups in London but there is some evidence to suggest that the proportion of people who assess their health as good is lower among older people and among disabled people.

Implications for action

Last year's report contained a series of recommendations for policy makers and practitioners. These recommendations are being acted on in various ways and at different levels.

The London Health Commission is also committed to carrying out and publishing a wide-ranging review of progress on the recommendations.

This final part of this section highlights ongoing and additional *implications for action* arising from the key findings of the 2003 report. How have some areas of London succeeded in increasing opportunities for a wide range of people to live healthy lives? And how can agencies, organisations and partnerships across the capital learn from each others' experience in information gathering, action and evaluation?

Local and regional organisations and partnerships are encouraged to explore in a practical way how they can take action to respond to the following key questions:

- What new information needs to be collected and shared? Gaps in our existing knowledge need to be filled to enable us to work together to direct our effort more effectively.

- How can more effective use be made of what is known already? We need to review, plan and coordinate our activities and programmes so as to build on what has already been learned.

What new information needs to be collected and shared?

- Further data needs to be collected on:
  - ethnicity and health outcomes, and ethnicity and determinants of health

  - the experience of disabled people in relation to the determinants of health and access to services.

- The recording of ethnicity needs to be built into routine data collections that enable health monitoring and planning. For example, many of the London Health Strategy indicators – such as those relating to education and housing – do not provide ethnicity data. The recording of ethnicity on birth and death certificates – the subject of an active campaign to be spearheaded by the London Health Observatory and London Health Commission – can be seen as a vital part of this process.

- Further research needs to be carried out into:

  - self-assessed health and individuals' perceptions of quality of life
  - the effectiveness of different kinds of intervention designed to reduce road injuries and deaths
  - factors which affect the access of disabled people to appropriate educational opportunities
  - identification of the economic sectors and types of employer least likely to offer appropriate job opportunities to socially excluded Londoners, and analysing the nature of the barriers
  - quantifying the need for, and availability of, housing that meets the needs of disabled Londoners
  - the apparently contradictory finding that although there are many racially motivated crimes in London, ethnicity is not of itself a major risk factor.

How can more effective use be made of what is known already?

Local focus

- Organisations across London – including boroughs, primary care trusts and other local agencies – can usefully explore ways of increasing their use of comparable data sources and formats, including indicators.

- Existing information on ethnicity, disability and other dimensions of inequality needs to be used to target resources for work with London's most deprived communities, including communities known to be experiencing multiple deprivation.

- In particular, Race Equality Schemes (a requirement placed upon many public sector organisations by the Race Relations (Amendment) Act 2000) should be used as a driver to underpin the new 'duty to promote racial equality'.

- Action needs to be taken at local level to understand and reduce health inequalities within and between boroughs – for example, through health scrutinies and health equity audits.

Using and reviewing high level indicators

- High level indicators and other comparative data need to be introduced and used at all levels to probe underlying problems, their causes and effects, and to raise questions about why the experience of some groups and/or certain areas seems worse than others' experience in London.

- The high level indicators used by the London Health Commission need to be reviewed in the light of on-going national work to develop a 'basket of indicators' for measuring health inequalities.

Focus on disabled Londoners

- The Disability Discrimination Act, along with the status of 2003 as European Year of Disabled People, should be used at all levels as drivers to focus on health inequalities and disability and to address the needs of disabled people more effectively.

- The Greater London Authority project, 'Disability Capital', needs a wide range of participants in order to build up a detailed picture of disabled Londoners' everyday experience of living in the capital, the barriers they face, and the positive steps that can be taken to move towards an accessible and inclusive city.

- The perspective associated with a social model of disability needs to be made more widely known and used to challenge policies and practice which discriminate against disabled Londoners. Organisations and strategic partnerships of every kind within London need to work with disabled members of the community to ensure they have as much opportunity as people who are not disabled to direct, control their lives and to be part of mainstream society.