Focus on Health paints a picture of the health of people living in Britain. It includes information on broad measures of health, mortality, risk factors, some preventive measures and service provision. Particular emphasis is placed on changes related to age and trends over time.

There are substantial geographical and occupational variations in self-reported general health, with people in higher managerial and professional occupations reporting the best health. In terms of location, those in the South East reported the best health. People live longer and healthier now but not all the extra years gained are necessarily in good health. Women still live longer than men, but the gender gap is narrowing.

One in three people will develop cancer during their lives and one in four will die from cancer. However, survival rates improved for most cancers during the 1990s.

Health Status ................................................................. 2
Health Expectancy .......................................................... 3
Mortality .............................................................................. 4
Cancer ............................................................................... 5
Smoking ............................................................................... 6
Drinking ............................................................................... 7
Preventive Measures .......................................................... 8
GP Consultations .............................................................. 9
Informal Care ...................................................................... 10
Human Resources ............................................................. 11
Health Status

Higher social groups report best health

General health

In the 2001 Census, nine in ten people (91 per cent) in private households in England and Wales reported good/fairly good health. The age-standardised rates (all ages) of good/fairly good health were similar for men and women. Children aged under 16, were reported as having the best health, with 99 per cent having good/fairly good health. For those aged 16 and over, the age-specific rates of good/fairly good health declined with age. The least healthy section of the population was elderly people aged 75 and over, 72 per cent said they were in good/fairly good health.

There are substantial variations in reported health status by National Statistics Socio-economic Classification (NS-SEC) as measured by occupation. Among those in employment, people in routine occupations had the worst self-reported health in 2001. The age-standardised rates for people in routine occupations who rated their health as not good were more than double those for people in higher managerial and professional occupations. People not in employment had even worse health than those in routine occupations. The age-standardised rate for the long-term unemployed who rated their health as not good was three times the rate for those in higher managerial and professional occupations.

People who had never worked had the highest rate of not good health, six times higher than the rate for those in higher managerial and professional occupations.

Age-standardised rates of good/fairly good health for local authority districts/ unitary authorities reveal considerable geographical clustering. The ten local authorities with the highest rates were all in the south of England in the counties of Buckinghamshire (Chiltern, South Bucks), Hampshire (Hart, Winchester), Berkshire (Wokingham), Surrey (Elmbridge, Surrey Heath, Mole Valley, Waverley) and West Sussex (Horsham).

The 10 local authorities with the lowest rates were primarily in Wales (Merthyr Tydfil, Blaenau Gwent, Rhondda Cynon Taff, Neath Port Talbot, Caerphilly) or the north of England (Easington, Manchester, Liverpool, Knowsley), although one was in London (Tower Hamlets).

Limiting long-term illness or disability

The overall proportion of people reporting a long-term illness or disability which restricted their daily activities was 18 per cent. The age-standardised rates were similar for men and women (16 per cent for men, 15 per cent women). In general, the proportion reporting a long-term illness or disability increased with age, first slowly and then sharply from age 45, further accelerating in later life. The level was lowest in children aged under 5 (3 per cent), and highest for elderly people aged 90 and over (75 per cent).

The prevalence of long-term illness or disability by NS-SEC followed a similar pattern to ‘not good’ general health, increasing from higher managerial and professional occupations to those who had never worked. Among those in employment, the age-standardised rates for people in managerial and professional occupations were half of those in routine occupations. People not in employment had far higher levels of a long-term illness or disability than those in employment. The age-standardised rate for the long-term unemployed was three times higher than the rate for those in managerial and professional occupations. The rate for those who had never worked was six times the rate for those in managerial and professional occupations.

Although related, the census questions on general health and limiting long-term illness or disability measure different dimensions of health. Many people who rated their health as not good also reported having a limiting long-term illness or disability (85 per cent). Conversely, only 43 per cent who reported limiting long-term illness or disability also said their health was not good.

The prevalence of long-term illness or disability by NS-SEC followed a similar pattern to ‘not good’ general health, increasing from higher managerial and professional occupations to those who had never worked. Among those in employment, the age-standardised rates for people in managerial and professional occupations were half of those in routine occupations.

People not in employment had far higher levels of a long-term illness or disability than those in employment. The age-standardised rate for the long-term unemployed was three times higher than the rate for those in managerial and professional occupations. The rate for those who had never worked was six times the rate for those in managerial and professional occupations.

Although related, the census questions on general health and limiting long-term illness or disability measure different dimensions of health. Many people who rated their health as not good also reported having a limiting long-term illness or disability (85 per cent). Conversely, only 43 per cent who reported limiting long-term illness or disability also said their health was not good.
Health Expectancy

Living longer, more years in poor health

The population of Great Britain has been living longer over the past 20 years, but the extra years have not necessarily been lived in good health. Life expectancy and healthy life expectancy (expected years of life in good or fairly good health) both increased between 1981 and 2001, with life expectancy increasing at a faster rate than healthy life expectancy.

Life expectancy is higher for females than for males. In 2001 the life expectancy at birth of females was 80.4 years compared with 75.7 years for males.

Life expectancy for males has been increasing faster than for females. There was an increase of 4.8 years in male life expectancy between 1981 and 2001. For females the corresponding increase was 3.6 years.

The gap between males and females is smaller in terms of the number of years they can expect to live in good or fairly good health. In 2001, healthy life expectancy at birth was 67.0 years for males and 68.8 years for females, a gap of 1.8 years.

The difference between life expectancy and healthy life expectancy can be regarded as an estimate of the number of years a person can expect to live in poor health. In 1981 the expected time lived in poor health for males was 6.5 years. By 2001 this had risen to 8.7 years.

Females can expect to live longer in poor health than males. In 1981 the expected time lived in poor health for females was 10.1 years, rising to 11.6 years in 2001.

At age 65, as well as at birth, the number of expected years of remaining life is higher for women than for men. In 2001, women at age 65 could expect to live 19.0 further years compared with 15.9 years for men.

Life expectancy at age 65 for women increased by 2.1 years in the 20 years up to 2001. For men the increase was much greater, at 2.9 years.

Healthy life expectancy for men at age 65 has also increased faster than for women. In the 20 years to 2001 the expected number of further healthy years of life for men aged 65 rose by 1.7 years to 11.6 years. For women there was a rise of 1.3 years to 13.2 years.

In 1981 the expected time lived in poor health from age 65 onwards for men was 3.1 years. By 2001 this had risen to 4.3 years. For women in 1981 the corresponding figure was 5.0 years, rising to 5.8 years in 2001.

Sources:
Government Actuary’s Department for expectation of life data. ONS for healthy life expectancy data.

Notes:
The charts show life expectancy (LE) & healthy life expectancy (HLE) estimates based on a 3yr moving average plotted on the central year. HLE data for ’96, ’98 and ’00 are unavailable because the General Household Survey (GHS) was not carried out in ’97 and ’99. HLE incorporates an adjustment to LE using information from survey sources for ill health to arrive at expected years of healthy life. A full description of the methodology and sources used in ONS’ calculations of HLE can be found in Health Statistics Quarterly 07. The health status ‘good’ or ‘fairly good’ is taken from the response to the GHS question ‘Over the last 12 mths would you say your health has on the whole been good, fairly good or not good?’ This is hence a subjective measure and the meanings attached by respondents to the categories may have changed over time due to medical advances.
Mortality

Circulatory diseases - leading cause group

Circulatory diseases (which include heart disease and stroke) have remained the most common cause of death in England and Wales over the last 90 years among both males and females, with the exception of 1918 to 1919. The chart presents the four disease groups which have each at some time during the last 90 years been among the three disease groups with the highest mortality rates.

Male death rates from circulatory disease are higher than those for females: 312 per 100,000 males and 194 per 100,000 females in 2002. Within these, death rates from heart disease were higher than stroke among both males and females.

Cancers are now the second most common cause of death among males and females. Female cancer mortality rates decreased during the 1940s and 1950s, then rose to a peak in the late 1980s, declining again during the 1990s. Among males the pattern was different. Rates increased substantially to the late 1970s and then declined more rapidly from the 1990s.

Death rates for infectious and respiratory diseases declined in the first half of the 20th Century, although the 1918-19 influenza pandemic claimed the lives of 152,000 people in England and Wales alone and 20 to 50 million people worldwide. In the last 50 years death rates from circulatory diseases decreased more rapidly.

Mortality rates by cause of death vary with age and sex. In 2002, for young people aged 15 to 29, mortality rates were highest for injury and poisoning (41 per 100,000 population for men and 10 per 100,000 for women).

In adults aged 30 to 44, the major cause of death differed for men and women. Injury and poisoning was the leading cause of death for men (45 per 100,000 population) and cancers the leading cause of death for women (32 per 100,000 population).

For those aged 45 to 64, cancers were the leading cause of death among both men and women, with mortality rates of 245 per 100,000 for men and 218 per 100,000 for women. Injury mortality rates among men aged 45 to 64 were lower than for those aged 15 to 29 and 30 to 44.

In older people aged 65 to 84, circulatory diseases were the leading cause of death, for both men and women, although rates for all the causes shown in the table were higher than those at younger ages. The highest mortality rates were in people aged 85 and over, with circulatory diseases having the highest rates followed by respiratory diseases and cancers.

Source:
Office for National Statistics.

Notes:
Age-standardised rates allow comparisons between populations with different age structures. The method used is direct standardisation using the European Standard Population.
Trends for Scotland and Northern Ireland have not been included because electronically-held data are not available before 1974. It is difficult to give a listing of the 'top causes of death', as this depends on how different causes are grouped together. Thus comparing all cancers with heart disease will give a different answer to comparing lung cancer with heart disease. This overview uses broad disease groups (Chapters of the International Classification of Diseases).
Over the years, there have been changes in the coding and classification of mortality data. Recent changes are the introduction of ICD-10 (2001) and different rules to code cause of death (1984 to 1992). Neonatal deaths (deaths under 28 days) excluded from the table.
Cancer
1 in 3 develop cancer during their lives

Incidence
The four most common cancers - breast, lung, colorectal and prostate - accounted for over half of the 225,000 new cases of malignant cancer (excluding non-melanoma skin cancer) registered in England in 2001. Around 113,000 of the total were in males and 112,000 in females. Breast cancer accounted for 31 per cent of cases among women and prostate cancer for 23 per cent among men.

Cancer is predominantly a disease of the elderly - only 0.5 per cent of cases registered in 2001 were in children (aged under 15) and 25 per cent were in people aged under 60.

Between 1971 and 2001, the age-standardised incidence of cancer increased by around 20 per cent in males and 39 per cent in females.

Mortality
One in four people die from cancer.

The four most common cancers accounted for just under half of the 128,000 deaths from cancer (excluding non-melanoma skin cancer) in England in 2002. Around 66,000 of the total were in males and 61,000 in females. Cancer accounted for 28 per cent of all deaths in males and 23 per cent in females.

Between 1950 and 2002, age-standardised cancer mortality in England and Wales changed very little. However, cancer became a more common cause of death than heart disease in females from 1969 and in males from 1995, due to the decline in mortality from heart disease.

Survival
Survival varies by type of cancer and, for each, by a number of factors including sex, age and socio-economic status.

Five year relative survival is poor for cancers of the lung, oesophagus, pancreas and stomach, in the range 6-15 per cent for patients diagnosed in 1996-99, compared with colon cancer (around 47 per cent), cancers of the bladder, cervix and prostate (56-65 per cent) and breast cancer (78 per cent).

For the majority of cancers, a higher proportion of women than men survived for at least five years after diagnosis. Among adults, the younger the age at diagnosis, the higher the survival for almost every cancer. Survival improved for most cancers in both sexes during the 1990s.
Smoking

Rates highest in early 20s

In 2002/03, 26 per cent of adults aged 16 and over in Great Britain were cigarette smokers - a slightly higher proportion of men (27 per cent) than women (25 per cent).

The proportion of adults who smoked was greatest among those aged 20 to 24 (37 per cent of men and 38 per cent of women). It then steadily declined with increasing age to 17 per cent of men and 14 per cent of women aged 60 and over.

Although, overall, a greater proportion of men than women smoke, this is not the case for young people aged 16 to 19. In 2002/03, 29 per cent of these young women were cigarette smokers compared with 22 per cent of young men.

The percentage of adults who smoked cigarettes fell substantially in the 1970s and the early 1980s – from 45 per cent in 1974 to 35 per cent in 1982. After 1982 the rate of decline slowed and then levelled out from 1992/93, at around 26 to 28 per cent.

In the 1970s men were far more likely than women to be smokers. In 1974, 51 per cent of men and 41 per cent of women smoked cigarettes. During the 1970s and 1980s the gap between men and women narrowed. It has still not disappeared completely but had fallen to 2 percentage points in 2002/03.

Smoking has declined across all age groups. The largest decrease was among those aged 50 and over, from 40 per cent in 1974 to 19 per cent in 2002/03. The decrease was smaller among those aged 20 to 24, falling from 48 per cent to 38 per cent over the same period.

Consistent with the pattern since the 1970s, in 2002/03 the prevalence of smoking was lower in England (26 per cent) and in Wales (27 per cent) than in Scotland (28 per cent). Across England, prevalence tended to be higher in the north than in the Midlands and the south.

Smoking may lead to addiction and dependence. In 2002/03 more than half (57 per cent) of smokers in Great Britain said that they would find it difficult to go without smoking for a whole day.

Smoking is known to cause lung cancer and heart disease, and it contributes to a range of other diseases and conditions. Smoking is the main cause of lung cancer, responsible for 90 per cent of all lung cancer cases. It is estimated that each year over 120,000 people in the UK die from smoking-related causes, constituting around a fifth of all deaths.

In 1998 the Government set a target of a fall in the overall proportion of smokers in England from 28 per cent in 1996 to 24 per cent or less by 2010.

Sources:
Office for National Statistics, General Household Survey for data on smoking prevalence;

Notes:
Data have not been age standardised.
The General Household Survey figures before 1998/99 are based on unweighted data and from 1998/99 onwards on weighted data. The weighting procedure adjusts for differential non-response in different population groups.
Drinking

Drinking to excess rising among women

In 2002/03, around two thirds of adults aged 16 and over in Great Britain had had an alcoholic drink on at least one day during the previous week (74 per cent of men and 59 per cent of women).

Nearly one in three adults (30 per cent) had exceeded the recommended daily benchmark (of 4 units for men and 3 units for women) on at least one day during the previous week. Men were more likely to exceed the benchmark than women - 38 per cent of men compared with 23 per cent of women.

The proportion exceeding the daily benchmark was highest among young people aged 16 to 24 (45 per cent) and lowest among older people aged 65 and over (10 per cent). Nearly half (49 per cent) of young men aged 16 to 24 exceeded the benchmark compared with 16 per cent of older men aged 65 and over. Likewise, 42 per cent of young women aged 16 to 24 exceeded the benchmark compared with 5 per cent of older women aged 65 and over.

Across the GB regions, the proportion of adults exceeding the daily benchmark was highest in the North East (39 per cent) followed by Scotland and Wales (35 per cent). The lowest percentages were in London and the East of England (25 per cent), the South East and the West Midlands (27 per cent).

Heavy drinking (defined as above 8 units for men, and above 6 units for women, on at least one day in the last week) follows a very similar age pattern to drinking above the daily benchmark. Among both men and women, young people aged 16 to 24 were the most likely to drink heavily (35 per cent of men and 28 per cent of women) and older people aged 65 and over the least likely to drink heavily (5 per cent of men and 1 per cent of women).

Trends over time are only available for the previous guidelines of weekly recommended benchmarks (21 units for men, 14 units for women). Since the late 1980s there has been an increase in the proportion exceeding this level, almost entirely due to an increase among women. The proportion of women exceeding the weekly benchmark increased from 10 per cent in 1988/89 to 17 per cent in 2002/03 compared with an increase from 26 per cent to 27 per cent for men over the same period.

Drinking above the weekly benchmark increased across all age groups among women, but most markedly among young women aged 16 to 24. Their rate more than doubled from 15 per cent in 1988/89 to 33 per cent in 2002/03. This compared with an increase from 31 per cent to 37 per cent over the same period for young men of the same age.

Drinking above the recommended guidelines leads to increased risk of harm, both immediately and in later life. High levels of drinking play a part in mortality due to accidents and a number of diseases, including cirrhosis of liver, heart disease, strokes and some cancers.

In 2000, there were 11,800 drink-drive accidents in Great Britain, resulting in 530 deaths. It is estimated that there were 5,543 alcohol-related deaths in total in England and Wales in 2000.
Preventive Measures

Turning point in MMR vaccinations?

Immunisation

The immunisation rate for the measles, mumps and rubella (MMR) vaccine among 24 month old children living in the UK fell by 10 percentage points over the ten years to 2002/03, from 92 per cent in 1993/94 to 82 per cent in 2002/03. Concerns by some over the safety of the MMR combined vaccine led to this fall.

By the last quarter of 2002/03, the MMR vaccination rate had in fact dropped to 79 per cent. However, more recent quarterly figures show consistent increases in each quarter of 2003/04, to 82 per cent in the final quarter.

The proportion of children immunised against diphtheria by their second birthday has been much more stable, falling from 95 per cent to 94 per cent over the ten-year period.

The World Health Organisation (WHO) target coverage for MMR and diphtheria immunisation is 95 per cent.

Breastfeeding

Between 1995 and 2000, the rate of breastfeeding at birth in the UK rose from 66 per cent to 69 per cent. Northern Ireland experienced the greatest increase, rising from 45 per cent to 54 per cent, closely followed by Scotland where the rate rose from 55 per cent to 63 per cent.

Breastfeeding at birth is related to age of mother. In 2000, the UK rates ranged from 46 per cent among teenage mothers to 78 per cent for mothers aged 30 and over. Rates are also related to age of leaving full-time education. In 2000, 54 per cent of mothers educated to age 16 or below initiated breastfeeding compared with 88 per cent of those educated to at least age 19.

In Scotland, 40 per cent of mothers who started breastfeeding at birth were still doing so six months later. This compared with 34 per cent of those in England and Wales and only 21 per cent in Northern Ireland.

Research has shown that breast milk protects young children from a variety of illnesses, and enhances their cognitive development. Mothers who breastfeed are also protected against cancer and osteoporosis. Following WHO guidance, breastfeeding in the UK is recommended for the first six months of an infant’s life.

Sources:

NHS Immunisation Statistics, Department of Health for yearly immunisation data;
Communicable Disease Report Weekly, Health Protection Agency for quarterly immunisation data;
Infant Feeding Survey 1995 and Infant Feeding Survey 2000, Department of Health for breastfeeding data;
Evensen, S (1982) Relationship between infant morbidity and breastfeeding versus artificial feeding in industrialised countries: a review of the literature, Copenhagen, WHO Regional Office for Europe;

Notes:

Yearly immunisation data relate to the period April to March.
Rate of breastfeeding at birth is defined as the proportion of babies who were breastfed initially and this includes babies who were put to the breast at all, even if only on one occasion.
Health

GP Consultations

Home visits fall to 5%

Over the past 30 years there has been a shift in the way that people access their General Practitioners (GPs). In 2002/03, most GP consultations (86 per cent) in GB took place in surgeries or health centres. This proportion increased from 73 per cent in 1971.

GP home visits decreased considerably over the same period, from 22 per cent of all consultations in 1971 to 5 per cent in 2002/03. Telephone consultations more than doubled from 4 per cent in 1971 to around 10 per cent from 1998/99 onwards. During this period phone ownership has increased and telephone consultations with GPs have been made more widely available.

A GP’s decision on whether to visit a patient at home will depend upon a number of factors. These include the severity and urgency of the condition, as well as the patient’s access to transport, distance from the practice and their ability to communicate over the phone.

People aged 75 and over are the most likely to receive a home visit. In 2002/03, 17 per cent of GP consultations for people in this age group were home visits. Older people are more vulnerable to illness, are less likely to own a car, may be less willing or able to use a phone and are more likely to be housebound than younger age groups.

The change in site of consultation represents improved access, convenience to patients and more efficient use of GP time. The criteria for deciding whether a home visit is necessary have become more rigorous.

There are now more ways to access primary care than in the past, especially out-of-hours, when many home visits occur. These include nurse-led walk-in centres (which have long opening hours), NHS Direct, and ferrying people to a central surgery by car for emergency consultations.

Source:
Office for National Statistics, General Household Survey for GP consultation data.

Notes:
The GHS figures before 1998/99 are based on unweighted data and from 1998/99 onwards on weighted data. The weighting procedure adjusts for differential non-response in different population groups.
Informal Care

5.2 million carers in England & Wales

In April 2001, 5.2 million people were providing unpaid care in England and Wales. People in their fifties were the group most likely to be providing care. More than one in five were doing so. The proportion then declined with age.

A greater proportion of women than men were carers, both in the population as a whole and in age groups up to 64 years. Among those aged 65 and over, men were more likely than women to be carers.

The proportion of adults (people aged 16 or over) who provided care varied substantially according to local authority. Overall, the five local authorities with the highest percentage of carers were: Neath Port Talbot (17 per cent); Easington (16 per cent); Torfaen (16 per cent); Merthyr Tydfil (16 per cent); and North East Derbyshire (16 per cent). Seven of the ten local authorities with the highest proportions of adult carers were in Wales. Most of these ten local authorities also have high rates of limiting long-term illness or disability.

Local authorities in England and Wales with the lowest proportions of adult carers were concentrated in London and the South East. The ten with the lowest proportion were all Inner London boroughs. The five lowest all had proportions around 8 per cent. They were Wandsworth, Westminster, Hammersmith and Fulham, Kensington and Chelsea, and Lambeth.

Among 16 to 74 year olds, 13 per cent provided some unpaid care for other people in 2001. In this age group, 12 per cent of people in work were unpaid carers, compared with 15 per cent of people not in work.

Of those in paid work, part-time workers (15 per cent) were more likely to provide care than full-time workers (11 per cent). Self-employed people (13 per cent) were slightly more likely to provide care than people who were employees (11 per cent).

People who were not in paid work and who looked after the home and/or family were the most likely to provide care (24 per cent). This group also had the highest proportion (43 per cent) of its carers providing 50 or more hours per week of care.

Of the two remaining groups not in paid work, retired people (17 per cent) were more likely than the average to be carers. There was also substantial provision of care among people who were themselves permanently sick or disabled (14 per cent).

Source:
Census, April 2001, Office for National Statistics.

Notes:
The 2001 Census, for the first time, asked a question about the provision of unpaid care. It asked ‘do you look after, or give any help or support to family members, friends, neighbours or others because of long-term physical or mental ill-health or disability, or problems related to old age? Do not count anything you do as part of your paid employment’. Responses were only collated for those aged over 4.
Human Resources

2.5m work in health & social care in England & Wales

In 2001, 2.5 million people worked in the health and social care industry (excluding veterinary activities) in England and Wales. This included both the public and private sectors.

This analysis concentrates on some selected occupational groups in the health and social care industry: managers, health professionals, researchers, social and care workers, nurses and midwives, therapists, other health professionals and support staff. In total there were 1.5 million people employed in these occupations.

The largest single occupational groups were: care assistants and home carers (450,000), nurses (392,000), medical practitioners (115,000) and nursing auxiliaries and assistants (109,000). Other key occupations were dental practitioners (21,000) and midwives (25,000).

For every 10,000 people in England and Wales, there were 86 care assistants and home carers, 75 nurses, 22 medical practitioners, 5 midwives and 4 dental practitioners.

Overall, women made up 81 per cent of the workforce in the selected occupations. This varied greatly between occupations. In some occupations more than nine in ten employees were women - 99 per cent of midwives, medical secretaries and dental nurses, 97 per cent of speech and language therapists, 93 per cent of occupational therapists and 92 per cent of pharmaceutical dispensers. The only occupation where men comprised more than nine in ten of the employees was hospital porters (94 per cent).

A much larger proportion of men than women worked full time. The proportions working full time varied with occupation, from 59 per cent of male and 35 per cent of female therapists, to 99 per cent of male and 90 per cent of female paramedics.

A considerable number of people with professional health qualifications were not working. Around 7,500 doctors, 1,700 dentists, 57,300 nurses and 4,200 midwives - all of working age (16 to 64) and qualified - were unemployed or economically inactive.

Source:
Census, April 2001, Office for National Statistics for workforce and qualifications data.

Notes:
The Standard Industrial Classifications used were health and social work (N) excluding veterinary activities (852).
The Standard Occupational Classifications used were managers (1181-5), health professionals (2211-5), researchers (2321-2, 2329), social and care workers (2442, 6114-5), nurses and midwives (3211-2), therapists (3221-3, 3229), other health professionals (3213-8, 3567-8), support staff (4211, 6111-3, 9221).