Focus on Health describes the health of people living in the UK across five key dimensions: health status, risk factors, ill-health, preventive, curative and long-term care services and mortality. Emphasis is placed on trends over time.

Over the last 25 years, improvements in survival have resulted in more people living longer and an increasing proportion of deaths occurring in older ages. However, there remain substantial social and geographical variations in health status, with people who are disadvantaged in terms of their educational, employment and socio-economic background having higher rates of reported poor health and limitations in daily activities. On average, the population in England had better reported health than the other countries in the UK.

Trends in behaviour such as smoking and heavy drinking and increases in obesity and sexually transmitted diseases which are known risk factors for disease and poor outcomes are not improving, particularly among young people.
Health

Higher social groups report best health

In the 2001 Census, 40 million out of the 59 million people living in the UK rated their general health in the last year as ‘good’, a further 13 million rated it as ‘fairly good’, while 6 million people rated their health as ‘not good’. Children (aged 0 to 15) had the highest rate of good general health at over 90 per cent, with an additional 8 per cent rating their general health as fairly good.

Rates of good health decrease steadily with age with corresponding increases in rates of fairly good and not good health. While individuals aged over 65 account for just 16 per cent of the population, they represent 40 per cent of all those in not good health.

Men were more likely than women to report good health with rates of 74 per cent and 71 per cent, respectively. The overall difference between the sexes in rates of not good health was just 1 percentage point (7 per cent and 8 per cent respectively) once the age distribution of the population was taken into account.

Rates of not good health varied between 8 per cent in England to 11 per cent in Northern Ireland; rates for Scotland and Wales were 9 and 10 per cent respectively. Variation between rates of not good health between Government Office Regions (GORs) in England was wider, with a clear north-south divide. The GORs with the lowest rates of not good health were the South East and East (6 per cent) and the highest were the North East and North West (10 per cent).

There are substantial variations in reported health status by social group. Among those in employment, rates of not good health for people in routine occupations were more than double those for people in higher managerial and professional occupations (8.6 per cent and 3.4 per cent respectively). Those who had never worked or were long-term unemployed had even higher rates of not good health (18.5 per cent).

Other indicators of social position, such as housing tenure, also point to a social divide in health status. In 2001 those living in social housing had the highest rates of not good health, twice as high as those who rent privately and three times higher than owner-occupiers.

Sources
Census 2001, Office for National Statistics; Census 2001, General Register Office for Scotland; Census 2001, Northern Ireland Statistics and Research Agency

Notes
It can be assumed that the form filler answered the general health question on behalf of young children.
Data on housing tenure is only provided for Great Britain because Northern Ireland uses a different coding system from the rest of the UK to describe tenure.
Excludes residents of communal establishments.
Limiting illness

Daily activities limited for 1 in 6 people

In the 2001 Census, one in six people in the UK (10.3 millions) living in a private household reported having a limiting long-term illness (LLTI). There was a steady increase in rates of LLTI with age for both males and females. Below age 30, rates were less than 10 per cent but were more than twice this for those aged 45 to 59. Rates virtually doubled again at ages 60 to 74, reaching 41 per cent for men and 38 per cent for women.

In each age group up to age 59 the differences in rates of LLTI between males and females were minimal, at around 1 percentage point. However differences between the sexes were greater among people aged 60 and over. In the 60 to 74 age group men had a higher prevalence of LLTI than women; the situation was reversed for those aged 75 and over, with more women than men reporting an LLTI.

In the 2002/03 Family Resource Survey, the most common limitation reported by both men and women in GB was mobility, followed by the ability to lift, carry or move objects, and then by manual dexterity. The most common condition was musculoskeletal disorders, followed by heart and circulatory problems and then respiratory diseases.

The lowest rate of LLTI was among those working in higher managerial and professional occupations (7 per cent), which was half that of those working in routine occupations (15 per cent). People who had never worked or were long-term unemployed had the highest rate of LLTI (37 per cent) of any socio-economic group.

In most NS-SEC categories, there was little difference in LLTI rates between the sexes. However, men had higher rates of LLTI than women in the intermediate group, 12 and 9 per cent respectively, and never worked and long-term unemployed group, 41 and 34 per cent respectively.

Rates of LLTI also varied in relation to marital status. The highest rates were among those who were widowed (29 per cent), divorced or separated (25 per cent) or single (23 per cent). Married people had the lowest rate of LLTI at 18 per cent.

Sources

Census 2001, Office for National Statistics; Census 2001, General Register Office for Scotland; Census 2001, Northern Ireland Statistics and Research Agency

Notes

All relate to residents in private households.

Limiting long-term illness or disability that restricts daily activities is calculated from a ‘Yes’ response to the question in the 2001 Census: ‘Do you have any long-term illness, health problem or disability which limits your activities or the work you can do?’

Age-standardised rates allow comparisons between populations with different age structures. The method used here was direct standardisation using the European Standard Population.
Smoking

1 in 4 adults were smokers in 2003

Among adults aged 16 and over in GB, one in four (26 per cent) were cigarette smokers in 2003 – with a slightly higher proportion of men (28 per cent) than women (24 per cent). The proportion of smokers in routine and manual households was twice that of smokers in managerial and professional households (33 per cent compared with 15 per cent).

The proportion of adults who smoked was greatest among men aged 20 to 34 (38 per cent) and women aged 20 to 24 (34 per cent). It then steadily declined with increasing age to 16 per cent of men and 14 per cent of women aged 60 and over. In contrast, the average number of cigarettes smoked per day in 2003 was highest for smokers aged 50 to 59 – 18 by men and 15 by women. Average daily cigarette consumption by adults in 2003 was 15 for men and 13 for women.

Smoking prevalence 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, at around 27 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 falling to 2 percentage points in 1990. Since then, the gender gap has remained fairly constant, fluctuating between 2 and 4 percentage points.

Smoking has declined in all age groups. The largest decrease was in the 50 to 59 age group, from 51 per cent in 1974 to 25 per cent in 2003. The smallest decrease was in the 20 to 24 age group, falling from 48 per cent to 36 per cent over the same period.

In a separate survey of school pupils in England in 2004 the proportion of regular smokers (smoking at least one cigarette a week) increased substantially with age. By age 15, 26 per cent of girls and 16 per cent of boys smoked regularly.

Since 1986 the proportion of girls aged between 13 and 15 who were regular smokers has exceeded the corresponding proportion of boys.

Among regular smokers aged 11 to 15, the average number of cigarettes smoked per day remained fairly stable between 1982 and 2002 but was higher for boys (over seven per day) than for girls (between six and seven).

Smoking is the main cause of lung cancer, responsible for nine out of ten cases, and it contributes to a range of other diseases and conditions, such as heart and respiratory diseases. It is estimated that between 1998 and 2002 on average 106,000 people a year died from smoking-related causes in the UK – around one in six of all deaths.

Sources

General Household Survey, Office for National Statistics
Smoking, drinking and drug use among young people in England in 2004, National Centre of Social Research/National Foundation for Education Research for Department of Health

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 among girls continues to rise

Young drinkers aged 11 to 15 in England doubled their average weekly consumption of alcohol during the 1990s – from 5.3 in 1990 to 10.4 units in 2004. It has since stabilised for boys and continues to increase for girls. The greatest increase has been among girls aged 14, from 3.8 units in 1992 to 9.7 in 2004. In each year, among those who drank, boys consumed more alcohol than girls in every age group.

The proportion of children who drank increased with age, from 4 per cent of 11-year-olds to 45 per cent of 15-year-olds in 2004. Among both boys and girls, 23 per cent aged 11 to 15 drank alcohol in the previous week. Before 2004 the percentage was higher for boys than girls.

Among adults in GB in 2003 nearly one in three (31 per cent) exceeded the recommended daily benchmark (of no more than four units for men and three units for women) on at least one day during the previous week. Men were more likely to exceed the benchmark than women – 40 per cent of men compared with 23 per cent of women.

Younger people were more likely to exceed the daily benchmarks. Just over half (51 per cent) of men aged 16 to 24 did so on at least one day during the previous week compared with 19 per cent of men aged 65 and over. The corresponding figures for women were 40 per cent and 4 per cent.

Heavy drinking – defined as more than eight units a day for men and six units a day for women – on at least one day during the previous week was much more common among men (23 per cent) than women (9 per cent). Young people aged 16 to 24 were the most likely to drink heavily (37 per cent of men and 26 per cent of women). People aged 65 and over were the least likely to drink heavily (6 per cent of men and 1 per cent of women).

Drinking above the recommended guidelines leads to increased risk of harm, both immediately and in later life. It is estimated that there were 5,500 alcohol-related deaths in England and Wales in 2000, the majority from chronic liver disease such as cirrhosis.

Each year there are also approximately 3,500 deaths on UK roads, of which around one in six are alcohol related. Drink-drive fatalities have fallen by two-thirds since the late 1970s. In 2003, Department of Transport estimates showed there were still 580 fatalities and 2,600 serious injuries where at least one of the drivers involved was over the legal limit.

Sources
Survey of smoking, drinking and drug use among young people in England, Department of Health.
General Household Survey, Office for National Statistics.

Notes
Data presented in two-yearly intervals
In 1992, the Government introduced the weekly guideline that men should drink under 21 units per week and women under 14 units per week. In 1995, the guidelines were changed from weekly to daily, advising that men should drink no more than four units per day and women no more than three units per day. A unit is defined as 8 grams of alcohol which is equivalent to half a pint of ordinary strength beer, a small (125ml) glass of wine (at 9 per cent strength) or one measure of spirits.

The legal limit for the alcohol level for driving is 80 milligrammes of alcohol in 100 millilitres of blood.
Eating & exercise

1 in 6 children were obese in 2002

The prevalence of obesity in England has increased markedly among both adults and children since the mid 1990s. In 2002 it was similar for both sexes; the rate for boys and girls was 17 per cent and for adults was 23 per cent. In 1995 the equivalent figures were 10 per cent for boys and 12 per cent for girls, 15 per cent for men and 18 per cent for women.

There is no evidence that the average calorific intake or consumption of foods rich in fat and added sugar has increased in the UK since the mid 1980s. Men aged 19 to 64 in 2000/01 reported a daily energy intake of approximately 2,323 kcal (a reduction of 6 per cent since 1986/87). Women in the same age groups reported 1,642 kcal, a reduction of 3 per cent.

Reductions over the same period were also observed in the contribution of total fat to total energy intake (from 38 to 34 per cent in men and from 39 to 34 per cent in women) and saturated fat (from 15 to 13 per cent in men and from 17 to 13 per cent in women).

In 2003 the percentage of adults meeting the recommendations for physical activity in England declined with age for both sexes. Men were more active than women in every age group and their activity levels declined steadily with age. For women, activity levels remained the same until the 45 to 54 age group, and then declined.

Since the early 1990s there has been a steady increase in the use of cars and a decrease in walking and cycling to school or to work in GB. Among children aged five to ten, the proportion who walked to school fell from 61 per cent in 1992–94 to 52 per cent in 2002–03, mirroring the equivalent 10 percentage point rise in the proportion of school journeys by car, from 30 per cent to 40 per cent.

Among adolescents aged 11 to 16, the proportion of journeys to school by car increased from 16 to 23 per cent over the same period, reflecting the combined decrease in journeys on foot or by bicycle.

For adults aged 17 and over, the proportion of journeys to work where the main mode of travel was by car rose from 66 per cent in 1989–91 to 71 per cent in 2002–03. During the same interval journeys that were mainly on foot fell from 13 to 10 per cent.

Notes:
Adults are people aged 16 and over.
Obesity in children is defined as those boys and girls who had a BMI in the top five per cent of the 1990 UK BMI measurements taking into account their age and sex. Obesity in adults is defined as those who had a BMI greater than 30 kg/m2.
Department of Health recommendations are that total daily food intake should not comprise more than 35 per cent total fat and 11 per cent each of saturated fat and added sugars.
The Chief Medical Officer recommends that all adults should achieve a total of at least 30 minutes a day of at least moderate intensity physical activity on 5 or more days of the week.
Obesity prevalence rates are not age standardised.
Sexual health

HIV & chlamydia diagnoses increasing

New diagnoses of HIV among heterosexuals tripled between 1998 and 2003, reaching 3,800. Since 1999 heterosexual transmission has predominated. Before this sex between men was the main route of infection in the UK. New diagnoses of HIV following sex between men exceeded 1,700 in 1991, after which the number fell to less than 1,400 in 1999. The annual figure then increased, exceeding 1,700 once more by 2001.

The number of diagnosed HIV-infected patients receiving care in the UK in 2003 exceeded 37,000. Half lived in Greater London.

An estimated 14,300 infected adults aged over 15 were undiagnosed. Among those infected through heterosexual activity, 39 per cent of men were estimated to be undiagnosed compared with 22 per cent of women.

Chlamydia is the most common sexually transmitted infection (STI) in the UK. It is often undiagnosed, since it is asymptomatic in 70 per cent of infected women and 50 per cent of infected men.

Between 2000 and 2004, the rate of new diagnoses of chlamydia among people who attended Genitourinary Medicine (GUM) clinics greatly increased from 116 to 175 per 100,000.

The largest increases in chlamydia rates were seen in persons under the age of 16. However, the highest rates were in females aged 16 to 19 (1,339 per 100,000), and males aged 20 to 24 (1,034 per 100,000).

In 1999/2001 more men (15 per cent) had concurrent partners than did women (9 per cent). Concurrent sexual relationships increase the probability of STI transmission.

Sources
Health Protection Agency

Notes:
Round figures are quoted for HIV diagnoses because these counts are subject to change as further reports are received.
Human immunodeficiency virus (HIV) is mainly transmitted through sex. Other routes of infection affect a much smaller group of people: for example injecting drug users and mother to infant.
The prevalence of arthritis and rheumatism is higher in women than in men and also increases with age in both sexes. In 2003 the rates for men and women in GB were less than 25 per 1,000 population up to age 44. After that there was a rapid increase in prevalence, with rates increasing sixfold to age 64. The rates for women then rose more sharply than for men: among those aged 65-74, the prevalence rate for women was twice that for men (227 per 1,000 compared with 113).

The two most common forms of the disease are osteoarthritis and rheumatoid arthritis. Osteoarthritis, sometimes called degenerative joint disease, is uncommon in people under 40 and increases with age thereafter. Other risk factors include being overweight and having an injury, operation or repeated strain on a joint. In rheumatoid arthritis, the immune system starts attacking the joints and sometimes other parts of the body. People of all ages can have the condition, but it most commonly starts between the ages of 30 and 50. There are a variety of treatments available for arthritis including medication (for example non-steroidal anti-inflammatory drugs and disease-modifying drugs), physiotherapy and surgery.

Migraine prevalence varies dramatically between the sexes. In 1991/92 the illness was some three or four times more common in women than in men in all age groups between 16 and 54 in England and Wales. This female preponderance is commonly assumed to be associated with fluctuating hormonal levels during the female menstrual cycle. Rates were around 25 per 1,000 population for all age groups between 16 and 54. Beyond this age the rate falls gradually from 13 per 1,000 for women aged 55-64, to 4 per 1,000 for the oldest age group. The male rate is relatively stable and less than 7 per 1,000 population throughout the life span.

The condition can have a very disruptive effect on the lives of sufferers because severe episodes can last as long as three days, during which the person is unable to carry out any of the activities of daily life. Measures of health-related quality of life have been found to be worse for migraine sufferers than for people with asthma. One in three sufferers believe that the condition controls their life.

Sources
General Household Survey, Office for National Statistics
Fourth National Morbidity Study from General Practice 1991/92, Office for National Statistics

Notes:
The prevalence rates for arthritis reported here are based on respondents coded into the General Household Survey category ‘arthritis/rheumatism’ and thus are a proxy for arthritis. All forms of arthritis will be included if the symptoms are sufficiently severe to have troubled the informant over a period of time.
Cancer

1 in 3 develop cancer during their lives

Incidence
The four most common cancers – breast, lung, colorectal and prostate – accounted for just over half of the 227,500 new cases of malignant cancer (excluding non-melanoma skin cancer) registered in England in 2003. Around 112,700 of the total were in males and 114,700 in females. Breast cancer accounted for 32 per cent of cases among women and prostate cancer for 24 per cent among men.

Cancer is predominantly a disease of the elderly – only 0.5 per cent of cases registered in 2003 were in children (aged under 15) and 26 per cent were in people aged under 60.

Between 1971 and 2003, the age-standardised incidence of cancer increased by around 17 per cent in males and 40 per cent in females.

Mortality
One in four people die from cancer.

The four most common cancers accounted for just under half of the 126,800 deaths from cancer (excluding non-melanoma skin cancer) in England in 2003. Around 66,000 of the total were in males and 60,800 in females. Cancer accounted for 28 per cent of all deaths in males and 23 per cent in females.

Between 1950 and 2003, age-standardised cancer mortality in England and Wales changed very little. In contrast, mortality from the other main causes - heart disease, stroke and infectious diseases - declined. Consequently, all cancers became the most common cause of death in females in 1969 and in males in 1995, if heart disease and stroke (both diseases of the circulatory system) are regarded separately. However, no single cancer is more common as a cause of death than 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 very low for cancers of the pancreas, lung, oesophagus and stomach, in the range 2-15 per cent for patients diagnosed in England in 1998-2001, compared with colon cancer (around 50 per cent), cancers of the bladder, cervix and prostate (53-71 per cent) and breast cancer (80 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.

Source
Office for National Statistics

Notes:
Detailed results for incidence and mortality have been published in the MB1 and DH2 series, respectively.

Age-standardised rates allow comparisons between areas or over time where populations have different age structures. The method used here is direct standardisation using the European standard population (see ‘Glossary’ in Focus on Health report).

The registration of non-melanoma skin cancer has varied widely across the cancer registries, depending on both their degree of access to out-patient records and GPs, and their policies and practices on the registration of multiple tumours in one patient. The figures for ‘all malignancies’ therefore exclude non-melanoma skin cancer.

Relative survival estimates survival from the cancer concerned by taking into account mortality from other causes in the general population (of the same age and sex).
Mental health

1 in 6 adults have a neurotic disorder

In 2000 one in six adults in Great Britain had a neurotic disorder (such as anxiety and depression), while one in seven had considered suicide at some point in their lives. One in 200 had a psychotic disorder such as psychosis and schizophrenia.

The most common mental disorders were: mixed anxiety and depression (7 per cent for men, 11 per cent for women), anxiety (4 per cent for men, 5 per cent for women) and depression (2 per cent for men, 3 per cent for women). All neurotic disorders were more common in women than men, except for panic disorder which was equally common in both sexes.

Psychiatric disorders and suicidal attempts were more likely to occur in people facing socio-economic disadvantage: that is people with unskilled occupations or who were unemployed, who lacked formal qualifications, who were renting accommodation from a local authority or housing association, who were living alone, or were separated or divorced.

The rates of psychiatric disorders in 1993 and 2000 were similar, but the proportion of people receiving treatment increased considerably over the period. In 2000, overall 24 per cent of people received treatment compared with 14 per cent in 1993. The rise was a result of a doubling in the proportion receiving medication, from 9 per cent in 1993 to 19 per cent in 2000. The proportion receiving psychological treatment, however, remained level, at 9 per cent in 2000 – 1 percentage point higher than in 1993. The proportion of people receiving both medication and psychological treatment also remained level at 3 per cent in 1993 and 4 per cent in 2000.

Psychotic disorders, although less frequent than neurotic disorders, were more likely to be treated because of the nature and severity of the condition. In 2000, 85 per cent of people with psychosis were receiving some kind of treatment; 83 per cent medication and 40 per cent psychological treatment.

People with a psychotic disorder were also more likely to use mental health services on offer in community and in hospitals than people with a neurotic disorder. In 2000 two in five people with a psychotic disorder had used at least one community care service (consulting a psychiatrist/psychiatric nurse, seeing social worker) in the past three months, compared with less than one in ten of people with a neurotic disorder. Likewise, more than one in five of people with a psychotic disorder had visited a psychiatric outpatient clinic compared with only one in twenty people with a neurotic disorder.

A follow up survey in 2001 showed that half of people with neurotic disorders had not recovered 18 months later. Many of the socio-economic factors associated with the prevalence of neurotic disorders were also associated with a reduced chance of clinical recovery. The survey showed that people who had received treatment over the 18 months were twice as likely to recover as the people not receiving treatment. In contrast, psychotic disorders have a more prolonged course, with relapses followed by periods of remission over many years.

Sources

Surveys of Psychiatric Morbidity among Adults in Great Britain, Office for National Statistics
Better or worse: a longitudinal study of the mental health of adults living in private households in Great Britain, Office for National Statistics.
Preventive measures

Fivefold rise in mumps among young adults

Over 16,000 new cases of mumps were notified in 2004, a fourfold rise compared with 2003. This followed a doubling in the number of cases over the previous year. The substantial rise in mumps mostly occurred in adults, with a more than fivefold rise between 2003 and 2004, to over 13,000 cases. Over 11,000 of these cases (84 per cent) were among young people aged 15 to 24. The rise for children under 15 was more gradual, nearly doubling over the same period to reach 2,800 cases, the highest level since 1990.

The increase largely reflects lower immunity among older teenagers and young adults in their early 20s, particularly those born between 1983 and 1986 immediately before the introduction of routine vaccination in 1988. These young people would not have been exposed to mumps in childhood because of the swift success of the MMR (measles, mumps, rubella) vaccine in controlling the disease. Older adults were more likely to have had mumps when it was still a common childhood infection.

The introduction of the MMR vaccine in 1988 had an almost immediate effect on the incidence of mumps. Consultations with general practitioners for the illness fell from 2.2 per thousand in that year to 0.6 per thousand in 1990 in England and Wales. There was also a steep decline in notified cases from nearly 21,000 in 1989 to about 2,400 in 1992, as the vaccine became established, with coverage in England, for example, reaching 92 per cent in 1992/93.

The number of cases remained low during the 1990s for all ages. However there was an increase in notified cases for children under 15 at the turn of the century. Although 2002 showed some remission, the number of cases for this age group had risen to over 2,800 by 2004, the greatest number since 1990.

Mumps is an acute viral illness spread through coughing or sneezing and through direct contact with saliva. Symptoms include fever, headache, and painful swollen glands, and in more severe cases complications such as swelling of the testes or ovaries, deafness, or meningitis may occur.

By 1996/97 MMR coverage at 24 months of age reached 92 per cent. In 1997/98, however, uptake of MMR began to fall, declining to 81 per cent in 2003/04. There has since been a slight improvement, to 82 per cent in 2004/05. MMR coverage fell dramatically, unlike diphtheria where levels of coverage dipped slightly from 96 per cent to 94 per cent. There is substantial variation between countries. In 2004/05 MMR coverage was lower in England (81 per cent) and Wales (82 per cent) than in Scotland and Northern Ireland (88 per cent). The World Health Organisation (WHO) recommends immunity levels of around 95 per cent to prevent outbreaks of disease.

Sources
Health Protection Agency

Notes
Vaccination courses completed by age 24 months.
Use of Services

Home visits fall to 4% of GP consultations

Over the past 30 years GP home visits have declined as a proportion of all consultations, reflecting the increase in the proportions of both telephone and surgery consultations. In 2003, 86 per cent of GP consultations in Great Britain took place in surgeries or health centres compared with 73 per cent in 1971. Over the same period telephone consultations more than doubled from 4 per cent in 1971 to around 10 per cent between 1998 to 2003. In contrast, the proportion of home visits declined by a fifth from 22 per cent in 1971 to 4 per cent in 2003.

Recent surveys of NHS patients’ experience of GP services in England show satisfaction with GP services generally remains high. However, more patients reported having to wait for appointments: 72 per cent said they had to wait two or more days to see their preferred GP compared with 63 per cent in 1998. In 2002 patients contacting the out of hours service were less likely to receive a home visit (33 per cent) than in 1998 (47 per cent). Those receiving home visits out of surgery hours were also more likely to wait an hour or more for a doctor to arrive in 2002 than in 1998 (55 per cent compared with 47 per cent).

Since 1972 the average number of GP consultations per person in Great Britain has remained relatively stable at around four consultations per year. However, over the years the role of the practice nurse in GP surgeries has expanded significantly, particularly in the management of chronic diseases (eg diabetes, asthma) and preventive services (eg vaccinations and contraceptive advice). In 2003, 5 per cent of people in the UK reported consulting a practice nurse in the past fortnight compared with 15 per cent consulting their GP.

There are now also new ways to access primary care health services, serving mainly as an additional out of hours service. These include NHS Walk-in centres (usually sited in hospitals and city centres) and NHS Direct.

NHS Direct was launched in England in March 1998 to complement GP services. It is a 24-hour nurse-led telephone helpline, which provides quick and convenient access to health care information and advice. NHS Direct has been gaining in popularity with the general public. The number of calls handled has been increasing year on year, from around 100,000 calls in 1998/99 when it was launched to 6.4 million in 2003/04. Similar services have been set up in Wales and Scotland.
Caring and Carers

6 million unpaid carers in the UK

Around 6 million people (11 per cent of the population aged five years and over) provided unpaid care in the UK in April 2001. While 45 per cent of carers were aged between 45 and 64, a number of the very young and very old also provided care.

There were 114,000 children (just over 1 per cent) aged 5 to 15 years providing care in 2001, with 9,000 of these (8 per cent) caring for 50 or more hours a week. Around 44,000 people (5 per cent) aged 85 and over provided care, with around half of these (51 per cent) spending 50 or more hours a week caring.

Under the age of 65 a larger proportion of women than men were carers. The number of hours of care given was related to age, with a higher percentage of older carers providing 50 or more hours a week. The proportion of carers providing this level of care rose sharply from age 65.

The percentage of people aged 16 to 64 providing unpaid care does not vary greatly by social group. For both sexes the difference between those groups with the lowest and the highest proportion of carers was just 2 percentage points.

However, there was a clear variation across the social groups in the number of hours of care provided. Over a fifth (22 per cent) of carers in routine occupations and nearly two-fifths (37 per cent) of carers who had never worked or were long-term unemployed provided 50 or more hours of care per week. This compares with less than one in ten (8 per cent) of carers in the higher managerial and professional group.

While family and friends may provide unpaid care, a number of people receive formal care services either in institutions or their own homes. Social Services and the NHS, as well as both private and charitable organisations, have a role in providing formal care.

The amount of formal care provided by local authorities has increased markedly in recent years. Councils with Social Service Responsibilities (CSSRs) provided or purchased an estimated 3.4 million contact hours of home help or home care in a single week in September 2004. This was almost twice the amount provided in 1993 (1.8 million hours per week). More than two thirds (69 per cent) of all paid home care was provided by the independent sector with less than one third (31 per cent) directly provided by CSSRs.

In 2001, 510,000 people in the UK were living in medical and care establishments, two fifths (43 per cent) of whom were aged 85 and over. The majority of people were living in residential care homes (52 per cent) and nursing homes (35 per cent). Females made up 69 per cent of those living in medical and care establishments.

Sources
Census 2001, Office for National Statistics; Census 2001, General Register Office for Scotland; Census 2001, Northern Ireland Statistics and Research Agency

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 four.
Age-standardised rates allow comparisons between populations with different age structures. The method used here was direct standardisation using the European Standard Population.
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: 300 per 100,000 males and 190 per 100,000 females in 2003. 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 2003, for young people aged 15 to 29, mortality rates were highest for injury and poisoning (40 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 (43 per 100,000 population) and cancers the leading cause of death for women (30 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 240 per 100,000 for men and 213 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.

### Major cause of death: by sex and age, 2003

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<td>Injury and poisoning</td>
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<tr>
<td>All causes</td>
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<td>All causes</td>
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<td><strong>All Persons</strong></td>
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<td>Circulatory diseases</td>
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<td>All causes</td>
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### 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.
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Links to further information can be found in the online overviews.

www.statistics.gov.uk/focuson

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