Review of the London Health Strategy

high level indicators

- 2003 update
- Focus on the experience of disabled Londoners

London Health Commission
Cover photos (clockwise from top left):

Man with learning difficulty painting wall mural
Visually impaired child playing
John Birdsall Photo Library
www.johnbirdsall.co.uk

Smiling schoolboy with hearing impairment
Disability Rights Commission (Manchester)
www.drc.gov.uk

Disabled man attending fitness club
Third Avenue
www.third-avenue.co.uk
This report presents work developed by the Greater London Authority and the London Health Observatory, brought together and published by the London Health Commission.

**Aims of the report**

- to provide London-wide information on health and the determinants of health in a form that will support discussion and action by agencies at local, regional and national level
- to identify important inequalities in health and the determinants of health in London, and to track trends in inequalities
- to highlight how disabled people in London experience the determinants of health, indicating key areas where action is needed to reduce inequality
- where appropriate, to draw out implications for action from the report's findings.

**Editorial notes**

*Ethnicity:*

There is much debate about terminology relating to race and ethnicity and about whether any terms or categories, including those used in official statistics (e.g. 'non-white'), can claim to be accurate, appropriate, sensitive or value free. We can only touch on the existence of this debate here. No single term is entirely adequate and none will serve all purposes, as most commentators observe. Clearly, however, some choice of terms has to be made, including in relation to citing official statistics. Accordingly, a range of 'umbrella' terms is used in this publication.

*Maps:*

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Foreword

Health in London was first published in March 2002, and provided much-needed insights into patterns of health between boroughs and communities and across London as a whole. The report was welcomed and put to practical use by a wide range of agencies and partnerships at local, regional and national level. This year's update has again been made possible by partnership working between the London Health Commission, Greater London Authority and the London Health Observatory.

When I set up the independent London Health Commission in 2000, my hope was that it would form a focus for collective action across the capital to strengthen work in key areas that influence the health and well-being of Londoners. The commitment to map and respond to inequalities in health was then and is now a key driving force. This report adds to our understanding of health in London, offers pointers to where further research is needed and highlights opportunities for practical action.

Inequalities in health take many different forms and arise from a variety of causes. It is now accepted that there are clear relationships between wealth and health (and London has three out of five of the most deprived boroughs in England). However, many other factors also affect people's health, including ethnicity, social networks, education, and living and working conditions. The inter-relationships between factors of this kind are complex in nature. For some individuals and communities they may have a 'snowballing' effect where the combined negative impact is strong.

2003 is the European Year of Disabled People, and our second Health in London report includes a focus on the experience of disabled Londoners, who make up over 20 per cent of our population. The report clearly shows some of the inequalities experienced by disabled people regarding access to the opportunities and services that make a difference to health and well-being. It also demonstrates the lack of research and information on many aspects of disabled people's lives, and identifies areas for further work.

Health in London contributes to our ongoing work with partners to better understand and tackle the barriers affecting the lives of disabled people and is a timely reminder of the challenges we all face in making London a more accessible and inclusive city.

The review makes it clear that London continues to be a much healthier place for some than for others. I commend this report to those individuals, organisations, agencies and partnerships who want to know more about the scale and nature of the task facing all of us in driving forward health improvement and tackling health inequalities in London.

Ken Livingstone
Mayor of London
Key findings and implications

Section 1

Key findings and implications

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

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.
2003 review of the London Health Strategy high-level indicators

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

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.
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.

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.

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.

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.

- Levels of some pollutants, including nitrous dioxide (NO2) and fine particles (PM10), 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.

- 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.

- 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.

- 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.

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 other's 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.

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.

2003 review of the London Health Strategy high-level indicators
• 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.
In this section:

• The context for the report is described, along with its main aims.
• Potential uses of the report are outlined.
• Perspective is given on the kind of insights provided by the indicators.
Aims of the report

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

Like the earlier report, this publication focuses on inequalities in health. A particular focus for 2003, the European Year of Disabled People, is the experience of disabled Londoners. The report for 2004 will focus on the health-related experience of black and minority ethnic communities: significant information in this field will be collected and analysed during the coming months.

The aims of the report are:

• to provide London-wide information on health and the determinants of health in a form that will support discussion and action by agencies at local, regional and national level
• to identify important inequalities in health and the determinants of health in London, and to track trends in inequalities
• to highlight how disabled people in London experience the determinants of health, indicating key areas where action is needed to reduce inequality
• where appropriate, to draw out implications for action from the report's findings.

Context for the report

This report presents work developed by the Greater London Authority and the London Health Observatory, brought together and published by the London Health Commission. (For further information on these bodies, please see the back cover.)

The report arises from work on the London Health Strategy, developed in 1999-2000 by a partnership of regional and local agencies. Laying the foundations for the work of the London Health Commission, the London Health Strategy aims to improve the health of Londoners and reduce health inequalities across the capital. The priorities of the London Health Strategy have been incorporated into the London Health Commission work programme, which includes additional priority areas subsequently identified with partners.
For more information on the origins and nature of the London Health Strategy, please see Section 2 of the 2002 Health in London report.

The process of developing the London Health Strategy included identifying a set of high level indicators – listed on page 10 – that would be used to measure changes over time and to monitor progress towards reducing health inequalities. Section 4 of this report defines and discusses the indicators, and, for each indicator, reviews key developments in London during 2002-2003.

Who is the report for, and how might it be used?

The report is designed to be useful to a wide range of individuals, organisations, agencies and partnerships. At local level, for example:

• Local strategic partnerships and their partner organisations, such as primary care trusts, can identify patterns of health and well-being in the geographical areas of most concern to them, and explore how their findings compare with the picture elsewhere in London.

• Multi-sector partnerships can use the findings to help inform their needs assessments of different populations and areas.

• Community groups can draw on the findings to identify outstanding needs and build a case for improved services.

At regional and national level, agencies will be able to draw on the report in order to:

• identify pan-London trends
• track emerging issues that cross borough boundaries or affect particular populations
• identify trends over time.

What kind of insights do the indicators provide?

Shedding light on the determinants of health

Many different factors influence health. The factors which have been found to have the most significant influence – for better or worse – are known as ‘the determinants of health’. While health and social services make a contribution to health, most of the key determinants of health lie outside the direct influence of health and social care.

Figure 1 (see page 12) presents the determinants of health in terms of layers of influence, starting with the individual and moving to wider society. Included in these layers are the first seven of the ten indicators of the London Health Strategy. They have been designed to highlight significant aspects of the key factors affecting health. The final three indicators – life expectancy at birth, infant mortality rate, and the proportion of people with self-assessed good health – are rather different in nature and purpose, and fall outside the scope of this particular diagram. They offer a means of judging health outcomes themselves – that is, the results for individuals and communities of the interplay of the different influences shown in the diagram.

Highlighting areas of health inequality

Broadly speaking, there are three types of inequality in health:
inequalities in the determinants of health (for example, in education, employment or housing)

• inequality in access to health care (for example, refugees in London often have difficulty in obtaining primary health care)

• inequalities in health/health outcomes (for example, there are six years difference in average life expectancy at birth between the boroughs in London).

The high level indicators that are the subject of this report focus strongly on health outcomes and health determinants. The reason for this is that, as discussed earlier, most health is gained or lost outside the sphere of influence of the health service. That said, however, as one of London's biggest employment sectors, the health and social services have a huge potential contribution to make to many of the key determinants of health.

More information on the determinants or indicators selected and how they are related to health is discussed in Section 4. Further background information can be found on the London Health Observatory web site at www.lho.org.uk.

Dimensions of inequality

As the report shows, different groups of people have very different experience of the determinants of health. These different experiences can have an effect on health. Some of the groups involved are well known – in particular, gender, class, ethnic group, age and geographical area. Others might be less obvious – such as disability, single parenthood, quality of school, age of housing stock, type of road user. Inequalities can become entrenched when these categories overlap (for example, individual lifestyle factors, social and community networks, general socio-economic, cultural and environmental conditions).
example, in a combination of ethnic group, age, area). In these circumstances, there can be a 'snowballing' effect where it is unclear exactly how the determinants are related to each other – but it is clear that the combined negative impact is strong.

Some factors, like age, are dynamic; people do not necessarily stay in poverty – they can move in and out of it. The report attempts to deepen understanding of many of these dimensions in London – though by no means all. Section 3 focuses on the experience of disabled Londoners.

The national context

The work represented by the report fits well with work being carried out nationally to identify and combat inequalities in health and the factors influencing health.

In 1998 the Independent Inquiry into Inequalities in Health (Acheson) undertook a comprehensive review of health inequalities in England, including analysis by geography, age, class, gender and ethnicity, and made 39 recommendations for action. In July 1999 the White Paper Saving Lives: Our Healthier Nation (DOH 1999) was published. It aims to 'improve the health of everyone and the worst off in particular'. Following this, the Government gave a commitment in the NHS Plan (DOH 2000) to reducing health inequalities.

New national targets for reducing health inequalities in life expectancy and infant mortality were announced in February 2001 (DOH 2001). In a streamlined form, these targets appear in the Department of Health public service agreement which takes effect from 2003. Life expectancy and infant mortality are included as two of the indicators in this report.

A consultation on an action plan for the delivery of these targets was initiated in 2001 (DOH 2001) and a plan to tackle inequalities in health will be released later in 2003. Alongside this there will be a 'basket of indicators' that can be used to monitor trends in health inequalities. The 2002 release of the Priorities and Planning Framework presents NHS organisations at a local level with an opportunity to plan investment in some important areas relating to inequalities.

The importance of addressing health inequalities is being actively acknowledged well beyond the Department of Health. During 2001-2, a Treasury-led cross-government spending review explored how spending can be modified – or new spending introduced – to maximise the impact on health and health inequalities. As a result, most government departments are signing up to binding proposals for modified or new spending during the next spending review period – 2003-7.
Section 3

Focus – Living in a disabling world

In this section...

• Influences on the health of disabled Londoners are described.
• The social model of disability is described and discussed.
• The challenge of making London more accessible to disabled people is discussed.
What part can this report play?

The 2002 Health in London report noted that the high level indicators associated with the London Health Strategy give comparatively little information about the health and well-being of disabled people. This is because the indicators are themselves based on information that is relatively easily available – and there is a lack of good quality information on disabled people's access to and experience of the determinants of health. For this reason, a key recommendation from the report was that action should be taken to improve the quality and extend the coverage of information of this kind.

This year's report aims to contribute to increasing our collective understanding of the issues underlying the inequality of health experienced by disabled Londoners. In particular, it flags up significant new information and identifies major gaps in knowledge. Importantly too, the report indicates areas for further study and implications for future action.

Influences on the health of disabled people

The health and well-being of disabled people are affected by the same range of influences described in Section 2. The importance of different influences may differ markedly, however. For example, accessibility – of services and of different aspects of the environment – is key to the quality of life of most disabled people. Similarly, the attitudes of some non-disabled people can profoundly affect the lives of disabled people – for example some educators or employers make assumptions about abilities or limitations, so restricting access to choice about education and employment opportunities. Organisations of disabled people have significant concerns that the attitudes of some non-disabled health professionals influence access to health and related services. For example, people with learning difficulties have lower rates of cancer screening, illustrated by a Department of Health study that showed uptake of cervical screening was only 20% for women with learning disabilities, compared with an average UK uptake figure of 85%.

There has also been shown to be a close connection between impairment and socio-economic factors, like employment, income, and educational success, and this report further considers some of these issues. Although some individuals are able to maximise their potential, others may be caught in a vicious cycle where, for example, poor housing conditions and lack of access to opportunities and services affect health adversely, which in turn impacts on ability to engage in education or employment opportunities. Disability co-exists with other dimensions of inequality – such as ethnicity – compounding the effects of individual factors; and the impact of being a disabled person may vary considerably during different periods of an individual's lifetime.

Disabled people

Disability is described in many different ways, often reflecting the way of thinking of those defining the 'problem' or source of disablement.
Greater London Action on Disability defines disabled people as 'those who are prevented by barriers put up by society from taking part in aspects of everyday life on equal terms with non-disabled people'.

This definition is based on the social model of disability which makes the important distinction between 'impairment' and 'disability' and is the response of the disabled people's civil rights movement to oppression experienced by disabled people. It reflects a way of thinking which locates the problem in a disabling world where individuals are disadvantaged or excluded by barriers which exist because little or no account has been taken of people who have impairments.

Barriers include inaccessible information, poor design in the built environment, other people's attitudes (including fear, negative assumptions and low expectations), or organisational issues (such as the way services are defined and made available).

The Greater London Authority has formally accepted that disability is a social phenomenon, and that disabilism is a form of oppression in the same way as, for example, racism, sexism and homophobia.

For disabled people to be able to access mainstream society – as is their right – the barriers that exclude them need to be removed. The social model of disability offers a constructive approach which shifts the focus to the potential role of a wide range of people and organisations in identifying solutions. It encourages cooperative problem-solving, potentially removes barriers for others as well as disabled people, and acknowledges the right of disabled people to participate as full citizens (GLAD, 2002).

Some organisations and individuals, however, still define disability in a way which locates the problem within the disabled person, with a focus on the specific impairment or illness an individual person is identified as having. This approach is sometimes called the medical model or the individual model of disability. The logical response is that the disabled person needs to be treated, rehabilitated, or trained to be able to fit in to 'normal' society. Failing that, disabled people may be expected to access segregated services – such as 'special schools' or 'sheltered workshops' – rather than being empowered to access mainstream opportunities and services.

Appropriate access to rehabilitation and specialist services is an important aspect of maximising some disabled people's independence and well-being. In addition, disabled people need access to the full range of health promotion, screening and medical services to prevent and treat illness (as distinct from impairment).

Decisions about provision of medical and allied services must centre around the disabled person's own priorities and aspirations; respecting each individual's decision to access or decline treatment; and recognising their requirements and choices about how relevant services are provided. Further, medical and associated interventions should in no way be seen as substituting for ongoing work to challenge and deal with barriers faced by disabled people in mainstream society.
The Disability Discrimination Act (DDA) (1995) defines a disabled person as ‘anyone with a physical or mental impairment which has a substantial and long term adverse effect upon his or her ability to carry out normal day-to-day activities’.

This definition is not perfect but it does helpfully include a wide range of conditions in the terms of the Act including, for example: mental illness, HIV/AIDS, severe disfigurement and epilepsy; as well as physical, sensory or learning impairments. Although people often think about disability in relation to wheelchair use, permanent wheelchair users make up a very small proportion of the population – fewer than 5% of disabled people. On the basis of the DDA definition, there are roughly 8.5 million disabled people in Britain – one in seven of the population (Disability Rights Commission, 2003).

The GLA’s recent survey of over 8,100 households identified that 20% of households included a disabled person. Of these disabled people, 32% identified themselves as having a physical impairment, 9% as having mental health needs, 6% as having a sensory impairment, and 5% as having a learning impairment (The London Household Survey, GLA, 2003).

Equal access for disabled people?

The testimony below highlights the need to recognise that providing equal access to services and opportunities is likely to require organisations to develop a range of varied approaches to offering and delivering them. Put another way, ‘equal opportunities’ does not mean that all people are treated the same, but rather that their diversity is recognised and accommodated to enable them to access services and opportunities. Disabled people will have as wide a range of requirements and preferences as non-disabled people and may have additional needs regarding access, hence the need to make ‘reasonable adjustments’ to avoid discriminating against disabled people and to make London a more accessible city. The critical factor is ensuring that disabled people are at the centre of decision-making.

Health in London

‘Disabled people want the same life opportunities and the same choices in every day life that their non-disabled brothers and sisters, neighbours and friends take for granted. That includes growing up in their families, going to the neighbourhood school, using the same bus, getting employment that is in line with their education and abilities, having equal access to the same services and establishments of social life, culture and leisure.

Most importantly, just like everyone else, disabled people need to be in charge of their own lives, need to think and speak for themselves without interference from others. In order to reach the same control and the same choices in everyday life that non-disabled persons take for granted, a number of prerequisites are necessary. For persons with extensive disabilities there are two key requirements: personal assistance and accessibility in the built environment, including accessible housing.’

Adolf Ratzka (National Centre for Independent Living, 2003)
making and planning about issues that affect their lives and that they are represented at all levels of London life.

Despite the commitment and work of those in the disability rights movement, disabled people continue to face disadvantage in many aspects of daily life, as discussed further in Section 4. The Disability Discrimination Act (DDA) was passed in 1995, introducing new measures aimed at ending the discrimination which many disabled people face. It is intended to offer protection from discrimination for disabled people in the areas of employment; access to goods, facilities and services; and the management, buying or renting of land or property.

However, disabled people continue to experience disadvantage in accessing many opportunities and services which impact on their well-being and social inclusion. For example:

• Only 17% of public buildings in London are accessible to disabled people to the mobility standards (Part M) of the Building Regulations. (Equality and Diversity', Audit Commission, 2002).

• ‘Of young disabled people involved in the first stage of a survey for the Disability Rights Commission, 47% said that problems with public transport made it difficult for them to participate in activities that other people their age take part in’ (Disability Rights Commission).

• ‘Disabled people were four times more likely than non-disabled people to find dental practices unsuitable or...

The DDA requires that service providers (e.g. businesses and organisations):

• do not treat disabled people 'less favourably' than other people for a reason related to their disability (effective Dec 1996); and

• must make 'reasonable adjustments' for disabled people, such as providing extra help or making changes to the way they provide their services (effective Oct 1999).

In addition, from April 2004 service providers may have to make 'reasonable adjustments' to the physical features of their premises to overcome barriers to access. The DDA also requires that schools, colleges and universities:

• provide information for disabled people;

• treat disabled pupils and students as favourably as non-disabled; and

• make 'reasonable adjustments' to ensure disabled people can participate within mainstream education.

Finally, the DDA allows the Government to set minimum standards to assist disabled people to use public transport more easily.

Further information is available on the Disability Rights Commission website www.drc.gov.uk
Health in London is often inaccessible, and twice as likely to be unable to access their local doctor (Leonard Cheshire Social Exclusion Report, 2002).

• Household incomes tend to be 20-30% lower for disabled people (Child Poverty Action Group, 2001). The London Household Survey identified that 32% of disabled people were in receipt of income support, compared with 12% of non-disabled people in the sample.

This report provides information – where available – about disabled Londoners' access to some of the determinants of health, including education, employment and housing. It is important to recognise that a number of other issues which are beyond the remit of this report are equally important in their impact on disabled people's health and well-being, and may benefit from further consideration elsewhere.
The ten high-level indicators

Section 4

The ten indicators are described briefly, along with their relevance to health.

The indicators are updated, with a focus on disability.
The indicators and their relevance to reducing health inequalities

Part of the process of developing the London Health Strategy was identifying a set of high level indicators that would be used to measure changes over time and to monitor progress towards reducing health inequalities. These indicators are shown in Table 1 with a brief summary of their relevance to health and health inequalities. 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 more detailed information about the indicators, including definitions and how indicators have been developed, see Annex 1 'Sources and resources' and Annex 2 'Note on method'.

Health in London

The ten high level indicators:

• provide a 'snapshot' of the current status of seven of the key determinants of health and three health outcome measures
• enable trends to be measured over time – some trends may take longer than one year to emerge and this update report provides available information about what is known (see Section 5, 'Overall trends')
• enable comparisons to be made among different areas within and outside London and among different groups in the population.
High level indicator Relevance to health inequalities

Unemployment rate
Associated with morbidity, injuries, poisoning and premature mortality, especially coronary heart disease. Also related to depression, anxiety, self-harm and suicide.

Unemployment rate among particularly high in some ethnic minorities, black and minority ethnic which has implications for the health of the people involved.

Percentage of pupils achieving 5 GCSE grades A*–C Education reduces chances of unemployment and poverty, which have a negative effect on health. Relevant issues include: smoking, drinking, drugs, exercise, diet and safe play areas for children.

Proportion of homes judged Can cause or contribute to ill-health or exacerbate existing conditions, e.g. through damp, cold, bad lighting or design.

Burglary rate per 1000 resident Same factors that affect the local crime population rate also seem to affect health. Crime can also affect health directly.

Air quality indicators – NO2 Polluted air can damage health, especially and PM10 that of the most vulnerable – the very young and the old.

Road traffic casualty rate per Road traffic accidents are a major avoidable hazard to health.

Life expectancy at birth A good summary indicator of the health status of the population.

Infant mortality rate Another commonly used indicator of the health status of the population influenced by several factors including maternal health, quality of health care and socio-economic factors.

Proportion of people with A good indicator of people's health status self-assessed good health and among older people a good predictor of future mortality.
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.

In the quarter ending August 2002, the ILO unemployment rate (for a definition, see Annex 2, Indicator 1 – Unemployment) for London was 7.2 per cent, compared to 6.7 per cent a year previously. For each of the three preceding quarters, the rate was up on the previous year's. This ends the downward trend which started in 1993, when unemployment peaked at over 14 per cent.

London's unemployment was below average until 1991, since when it has been persistently higher than that of Great Britain as a whole. Unemployment in Great Britain fell from over 10 per cent in 1993 to 5.4 per cent in 2001, then rose slightly to 5.5 per cent in 2002 (figures for August quarters). Thus, the nationwide economic slowdown in the last year appears to be more marked in London.

London also has a higher rate of long-term unemployment than does the country as a whole. This is especially true of the inner city:

• In the inner London boroughs, 42.5 per cent of unemployed persons have been so for more than 6 months. The figure for outer London is 35 per cent and for Great Britain, 32.8 per cent.
• Of those unemployed in the inner boroughs, 21.7 per cent have been so for more than a year, compared to 16.5 per cent in outer London and 16 per cent in Great Britain.

In areas of high unemployment, the duration is also longer and this increases the health risks. (Duration figures are from claimant count, Oct. 2002).
Comparisons among London boroughs

Map 1 shows claimant count data in the boroughs for October 2002 (ILO samples in a number of boroughs are too small for reliability).

Unemployment ranges widely, from 2.0 per cent in Havering to 12 per cent in Tower Hamlets; Southwark, Lambeth, Hackney and Newham all have rates of more than 8 per cent. The London average is 4.9 per cent, up on the previous year's figure of 4.5 per cent (note that figures using the ILO definition would be much higher). The inner London unemployment rate is nearly twice that of outer London, as compared with last year's report where the rate was more than twice. But there are some exceptions, like Brent, which has high unemployment and Kensington and Chelsea with a low rate. A socio-economic categorisation of the boroughs would not entirely coincide with the inner/outer distinction. There is also a tendency for unemployment to be higher in east inner London, a traditionally deprived area.

Ethnicity

Please see full discussion in the following subsection, 'Unemployment rate among black and minority ethnic people.'

Other differentials

Table 2 (on page 26) shows the pattern and distribution of unemployment in London during the period March 2001–February 2002. Both pattern and distribution are broadly the same as the previous year's with a slight increase in the proportion of unemployed people in the 16–19 and 20–24 year age groups. More than a quarter of male teenagers continue to be unemployed.
Table 3

Employment and disability: summary

<table>
<thead>
<tr>
<th>Aspects of Comparisons</th>
<th>Risk Unexplained Inequality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment factors</td>
<td>Differences</td>
</tr>
<tr>
<td>Unemployment</td>
<td>52% disabled people, 85% non-disabled people active in UK</td>
</tr>
<tr>
<td>Economic activity</td>
<td>20% pay gap</td>
</tr>
<tr>
<td>Pay</td>
<td>Disabled people half as likely to be managers/professionals</td>
</tr>
<tr>
<td>Occupation</td>
<td>Learning difficulties</td>
</tr>
<tr>
<td>Mental health problems</td>
<td>Severe of impairment</td>
</tr>
<tr>
<td>Low qualifications</td>
<td>Age, gender, marital status, education, qualifications, region, industry, explain some differences. However, unexplained differences are greater. 1979-97. If anything, the position of disabled people in the labour market deteriorated, especially if they were severely impaired.</td>
</tr>
</tbody>
</table>

Table 2

Unemployment % in London by age, gender and ethnicity, March 2001 – February 2002

<table>
<thead>
<tr>
<th>Age-group</th>
<th>All Male</th>
<th>All Female</th>
<th>White Male</th>
<th>White Female</th>
<th>Non-white Male</th>
<th>Non-white Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-19</td>
<td>23.4</td>
<td>25.9</td>
<td>20.2</td>
<td>20.3</td>
<td>30.5</td>
<td></td>
</tr>
<tr>
<td>20-24</td>
<td>10.9</td>
<td>12.5</td>
<td>9.2</td>
<td>8.3</td>
<td>17.8</td>
<td></td>
</tr>
<tr>
<td>25-34</td>
<td>5.5</td>
<td>6.2</td>
<td>4.6</td>
<td>3.9</td>
<td>10.5</td>
<td></td>
</tr>
<tr>
<td>35-44</td>
<td>6.0</td>
<td>6.2</td>
<td>5.6</td>
<td>4.5</td>
<td>9.6</td>
<td></td>
</tr>
<tr>
<td>45-54</td>
<td>3.6</td>
<td>3.7</td>
<td>3.5</td>
<td>3.0</td>
<td>6.1</td>
<td></td>
</tr>
<tr>
<td>55-64</td>
<td>5.9</td>
<td>7.3</td>
<td><strong>4.3</strong></td>
<td></td>
<td><strong>6.1</strong></td>
<td></td>
</tr>
<tr>
<td>All ages</td>
<td>6.7</td>
<td>7.4</td>
<td>5.8</td>
<td>5.1</td>
<td>11.7</td>
<td></td>
</tr>
</tbody>
</table>

*** Sample too small for reliability. **Note: These figures are estimates. In the smaller samples, figures may vary up or down by as much as a third.***
Recent figures have been published for Standard Occupational Classification; this is non-hierarchical and not the same as social class, although there is a connection between the two. In summer 2002 in Great Britain, 2-2.5 per cent of professionals/managers and senior officials were unemployed, compared to 7.9 per cent of people in elementary occupations. The difference for long-term unemployment is extreme: Of those unemployed, 12-16 per cent of professionals/managers and senior officials have been so for more than a year, compared with 67 per cent of people in elementary occupations. (Labour Force Survey Quarterly Supplement, November 2002).

Qualifications also have an important influence. About half of all working-age people with no qualifications are in employment, compared with over three quarters of those with qualifications. Among people who are economically active (see Glossary), unemployment is much higher for people without qualifications. (Social Trends 2001 and 2002).

Focus on disability

This section focuses on people who have a current long-term impairment or health problem which limits their daily activities, as covered by the Disability Discrimination Act, and/or a 'work-limiting' disability/health problem, as defined by the Labour Force Survey. (Annual Local Labour Force Survey 2001/02).

See Table 3 for a summary of the main points discussed.

Disabled people in London and the UK have an unemployment rate nearly twice as high as that of the rest of the population. In 2001/02, for example, 11.0 per cent of disabled Londoners were unemployed, compared to 6.2 per cent of non-disabled Londoners. This wide gap persists across gender, ethnic group and age. The rate was especially high for young disabled people (16-24), at 26 per cent. (GLA. 2003. Note that some of the London samples are small, leaving a wide margin of error). Further important points emerge from an analysis of the UK:

• Unemployed disabled people tend to be older than their non-disabled counterparts.
• Unemployment lasts longer for people who are disabled. 34.8 per cent of disabled unemployed people have been so for more than a year, compared to 20.5 per cent of non-disabled people. Long-term unemployment can have adverse health effects and could contribute to a vicious circle for people who already have a long-term illness.
• Unemployment is particularly high among people with learning difficulties (26 per cent) and mental illness (18 per cent). (The Labour Force Survey refers to "severe" or "specific" learning difficulties, which may limit the number of replies unnecessarily. However, the LFS does demonstrate that people with learning difficulties have very high unemployment and economic inactivity rates).


Disability and long-term health problems are still more closely related to economic activity than to unemployment. In autumn 2001, 52.2 per cent of disabled people in the UK were economically active (see Glossary) among adults of working age, compared to 85.3 per cent of non-disabled people. However, of...
those who were economically inactive (see Glossary), 32 per cent wanted to work among the disabled group, compared to 26 per cent among the non-disabled. When persons unemployed are added to those who are economically inactive but want to work, one obtains a figure for the number of adults in the population who want to work but do not have a job:

- In the UK in autumn 2001, 24 per cent of disabled people wanted to work but did not have a job, compared to 9 per cent of non-disabled people (Labour Market Trends, August 2002).
- The equivalent figures for London in 2001/02 were 28 per cent and 11 per cent (GLA. 2003).

These figures demonstrate the widespread frustration among disabled people with their limited employment opportunities. A national survey carried out in 1996 showed that there was a strong consensus among unemployed disabled people on the importance of getting a job and that they would continue looking. The most common reasons for so-called economic inactivity were sickness/injury or the need to look after the family or home. However, many economically inactive people wanted a job and expected to be able to work in the future. Only a small proportion of the inactive group felt discouraged on the grounds of financial disincentive, no jobs available or discrimination. (DfEE RR69, 1999).

The employment rate varies widely with the kind of impairment or health problem. In the UK in autumn 2001, the employment rate was more than two thirds for people with hearing difficulties, 44-46 per cent for people with a physical or visual impairment, 39 per cent for those with a progressive illness, 21.4 per cent for people with learning difficulties (narrowly defined by the Labour Force Survey) and 18.4 per cent for people with mental illness. Similar differences apply in London. (The employment rate excludes the economically inactive and the unemployed, who are counted as economically active.)

Disabled employees tend to be in lower paid jobs, and are more likely to work part-time. In London, 21 per cent of disabled people are in lower and higher managerial and professional groups, compared with 42 per cent of those not disabled. The average hourly wage for disabled Londoners was £10.25, which is 20 per cent lower than the average for non-disabled Londoners. Even within each occupational group, earnings are lower for disabled people (GLA 2003).

One factor which affects the chances of disabled people is their lower average level of qualifications: For example in the UK, 30 per cent of working age disabled people had no qualifications in 2000/01, compared to 12 per cent of non-disabled people (Labour Market Trends August 2002). Qualifications are strongly related to economic activity and low unemployment. However, the London analysis shows that even within each qualification level, disabled people have lower levels of economic activity and higher unemployment rates than their non-disabled counterparts. There is also a pay gap at each qualification level. For instance, disabled Londoners educated to degree level or above earned 8% less than their non-disabled counterparts in 2000/2001 (GLA. 2003).

The Labour Market Survey does not attempt to measure the severity of disability. However, analysis of the Family Health in London...
Resources Survey found that impairment levels 1–2 (the least severe categories) reduced the chance of employment by one third, but levels 5–10 (up to and including the most severe category) by two thirds (Burchardt 2000, using OPCS impairment measures on a scale of 1 to 10). A national survey in 1996 found a strong link between severity and labour market experiences (DfEE RR69 1999). Severely disabled people were the most likely to have no qualifications and the least likely to receive job-related education and training. Experience of discrimination was also closely related to the level of severity.

A detailed analysis of official sources between 1981 and 1996 tried to isolate the various factors that affected the employment chances of disabled people (DfEE RR133, 1999). These included age, gender, marital status, education, qualifications, region and industry among others. The general findings were:

• that unemployment was a more serious problem for disabled people than lower earnings
• that when other factors like education were controlled, the gap between disabled and non-disabled people was reduced, but the unexplained difference was greater.

The 'unexplained differences' could be due in part to discrimination, although this is a difficult item to demonstrate. They were particularly large for people with mental health issues. One review found consistent reporting of discrimination, but no agreement on the extent of it (Christie 1999). According to the DfEE (1999), the most common type of discrimination, for all disabled people, is the (perceived) assumption by the employer that they would not be able to do the job as well as a non-disabled person.

It is easy to forget that disability and health problems do not just precede employment – they often occur during and/or after it. Each year, about 3 per cent of people in work become disabled, and more than half of these report being disabled the next or a subsequent year. After 5 years, 64 per cent of disabled people are still in employment, compared with 78 per cent of the non-disabled group (this excludes those who become disabled for one year or less). Many of those who leave report that they are dismissed or pressured into resigning (research quoted in Christie 1999). More research is needed on the factors which lead disabled people to leave work; these could be financial, employer, health or other pressures. There is evidence that employers can help to retain their staff by physical adaptations, allowing a slower pace of work, flexible working conditions and creating a less stressful environment (Burchardt 2000).

Two recent studies of official records suggest that, if anything, the position of disabled people in the labour market deteriorated between 1979 and 1997, especially for people with severe impairments or behavioural or intellectual impairments. Structural changes in the economy accounted for some of these trends, but more important were changes within the sectors in which disabled people's employment was concentrated. Those who have gained from benefits and earnings changes tend to be the people least impaired. (DfEE, RR133; Burchardt 2000).

It is too early yet to analyse the possible effects of the Disability Discrimination Act 1995 on the employment chances of disabled people.
Indicator L55474

Ethnicity and unemployment

Key findings

• 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.

What's new in 2003?

Changes

For the last 20 years, ethnic minorities have, overall, had a much higher unemployment rate than white people. In March 2001-February 2002, 11.7 per cent of non-white Londoners were unemployed; this is more than twice the rate for white Londoners, at 5.1 per cent (Table 4, below). In the last two years, both white and non-white unemployment have declined. The figures, which end in February 2002, do not fully take account of the recent economic slowdown (Compare Tables 2 and 3 on page 26).

More detailed breakdown reveals wide variation between groups:

• Other White people have above average unemployment, higher than that of Indians.

• Bangladeshis have by far the highest rate of unemployment (24.2 per cent), more than five times that of White British people. Their situation, relative to other groups, has not improved since the 1991 Census.

• Bangladeshis are followed by Mixed groups, Pakistanis and Black Africans.

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Unemployed %</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>5.1</td>
</tr>
<tr>
<td>White British</td>
<td>4.6</td>
</tr>
<tr>
<td>Other White</td>
<td>7.5</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>13.8</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>12.2</td>
</tr>
<tr>
<td>Black African</td>
<td>15.0</td>
</tr>
<tr>
<td>Other Black</td>
<td>***</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>10.2</td>
</tr>
<tr>
<td>Indian</td>
<td>6.1</td>
</tr>
<tr>
<td>Pakistani</td>
<td>15.4</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>24.2</td>
</tr>
<tr>
<td>Other Asian</td>
<td>11.0</td>
</tr>
<tr>
<td>Mixed groups</td>
<td>15.5</td>
</tr>
<tr>
<td>Other ethnic groups (incl. Chinese)</td>
<td>8.7</td>
</tr>
<tr>
<td>Chinese</td>
<td>***</td>
</tr>
<tr>
<td>Other</td>
<td>10.4</td>
</tr>
</tbody>
</table>

Table 4

Unemployment and ethnic group in London, March 2001–February 2002

Source: Annual Local Area Labour Force Survey 2001/2002

*** Sample too small for reliability

Note: These figures are estimates. In the smaller samples, figures may vary up or down by as much as one third.
all at around 15 per cent. The high
unemployment of Mixed groups
deserves further investigation.

• Black Caribbeans occupy an
intermediate position at 12.2 per cent,
still more than twice as high as white
people.

National figures show a pattern of ethnic
inequality that is broadly similar to but
less extreme than London’s. In
2000/2001, unemployment rates were
lower in the rest of Great Britain than in
the capital for most ethnic groups,
especially for Black Caribbeans (10.3 per
cent outside London, 15.7 per cent in the
capital). The white unemployment rate in
London was only just below the national
average, but significantly higher for the
inner city. Unlike the other groups,
Indians and Pakistanis were slightly more
likely to be unemployed in the rest of
Great Britain. (GLA, London Divided,
2002, quoting from Labour Force
Survey).

Ethnic inequalities in unemployment
rates are very persistent.

One way to
measure the gap is to divide the non-
white unemployment rate by the rate for
white people and obtain a ratio. In
1985/6, this ratio was 1.9 for London.
Since then, it has fluctuated but has in
general risen, reaching a peak of 2.63 in
2000/2001 (the last year for which data
are available with the old ethnic group
categories). Since 1993, when the last
recession hit a peak, the ratio has been
persistently higher than it was before.
(GLA, Planning for London’s Growth
2002, quoting LFS figures).

The gap has even grown slightly in
absolute terms, despite the reduction in
the overall unemployment rate since the
1980s. Thus, there was a gap of 7.7
percentage points in 1985, and of 8.4
percentage points in 2000/01.

These findings are consistent with figures
for Great Britain: Between 1984 and
2000, the ratio of non-white to white
unemployment has grown from 1.9 to
2.4, with rates consistently higher since
1993. In the late 1980s, the gap
narrowed some-what for men and to a
slight extent for women but this trend
was reversed in the early 1990s. The
widening gap coincided with London’s
overtaking the national unemployment
average in the early 1990s. There is one
difference between Great Britain and
London:

Since 1985, the national gap
between white and
non-white unemployment rates has
narrowed in absolute terms (from 10
percentage points to 7), whereas in
London, the gap has widened in this
way too.

(Labour Market Trends, January
2001).

Comparison with earlier years on the
basis of the new ethnic group categories
shows that unemployment in the UK has
fallen for all groups between 1997 and
2002. Although the absolute gap
between white and non-white is slightly
narrower now, the ratio of non-white to
white unemployment was higher in 2002
than in 1997 (Table 5). This applies to
both men and women. (Labour Market
Trends December 2002.Data for earlier
years have been revised backwards and
are estimates).

These trends in ethnic unemployment
raise many questions. Some of these are
technical; for example, procedural
changes in 1992 have reduced sampling
variation, which may affect the compari-
sons with what went before. However,
this is a long time-series, with enough
consistency to give weight to the findings.

There are also problems of interpretation.
Does the persistent gap reflect the arrival
of new groups, which have not yet been
absorbed into British society? The answer
to this is probably, to some extent (Black
2003 review of the London Health Strategy high-level indicators}
Africans are relatively recent arrivals, highly concentrated in inner London) but long-established groups such as Pakistanis and Black Caribbeans have persistent problems with finding employment. Only more detailed research on each group can answer such a question properly.

Further questions include:

• Are the ethnic minorities at greater risk on the arrival of a recession (see, for example, the apparent growth of inequality in 1993)? Does the set-back persist?

• How long-term is the unemployment of ethnic minorities? How far does this influence the persistence of inequality?

• In which employment sectors do ethnic minorities face most difficulty?

The gap appeared to be narrowing in the late 1980s. It would be interesting to investigate this further.

Examination of employment trends sheds some light on the first question. Since 1993, London’s employment has increased rapidly, but this does not represent recovery of lost employment. Manufacturing and skilled lower paid jobs have continued to decline. There has been little new opportunity for lower paid workers except in part-time jobs. Growth has been concentrated in higher paid occupations requiring a degree or equivalent, especially in financial and business services. These changes have, on the whole, not benefited London’s ethnic minorities, which at the time of the recession were over-represented in areas of weak growth or decline, such as craft occupations and plant and machine operatives. (GLA, London Divided 2002).

Other differentials

Few changes have emerged in the past year about ethnicity, gender, economic activity rate and economic participation. (See last year’s report.)

Gender

In each white and black ethnic group, UK unemployment remains higher for men than for women.

Age

Ethnic minorities continue to have higher unemployment at all ages (see Table 2). Extremely high unemployment rates of ethnic minority youths persist. 30.5 per cent of non-white 16 to 19 year-olds were unemployed in 2001/2002.

Social class and qualifications

Social class alone does not explain the persistent higher unemployment of non-white people, although it is a factor.

Health in London

<table>
<thead>
<tr>
<th>Gender</th>
<th>Non-white</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>15%</td>
<td>6%</td>
</tr>
<tr>
<td>Men</td>
<td>12%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Source: Labour Market Trends December 2002, using back-cast estimates based on new ethnic group categories

Table 5

Recent unemployment trends in the UK, by ethnic group and gender

<table>
<thead>
<tr>
<th>Summer 1997</th>
<th>Summer 2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Summer 1997</th>
<th>Summer 2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
</tbody>
</table>
In 1998/2000, national ethnic minority unemployment rates in the top four social classes were, on average, more than twice those of white people. The difference in the partly skilled and unskilled classes was less in proportional terms, but still high in absolute terms. (Social Trends 2002).

Social class is related to education and qualifications. Within each broad qualification level (high/other/none), in each age-group, the national ethnic minority unemployment rate was about twice as high as that for white people in 1998-2000. There is, it appears, an ethnic penalty, as confirmed by earlier research (e.g. Policy Studies Institute 1997).

It would be useful to pinpoint the economic sectors and types of employer that present most difficulty to ethnic minorities. (Labour Market Trends January 2001).

Focus on disability
In the capital, non-white people as a whole report above average rates of disability, for each age-group except 16-24. The differences are more pronounced in the older age-groups. Samples are too small for a further ethnic breakdown, but the 1991 Census showed marked differences between ethnic minorities (GLA. 2003). Despite their forming a large minority, there is a lack of research on the experiences of disabled people from ethnic minorities (Christie 1999).

The rest of this section refers to the UK (autumn 2001 figures, Labour Market Trends August 2002. This analysis does not take account of age, because of limits to sample size).

Ethnic minority unemployment is well above average, for disabled and non-disabled groups (Table 6, for autumn 2001). The relative disadvantage of non-white people is similar, whether they are disabled or not: For all groups, the ethnic minority unemployment rate is two to three times as high as the white equivalent.

For disabled people, the unemployment rate is one and a half to twice as high as that of their non-disabled counterparts, in all groups. The relative disadvantage of disability/long-term illness is similar for white and non-white people. However, the relative disadvantage is higher for men than women, regardless of their ethnicity.

### Table 6

<table>
<thead>
<tr>
<th></th>
<th>All Men</th>
<th>Women</th>
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<tbody>
<tr>
<td>Disabled</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>7.7</td>
<td>8.8</td>
</tr>
<tr>
<td>Non-white</td>
<td>18.9</td>
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</tr>
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<td>All ethnic groups</td>
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<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Not disabled</td>
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<td></td>
</tr>
<tr>
<td>White</td>
<td>4.4</td>
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</tr>
<tr>
<td>Non-white</td>
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</tr>
<tr>
<td>All ethnic groups</td>
<td>4.8</td>
<td>5.0</td>
</tr>
</tbody>
</table>

Source: Labour Market Trends August 2002
The third dimension is the gender gap. Male unemployment is higher for all groups, but the gap is particularly striking among ethnic minority disabled people. 23 per cent of non-white disabled men are unemployed, nearly twice the rate of their women counterparts. The figure of 23 per cent combines the disadvantages of ethnic group, disability/illness and gender. It is more than five times as high as the unemployment rate of white, non-disabled women (4.2 per cent).

The figures in Table 6 must be treated with caution, because they are based on one quarter only and the samples in some of the categories are small. The differences are significant, but the margin of error can be fairly wide. For example, the 8.7 per cent unemployment rate for ethnic minority non-disabled women contrasts with the figure of 12 per cent for all non-white women in Table 5, and is almost certainly due to sampling variation. Among the smaller groups, only the large differences deserve attention. This also explains why only the broad categories white and non-white can be used.

The employment rate for ethnic minority disabled people in autumn 2001 was 36 per cent, compared to 48.8 per cent for their white counterparts (the figures leave out the unemployed and economically inactive). The differences are more apparent when one puts the three dimensions together. Thus, 87.8 per cent of white male non-disabled people of working age were employed, compared with 29.7 per cent of ethnic minority disabled women. In London, there is a similar gap between the employment rates of white and non-white disabled people (GLA Jan. 2003).

Indicator /L55475 – Educational attainment

Key findings

• 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 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.

What's new in 2003?

Changes – London and national

Table 7 shows a steady rise in performance from 1996 to 2001, in London and England. Between 2000 and 2001, the improvement was especially marked in...
Provisional figures for 2002 show a further rise, to 48.5 per cent for London and 49.5 per cent for England (maintained schools only, including LEA-run schools). If independent schools are included, the national target of 50 per cent was already reached a year early, in 2001, and surpassed in 2002. (DfES, 2003. Provisional figures usually differ very little from the eventual final results).

Comparisons among London boroughs

Map 2 (on page 36) shows the borough distribution for 2002. The highest performing borough, Sutton, has more than twice the achievement rate of Hackney – 64.8 per cent compared with 31.1 per cent. The range has narrowed since the previous year (2001). Although outer London performs better in general, there are a number of low performing outer boroughs. There is also an association between east London and lower scores. Performance has to be considered against the socioeconomic background of the pupils and the school resources.

Less controversial are the differences between areas and groups. The capital is slightly below the national average, 2003 review of the London Health Strategy high-level indicators

Boys

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Girls

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<td>54.3</td>
<td>55.3</td>
<td>55.8</td>
<td></td>
</tr>
<tr>
<td>Inner</td>
<td>36.8</td>
<td>37.5</td>
<td>39.5</td>
<td>41.9</td>
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<td></td>
</tr>
<tr>
<td>Greater</td>
<td>44.1</td>
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<td>52.0</td>
</tr>
<tr>
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<td>47.5</td>
<td>49.2</td>
<td>51.2</td>
<td>52.5</td>
<td>53.4</td>
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All pupils

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<tbody>
<tr>
<td>Outer</td>
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<td>46.6</td>
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</tr>
<tr>
<td>Inner</td>
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<td>32.4</td>
<td>34.1</td>
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<tr>
<td>Greater</td>
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<tr>
<td>England</td>
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<td>42.5</td>
<td>43.8</td>
<td>45.7</td>
<td>47.0</td>
<td>47.9</td>
</tr>
</tbody>
</table>

* Data not available

Source: Department for Education and Skills (2002)
because of the low levels of attainment in the inner city. However, between 2000 and 2001, inner London reduced the gap with outer London to 11.9 per cent.

Ethnicity
Schools keep ethnic group records, but these are not published nationally and the codes are being changed. However, the GLA now has access to the London statistics, and in future years it should be possible to publish some details.

There is a pattern of under-achievement in some ethnic groups, although there are signs that this pattern may be changing. Last year’s report included a section on education and ethnicity, based on the Youth Cohort Study and a government review of research. Updated results should be available for the next report.

Other differentials
The lead of girls over boys has not narrowed with time; the ratio of girls’ achievement to boys’ has stayed level since 1996 (Table 7). Kensington and Chelsea is the only local authority in the country where boys do better.

This wide gap in achievement is acknowledged to be a problem, but there is no agreed interpretation or solution.

Social class of parents is closely related to the level of achievement of their children at school and social class affects academic performance at an early age. For definition of social class and further discussion of its relation to educational achievement, see Health in London 2002 page 20.
Focus on disability

There is a strong link between qualifications, economic activity and low unemployment, for both disabled and non-disabled people.

More than 40 per cent of disabled people felt that teachers had underestimated their ability, in one 1994 survey (Lamb and Layzell, quoted in Christie 1999). Barnes et al. found that disabled people themselves reported inadequacies in education as one of two major obstacles to progress in the labour market (the other being the benefits system) (Barnes et al. 1998, quoted in Christie 1999).

About one in five children in London's schools is classified as having special educational needs (SEN) which is not far from the national average. Of these, less than 10 per cent go to special schools or pupil referral units but this sub-group forms the majority of those with statements of SEN (who tend to be children with more severe impairments.)

There is wide variation between local authorities in the extent to which they place children with SEN in special schools. SEN categories are provided by OFSTED, and include various kinds of learning difficulty, autism, sensory, physical, mental health, speech, language, communication, behavioural, social, emotional and other needs. There are disabled children who do not have special needs and not all SEN children are disabled; however, the extent of overlap is unknown.

Statistics on educational achievement and qualifications have no separate category for people with learning difficulties, which limits the value of the results. However, the proportion of disabled adults and children with learning difficulties is relatively small:

• According to the Youth Cohort Study, 28 per cent of 16 year olds in England and Wales with a long-term disability had 5 GCSEs grade A*-C in 2000, compared with 51 per cent of their non-disabled peers. (DfES. 2001).
• 11 per cent of disabled 16 year olds were not in training, education or employment, compared with 6 per cent of those not disabled. (DfES 2001).
• In the London Labour Force Survey, non-disabled people in 2001/02 were around twice as likely to have higher level qualifications in every working-age group (NVQ level 4 or above); conversely, disabled people were far more likely to have no qualifications, when age was controlled (GLA 2003).
What's new in 2003?

Changes – London and national

There were an estimated 220,000 unfit dwellings in London in the year ending April 2001, representing 7.0 per cent of the dwelling stock. The figures have improved each year since 1997, when 8.2 per cent of London housing was unfit (HIP data 2001). Note: The previous year's figure of 7.7 per cent was probably too high and may have been more like 7.3 per cent (GLA estimate).

A recent government estimate of unfit stock in Haringey's private sector implies that the recorded level in 2000 was much too high (private communication from ODPM).

Comparisons among London Boroughs

Borough stock surveys take place every few years and a new one can lead to an abrupt change in the recorded level of unfitness. Tower Hamlets and Barnet record sharp rises on the previous year, whereas Kensington and Chelsea, Westminster, Harrow and Lewisham all show steep falls. Most of these changes were in the private sector but in Tower Hamlets, the estimated level of unfitness rose in the local authority sector, which houses a large part of London's Bangladeshi population.

Map 3 (on page 39) displays estimated levels of unfit housing as reported in HIP2001. The range in April 2001 was even wider than a year previously, from Sutton with 1.6 per cent to Newham with 18.3 per cent – nearly one dwelling in five. The housing map is different from all the others, with only a slight inner/outer London distinction and no clear bias to east or west. Although, on the whole, conditions are better in the more affluent boroughs, there are exceptions. For examples, Lewisham and Southwark are deprived inner city boroughs with low levels of unfitness. On the other hand, Merton, Redbridge and Hounslow are relatively affluent outer London boroughs with high levels of unfitness. Affluent areas can contain old stock and conversely, much council housing is relatively new.

The English House Condition Survey 1996 showed that there were very high levels of unfitness in older London boroughs, whereas suburban boroughs were close to the national average (for definitions, see glossary).

Ethnicity

The English House Condition Survey (EHCS) 1996 showed that non-white households in England were twice as likely to live in unfit dwellings as white households. (DEFRA 2002, unpublished information from the survey. Reliable figures are not available for each ethnic minority or for London). Further data on ethnic groups will become available when the English House Condition Survey 2000 is published.

Information on the housing conditions of ethnic groups from the 2001 Census is not available yet.

Other differentials


Focus on disability

"How can you make a tough decision in a house that's not a home? Within 24 hours of being in this house it was like WOW! She was a different child."
Mother on moving into a specially built house, which the family had designed themselves. From Rowntree Trust research (1999).

The English House Condition Survey 1996 (DETR 1998) collected information on heads of household with a long-term sickness or impairment. The following results apply to England (the numbers being too small for a separate analysis of London):

- There was no difference between disabled and non-disabled people in the fitness of their housing for habitation (DEFRA 2002, unpublished data from the survey).
- Disabled people under 60 were more likely than their non-disabled counterparts to live in social housing.
- Differences in 'poor housing' (unfitness, substantial levels of disrepair, and the need for essential modernisation) were not major. However, disabled people in such housing were more likely than others to want to move, and more dissatisfied with the home and state of repair.

13.1 per cent of long-term sick/disabled people under 60 were in poor living conditions, compared to 6 per cent of all interviewees. The total includes people of 60 and over but it is safe to conclude that non-disabled people under 60 were in better living conditions than their disabled counterparts. 'Poor living conditions' include local concentrations of housing in substantial disrepair; vacant and/or derelict housing or sites; other forms of neglect or misuse, such as vandalism, graffiti and rubbish dumping.

Disabled people in such conditions were less likely than others to wish to move. This contrasts with their attitude to the house itself. This does not necessarily

2003 review of the London Health Strategy high-level indicators

Barnet
Bexley
Brent
Bromley
City
Camden
Croydon
Ealing
Enfield
Greenwich
Hackney
Hammersmith
Haringey
Harrow
Havering
Hillingdon
Hounslow
Islington
Kensington
and Chelsea
Lambeth
Lewisham
Merton
Newham
Redbridge
Richmond
upon Thames
Southwark
Tower
Hamlets
Waltham
Forest
Wandsworth
Barking and Dagenham
Kingston
upon Thames
Sutton

Note: The bands have been changed from those of last year, to take account of new distribution.
mean that the house is more important to them than the neighbourhood; it might imply that their expectations of the neighbourhood and/or their access to the neighbourhood are relatively low.

The London Household Survey 2002 (GLA, 2003) used the Census definition of disability. It showed that disabled people were much more likely to live in the social rented sector, and less likely than others to be in the private rented sector or to own their own home. In households with a disabled person, the interviewee was:

- more likely to be dissatisfied with the accommodation
- more likely to say that the home was not heated to satisfactory standards.

(N.B. The interviewee was the highest income householder or partner, and may or may not have been disabled. The distinction is between households with or without a disabled person.)

It is important to get the perspective of disabled people and their families, as well as quantitative information. The Rowntree Trust (Oldman and Beresford 1998) surveyed 230 low-income families with a severely disabled child in the Northern and Yorkshire regions, then interviewed some of the parents and children in depth and found:

- Just under a fifth of families lived in cold damp housing in poor repair.
- One in ten reported overcrowded conditions.
- More than one in ten disliked their neighbourhoods.

Although the families that reported unfit or poor housing were a minority, three quarters of the sample reported unsuitable housing. Suitability depends on the individuality of the occupiers, and impairment is a significant factor. Space turned out to be a key issue for many of these families, both children and parents. In other respects, parents and children had different points of view: Parents were concerned at the risks in some areas but seldom mentioned the kitchen. Children were frustrated at being unable to use or even be in the kitchen, which prevented them from helping in family chores or from preparing drinks and snacks; the children wanted more independence and privacy.

Low income was the greatest barrier to a satisfactory solution, since there was a shortfall in public resources for adaptations in the areas surveyed. Yet, in many cases a move or adaptation did not resolve the problem. Adaptations were often done piecemeal or on the cheap. Families often did not know how to access resources and professionals sometimes showed insufficient awareness of how unsuitable housing affected households with disabled children.

The Rowntree Trust recommended a review of the legislative structure. Separate responsibilities for disabled children and adults, under the NHS and Community Care Act 1990 and the Children Act 1989, mean that the specific needs of disabled children tend to be overlooked.

A number of studies suggest that in general, around half of families with a disabled child live in unsuitable housing; there is also evidence that such housing leads to high levels of mothers' stress. Unsuitable housing may affect disabled children more than most, because they tend to spend more time at home.
• 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.

What’s new in 2003?

Changes – London and national

In England and Wales, crime in general rose throughout the 1980s and until 1995, then fell until 2001. Burglaries followed a similar pattern, but fell from 1993 till 2001. These trends affected the capital as well. Both the police figures and the British Crime Survey confirm these long-term changes. Their combined evidence also suggests that in England and Wales the fall in crime has stopped and that the overall crime level has been stable over the last year (2001/2). The same points apply to burglary: Both the numbers and the risk of burglary fell until 2001. This is the general context for the recent London figures. According to police records, London had 73,900 domestic burglaries in the year ending March 2002, a rate of 10.3 per thousand residents. This was a rise of 5 per cent over the previous year, which also had a lower rate of 9.9 per thousand. (The GLA has revised the mid-year population estimates for 2001 and for previous years, in the light of the 2001 Census results. This means that the burglary rate for the year ending March 2001 has also been revised). Home Office analysis suggests that in England and Wales, most of the increase in the police figures for crime and burglary over the last year is the result of changes in police recording practice; the British Crime Survey actually shows slight falls. It is probable that these changes in recording practice have also affected the London figures. One can summarise the situation as follows: In London, the decline in the domestic burglary rate seems to have stopped; ostensibly, the figures have deteriorated in the last year but when recording changes are allowed for, it appears that the real figures have been fairly stable.
In London and some other metropolitan areas, street crime (defined as personal robberies and snatches) is much higher than average. It has been rising for several years, unlike crime in general, and this is not due to changes in recording practice. In addition, there was an exceptional increase in London's street crime from September 2001 to January 2002.

The rise in muggings in late 2001 led the police, with government encouragement, to set up street-crime initiatives, in London and other areas. These initiatives, which started early in 2002, diverted officers from other duties and led to concern among senior police officers that other types of crime would go up.

In February 2002, there was a steep fall in street crime, followed by a slight decline in the following months. Table 8, which removes seasonal effects, shows that in April to August 2002, personal robberies (the larger component of street crime) were down on the same period for the previous year; in September to December 2002, both personal robberies and snatches were far below the equivalent months in 2001, when the figures soared. Initiatives are associated with a fall in street crime, compared to a year previously, and the final figures for 2002/03 are likely to register a decline.

A nationwide analysis of 2,000 personal robberies in the spring and summer of 2001 in nine areas showed that more than a third involved mobile phones, with teenagers and children likely to be victims and offenders (Home Office 2002). There has been no equivalent progress for other types of crime, although there are signs that burglary figures may be reduced in the latter half of 2002/03, compared with 2001/02. Total crime figures for September to December were similar in 2002 and 2001. From this limited analysis, there is no evidence that street crime initiatives have permitted a rise in other types of crime, such as burglary. Although the hike in total crime figures started early in 2001/02, before the terrorist attacks, much of this may be accounted for by changes in police recording practice (see above). More recently, in April 2002, the National Health in London

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<td>Periods compared one year apart</td>
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<td>April-Aug Sept 2001 Feb-March April-Aug Sept-Dec</td>
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<tr>
<td>% change over same period 1 year previously</td>
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<td>Personal robberies</td>
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<tr>
<td>Snatches</td>
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<tr>
<td>Domestic burglaries</td>
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<td>ALL CRIMES</td>
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Note: Comparison of same periods for each year removes seasonal effects. The chart demonstrates rates of change. Positive figures show a rise in crime. From left to right, rising positive figures show accelerating crime, falling positive figures show that crime is increasing but more slowly. Minus figures signify a fall in crime.

Source: Metropolitan Police Statistics
Crime Recording Standard (NCRS) was introduced in London; the Metropolitan Police Authority estimates that this has led to an increase in recorded crime of from 3 to 11 per cent. The various changes in recording practice have little effect on street crime figures but affect other types of crime statistic. It must not be forgotten that the police are under pressure from the government to meet targets, but results so far in 2002/03 give some grounds for cautious optimism.

Comparisons among London Boroughs

Map 4 displays police-recorded burglaries in London for the year ending March 2002. The map shows that burglary is concentrated in the inner city, and that west London is at greater risk than the east. The risk varies more than fourfold, between Kingston-upon-Thames at 4.4 per thousand to Lambeth at 20.3. Other low-risk areas are Bexley, Havering and Kingston-upon-Thames. High-risk areas also include Haringey, Hackney, Islington and Camden.

Ethnicity

The British Crime Survey provides information on ethnic groups at national but not at London level. The latest published figures are for 1999, and show that overall, ethnic minorities are at greater risk of crime, including burglary. The differences are substantial but ethnicity as such is not the main factor. When other factors are taken into account, such as being under 50 and living in an inner city area, there turns out to be little difference between ethnic groups. Black and Asian households tend to be young and to live in such areas but the greater risk affects all groups. There are some exceptions, where ethnicity as such appears to have an effect on the figures:
1. Indian households are more likely to be burgled, even when other factors, like living in a high risk area, are taken into account.

2. When other factors are taken into account, Black, Indian and Pakistani/Bangladeshi households are at reduced risk of personal crime (see glossary), compared to white households. These differences are statistically significant, although in each case, ethnic group is less important than other factors, like age and area.

Although ethnic group in itself is not a major risk factor, there are large numbers of racially motivated crimes, which are now monitored by the police and the British Crime Survey. There are also many racially motivated incidents, such as insults and pestering, which do not count as crimes (Home Office 2001).

It is hard to reconcile the large number of racially motivated crimes with the finding that ethnicity is not of itself a major risk factor. This is an area that needs further investigation.

Other differentials

Being a single parent or young head of household nearly trebles the risk of burglary. A high level of physical disorder in the neighbourhood (rubbish, graffiti etc) nearly doubles it. Low income is also a risk factor. (Home Office 2002, using British Crime Survey 2001/02).

Security measures are important and there is evidence that they have contributed to the fall in the burglary rate. (Home Office 1999)

Focus on disability

The British Crime Survey allows us to analyse personal crimes by disability, but not household crimes such as burglary. (The disability question refers only to the interviewee and not other members of the household).

In England and Wales, there is generally little difference in the risk of crime for disabled and non-disabled people. For common assault and stranger violence, people with a limiting illness or disability are significantly less at risk. (Home Office, unpublished data from British Crime Survey 2001/02).

In London in 2001/02, 7.5 per cent of people with limiting disability or illness were victims of violent crime, compared to 4.3 per cent of non-disabled people. Although the numbers are small (37 disabled people were victims of violent crime), the difference is statistically significant.

It is not clear why London should differ from England and Wales in this respect. If the trend is persistent, then it merits investigation. Interpretation of such figures is not easy.

There has been little research on disabled people's experiences of crime, but Hammersmith and Fulham Council conducted a survey and discussion groups on this topic in 1993. Preliminary research compared disabled with non-disabled people. In the final stage, 195 disabled people were interviewed, of whom three quarters had experienced a crime in the last year; the interviewees were randomly selected to be representative by age, gender and ethnic group, and the focus was on physical impairment. Half the respondents were over 60, one quarter were from ethnic minorities (including Irish), and 44 per cent lived in local authority housing. The unemployment rate was 27 per cent and two thirds did not have access to a car. Many of the interviewees had multiple difficulties.
Preliminary research (which included all kinds of disability) found that households including a disabled person were one and a half times more likely than the rest to have been victims of incidents relating to the home; for incidents outside the home, there was little difference. However, disabled people were especially likely to be the victims of burglary by a confidence trickster, of attacks in the home, and of harassment, abuse or threats outside the home. Multiple victimisation was also common. These findings augment the somewhat puzzling results for London and the nation (above) and suggest that local conditions strongly affect the impact of crime on disabled people.

The final stage (interviews with 195 physically disabled people) found that perceived vulnerability to crime was widespread among disabled people, especially if they had impairments to mobility. Precautionary measures, such as avoiding certain areas, distinguished disabled men from those not disabled; women tended to be more cautious anyway, whether disabled or not. Many disabled people also wanted more and better locks and stronger doors, especially in the public sector; there was frustration at the lack of response from the Council and their inability to afford these measures. The most common result of an incident was a psychological after-effect, such as loss of sleep or confidence, mentioned by 28–45 per cent of interviewees, depending on the type of crime or event.

The report recommended more home security initiatives (this was in 1993), low cost insurance schemes, better street lighting, training in self-defence and assertiveness, among other measures. The results of this research are of interest because they are based on the replies of disabled people themselves, in a deprived part of London. The sample, though random, was small, which means that results must treated with caution. National surveys are unable to cover local conditions in depth, yet the impact of crime and policing is geographically and socially focused. This impact may be more severe in certain neighbourhoods, and where disability is combined with other risk factors, such as unemployment and belonging to an ethnic minority.
London's air quality is amongst the worst in the UK, as shown by the government's automatic monitoring network. It is more realistic to make comparisons with other very large cities, such as Berlin, Paris and Moscow; in this respect, London may be about average (Prescott-Allen 2001; London's Partnership Cities Environment Seminar, June 2002).

Air pollution levels depend on three factors – emissions, the weather and topography. In London, road traffic accounts for more than half of the NO2 emissions and two thirds of PM10 emissions (although much of the actual concentration of PM10 comes from sources outside the capital). Road transport emissions dominate in London far more than nationally; this is due to the high traffic levels and the small number of large industrial processes and power stations. (GLA Air Quality Strategy, TfL 2002)

Air quality has improved since 1996, mainly because of improvements in road vehicle emissions. In London, this has still not been fast enough to reduce emissions sufficiently to achieve the national air quality objectives. An improvement between 1996 and 2001 (November) is illustrated in Figure 2. This graph displays running annual averages for a range of automatic sites covering different types of location for six major pollutants – NO2 (nitrogen dioxide), NOX (oxides of nitrogen), O3 (ozone), CO (carbon monoxide), SO2 (sulphur dioxide), and PM10 (fine particles). Running annual averages eliminate seasonal variation (for definition, see Glossary).

The graph shows marked decreases for most pollutants over a five-year period. However, during 2000 and 2001, annual average concentrations of CO, SO2 and PM10 were relatively stable. NO2 has only declined slightly since 1996, and ozone has increased. It is thought that a more significant reduction in NOX is a prerequisite for a fall in NO2.

NO2 is measured at 84 sites in London, and PM10 at 65 sites.

- In 2000, the annual mean NO2 limit was exceeded at around one third of the monitoring sites in London. The hourly mean limit was exceeded at only five sites.
• The annual mean PM10 limit was exceeded at only two sites. However, the daily mean PM10 limit was exceeded at nine sites. The unsettled conditions of autumn 2000 were exceptionally favourable for the dispersal of NO2, which could affect the results for that year. Some cautious projections can be made on the basis of current trends. It is expected that from 1995 to 2010 national vehicle emissions will decrease rapidly as the rate of reduction in emissions outstrips traffic growth. In the longer run, however, vehicle improvements are unlikely to keep pace with traffic growth, and emissions are likely to rise again. If the extra measures recommended by the Mayor's Air Quality Strategy are implemented, PM10 exceedances are expected to be confined to major roadsides and junctions by the target date of 2004. However, even with the extra measures, the NO2 target for 2005 is likely to be exceeded in large parts of London. The introduction of congestion charging for central London in February 2003 is expected to produce a small overall benefit for London's air quality. Comparisons among London Boroughs Maps 5 and 6 show models of London's daily average PM10 and annual average NO2 concentrations, derived from the latest available data. They are based on emissions (not concentrations) for 1999. To this are added data for "poor" (high pollution) weather years, which vary by pollutant. (Policies should not be based on 1999 weather, which was favourable to air quality). The use of relatively poor weather years allows a realistic margin of error. The objectives must be met, not only during the year of the objective 2003 review of the London Health Strategy high-level indicators.
Modelled 1999 daily mean PM10 concentrations, in number of days above the national objective level of 50 µg/m³ (poor weather year)

Source: OS data © Crown copyright. All rights reserved (GLA) (LA100032379) (2002)

Note: A ‘poor’ weather year is one where weather conditions give rise to elevated air pollution levels. These years may vary by pollutant date, but in all subsequent years. The model includes other knowledge-based assumptions, for example, about how concentrations change at various distances from the roadside and how pollutants interact.

It is important to realize that these are models, not measurements of the actual concentrations in 1999. One reason for this is that there are only a limited number of sites, which means that concentrations between the sites are estimates only. Another reason is the need to allow for “poor” weather. The maps can best be viewed as “realistic” models of the current air quality across the capital. The models can be extended into the future by, for example, forecast changes in emissions. The maps should be viewed across London as a whole and are not intended to provide borough-level comparisons. They are improved versions of the maps displayed in last year’s Health in London report (which also relate to 1999).

On both maps, yellow, red and purple indicate concentrations in excess of the national targets (2004 for PM10, 2005 for NO2). Maps 5 and 6 show that, allowing for weather variations, much of London fails to meet the objectives for NO2 and PM10. Annual NO2 exceedances cover most of the capital, with especially high concentrations in the centre and around Heathrow. Excessive daily PM10 concentrations are marked along a filigree of roads, especially in the centre and west and along the M25; away from the roads, much of the capital is close to the limit, and it is thought that there may be no safe lower limit for fine particles. These models are consistent with the findings of the London borough reviews and assessments and the government’s work.

Ethnicity and other differentials

Old people and young children are the most vulnerable to the effects of air pollution.
In general, the wealthier residents of London tend to live in the less polluted areas (London Health Commission 2001). However, there are many exceptions to this tendency. For example, wealthy as well as poor people live along major roads, and outer London, which is relatively affluent, receives more ozone. Some ethnic groups are more concentrated in central and inner London, which receive high levels of NO2 and PM10.

A government report in 1997 found a clear relationship between NO2 and PM10 levels and deprivation indices by ward (Pye 2001, quoted in The Mayor's Air Quality Strategy). This study concluded that policies focused on areas of high pollution could marginally reduce the apparent disadvantage of deprived communities in terms of air quality.

The more deprived residents are more likely to die of respiratory diseases, which are linked to air pollution (Environmental Health News 1999). However, there is as yet no direct evidence that the more deprived residents suffer poorer health or higher mortality through being exposed to higher concentrations. This is an area for further research.

Focus on disability

Air pollution can aggravate existing conditions, especially cardiovascular and respiratory diseases, and bring forward the deaths of vulnerable people. For example, PM10 has an effect on asthma and NO2 can set off allergenic responses. Ozone, the third problem pollutant for London, can worsen the symptoms of asthma and lung disease.

Air quality has not been studied in relation to disabilities as a whole, and for some kinds of impairment, statistics would probably not be meaningful.
Health in London

Slight injuries

- Number: 38,997, 38,696, 39,857, 39,770, 38,393, -2%

Killed/seriously injured

- Number: 6,684, 6,861, 5,940, 6,117, 6,101, -9%

Overall number: 45,681, 45,557, 45,797, 45,887, 44,494, -3%

Overall rate: 6.6, 6.5, 6.5, 6.4, 6.2, -6%

Table 9

<table>
<thead>
<tr>
<th>Year</th>
<th>1994-98 average</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>b</td>
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<tr>
<td>1999</td>
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<tr>
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<td></td>
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<tr>
<td>2002</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>change</td>
</tr>
</tbody>
</table>

Sources: TfL 2002; new mid-year population estimates based on 2001 Census - ONS (2001) and GLA (earlier years).

- Year: the 2001 Census shows that London's population is lower than was thought, which probably accounts for some of the change.
- Extent of migration from the capital has been underestimated over the last decade.
- In London, the number of casualties has followed a similar trend to the casualty rate, but the effects are less marked (Table 9 above).
- Overall, there was little change from the 1994-98 average until 2001, when there was a 3 per cent fall, which reflects a fall in slight injuries.
- When population growth is allowed for, the signs are more encouraging than they are for casualty numbers.
- However, the casualty rate excludes non-residents, and is not a target.

Table 10 compares results with 2010 targets. Fatal/serious injuries for powered two-wheelers are way off schedule for 2010. In the other five target areas, figures are below the 1994-98 average, but further large reductions will be necessary for all of them, especially slight injuries.

Only rough predictions can be made on the basis of changes between 1998 and 2001. Longer term trends through the 1990s show that fatal/serious injuries have fluctuated and that the level of slight injuries has remained much the same.

There are some further points of interest, most of which affect specific groups:

- There were 299 road deaths in 2001, two thirds of which were accounted for by pedestrians and powered two-wheelers. This was an increase over 2000, but some of this may have been due to more rigorous checking by the police and small numbers also lead to large fluctuations.
- However, fatalities have risen for the third year running and are now 20 per cent above the 1994-98 average.
- Far more pedestrians die each year than any other road user group. In 2001, there was a drop in the number of fatalities, and also of serious injuries, but there is still a long way to go.
Child fatalities/serious injuries have fallen each year since 1998. However, figures for the biggest category, child pedestrians, rose in 2001.

Powered two wheeler casualties of all kinds have continued to rise, and fatalities have soared since 1997, making up nearly one quarter of all road deaths in London. Yet, this form of transport comprises only about 2 per cent of all trips in London. The trend in fatal/serious injuries has been roughly matched by a rise in the number of motorbike licences in the capital and an increased flow of this type of traffic.

There was a rise in the number of cyclist fatalities and also of serious injuries in 2001. Statistics fluctuate widely because of the small numbers.

Car occupants account for 35 per cent of fatal/serious injuries but one half of all slight injuries. In the last decade, there has been no improvement in the number of car occupant slight casualties.

Britain's child fatality rate (per 100,000 child population) is better than average for European countries but one of the worst in Europe for child pedestrians. Possible reasons for Britain's poor child pedestrian record are:

- land use patterns, such that children here have to spend more time on and cross more major, busy roads
- less traffic calming and other slow-down measures
- children here are more likely to be accompanied by other children
- they use marked crossings less.

An article in Radical Statistics (summer 2002) suggests that the main reason why child casualties in Britain have fallen

<table>
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</thead>
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<tr>
<td>Fatal/serious injuries</td>
<td>40</td>
<td>34</td>
<td>On target</td>
<td>9</td>
<td>40</td>
<td>-40</td>
<td>On target</td>
</tr>
<tr>
<td>Pedestrians</td>
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<td>On target</td>
<td>-16</td>
<td>40</td>
<td>-9</td>
<td>On target</td>
</tr>
<tr>
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<td>22</td>
<td>On target</td>
<td>-18</td>
<td>40</td>
<td>-9</td>
<td>On target</td>
</tr>
<tr>
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<td>78</td>
<td>OFF</td>
<td>+38</td>
<td>40</td>
<td>-31</td>
<td>OFF</td>
</tr>
<tr>
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<td>50</td>
<td>48</td>
<td>On target</td>
<td>-23</td>
<td>50</td>
<td>-22</td>
<td>On target</td>
</tr>
<tr>
<td>Slight injuries</td>
<td>-10</td>
<td>-12</td>
<td>OFF</td>
<td>-2</td>
<td>-10</td>
<td>-12</td>
<td>OFF</td>
</tr>
</tbody>
</table>

* This is based on the trends in the casualty figures from 1998 to 2001. 1998 is the year for which data were available when the national strategy was published. These trends are then continued up to 2010, and related to the 1994-98 average.
is the shift to car use. However, low-income households cannot do this. The article argues that the government emphasises education too much, at the expense of urban design. Sweden has introduced developmental planning for child safety, and in 1997 had less than half the child pedestrian fatality rate of Britain. Recent research suggests that there is a limit to child education because young children cannot accurately judge gaps. Slightly more than half of all child fatalities in Britain are for pedestrians. (Sources on child pedestrians: DETR 2000; P Hewson, Radical Statistics summer 2002)

Comparisons among London Boroughs

Map 7 shows the number of casualties of all kinds per 1000 residents, making use of the 2001 Census data. There is a fourfold range in the casualty rate, from 3.8 in Harrow to 15.1 in Westminster. Other boroughs with high levels are Camden and Islington, whereas Bexley and Kingston-upon-Thames have low levels. (The City is excluded, because most of those involved are not residents. To a lesser extent, this affects other central areas). There is also a tendency for casualties to be concentrated in a corridor towards west London.

The number of casualties (as opposed to the rate) fell in most boroughs, most notably in Kensington and Chelsea with a 21 per cent drop in 2001 compared with the previous year. In contrast, Havering showed a 22 per cent rise, from 1064 to 1297.

Ethnicity

In almost all countries where data are available, children from ethnic minority backgrounds suffer a substantially greater risk of pedestrian injury than do their peers in the majority population. Data on ethnicity and road safety are not regularly collected in the UK. Evidence that Asian children in the UK are more at risk of pedestrian injury or death than their peers has emerged through the observations of professional workers and a small number of research studies. (Other minorities have not been systematically studied, but it is possible that they are also at a disadvantage). (Source: DETR 2001).

For more details, see Health in London 2002.

Other differentials

The relationship between social class and child pedestrian injury is well established, more so than that for ethnic groups. The DETR, in its international review, found that the child casualty rate is typically four times that of the lowest socio-economic group, when compared to the highest group (DETR 2001). Income has a particularly close correlation with child casualties. For more details, see Health in London 2002.

Focus on disability

The government commissioned a review of the road safety of disabled children and adults, which has recently been published (TRL, 2002). Not much is known about the risk of road injury faced by disabled people in Britain, because regular records are not kept, and there has been insufficient research. However, a number of research studies in different countries have related road casualties to different kinds of impairment. The samples are usually small, and the risks cannot as yet be...
quantified, but the results are generally in the same direction. Increased risk is associated with learning difficulties, attention deficit hyperactivity disorder, hearing and visual impairments:

• One large-scale Californian study of 15-59 year-olds, which took into account exposure, age and gender, found that people with learning difficulties had 2.8 times the risk of being killed in a pedestrian accident, compared with the general population; the risk was statistically significant and was highest among those who lived semi-independently rather than with parents or in care.

• Several studies, including one in Britain, found that children with attention deficit hyperactivity disorder were at increased risk of pedestrian and cycling accidents. One New Zealand study also reported a connection between childhood ALDT and later motor accidents.

• Three smallish studies, including two in Britain, found a connection between hearing impairments and pedestrian accidents in children. Similar research has not been carried out on adults.

• British and other studies found a connection between road accidents and visual impairment in children and adults.

• There is very little evidence on the risk of road accidents faced by physically disabled people.

• Mental health issues do not feature in the review.

It is wrong to assume that for a given impairment, the relative risk will be the same in different countries or even local authorities. In an ideal environment, an impaired person will be at no greater risk than anyone else, in other words, he or she will not be disabled. However,
research demonstrates that the situation is less than ideal. The review also examined remedial measures, especially in education and engineering. Educational measures have been developed mainly for people with learning difficulties, and also to some extent for wheelchair users and people with sensory impairments. For people with learning difficulties, classroom teaching alone is insufficient and roadside training is usually more effective. Road safety education in Britain is well established among children in general but provision for disabled children and adults is patchy. The authors recommend that guidance on road safety education for disabled people be issued to stakeholders, after evaluation of current training and collation of best practice. One general conclusion is that real-world experience should be encouraged; besides being effective for some groups, it can increase social interaction and confidence.

Engineering measures such as tactile pavements and lowered kerbs are already in widespread use. The review recommends that local authorities consider further measures, such as guardrails outside special schools. PUFFIN crossings are useful for people with hearing impairments, because the green/red man is placed on the same side of the road as the pedestrians, which encourages them to look at the oncoming traffic.

It is surprising that money is regularly spent on engineering adaptations, yet little is known about the risks faced by disabled people. The review argues for disability monitoring in the official statistics, so that priorities can be better identified.
A review of the London Health Strategy high-level indicators has not changed significantly since the previous report.

Comparisons among London Boroughs (Maps 8 and 9 on page 55) show inequalities in average life expectancy by London borough in 1999-2001. The maps clearly show that despite the fact that London as a whole had a very similar average life expectancy to England as a whole, there were areas within London that experienced some of the longest or the shortest life expectancy in the country. For males, Lambeth, Southwark, Tower Hamlets, and Newham had the shortest life expectancy. The longest life expectancy was seen in Kensington and Chelsea and a number of Outer London boroughs.

For females, the picture is slightly different. Newham, Lewisham, Lambeth, Tower Hamlets, Islington, and Waltham Forest had the shortest life expectancy while the boroughs with the highest life expectancy were Kensington and Chelsea and Harrow.

These new data use new population estimates for 2001 based on the 2001 Census to calculate life expectancy. There have been considerable changes to last year, but this is due to very large decreases in the population of some local authorities in London, not real changes in health or death rates.

Some of the key points are:

- Life expectancy among males in London is now highest in Kensington and Chelsea at 78.5 years.
- Life expectancy among males in Newham is still the lowest in the capital at 72.5 years.
- Life expectancy among females in London is now highest in Kensington and Chelsea at 83.1 years.
- Life expectancy among females in Newham and Islington is the lowest in the capital at 78.5 years.

Despite the large changes in population estimates, inequalities in life expectancy are still as large as reported in last year's report. The difference in life expectancy between boroughs is 6 years for males and 4.6 years for females. However, until revised population estimates for the years 1991-2000 are available, it is not possible to recalculate trends in life expectancy and determine whether inequalities are increasing or decreasing.

Figure 3 (on page 56) shows that at borough level within London average life expectancy was closely related to the level of deprivation. Deprivation was measured here using the former DETR index of multiple deprivation. (Department of the Environment Transport and the Regions 2000) The higher the DETR deprivation score, the more deprived the borough. Boroughs which had high deprivation scores generally had lower life expectancies than areas which had low deprivation scores.
Health in London

Barnet
Bexley
Brent
Bromley
City
Camden
Croydon
Ealing
Enfield
Greenwich
Hackney
Hammersmith and Fulham
City of Westminster
Haringey
Harrow
Havering
Hillingdon
Hounslow
Islington
Kensington and Chelsea
Lambeth
Lewisham
Merton
Newham
Redbridge
Richmond upon Thames
Southwark
Tower Hamlets
Waltham Forest
Wandsworth
Barking and Dagenham
Kingston upon Thames
Sutton

Life expectancy in years

Map 8
Geographical inequalities in male life expectancy at birth by borough 1999-2001
Source: Office for National Statistics, Crown Copyright

Map 9
Geographical inequalities in female life expectancy at birth by borough 1999-2001
Source: Office for National Statistics, Crown Copyright
scores. An analysis (linear regression) of the association between life expectancy and deprivation for each borough showed that deprivation could explain 78 per cent of the variation in life expectancy for males. However, only 52 per cent of the variation in female life expectancy by borough can be explained by the deprivation index. Therefore, there is a stronger association between life expectancy and deprivation for males than for females.

This pattern is very similar to that found in last year's Health in London report. However, the most recent analysis shows a slightly larger proportion of the variation that can be explained by the deprivation index. This is possible due to the fact that the populations from the 2001 Census may more accurately reflect the number of people and therefore produce more accurate estimates of life expectancy.

Ethnicity

No conclusions can be drawn about ethnic differences in life expectancy as ethnicity is not recorded on death certificates. Legislation would need to be introduced to change this situation. The London Health Observatory is working to influence changes in data collection for births, stillbirths and deaths, formulating the case for the introduction of ethnicity as part of the registration process.

Other differentials

Although female life expectancy is greater than male life expectancy in every borough, the difference between the sexes is most marked in areas of high deprivation. This is consistent with the findings presented in the previous report. There are also no reliable robust local data to enable us to calculate up-to-date estimates of life expectancy by social class for London. However, data for England shows that in 1997-99 life expectancy among males in Social Class I was 78.5, compared to 71.1 in Social Class V; a difference of 7.4 years. For females, life expectancy in Social Class I was 82.8, compared to 77.1 in Social Class V; a difference of 5.7 years.
Focus on disability

'I was a few days old when the seriousness of my disability was discovered. My mother was told to take me home and enjoy me, as I would die within a year. Strange as it may seem I unconsciously sensed the change in the attitude of the people around me, from calm and loving to panicky and hostile. A message slipped into my unconscious saying that people would prefer it if I died. As so often with severe impairments, the doctors were wrong. I was frequently unwell, mostly with serious chest infections, but I am still here. I have spent nearly all my life desperately trying to prove that I should be alive, that I am not suffering, that I am not worthless.

The truth is that our lives are seen as inferior to those of non-disabled people. The Disability Rights Commission, of which I am a commissioner (although these views are my own), has heard from disabled people and their families that decisions on whether or not to offer life-saving treatment are often made in an environment of ignorance and discriminatory attitudes. We live with the negative stereotype that disability equals a state worse than death, an idea reinforced by our collective obsession with the body beautiful.'

Jane Campbell, Director of the Social Care Institute of Excellence

Future reports

It is possible to produce estimates of average life expectancy for electoral wards in London, however, as the number of deaths in any given year is small, these results have to be interpreted with caution. Many primary care trusts are producing estimates of life expectancy by ward for their patches and the London Health Observatory (LHO) has produced life expectancy for groups of electoral wards, grouped within proposed strategic health authorities (StHA) by the level of deprivation. (Fitzpatrick & Jacobson 2001). The LHO is currently investigating the possibility of producing estimates of expectation of life at ward level.

It is currently not possible to present trends in life expectancy by London borough as new populations for the 1990s, based on the 2001 Census are not yet available. Trends will be available early in 2003 and will be included in the next Health in London report for 2004.

Indicator/L55481

Key findings

• 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.
What's new in 2003?

In last year's report we presented infant mortality rates for 1993-98 combined in order to provide a robust breakdown of infant mortality by mother's country of birth, deprivation, social class and registration type (e.g. inside marriage, sole registered by the mother alone). This year our aim is to provide as much detail as possible on trends in infant mortality by borough. We present data on infant mortality for 1996-2001 by borough and comment on significant changes since 1993-98. Also included in this section is some new analysis of infant deaths among sole registered births (births outside marriage registered by the mother alone).

Changes – London and nationally

Last year's report showed that the overall infant mortality rate in London was very similar to infant mortality in England and Wales as a whole. The Infant mortality rate in London (5.9 deaths per 1,000 live births) is still similar to infant mortality in England and Wales as a whole (5.7).

Comparisons among London Boroughs

Although the level of infant mortality in London is similar to England, there were wide differentials in infant mortality rates within London itself. Map 10 and Table 11 (on page 61) show the distribution of infant mortality rates by London borough for 1996-2001. Lambeth, Southwark, Lewisham and Hackney had the highest rates and all were significantly higher than the London rate. These boroughs were also those identified as having the highest rates in 1993-98, the years of data used in the previous Health in London report.

The lowest rates were mainly found in parts of outer south west and outer south.
### Table 11

Geographic inequalities in infant mortality within London

<table>
<thead>
<tr>
<th>Borough</th>
<th>Infant mortality rate</th>
<th>Number of deaths</th>
<th>Number of births</th>
<th>Infant mortality limit*</th>
<th>Significantly lower or higher</th>
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</thead>
<tbody>
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<td>3.7</td>
<td>302</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Barking and Dagenham</td>
<td>5.7</td>
<td>82</td>
<td>143</td>
<td>4.6</td>
<td></td>
</tr>
<tr>
<td>Barnet</td>
<td>5.5</td>
<td>120</td>
<td>250</td>
<td>4.8</td>
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</tr>
<tr>
<td>Bexley</td>
<td>3.6</td>
<td>low</td>
<td>71</td>
<td>4.3</td>
<td></td>
</tr>
<tr>
<td>Brent</td>
<td>6.8</td>
<td>174</td>
<td>238</td>
<td>7.3</td>
<td></td>
</tr>
<tr>
<td>Bromley</td>
<td>5.1</td>
<td>92</td>
<td>216</td>
<td>4.3</td>
<td></td>
</tr>
<tr>
<td>Camden</td>
<td>4.6</td>
<td>low</td>
<td>79</td>
<td>4.9</td>
<td></td>
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<tr>
<td>Croydon</td>
<td>6.7</td>
<td>197</td>
<td>275</td>
<td>7.1</td>
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<tr>
<td>Ealing</td>
<td>4.8</td>
<td>low</td>
<td>135</td>
<td>5.1</td>
<td></td>
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<td>Enfield</td>
<td>5.8</td>
<td>131</td>
<td>232</td>
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<td>191</td>
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<td>8.9</td>
<td>high</td>
<td>186</td>
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<td>6.2</td>
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<td>102</td>
<td>160</td>
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<td>Havering</td>
<td>5.6</td>
<td>70</td>
<td>148</td>
<td>4.7</td>
<td></td>
</tr>
<tr>
<td>Hillingdon</td>
<td>5.4</td>
<td>98</td>
<td>203</td>
<td>4.8</td>
<td></td>
</tr>
<tr>
<td>Hounslow</td>
<td>4.9</td>
<td>low</td>
<td>111</td>
<td>5.7</td>
<td></td>
</tr>
<tr>
<td>Islington</td>
<td>4.7</td>
<td>low</td>
<td>83</td>
<td>5.4</td>
<td></td>
</tr>
<tr>
<td>Kensington and Chelsea</td>
<td>6.8</td>
<td>77</td>
<td>120</td>
<td>6.4</td>
<td></td>
</tr>
<tr>
<td>Kingston-upon-Thames</td>
<td>3.9</td>
<td>low</td>
<td>37</td>
<td>3.4</td>
<td></td>
</tr>
<tr>
<td>Lambeth</td>
<td>7.8</td>
<td>high</td>
<td>198</td>
<td>7.6</td>
<td></td>
</tr>
<tr>
<td>Lewisham</td>
<td>8.4</td>
<td>high</td>
<td>199</td>
<td>8.6</td>
<td></td>
</tr>
<tr>
<td>Merton</td>
<td>5.3</td>
<td>66</td>
<td>161</td>
<td>4.1</td>
<td></td>
</tr>
<tr>
<td>Newham</td>
<td>7.3</td>
<td>213</td>
<td>286</td>
<td>7.4</td>
<td></td>
</tr>
<tr>
<td>Redbridge</td>
<td>4.8</td>
<td>low</td>
<td>101</td>
<td>5.4</td>
<td></td>
</tr>
<tr>
<td>Richmond-upon-Thames</td>
<td>4.4</td>
<td>low</td>
<td>56</td>
<td>3.9</td>
<td></td>
</tr>
<tr>
<td>Southwark</td>
<td>8.2</td>
<td>high</td>
<td>194</td>
<td>7.8</td>
<td></td>
</tr>
<tr>
<td>Sutton</td>
<td>4.6</td>
<td>low</td>
<td>61</td>
<td>4.5</td>
<td></td>
</tr>
<tr>
<td>Tower Hamlets</td>
<td>6.7</td>
<td>128</td>
<td>211</td>
<td>6.1</td>
<td></td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>7.1</td>
<td>158</td>
<td>214</td>
<td>7.4</td>
<td></td>
</tr>
<tr>
<td>Wandsworth</td>
<td>5.5</td>
<td>119</td>
<td>245</td>
<td>4.9</td>
<td></td>
</tr>
<tr>
<td>Westminster, City of London</td>
<td>7.2</td>
<td>91</td>
<td>146</td>
<td>6.2</td>
<td></td>
</tr>
<tr>
<td>England &amp; Wales</td>
<td>6.1</td>
<td>3752</td>
<td>6307</td>
<td>5.9</td>
<td></td>
</tr>
<tr>
<td>London</td>
<td>6.0</td>
<td>20343</td>
<td>37463</td>
<td>5.7</td>
<td></td>
</tr>
</tbody>
</table>

* 95% confidence interval
east London, with Kingston, Merton and Richmond having the lowest rate. Kingston had the lowest infant mortality rate of 3.4 infant deaths per 1000 live births. Lewisham had the highest infant mortality rate of 8.6. The range in rates between these two boroughs is 5.2 and the rate in Lewisham was 2.5 times higher than the rate in Kingston. This is a similar range and ratio to that between the highest and lowest boroughs in the previous Health in London report.

Figure 4 shows the relationship between borough-level infant mortality rates and the level of deprivation within the borough. Deprivation was measured by the DETR Index of Multiple Deprivation (Department of the Environment Transport and the Regions 2000). The higher the DETR deprivation score, the more deprived the borough.

Figure 4 shows that there was a general increase in infant mortality with an increase in the level of deprivation within each borough. The line on the chart shows the line of best fit; however, there is a lot of scatter about this line showing that the relationship between infant mortality and deprivation is not clear. An analysis (linear regression) of the association between infant mortality and deprivation for each borough showed that deprivation could explain 43 per cent of the variation in infant mortality. It is possible that the small numbers of deaths involved could explain the poor association with deprivation.

Ethnicity
As reported in last year's Health in London report it is not possible to calculate infant mortality rates by ethnic group, as ethnicity is not recorded on death certificates (see indicator 8). However, country of birth of mother is recorded on birth certificates and therefore it is possible to calculate infant mortality rates by country of birth. These were presented in last year's report. Births to mothers that were born outside England and Wales had higher infant mortality rates (6.9) than those to mothers born inside England and Wales (5.7).

Other differentials
Last year's report also demonstrated that the infant death rate in London among births to fathers in manual social classes (6.1) was slightly higher than the infant death rate among births to fathers in the
However, this difference was not found to be statistically significant. However, sole registered births (births registered by the mother alone that cannot be allocated a social class based on the father’s occupation) had by far the highest mortality rate of 9.5 per 1000 live births. Between 1993-99 approximately 8% of births were registered by the mother alone. Young age of mother, low birthweight and mothers country of birth outside England and Wales are known risk factors for infant death. (Fitzpatrick & Jacobson 2001). Figures 5 and 6 show infant mortality rates by mothers country of birth, birthweight and registration type, London 1993-99. The London Health Observatory is currently analysing further factors which might affect the very high infant death rates among sole registered births by these factors. Sole registered births have the highest mortality rates in each country of birth group, birthweight group and at every mothers age group. The difference between the mortality rates among sole registered births and those inside marriage or registered by couples is in fact very small in the young mother age groups and highest in the 30-34 age group.
Table 12

Self-assessed health status in London 1999 – 2001

<table>
<thead>
<tr>
<th>Year</th>
<th>Good</th>
<th>Fairly Good</th>
<th>Not Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>66%</td>
<td>22%</td>
<td>11%</td>
</tr>
<tr>
<td>2000</td>
<td>67%</td>
<td>23%</td>
<td>10%</td>
</tr>
<tr>
<td>2001</td>
<td>64%</td>
<td>26%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Source: ALG London Residents Survey
Health in London

Barnet  Bexley  Brent  Bromley  City  Camden  Croydon  Ealing  Enfield  Greenwich  Hackney  Hammersmith  and Fulham  City of Westminster  Haringey  Harrow  Havering  Hillingdon  Hounslow  Islington  Kensington and Chelsea  Lambeth  Lewisham  Merton  Newham  Redbridge  Richmond  upon Thames  Southwark  Tower Hamlets  Waltham Forest  Wandsworth  Barking and Dagenham  Kingston upon Thames  Sutton

74.0 and over    (3)
72.0 to 73.9      (8)
70.0 to 71.9    (11)
68.0 to 69.9       (8)
less than 68.0   (3)

Percentage of population

Map 11

Percentage of the population that reported good health by London borough 2001

Source: Office for National Statistics 2001 Census, Crown Copyright

Figure 7

Percentage of the population reporting good health 2001 against index of deprivation

$R^2 = 0.4827$
2003 review of the London Health Strategy high-level indicators population that reported good health by London borough. Generally boroughs in the South and West of London reported better health than boroughs in the East of London. Boroughs that had the lowest percentages that reported good health are Barking and Dagenham, Tower Hamlets and Newham. Richmond, Wandsworth, Kingston-upon-Thames and Kensington & Chelsea had the highest percentages that reported good health.

Figure 7 shows the relationship between borough-level self-assessed health status and the level of deprivation within the borough. Deprivation was measured by the DETR Index of Multiple Deprivation (2000). The higher the DETR deprivation score, the more deprived the borough.

Figure 7 shows that there was a general decrease in the proportion that reported good health with an increase in the level of deprivation within each borough. The line on the chart shows the line of best fit; however, there is a lot of scatter about this line showing that the relationship between self-reported health status and deprivation is not clear. An analysis (linear regression) of the association between the proportion that reported good health and deprivation for each borough showed that deprivation could explain 48 per cent of the variation.

Ethnicity
Detailed information on self-assessed health status among different ethnic groups is not yet available from the 2001 Census and the number of people sampled in the ALG residents survey is too few to make meaningful comparisons between ethnic groups.

Other differentials
Detailed information on self-assessed health status is not yet available from the 2001 Census, however, there is some evidence from the ALG residents survey to suggest that the proportion of people saying their health is good is lower among older people (45% of those aged 60+). In addition, the proportion saying that their health is good is much lower among those with disabilities (12%).

Future reports
Data from the 2001 Census will be used in future reports to present a more detailed, accurate picture of inequalities in self-assessed health status in London.
Health in London
Section 5

Overall trends

In this section:
• Overall trends for London are discussed.
• An overview is provided by type of inequality.
• An overview is provided relating to disability.
• Some conclusions are drawn about inequality trends.
Table 13 summarises recent trends for the 10 indicators in London. All seven health determinants have improved since the mid-1990s but for unemployment and burglary, there has been a slight deterioration compared to the previous year. The unemployment figures reflect an economic slowdown, which will probably affect ethnic minorities as well (although this has not yet become apparent). The burglary rate and street crime rose after the terrorist attacks of September 11th 2001, but it seems that the crime wave following these events is now under control. The previous report showed that life expectancy is generally increasing nationally and in London. However, these trends need to be revisited when new population estimates for 1991–2000 based on the 2001 Census are available. Infant mortality is decreasing as well, but there is insufficient information to determine trends in self-assessed health status, although the previous report showed it had remained constant.

The general improvement since the mid-1990s must be weighed against doubts about the value of some of the indicators (e.g. GCSE performance), and setbacks in other respects (ozone increases, ethnic inequality). Moreover, the economic slowdown could have a negative effect on some of the determinants.

Inequality

Area

Table 14 (on page 70) demonstrates the contrasts between London boroughs on all 10 indicators. Compared with the last year, the gaps are wider for burglary, housing and road casualties, both proportionately and in percentage points (but casualty rates are affected by a major revision in the population estimate for Westminster). 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. For example, someone living in Hackney is three times as likely to be unemployed as a resident of Harrow, more than twice as likely to live in unfit housing, nearly twice as likely to be burgled and twice as likely to be a road casualty; the children’s success at GCSEs is half that of their contemporaries in Harrow. However, there are exceptions in this overall trend in inequality by area. For example, Lewisham and Southwark are deprived inner city boroughs with low levels of unfit housing. Although there is a considerable degree of overlap between the indicators, there is also some independent variation, which can easily be discovered by a comparison of the maps. Inner London fares worse on all the indicators, although for housing fitness the distinction is only slight. (A classification based on deprivation indices would not entirely coincide with the inner/outer division). East London tends to have higher unemployment and lower educational achievement. There is a rough similarity of pattern for the unemployment and education maps. In contrast, the road casualty and burglary rates tend to be concentrated in a corridor to the west and again, there is a similarity between the two patterns. Housing comes into a category of its own.

Ethnic group

Non-white groups fare worse on all the indicators for which data are available - unemployment, education, burglary, unfit housing and road casualties.
The gap between white and non-white is wide for all these determinants, though less so for burglary. However, the information on crime is somewhat conflicting and requires further investigation.

The most well-documented indicator, in this report, is unemployment. Here, there is clear evidence that the ethnic divide has grown since 1985, both in London and in Great Britain. Recent figures suggest that this gap may be widening still. Structural changes in the economy account for some of this trend. There is also evidence of an ethnic penalty, because non-white people are at a disadvantage within each social class.

### Table 13

**Determinants of health and health outcomes for London: Recent trends**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployment rate among New black and ethnic minority categories</td>
<td>Not comparable with earlier years.</td>
</tr>
<tr>
<td>Percentage of pupils achieving 5 GCSE grades A*–C</td>
<td>Still improving.</td>
</tr>
<tr>
<td>Proportion of homes judged unfit to live in</td>
<td>Falling slowly since 1997 (improved fitness).</td>
</tr>
<tr>
<td>Burglary rate per 1000 resident population</td>
<td>Rose or stabilized in 2001/02, after a seven year fall.</td>
</tr>
<tr>
<td>Air quality indicators – NO2</td>
<td>Subject to weather changes; improved for most and PM10 pollutants since 1996, but ozone concentrations worse.</td>
</tr>
<tr>
<td>Road traffic casualty rate</td>
<td>Improved in 2001 over previous year, and 6% per 1000 resident population below 1994-1998 average.</td>
</tr>
<tr>
<td>Life expectancy at birth</td>
<td>The previous report showed that life expectancy is generally increasing nationally and in London. However, these trends need to be revisited when new population estimates for 1991-2000 based on the 2001 Census are available.</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>Decreasing in London and nationally.</td>
</tr>
<tr>
<td>Proportion of people with self-assessed good health</td>
<td>Probably has remained constant.</td>
</tr>
<tr>
<td>Indicator</td>
<td>Range</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Unemployment rate – claimant count, Havering</td>
<td>2.0%</td>
</tr>
<tr>
<td>Tower Hamlets (GB) Oct. 2002</td>
<td></td>
</tr>
<tr>
<td>5 GCSEs A*-C, 64.8%</td>
<td>31.1%</td>
</tr>
<tr>
<td>Unfit housing, HIP data, 1.6%</td>
<td>18.3%</td>
</tr>
<tr>
<td>Sutton Newham, but thought to be lower</td>
<td></td>
</tr>
<tr>
<td>Burglaries per 1000 residents, police records,</td>
<td>4.4</td>
</tr>
<tr>
<td>Kingston-Lambeth (England and Wales) 2001/02</td>
<td></td>
</tr>
<tr>
<td>Thames Road casualties per 1000 residents in 2001</td>
<td>3.8</td>
</tr>
<tr>
<td>Harrow Westminster (GB)</td>
<td></td>
</tr>
<tr>
<td>Male life expectancy at birth 1999-2001</td>
<td>78.5</td>
</tr>
<tr>
<td>Kensington Newham &amp; Chelsea</td>
<td></td>
</tr>
<tr>
<td>Female life expectancy at birth 1999-2001</td>
<td>83.1</td>
</tr>
<tr>
<td>Kensington Newham &amp; Chelsea &amp; Chelsea (Islington) England</td>
<td></td>
</tr>
<tr>
<td>Infant mortality rate 1996-2001</td>
<td>3.4</td>
</tr>
<tr>
<td>Kingston-Lewisham (England and Wales)</td>
<td></td>
</tr>
<tr>
<td>Self-assessed good health 65.5%</td>
<td>76.3%</td>
</tr>
<tr>
<td>Barking and Richmond (England)</td>
<td></td>
</tr>
<tr>
<td>Dagenham</td>
<td></td>
</tr>
</tbody>
</table>

*a The figures are residence based, provided by GLA. They differ from the government figures, which are based on the local workforce.

**Note:** Borough figures would not be meaningful for air quality, but Maps 5 and 6 show the distribution of pollutants.
This suggests that no single remedy will help; a combination of general improvements in the economy and remedial and anti-discriminatory measures is required. The broad consideration of white and ‘other’ groups blurs important differences between, for example, Africans and Caribbeans, Indians and Pakistanis. The 2001 Census will also, for the first time, produce separate information about Irish people, whether born in the UK or not.

In several ways, the experience of Indians is similar to white British people in their living standards. In contrast, Bangladeshis are the most deprived of all the ethnic groups, as described in last year’s report and again confirmed in recent unemployment figures.

Gender
Women fare better than men on the life expectancy, unemployment and education indicators, and these differences have persisted over the years. There are no indicators on which men do better. These general observations need to be qualified, because the report is selective and does not consider, for example, the higher incomes of men. There are also particular groups of women who are at a disadvantage in relation to the health determinants:

• Indian, Bangladeshi and Pakistani women have higher unemployment rates than men.
• On the whole, men spend less time at home, and are less likely to experience the effects of unfit housing.
• Lone parent households are especially prone to burglary, and most lone parents are mothers. Women in general also express more fear of crime.

Age
No significant new findings since last year’s report. Continues to be a major element in health inequality.

Social class
No significant new findings since last year’s report. However, this also continues to be one of the most important dimensions of health inequality.

Other dimensions of inequality
A range of other features separate people on the indicators. Single parent status is associated with higher infant mortality, a higher risk of burglary and (in international research) with higher road casualty rates among children. Also important is the quality of the area; graffiti, rubbish etc. are associated with crime and unfit housing. Some types of London road user, like motorcyclists and child pedestrians, are especially at risk.

Disability
Disability is not monitored in the official statistics relating to this report, with the exception of the Labour Force Survey. Information on the other health determinants is patchy, although there has been some useful research. The British Crime Survey and The English House Condition Survey contain some questions which can be used nationally, but the amount of published information is limited. The HIP returns contain figures on housing adaptations but they relate to properties, not people. Figures on educational achievement do not separate physical and mental impairments. Records are

2003 review of the London Health Strategy high-level indicators
kept of special educational need, which overlaps with disability but is not the same.

A case could be made for including disability in the figures for police-recorded crime and road casualties, and for publishing regular information on education and disability, separating different kinds of impairment.

Despite these limitations in the data, one can draw some tentative conclusions at this stage, as follows:

• Disabled people fare worse on all seven determinants of health for which information is available. There are large inequalities in unemployment, both for white and ethnic minority disabled people. Disabled people have much lower educational qualifications, although only a small minority are mentally impaired. Their levels of housing fitness may be about average, but a high proportion live in housing unsuitable for their needs and they are more likely than others to live in run-down neighbourhoods. The figures for crime are somewhat conflicting but there is evidence that in deprived areas of London, they are especially vulnerable to home-related crimes and to threats and abuse outside the home. Finally, poor air quality is more dangerous for people with a pre-existing condition, like asthma.

• Research on crime and housing suggests that their impact on disabled people may be especially heavy in deprived areas or where other risk factors come into play.

• Studies of long-term trends show that the unemployment and earnings gap between disabled and non-disabled people grew between 1979 and 1997. Structural changes account for some of this, but the gap has also grown within each occupational group. Even when qualifications and age are taken into account, disabled people have significantly higher unemployment rates and lower pay. There is consistent reporting of discrimination, but little agreement on its extent. It is too early to assess the effects of the Disability Discrimination Act 1995.

Such evidence as there is, suggests that people with learning difficulties experience serious disadvantages on several of the health determinants – unemployment, education, road casualties and perhaps crime (e.g. burglary by fraud). People with mental health needs also have a very high unemployment rate but there is a lack of information on this group generally.

The severity of a person's impairment is strongly related to unemployment, lack of qualifications and probably other health determinants as well. One analysis of trends up to 1997 argues that whereas the least impaired people have gained from changes in the economy and the benefits system, the position of severely impaired people has deteriorated (Burchardt 2000). This is an area that needs further research and action.

These statistics say nothing about the experiences of disabled people themselves, but some research projects quoted in this report have attempted to do this. The common message that seems to emerge from this research is one of frustration:

• 28 per cent of disabled Londoners of working age would like to work, but do not have a job (Labour Force Survey).
• More than 40 per cent of disabled people felt that teachers had underestimated their ability, in one 1994 survey (Lamb and Layzell, quoted in Christie 1999).

• Severely impaired children living at home in the north of England wanted more independence, privacy and space.

• Many disabled people who had experienced crime in Hammersmith and Fulham wanted more and better locks and stronger doors, especially in the public sector; there was frustration at the lack of response from the Council and their inability to afford these measures (this was in 1993).

These people feel frustrated, not by their impairments, but by barriers in the external world. Changes in this world can have a major effect on their quality of life. Examples of possible changes can be found in Section 3. Some of these are repeated below to illustrate how a range of indicators can be used by local communities to help build up a broader picture of issues affecting disabled Londoners and to identify implications for action:

• Unemployment. When employees become disabled, employers can help to retain them by physical adaptations, allowing a slower pace of work, flexible working conditions and creating a less stressful environment (Burchardt 2000).

• Educational attainment. The Centre for Studies on Inclusive Education is urging the government to phase out special schools (Community Care).

• Proportion of homes judged unfit to live in. The Rowntree Trust in 1998 recommended a review of the legislative structure, which separates disabled children from adults (Oldman and Beresford).

• Domestic burglary rate. A report on crime and disabled people recommended more home security initiatives, low cost insurance schemes, better street lighting, and training in self-defence and assertiveness.

• Road traffic accidents. PUFFIN crossings are useful for people with hearing impairments; extra safety measures, like guardrails, should be installed outside special schools. Roadside training should be given to people with learning difficulties (TRL 2002).

In a review of the literature in 1998, Barnes et al found that disabled people themselves reported inadequacies in education and the benefits system as the two major obstacles to progress in the labour market (quoted in Christie 1999). More information is required to assist policy. Gaps in the official statistics have already been mentioned. There is also a need for research on:

• the experiences of disabled people from ethnic minorities
• the experiences and needs of severely impaired people.

Inequality trends

Last year's report reached the conclusion that although, over the years, the health determinants and health have improved, inequalities have not. (For more details on the persistence of these inequalities, see Health in London 2002).
That conclusion was probably not strong enough. Research suggests the following:

• Between 1979 and 1997, the position of disabled people in the labour market deteriorated somewhat. This trend probably applied most to people with severe impairments. (DfEE RR133 1999; Burchardt 2000).

• In London and Great Britain, the ratio of non-white to white unemployment has grown since 1985. (Labour Market Trends, January 2001).

Structural changes in the economy account for these trends only in part. When age, qualifications and occupational level are controlled, ethnic minorities and disabled people are still at a disadvantage. Discrimination is widely reported by ethnic minorities and disabled people and has, in some cases, been well demonstrated.

There is no simple solution for these persistent and growing inequalities, and the situations of ethnic minorities and disabled people are not the same. Both are very diverse groups. But while lessons need to be learnt from the failures of the past to help provide more effective remedies, progress is indeed being made in a number of areas, including improving access to information and supporting action to achieve change. This gives cause for optimism and working in partnership with communities has already begun to make a real difference. The London Health Commission will publicise these developments at a later date.

Health in London
Annex 1 Sources and resources

Sources


COMEAP (Department of Health Committee on the Medical Effects of Air Pollution) (2001) Quantification of the effects of air pollution on health in the United Kingdom. London, The Stationery Office

Community Care (November 12th 2002) 'Government under fire for low numbers of disabled children in mainstream schools' www.communitycare.co.uk

Community Care (November 18th 2002) 'Government urged to phase out special schools' www.communitycare.co.uk


Department for Education and Skills (January 2003) National Curriculum Assessments for Key Stage 3 (Revised), GCSE/GNVQ Examination Results (Provisional) and Associated Value Added Measures, for Young People in England 2001/02. London, DfES www.dfes.gov.uk


Health in London
New Earnings Survey time series data made available to GLA Office of the Deputy Prime Minister (2001)

Housing Investment Programme data 2001 www.odpm.gov.uk/local/hipoi/index.htm


Social Trends 31 Office for National Statistics (2002)


Transport for London Atmospheric emissions inventory, version February 2002


Health in London
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.met.police.uk (for Metropolitan Police statistics)

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

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

2003 review of the London Health Strategy high-level indicators
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

NO2 Nitrogen dioxide

NOX Oxides of nitrogen

NS-SEC National Statistics Socio-economic Classification

NVQ National Vocational Qualification

O3 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

PM10 Fine particles (less than 10 microns in diameter)

SEN Special Educational Need

SO2 Sulphur dioxide

SOC Standard Occupational Classification

TfL Transport for London

TRL Transport Research Laboratory

Health in London
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.


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:

<table>
<thead>
<tr>
<th>Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Higher managerial and professional occupations</td>
</tr>
<tr>
<td>2 Lower managerial and professional occupations</td>
</tr>
<tr>
<td>3 Intermediate occupations, e.g. mid-level sales and technical occupations</td>
</tr>
<tr>
<td>4 Small employers and own account workers</td>
</tr>
<tr>
<td>5 Lower supervisory and technical occupations</td>
</tr>
<tr>
<td>6 Semi-routine occupations</td>
</tr>
<tr>
<td>7 Routine occupations</td>
</tr>
<tr>
<td>8 Never worked and long-term unemployed</td>
</tr>
</tbody>
</table>

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 2003 review of the London Health Strategy high-level indicators.
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

Indicator \( L55473 \)

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...
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 /L55474 – 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'.

2003 review of the London Health Strategy high-level indicators
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 /L55475 – 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.

Indicator /L55476 – 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.
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 L55477 – 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.

2003 review of the London Health Strategy high-level indicators
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. It covers a 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 – Air Quality indicators: NO2 and PM10

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 NO2 and PM10 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 NO2, there is an annual and an hourly objective; for the latter, the level is set much higher, because it is a 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 PM10, 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 PM10 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 (NO2) and fine particles (PM10). 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
2003 review of the London Health Strategy high-level indicators for NO2 and daily average for PM10.

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/L55479 – 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...
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 /L55480 – Life expectancy**

**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’.

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.

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 /L55481 – 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 /L50181** – 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 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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**London Health Commission**

The London Health Commission (LHC) is a high level partnership that works to reduce health inequalities in the capital and to improve the health and well-being of all Londoners. The LHC recognises that this requires coordinated action to improve the determinants of health across London.

It promotes this action by:

- building partnerships across sectors and organisations
- influencing key stakeholders and policy makers
- providing practical support for local activities.

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**Greater London Authority**

The Greater London Authority (GLA) has a general duty to promote the health of Londoners in exercising its powers. It is also committed to tackling the inequalities in health that exist across London. A report on the health of Londoners is part of the GLA business plan, best value plan and work programme. Much of the work is undertaken in partnership with other organisations.

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**London Health Observatory**

The London Health Observatory (LHO) was set up in 2001 following the Government White Paper *Saving Lives: Our Healthier Nation* (DOH, 1999) and is key to developing the activities of the LHC. The LHO brings together the information and know-how needed to analyse and research health in the capital. It also has a role to help all those working to improve the health of Londoners to make better use of health and health-related information. The LHO is part of a national network of Public Health Observatories and had lead role on health inequalities, social exclusion and regeneration.

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