Section 2: health inequalities

Inequality in lifestyles and behaviours

a single version of the truth

NHS Wiltshire Clinical Commissioning Group
Wiltshire Council Where everybody matters
Wiltshire Assembly Public Services Board

Related briefings in the JSA for Health and Wellbeing

Briefing	Section
Entire section	Health inequalities
Entire section	Children and Young People
Entire section	Health promotion and preventative services
Entire section	Wider determinants of health
Deprivation	Resources

Outcome Frameworks Summary

The Public Health Outcomes Framework for England, 2013-2016[1] outlines the overarching vision for public health as "to improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest". Each indicator domain has an objective that includes health inequalities:

Domain	Objective
1. Improving the wider determinants of health	Improvements against wider factors that affect health and wellbeing and *health inequalities*
2. Health improvement	People are helped to live healthy lifestyles, make healthy choices and reduce *health inequalities*
3. Health protection	The population's health is protected from major incidents and other threats, while reducing *health inequalities*
4. Healthcare public health and preventing premature mortality	Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the *gap between communities*.

The NHS Outcomes Framework 2014/15[2] set out how the improvement of healthcare outcomes for all will be the primary purpose of the NHS. The Framework also focuses on reducing health inequalities and unjustified variation.

Edition

Edition	Version no.	Changes/Comments
2012/13	1	N/A
2013/14	1	N/A

Executive summary

The lifestyle factors which influence health inequalities are sometimes referred to as the "proximate" causes of health inequalities, because they are the immediate precursors of disease, as opposed to the 'distal', 'upstream' or 'wider determinants', such as poverty, housing or education. They include; smoking, alcohol consumption, physical activity etc.

Lifestyle factors vary by socio-economic gradient, with those in more deprived areas being more likely to have ‘unhealthy’ lifestyles such as smoking.

Within Wiltshire there is evidence of inequalities in lifestyles and behaviours similar to those seen nationally such as a strong correlation between alcohol related admissions and local deprivation, and prevalence of obesity is higher in the more deprived areas of Wiltshire.

Background

Lifestyles and behaviours such as smoking, alcohol consumption, poor diet, or physical inactivity have a major influence on health and well-being.

The lifestyle factors which influence health inequalities are sometimes referred to as the "proximate" causes of health inequalities, because they are the immediate precursors of disease, as opposed to the 'distal', 'upstream' or 'wider determinants', such as poverty, housing or education. They include:

- Smoking.
- Alcohol consumption.
- Nutrition.
- Physical Activity.
- Weight.
- Drug use.
- Sexual behaviour.
- Stress.

Lifestyle factors vary by socio-economic gradient, with those in more deprived areas being more likely to have ‘unhealthy’ lifestyles.

> “*However, these lifestyle-related causes of health inequalities reflect what are frequently referred to as the underlying causes—income, socio-economic group, employment status and educational attainment. There are many reasons why the poorest in society are less likely to adopt beneficial health behaviours. Firstly, information about how to behave healthily may not reach some groups of society; secondly, they may lack the material resources to live healthily, and the environments in which they live may make this doubly hard; behaviours such as smoking tend to be more heavily entrenched in those from lower socio-economic groups which makes positive change harder; and finally, for people living difficult lives, who may be faced with*

pressing problems with income, employment or even personal safety, changing health behaviour is unlikely to be a major priority."[3]

Figure 1 shows deprivation in Wiltshire according to the overall IMD deprivation ranking according to the 2011 Census LSOA adjusted scores.

Figure 1: Wiltshire 2011 Census LSOAs by Wiltshire IMD 2010 quintiles based on adjusted scores

Indices of multiple deprivation 2010 in 2011 Wiltshire LSOAs

Indices of deprivation quintiles within Wiltshire (1 being most deprived)
1
2
3
4
5

Malmesbury
Royal Wootton Bassett
Chippenham
Calne
Devizes
Melksham
Bradford on Avon
Marlborough
Trowbridge
Pewsey
Amesbury
Westbury
Salisbury
Warminster
Tisbury
Wilton

Map created by Simon Hodsdon, Public Health Intelligence Officer

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Lifestyle and behaviours in Wiltshire

The following is a summary of the health inequalities in a selection of lifestyles and behaviours. Further details are included within the individual chapters.

Smoking

There is a strong link between cigarette smoking and socio-economic group. Smoking has been identified as the single biggest cause of inequality in death rates between rich and poor in the UK.

In England smoking prevalence among adult males has dropped from 65% in 1948 to 42% in 1980 and 20% in 2010[4]. Over the same period the prevalence in adult females has also dropped, from 41% in 1948 to 19% in 2010. Smoking prevalence is higher among younger adults and peaks at 27% in 25-34 year olds for males and 30% for 20-24 year olds for females. Only 13% of those aged 60 or over smoke.

The prevalence gap between manual and non-manual workers has persisted over the last two decades[5]. In 1992, 33% of manual workers smoked compared to 23% of non-manual workers. By 2010, smoking rates had dropped in both groups (26% and 15%) but the gap has grown to 11%. Data from an alternative source, the Integrated Household Survey in the Tobacco Control profile[6] showed that 25.9% of routine and manual workers in Wiltshire, in 2011/12, were smokers. This was lower than England (30.3%) and the South West (30.2%).

Smoking in Pregnancy

The Infant Feeding Survey (2010) shows that women in managerial and professional NS-SEC social classes are less likely to smoke throughout pregnancy than those in intermediate occupations or routine and manual occupations (Table 1).

Table 1: Percentage of women who smoked before or during pregnancy and throughout pregnancy in England by NS-SEC class, 2010

NS-SEC class	% who smoked before or during pregnancy	% who smoked throughout pregnancy
Managerial & professional	14	4
Intermediate occupations	26	10
Routine & manual	40	26

Data source: Infant feeding survey 2010.[7]

There is no local data of smoking prevalence by deprivation quintile. However 13.3% of all maternities were smokers in 2012/13, which is not statistically different from the England value of 12.7%.[8]

Alcohol consumption

There is a strong correlation between alcohol related admissions and local deprivation. In 2012/13, In Wiltshire, admissions in the most deprived quintile are 40% higher than in the least deprived quintile[9].

There is substantial variation by age in alcohol related admissions and in 2012/13 admissions peaked in the 50-64 age group (26% of total admissions). [10]

Obesity

Nationally, females are three times as likely as males to be admitted to hospital with a primary diagnosis of obesity (33 per 100,000 population compared to 11 per 100,000 population) [11]. Additionally, it has been reported that poorly educated women are 2 to 3 times more likely to be overweight than those with high levels of education, but almost no disparities are found for men.

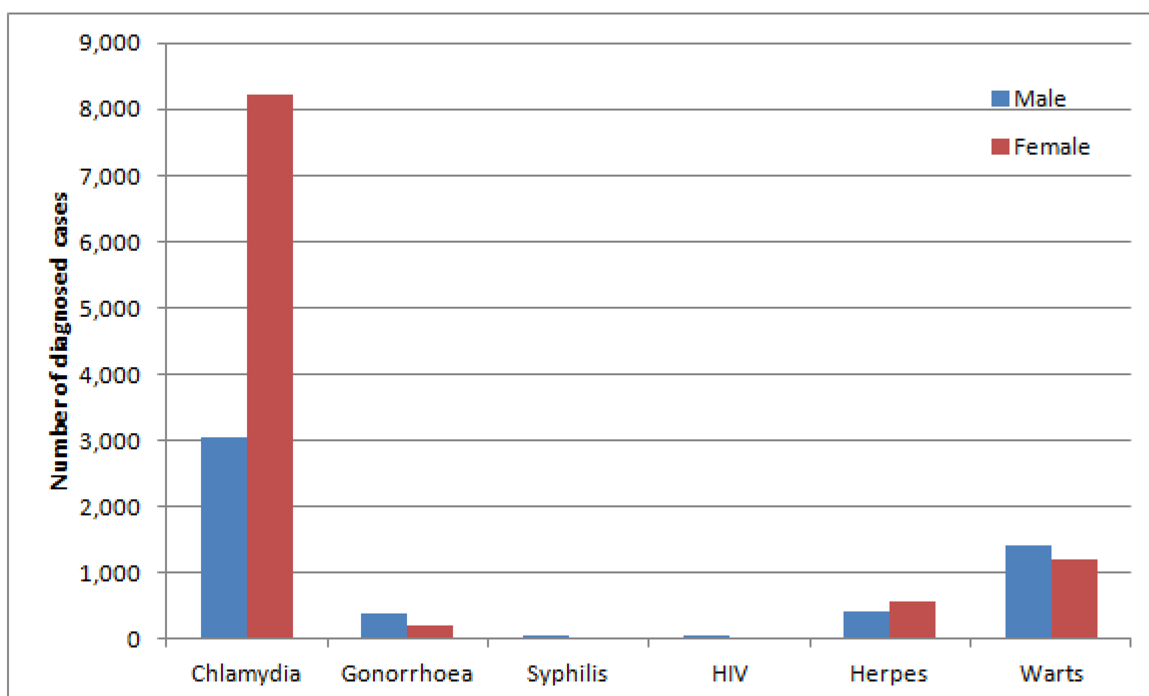
The prevalence of obesity is higher in the more deprived areas of Wiltshire. Based on 2009 data it was estimated that obesity was over 8% higher in the most deprived population quintile compared to the least deprived.

Sexual Health

Young people, black minority communities and men who have sex with men (MSM) are disproportionately affected by sexually transmitted infections (STIs).

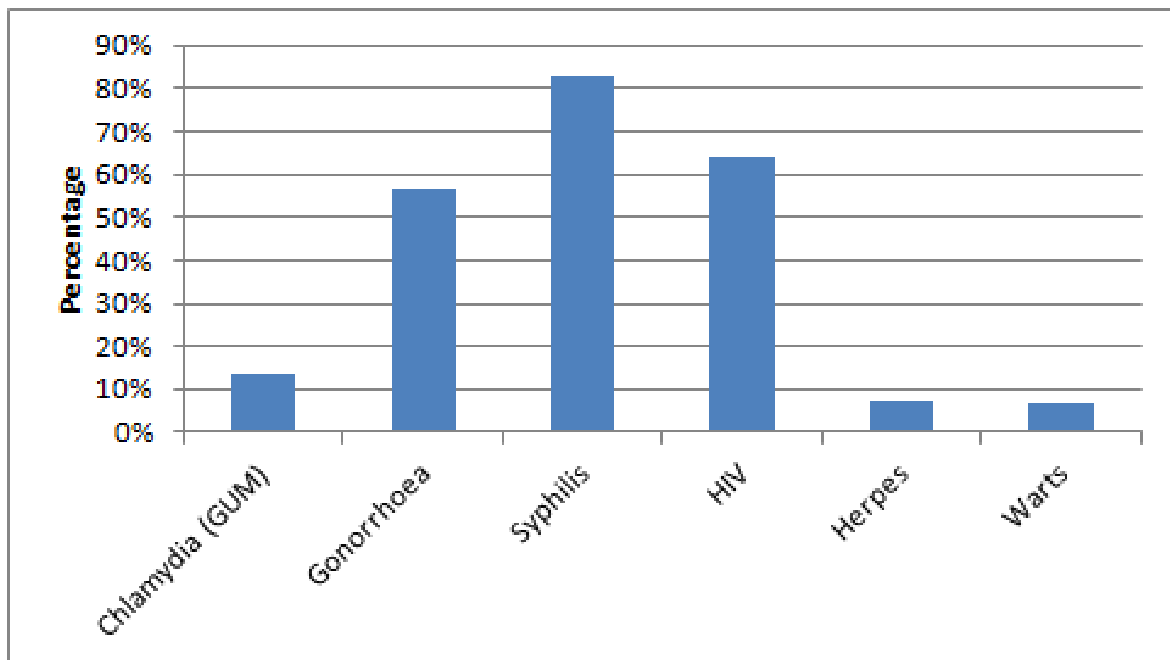
Figure 2 shows the distribution of STIs by gender in the Avon, Gloucester and Wiltshire Public Health Centre area. Figure 3 highlights that MSM are disproportionately affected by certain STIs, and shows that in the South West of all male diagnosis of HIV, 64% are in MSM. The number of diagnoses of syphilis and HIV are low within Wiltshire, but these aspects are still important to be considered within health planning.

Figure 2: Number of diagnosis of each STI by gender in the Avon, Gloucester and Wiltshire Public Health Centre area, 2012



Data source: Health Protection Agency 2012.[12]

Figure 3: Percentage of MSM diagnoses of each STI among all male diagnoses in the Avon, Gloucester and Wiltshire Public Health Centre area, 2012



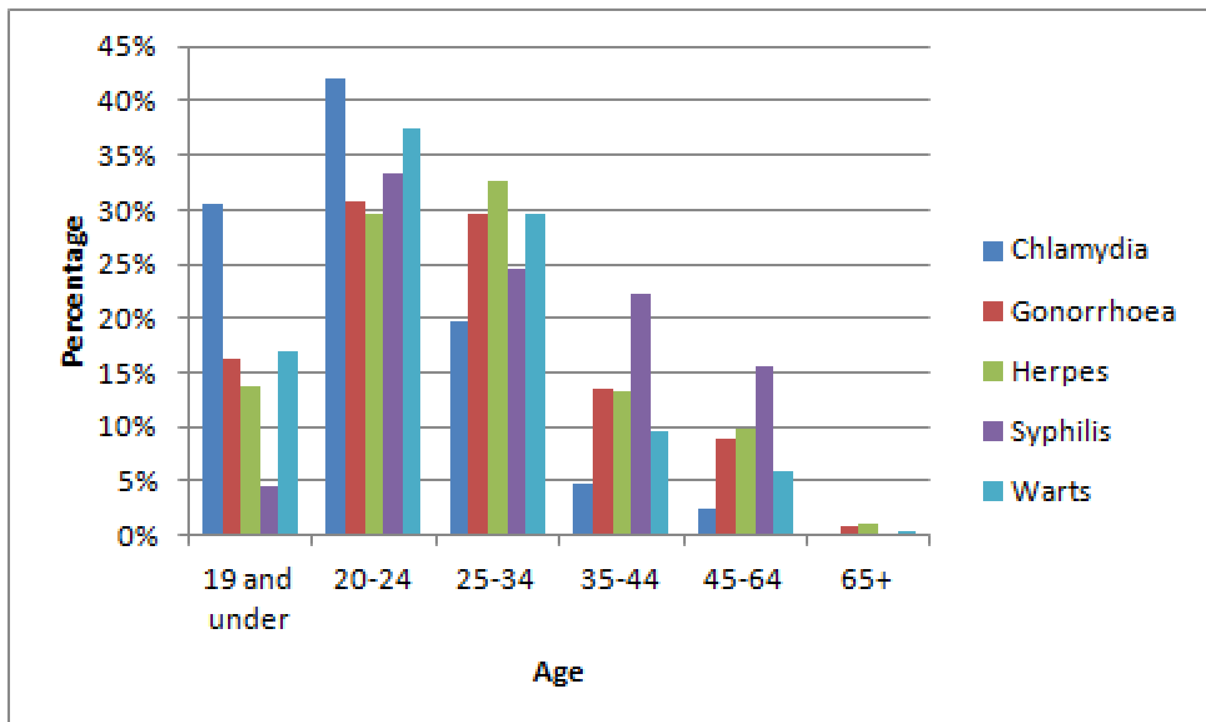
Data source: Health Protection Agency 2012.[13]
Note: only Chlamydia diagnoses at GUM services included.

A HPA report (2011)[14] shows that for the first time since 1998, the number of new HIV diagnoses in men who have sex with men (MSM) has surpassed new diagnoses in heterosexuals. Half of those diagnosed in 2011 (48%, 3,000) probably acquired their infection through sex between men and 47% (2,890) through heterosexual contact (data adjusted for undetermined risk).

"*Young people represent only 12% of the population, but account for nearly half of all STIs diagnosed in genitourinary medicine clinics across the UK in 2007.*"[15]

As can be seen in Figure 4, under 25 years olds account for approximately 73% of chlamydia, 47% of gonorrhoea, 43% of herpes and 55% of wart diagnoses. However it should be remembered that under 25s are targeted for chlamydia screening so the 'pick up rate' is likely to be much higher in this age group.

Figure 4: Percentage of selected STI diagnosis by age-group in the Avon, Gloucester and Wiltshire Public Health Centre area, 2012



Data source: Health Protection Agency 2012.[16]

In Wiltshire in 2012, 71% of those accessing care were from a white ethnic group. 19% were black-Africans, 3% black-Caribbeans and 7% of ‘other’ ethnicity. This compares to the overall population in Wiltshire in which there are 96.7% whites and only 0.3% black-Africans and 0.2% black-Caribbeans[17].

A higher proportion of people in Wiltshire’s most deprived quintile accessed HIV-related care in 2010 than in the other 4 quintiles. However, this calculation is based on small numbers and therefore there is a great deal of uncertainty about this result.

Children and Young People

Childhood accidents

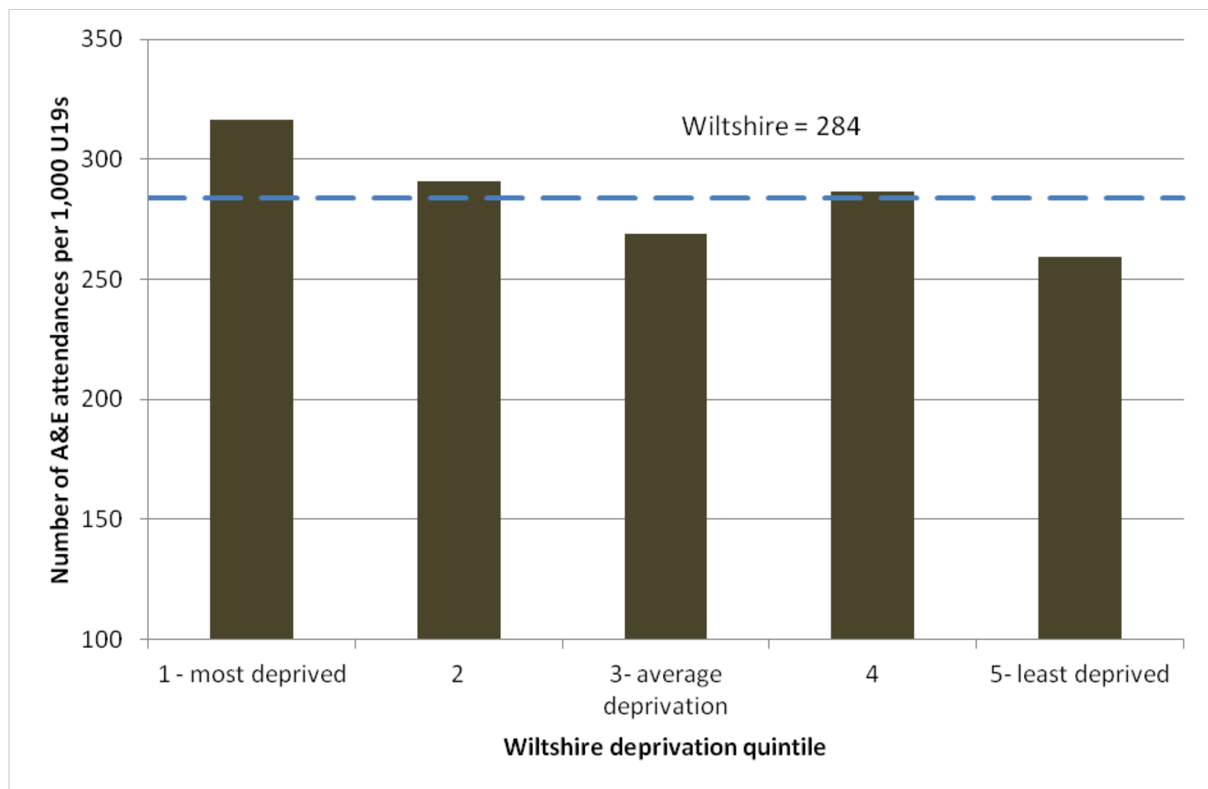
Unintentional injury is a leading cause of death among children aged 1-14 years, and puts more children in hospital than any other cause. Rates of unintentional injury in children show strong and persistent inequalities.[18]

“The Department for Trade and Industry’s (DTI) Home Accidents Surveillance System revealed that residential areas with higher proportions of lower socio-economic groups have higher rates of unintentional injury. The statistical relationship is most marked for children under 16 years, and particularly the under-fives. Children of parents who have never worked or who are long-term unemployed are 13 times more likely to die from unintentional injury, and 37 times more likely to die as a result of exposure to smoke, fire or flames than children of parents in higher managerial and professional occupations. In England, children in the 10 per cent most-deprived wards are three times more likely to be hit by a car

than children in the 10 per cent least-deprived wards. In addition, fatality is twice as likely in boys as girls (aged 1-14), a gap that increases with age."[19]

Based on A&E attendance data it appears that childhood accidents in Wiltshire are more prevalent in more deprived areas. In 2012/13, there were 317 attendances per 1,000 under 19s in Wiltshire's most deprived quintile compared to 245 per 1,000 in the least deprived quintile.

Figure 5: Attendances per 1,000 Under 19s by deprivation quintile (2012/13)



Source: NHS Wiltshire SUS data

Breastfeeding

Breastfeeding is known to have short and long-term health benefits and yet rates of breastfeeding remain relatively low in the UK. Wiltshire has a relatively high percentage of women initiating breastfeeding – 81% in 2012/13 compared with 73.9% for England. However, the percentage of mothers who continue breastfeeding to 6 weeks is 47.6% for 2012/13, only slightly higher than the England rate of 47.2%[20].

There are known to be socio-economic inequalities in breastfeeding: mothers in routine and manual occupations are less likely to breastfeed than mothers in managerial and professional occupations. Teenage mothers are particularly unlikely to breastfeed. Breastfeeding is a key strategy in tackling inequalities in health. In 2012/13 the prevalence of breastfeeding at 6-8 weeks in the most deprived population quintile was significantly lower than the Wiltshire average and significantly lower than the rate observed in any other deprivation quintile[21].

Wiltshire Projects

Universal Public Health Programmes in Wiltshire

- Health improvement campaigns:
    - Active Health (physical activity on referral) programme.
    - Adult and children weight management programmes.
    - Healthy schools programme.
    - Change 4 Life programme.
    - Implementation of Wiltshire Alcohol strategy.
    - Pharmacy health promotion campaigns.
    - Generic health promotion campaigns.

- NHS Health Checks offered by GPs for all those aged 40-74 years, not already on a CVD register.

- Stop Smoking Service.

- Pharmacy health promotion campaigns.

- Generic health promotion campaigns.

- Behaviour Change workshops to support front line workers (in statutory and voluntary organisations) who deal with 'lifestyle issues'. The training aims to explore client centred approaches which can 'help people help themselves' with regard to lifestyle issues.

Targeted Public Health Programmes in Wiltshire

- Health trainer programme
    - Working with probation, HMP Erlestoke, family member of military personnel and Wiltshire Addiction Support Programme.
    - Health Trainers help people to develop healthier behaviour and lifestyles in their own local communities. They offer practical support to change their behaviour to achieve their own choices and goals.
    - People in probation, prison and addiction support programmes are more likely to be at risk of a number of physical and mental health problems. Targeting these groups can therefore reduce health inequalities

- Early years healthy eating programme
    - Focused in areas with higher than average levels of obesity.

- Cardiovascular disease outreach
  - Activity by pharmacies – delivered in partnership with Local Pharmaceutical Committee.
  - *Ad hoc* sessions at markets and other venues - implemented via locality lead GPs and Public Health Lifestyles Team.
  - Targeting areas where the population is at greater risk of cardiovascular disease which is one of the main causes of mortality.

- NHS Health Check
  - HMP Erlestoke has offered to new arrivals aged 40-74 since March 2010.

- Citizens Advice in Primary Care.
  - Citizens Advice available in three GP practices with high levels of deprivation.
  - The aim of the project is to provide advice on housing, debt, benefits and employment to those that require it but may otherwise not access this advice, and thereby improve the wider determinants of people's health.

- College based sexual health drop ins
  - To address some of the issues of young people having access to appropriate clinics.

- Affordable Warmth Partnership
  - Targeted information about the assistance available to improve energy efficiency and to help with fuel bills.
  - This addresses some of the wider determinants of health, as well as having a potential to directly impact on health by people having warm enough houses.

- Breastfeeding peer support programme
  - Women with experience of breastfeeding are trained to support new mothers with breastfeeding in areas where breastfeeding rates are lowest.
  - Breastfeeding is known to be good for both mother and baby, and can affect health throughout the life course.

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