The Health of Londoners

A public health report for London

THE HEALTH OF
LONDONERS PROJECT

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Edited by Martin Bardsley, Maggie Barker,
Angela Bhan, Stephen Farrow, Mike Gill,
Bobbie Jacobson & David Morgan

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LONDONERS PROJECT

Contents

Preface

The Health of Londoners is the first public health report for Greater London. The work was commissioned from The Health of Londoners Project and sponsored by London's 16 health authorities and the North and South Thames Regional Offices of the NHS Executive. The Health of Londoners Project was established by London's Directors of Public Health in 1995 and provides a programme of health monitoring and analysis for Greater London (see Appendix 1).

We hope that this report will promote a much-needed tradition of objective reporting on health in the capital that is complementary to, but different from, the annual public health reports of London's directors of public health.

London lags behind other UK and European cities in its lack of a strong city-wide approach to health. It is time for the health of Londoners to be put firmly on the map. We see our report as a vital initial step in this process. The creation of a Greater London Authority with an elected Mayor for London and a single London office of the NHS Executive provide unparalleled opportunities for the health and well-being of Londoners to be given the long overdue attention they deserve.

This report follows on from the tradition established 150 years ago in the first Public Health Act for England in 1848. Our report focuses primarily on the **health** of Londoners, and necessarily concentrates on those factors – largely outside the NHS – that have an impact on health, such as housing, transport and education. However, no report could do justice to health in London without also considering the influence of London's health and other services. Our aim in this report has been to highlight some of the key health issues that need to be tackled in the capital rather than attempt to cover every aspect of health in London.

For each of the issues examined we have drawn out the further action needed at a pan-London level, in particular where there is, as yet, no united voice for the capital. At a time of rapid and unprecedented change in London's institutions and governance, it would be presumptuous of us to assign specific responsibilities for these actions. We would prefer to see the conclusions of our report fuelling the debate and catalysing long overdue action in these areas.

Above all, there is one over-arching challenge repeatedly thrown up by our analysis. It is that of tackling London's growing health divide. This challenge can be met only if London's constituent parts are deliberately steered in this direction both by London's new institutions and by central government. If our report shifts the emphasis in the capital from competition and fragmentation

between potentially warring 'republics' to one of commitment to targeting resources more effectively towards the most disadvantaged, the effort will have been worthwhile.

We believe that *The Health of Londoners* provides impetus for more effective public health action between the NHS, local authorities, the independent sector, London-wide agencies and central government into the new millennium.

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The Project is also grateful for the continued help we receive from a number of other organisations with whom we work closely, particularly the London Research Centre, the Association of London Government and the South East Institute of Public Health.

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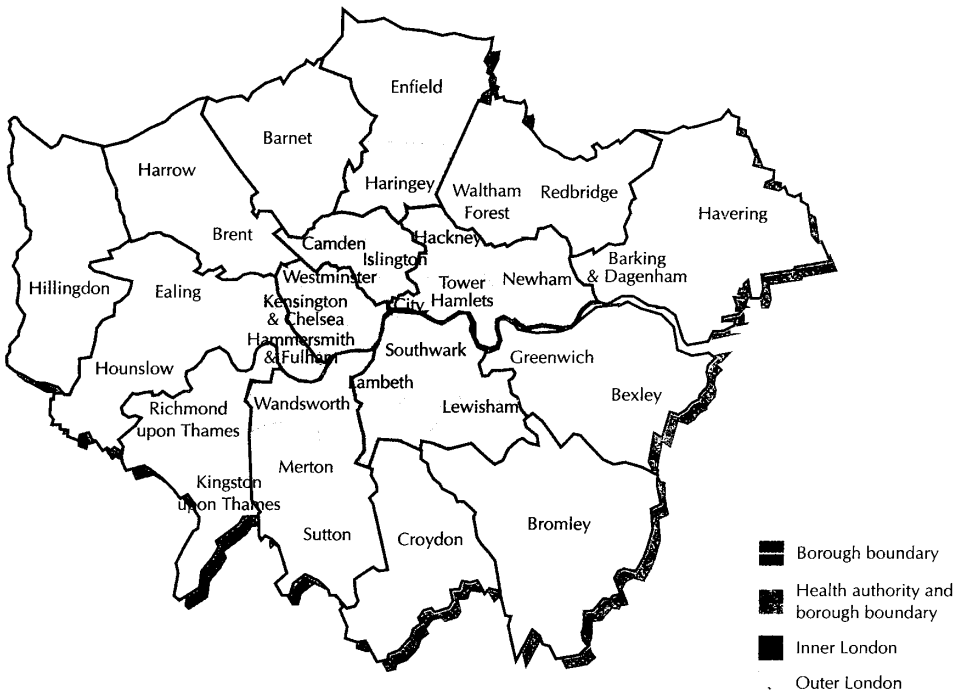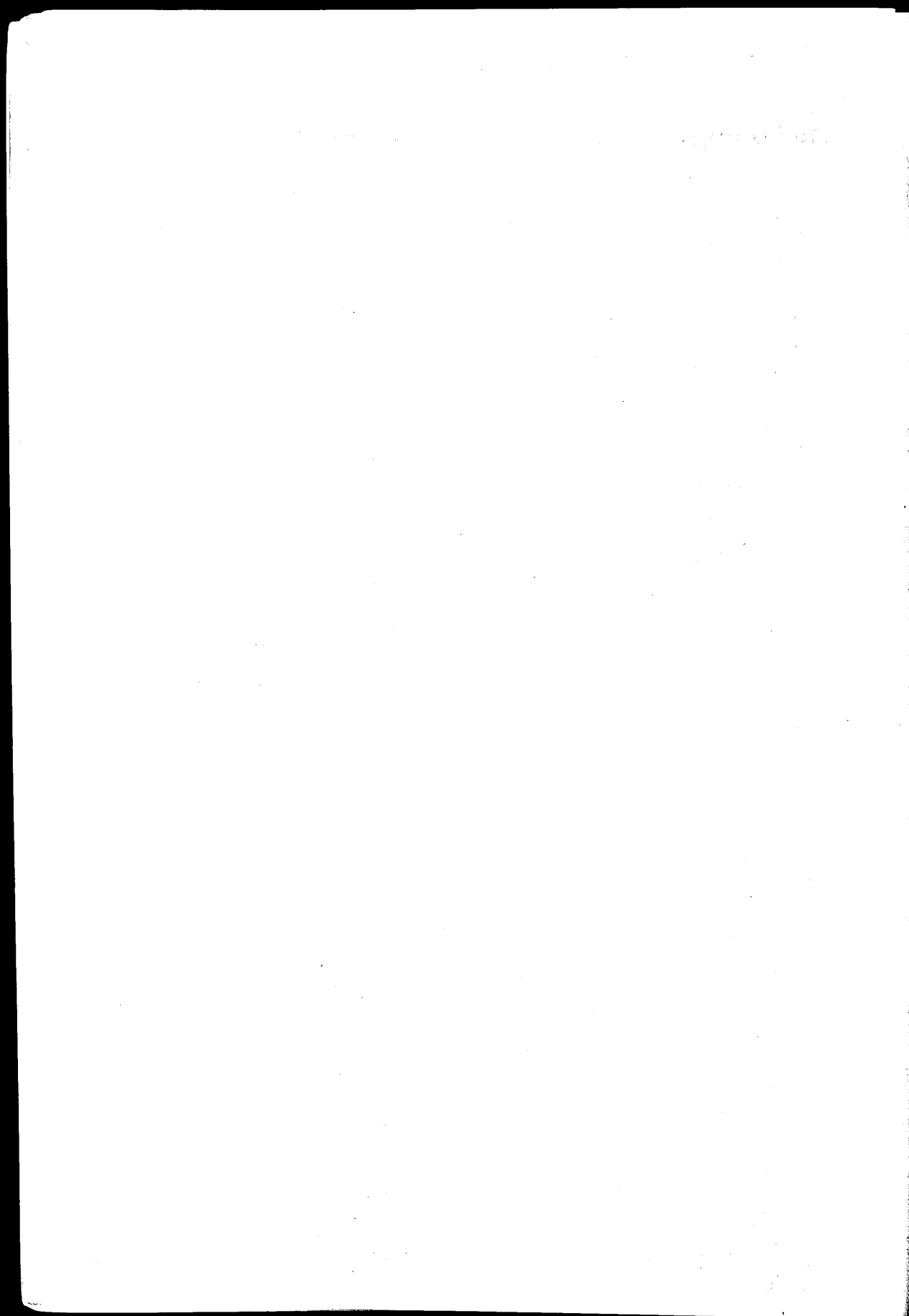David Morgan   Health Analyst, The Health of Londoners Project

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London boroughs and current health authority boundaries

Enfield

Barnet

Harrow

Haringey

Waltham Forest

Redbridge

Havering

Brent

Camden

Hackney

Islington

Westminster

Barking & Dagenham

Hillingdon

Ealing

Kensington & Chelsea

Tower Hamlets

Newham

City

Hammersmith & Fulham

Southwark

Greenwich

Hounslow

Lambeth

Richmond upon Thames

Wandsworth

Lewisham

Bexley

Merton

Kingston upon Thames

Sutton

Croydon

Bromley

■ Borough boundary

■ Health authority and borough boundary

■ Inner London

. Outer London

Summary

from *London's Directors of Public Health*

The Health of Londoners gives the most comprehensive picture yet of the determinants of health and their impact on London's health and well-being. It also examines what needs to be done *across the whole of Greater London* to strengthen local work. Current changes within the NHS and government for London present an unrivalled opportunity for focusing on the common themes identified in this report.

1998 is the 150th anniversary of the first Public Health Act for England. The Act recognised the impact on people's health of factors such as sewerage, clean water and housing, and placed a responsibility on local health boards to address these issues. It is therefore timely that this report identifies the public health issues of our time and recognises that the way they must be addressed is by coherent and collaborative action.

Factors shaping health in London

London is the largest city in the UK, with a population of more than 7 million in 1996 – larger than many entire European countries. It is home to the most diverse groups of people in the country, and includes some of the poorest and some of the most affluent communities, often living cheek by jowl. London boasts an equally wide range in terms of health indicators, from the very good to the very bad.

The extent of poverty, deprivation and social exclusion is a key characteristic affecting the state of health within the capital. Although Inner London seems worse on many health indicators, the problems associated with poverty and social exclusion are distributed throughout the capital and not just in the inner city (see Chapter 2). Even in the most affluent areas there are people living in poverty. Box S.1 summarises some of the key factors influencing health in London. Box S.2 shows some of the background socio-economic indicators for London.

BOX S.1 KEY FACTORS THAT SHAPE HEALTH IN LONDON

- Economic and social development, affecting general employment, income and opportunity.

- The physical environment, transport, air quality and economic developments, including the way in which available land is used.

- Poverty, deprivation and social exclusion existing in some form throughout the whole of London.

- Relatively more younger and fewer older people, resulting in many of the most pressing health concerns in London relating to younger age groups (e.g. mental health, HIV and AIDS, substance misuse).

- An ethnically diverse and mobile population, with relatively large numbers of people moving into and out of the city from the rest of the UK and from abroad.

- High levels of homelessness and problems associated with poor quality housing and the urban environment.

London is the most ethnically diverse of UK cities, and this is an important determinant in current and future patterns of health (e.g. the effects of a higher incidence of coronary heart disease and diabetes among south Asian communities), and in accessibility and appropriateness of health promotion and health services (see Chapter 2).

Box S.2 Social background – facts about London

- A third of secondary school pupils in London are eligible for free school meals.

- The proportion of London's population estimated to be living in poverty increased from 14 per cent in 1983 to 24 per cent in 1992.

- Nearly 40 per cent of the unemployed in 1997 had been out of work for more than 12 months.

- Unemployment among non-white ethnic groups is twice as high as national averages, and for some ethnic groups is over 33 per cent.

- 1 in 4 women living in Inner London is estimated to have experienced domestic violence.

- Estimates of the number of homeless in London (covering people on the streets, in temporary accommodation and single homeless) range from 100,000 to 250,000.

- 940,000 adults in London (17 per cent) receive Income Support and 750,000 receive Housing Benefit.

- There is a concentration of the highest earners in the country in London. In 1994/95, 21 per cent of household incomes in Greater London were in excess of £650 per week, compared to 14 per cent in England.

- There were 324,000 children living in non-earning households in 1991, more than the total population of cities such as Cardiff, Coventry or Nottingham.

- Two-thirds of refugees and asylum seekers in England and Wales arrive and settle in London.

- More than 2,000 pupils were permanently excluded from schools in London in 1996/97.

- 40 per cent of the population of London live in electoral wards that are among the most deprived 10 per cent of all wards in the country.

The current state of health in London

Inequality and premature death

Social, cultural and economic factors in London give rise to a range of health problems and an excess of premature death (see Box S.3). Although mortality rates are not a complete measure of health, in some boroughs the chances of dying before the age of 65 are 50 per cent higher than in others. Moreover, the health 'divide' between the most affluent and the deprived communities in the capital grew during the 1980s. Although premature mortality rates in London are falling, changes in London's rates are not keeping pace with changes at a national level (Box S.4) (see Chapter 2).

Box S.3 Premature death in London

- The chances of dying before reaching the age of 65 are almost twice as high in the most deprived areas of London as in the least deprived. This gap between rich and poor is increasing.

- Infant mortality rates in parts of Inner London are three times higher than those in Outer London. Rates in London are twice those in Stockholm.

- There were four-fold differences in infant mortality rates between London boroughs in 1996.

- Among men aged 35–50, mortality rates in Inner London are over twice the national average and increasing.

- The major causes of death in London in 1996 were cardiovascular disease (41 per cent), cancers (24 per cent) and respiratory disease (18 per cent). Inequalities in mortality from coronary heart disease are growing between Inner and Outer London.

- The average age at death of a group of people who died while living on London's streets was 42 years.

- In Inner London, HIV/AIDS is estimated to be the most common cause of death in men aged 15–54 and the second most common cause in women of the same age.

- Every year in London 250 people are killed and 6,500 seriously injured in road traffic accidents.

Box S.4 Trends in Our Healthier Nation mortality indicators

- Three targets relate to premature mortality. These are, by 2010:

  – to reduce the death rate from cancer among people aged under 65 years by at least a further fifth;

  – to reduce the death rate from heart disease, stroke and related illnesses among people aged under 65 years by at least a further third;

  – to reduce the death rate from suicide and undetermined injury by at least a further sixth.

- Mortality rates from cancers at ages under 65 are on average declining at about 1.4 per cent per year for England and Wales, and at 1.3 per cent per year for Greater London. The downward trend is significant in most boroughs but in many of them will not be sufficient to reach the national target.

- There is a clear downward trend in mortality from circulatory disease at ages under 65, the value for England and Wales falling by an average 4 per cent per year. If these trends continue, the national target should be exceeded. In London, although mortality rates are declining, the fall is not as fast as that seen nationally. Moreover, there are a number of boroughs that seem to have higher values and to be lagging behind in terms of annual percentage changes. This is an indicator where the growing gaps between the affluent and poor areas within London are becoming more marked.

- Mortality rates from suicide and undetermined injury are lower than for the other targets and there is more statistical uncertainty associated with projections of this indicator. In London, the decrease in rates has been greater than that for England and Wales as a whole. In Inner London, for example, rates in 1979 were 17.8 per 100,000 compared to 11.6 nationally; by 1996 the differences were much smaller (12.7 and 9.9 per 100,000 respectively).

In parts of Inner London, rates of infant and childhood mortality are particularly high, well above national averages and over three times higher than in some Outer London boroughs. Throughout the capital there are communities with children who are suffering from the effects of disadvantage, deprivation and social exclusion (see Chapter 8). Injuries are a major cause of death in young people, of which road traffic accidents are a significant proportion. Healthier and sustainable transport can help not only to reduce accidental deaths but also to improve general health and reduce the burden of cardiovascular disease (e.g. through more cycling and walking), which remains the biggest cause of premature death among Londoners (see Chapter 4).

The high incidence of HIV/AIDS is a major problem for people aged 15–54 in London, more so than in any other city in the UK (almost half of all cases reported in the UK live in London). AIDS-related mortality is now the most common cause of death in men aged 15–54 and the second most common cause in women of the same age in Inner London (see Chapter 5). It is estimated to be the fourth most common cause of death among men aged 15–54 in Outer London (behind heart disease, accidents and suicide).

Levels of ill health

Premature mortality provides only one view of the health of a community. There are other indicators that reflect different aspects of the health of a population (see Box S.5). A number are linked to poor quality housing and homelessness, which are particular problems in London. In addition, poor housing conditions are associated with higher costs to the NHS, with a greater use of hospital services by people who are homeless or living in poor quality housing (see Chapter 3).

The special health problems among younger people in London also reflect aspects of social background and lifestyle. HIV (see Chapter 5) and other sexually transmitted diseases (see Chapter 11) are more common in London than elsewhere in the country. Unintended pregnancies – as manifest in the numbers of teenage pregnancies and abortion rates – in parts of London are among the highest in the country (see Chapter 6).

Box S.5 Health and lifestyle indicators in London

- One in 4 young people (aged 16–29) in London have smoked cannabis in the previous 4 weeks.

- 4.7 per cent of men aged 15–69 in Inner London report having injected drugs at some time in their life.

- In 1996, 2,600 children were injured on London's roads, and there were about 13,500 accidents to children in the home that required either GP treatment or a visit to hospital.

- There are about 1,000 births to girls aged under 16 in London every year.

- Abortion rates in London are the highest in the country and up to three times higher than national averages in some parts of the capital.

- Hospital admissions for acute mental health problems among men aged 15–64 are twice as high as national averages. Twice as many patients per head of population in London are detained under sections of the Mental Health Act than in the rest of England.

- The number of admissions to medium-secure places in Inner London is almost four times higher than national rates.

- The average number of decayed, missing or filled teeth in 5-year-olds ranges from values of 1 for some health authorities to over 2.5 in others; 40 per cent of 5-year-olds in London have had tooth decay.

- Notifications for tuberculosis in some parts of the capital are up to six times higher than national averages.

Evidence suggests that levels of misuse of the most harmful drugs and consequent health problems are higher within the capital. One estimate suggests that almost 5 per cent of men and 2 per cent of women aged 16–59 in Inner London have injected drugs at some time in their lives. In London, nearly 11,000 individuals were notified to the Regional Drug Misuse Databases as presenting to drug services for treatment or advice in 1996/97 (see Chapter 7).

The proportion of children with decayed, missing or filled teeth is highest in the most deprived parts of the capital. The historical fall in levels of decayed teeth among children seems to have stopped in London. Oral cancers, which are more common in some ethnic groups, are high in London and increased by 18 per cent in men and 9 per cent in women between 1987 and 1996 (see Chapter 9).

The capital has higher levels of serious mental illness than any other city in the UK. It also has high rates for factors known to increase the risk of mental illness, such as levels of unemployment, the proportion of single-person dwellings and the proportion of the population aged 15–30. Serious mental health problems are most acute in the inner city and in areas with high levels of social deprivation. Demand for in-patient services is still rising and more so in London than elsewhere in the country (see Chapter 10), with little sign of services coping with these pressures.

Some communicable diseases, notably tuberculosis, are increasing in incidence in London and are more common than elsewhere in the country. In some boroughs, notifications and mortality from tuberculosis are up to six times higher than national averages (see Chapter 11).

Improving health through partnership

In tackling these major health problems, it is clear that the overall health of the population is the product of decisions and actions by organisations both in and outside the NHS (Calman, 1998). It is important, therefore, to recognise the potential for maximising health benefit through partnerships between agencies acting in concert. Although the chapters in our report support the recent policy in the NHS White Paper (Department of Health, 1997) and Our Healthier Nation (Department of Health, 1998a) of promoting better health through partnership, it is clear that there is much risk of fragmentation in a city as complex as London. Our analysis shows that we have yet to integrate health considerations into most decisions about

major determinants of health such as transport, housing or economic regeneration.

There are also excellent examples of work that crosses organisational boundaries. Most recently this has been embodied in the two Health Action Zones within London, and in the current development of multi-agency Health Improvement Programmes by all health authorities in the capital.

Why focus on pan-London action?

A repeated finding in our report is the lack of a clear pan-London dimension to London's health strategies. However, if we are to prevent duplication of effort and unnecessary bureaucracy, it is vital that any pan-London health action serves to **strengthen** and **not undermine** local initiatives. 'Quick fix' organisational solutions to problems will not provide any health benefit when what is required is long-term and deeply rooted collaborative work across the capital's many interest groups and potential partners.

The past year has seen developments that are important for government, health and health services in London. The White Paper *A Mayor and Assembly for London* (Department of the Environment, Transport and the Regions, 1998) proposes that 'The Mayor would look at the effect on health of all his or her policies and functions, and would have a duty to promote the improvement of the health of Londoners.' This move needs to be seen as an integral part of planning for health improvement across the city. The concept of an elected Mayor and Assembly has recently been supported by Londoners in a referendum. This focus on the capital as a whole has been mirrored in a recently announced move towards uniting London's NHS through the creation of a single Regional Office of the NHS Executive for London. As the White Paper on London government states:

A wide range of government policies impact on health and a number of the proposed responsibilities of the GLA (e.g. transport,

strategic planning) could have health implications. It is, therefore, important that the GLA should take the health of Londoners into account in developing policies.

Department of the Environment, Transport and the Regions (1998)

Developing a new strategic approach to health across London

For some issues, it has been suggested that London would benefit from city-wide health strategies (King's Fund London Commission, 1997). The recent Turnberg Review of London's health services identified the need for such a strategy in relation to mental health, and the Government's response suggests that this should be a key health area for the Regional Office(s) of the NHS Executive (Department of Health, 1998b). The advantages of pan-London strategies are set out in Box S.6. Essentially, they offer a framework for a Health Improvement Programme for the capital city.

Box S.6 Why have pan-London strategies?

- To identify more effective ways of coping with London's particularly complex administrative structures (see Chapters 3 and 7 for examples).

- To be able to define inequalities in health across the *whole* city.

- To direct priorities for investment, such as urban regeneration initiatives to target the most disadvantaged communities.

- To develop a better comparative framework for health surveillance, monitoring and audit.

- Some pan-London health problems need pan-London solutions (e.g. transport, air pollution, water fluoridation, services for mentally disordered offenders, specialist drug treatment support).

- To be able to develop a common framework for linking public health policy for London between the NHS, London government and other organisations.

What do we mean by 'pan-London strategies'?

Although recent reports on health and health services in London have advocated pan-London strategies, none has articulated what this might mean in practice. The findings in our report also point to a number of areas where London would benefit from a strategic approach applied across the city. In some cases there may be a need for an explicit strategy that is owned by all the relevant agencies and is agreed as a guide for service development in the city. The time and effort needed to develop such strategies should not be under-estimated. Past experience in the NHS and other large public sector organisations argues against a centralised planning system. Rather, what is needed is a clear framework within which new, city-wide collaborative action can be taken.

In the individual chapters of this report there are a number of common themes that are at present inadequately addressed on a pan-London basis. It is these elements that we see as forming the important functions within a more strategic approach to health in London. These are:

● Health monitoring and intelligence (including regular reports on health).

● Audit/scrutiny and objective reviews of key London health issues between parts of the capital – an extension of the health monitoring role that promotes public debate and greater public accountability.

● Collaborative and partnership working between district, local and pan-London organisations to address inequalities.

● Advocacy – a united voice for change that will benefit the health of Londoners.

These functions are neither mutually exclusive nor do they all need to be undertaken for every health issue. For example, local services such as community mental health teams need to be planned and managed *locally*, although there may be good reasons to audit their effectiveness across the whole of London. Table S.1 summarises from our report some examples of issues that require pan-London action within these different categories. It is important that pan-London initiatives are linked with local strategies and, in particular, with the Health Improvement Programmes that are now being developed.

Figure S.1 shows how individual strategies to tackle specific health issues may overlap and be linked to broader strategies aimed at reducing inequalities in

Fig. S.1 Example of interrelationships between pan-London health strategies
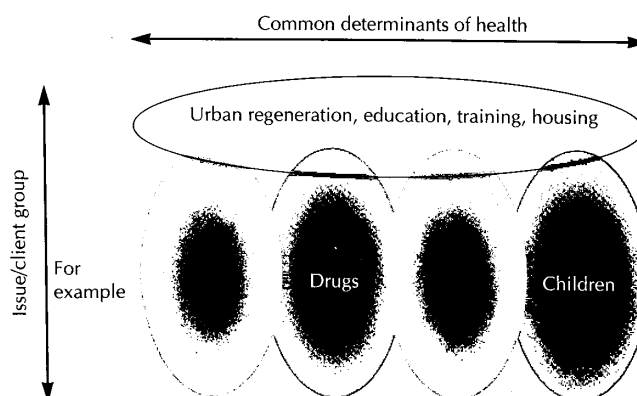
Table S.1 Examples of further pan-London or multi-district work needed to improve health in London

Function	Examples from our report	Chapter
Development of pan-London health planning and action	Co-ordination and planning across areas and agencies involved in reducing harm from drugs	7
Specific client groups	Introduction of water fluoridation as the most effective way to tackle inequalities in tooth decay	9
London-wide issues	City-wide strategies for communicable disease, particularly regarding surveillance and control of tuberculosis	11
	Approaches to voluntary antenatal HIV testing	5
	Tackling inequalities in health across all of London	2
	Mechanisms for the assessment of the health impact of alternative transport options	4
	Consideration of a jointly funded pan-London education and information approach to ethnic media	6
	Commitment and targets to reduce child poverty	8
Health monitoring/surveillance	Assessing the extent of inequalities in health across London	2
	Monitoring and surveillance of HIV/AIDS	5
	Developing robust pan-London information on drug misuse	7
	Monitoring and surveillance systems for communicable disease	11
Audit/scrutiny of health in London	Some assessment of how the Single Regeneration Budget process affects inequalities in housing and health across the capital	3
	Audit of antenatal HIV screening across London	5
	Audit of contraception and abortion services, using national criteria, should be undertaken in 2000	6
	Coverage by 'Healthy School' initiatives should be audited on a pan-London basis	8
	Development of a firmer evidence base to support good practice in treating people with 'personality disorders' and 'dual diagnoses'	10
Joint commissioning/collaboration	Build on successful inter-agency work improving access to services for people who are homeless or in temporary accommodation	3
Across sectors/agencies	Joint work on general public information about sexual health and access to services	5
Across districts	Inter-agency working, in particular development of comprehensive Children's Service Plans that include health, social services and education	8
Joint provision	Wider inter-sectoral collaboration promoting oral health as part of general health, especially in targeting needs of the most deprived communities	9
	Drugs services in London need a stable funding base if they are to work effectively, with the establishment of elements within local Health Improvement Programmes and strategies for tackling drug-related health problems	7
	Better integration of the responsibilities for prevention, surveillance and control of communicable disease is required between local authorities, health authorities and London-wide organisations and groups	11
Advocacy	The NHS needs to develop better partnerships on a pan-London basis that enable closer working with other agencies	1
	Develop more equitable mental health services by a review of resource allocation, particularly in supporting mentally disordered offenders	10
	Resource allocation mechanisms in the NHS in London need to take account of the size of and special problems associated with the homeless population	3
	A shift in resources towards the development of healthier alternatives of walking and cycling and reducing the dominance of car use in land use planning	4

the determinants of health, such as urban regeneration. It gives a simple representation of how strategies linking to specific client groups or issues overlap with each other and interact with broader strategic issues such as inequalities.

How can cohesive public health action for London be achieved?

This report has been commissioned by London's 16 health authorities. We intend to use it to put the health of Londoners firmly on the map. However, effective public action in the capital requires much broader partnerships between agencies and at many different levels. There are no simple answers, and the organisations responsible are undergoing a period of rapid change. It is not our role to prescribe who does what. Nevertheless, the priority must now be to develop better *systems* that provide the best balance between local and city-wide initiatives to tackle the causes and consequences of ill health, and to find better ways to involve Londoners actively in this process.

The changes in government and organisation at a London level, and in the relationships between the NHS and other agencies, present an unparalleled opportunity to improve the health of Londoners.

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Chapter 1

Introduction and context

Martin Bardsley & Bobbie Jacobson

Summary points

◻ This is the first major report to address a wide range of public health issues for the whole of Greater London.

◻ Improving the health of Londoners requires working across a range of organisational boundaries, within the health service and with other sectors. The complexity of government across London has tended to hamper broad strategies that address health issues of concern to the whole capital.

◻ Initiatives such as the World Health Organization's Healthy Cities programme can help in developing health-based strategies across sectors. Work is now underway to develop this approach on a pan-London basis but it is difficult with so many agencies involved.

◻ The proposals for a Greater London Authority offer an opportunity to develop the ways that
health is assessed across the entire city and to tackle problems such as inequalities in health care.

Implications for improvements in public health

London must identify the public health issues best suited to a pan-London approach and determine how best to tackle them.

◻ London needs systems for presenting and analysing health information that relates to the whole capital.

London's health services need to develop ways of looking at issues on a pan-London basis that enable closer working with other sectors on key strategic issues for the capital.

Why focus on health in London?

This report is primarily about health in London. Not on health services, nor on health care alone, but on the full range of factors that create, sustain or compromise health. The health of the 7 million people resident in London, and that of the people who work in and visit the capital, is the basis for economic prosperity. And economic prosperity is one of several factors – including housing, transport, nutrition and the environment – that provide the basis for good health.

Health services contribute to health, through health promotion and disease prevention, and provide effective treatment of illness and care for people with disability and disease. In recent decades there have been a number of reviews of health care in London: reviews of acute hospitals, of mental health services and of primary care. Every year over £4 billion is spent by the health service in London (NHS Executive, 1997) – these resources, of course, also provide employment. The levels of health are also influenced by the policies of European, national and local government and of the private and voluntary sectors. This means that, if we are to improve health, we must work in partnership with other agencies, the public, private and voluntary sectors, and assess the health consequences of a wide range of policies. This is a common issue throughout this report.

Directors of public health are required to publish a report of the health of their population each year, but, because there is no unitary authority for London, there has previously been no London-wide report (see Box 1.1). The Health of Londoners Project is a collaborative initiative between the directors of public health of the 16 London health authorities and of the North and South Thames Regional Offices of the NHS Executive. Previous reports from the Project have looked at specific health issues in some detail. This report takes a broad view of a wide range of important public health issues.

BOX 1.1 PUBLIC HEALTH REPORTS FOR LONDON

There is a long tradition of reporting on the state of public health within London. At local level, such annual reports have been produced by borough medical officers of health (until 1974) and (since 1974) by Directors of Public Health for the health authorities within London. However, there has not been a general report on the public health for the area we now know as London. The closest is the last report of the Medical Officer of Health for the London County Council (LCC) in 1964 (London County Council, 1965), just before the creation of the Greater London Council. The area covered by the LCC was a lot smaller than Greater London is today, and roughly matches today's definition of Inner London.

In 1964 Dr AB Stewart compared health then with the first LCC report of 1892, noting in particular the decline of death from infectious disease. Since 1964 London has become healthier. The infant mortality rate in 1892 was 154 deaths per 1,000 live births; by 1964 the rate had fallen to 21.3, and by 1996 to 6.9 (Inner London). It is interesting to note that the 1964 report includes a commentary on air quality and the successes of that time in reducing the smoke index. Other issues of concern in 1964 that have a familiar ring today include the quality of housing and medical priorities for new housing, and school health services.

Public health – the challenges

Better health for the people of London is achieved in three ways:

- enhancing determinants of good health,

- ensuring health promotion within the health services and elsewhere,

- providing effective health services.

However, health is measured in ways that cut across this framework and ill health can be seen in a number of different forms – for example, the

Fig. 1.1 **Leading causes of death in London 1995 (n = 64,609)**
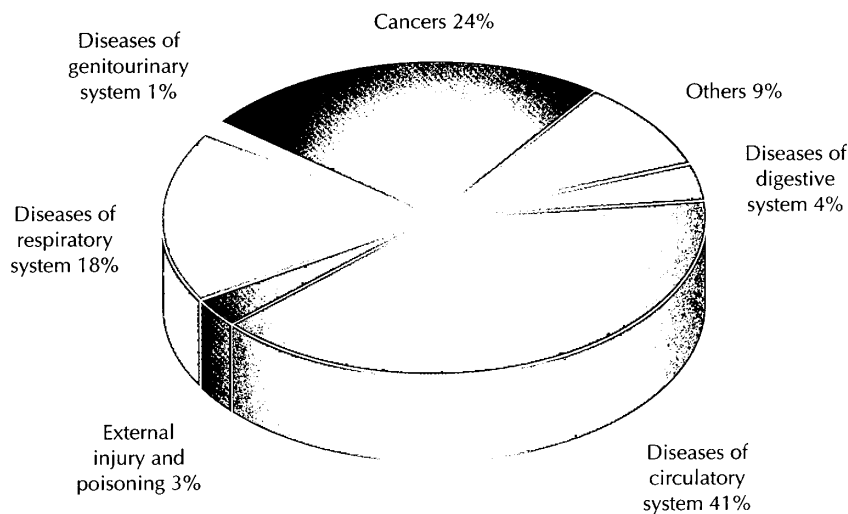
Source: Office for National Statistics (1996)

incidence of diseases, premature mortality, differences in behaviour and lifestyle, levels of social and psychological functioning, and quality of life. Health surveys can be used to measure people's own assessment of their health and estimates of 'risk factors' for ill health, such as smoking and drinking behaviour and insufficient exercise (Bardsley *et al.*, 1997a). Some typical results of such health surveys are given in Table 1.1.

The main diseases that cause premature death in Londoners are largely the same as for the rest of Britain (Benzeval *et al.*, 1994; Bardsley & Hamm, 1995), although there are some issues that are of specific concern to London (The Health of Londoners Project, 1997). Figure 1.1 shows the most common causes of death in London in 1995. Figure 1.2 summarises some data on relative mortality rates (under 75 years of age) in London for some major causes of death. In younger people, the major cause of death is accidents (see Chapters 4 and 8) whilst in middle and older age the most common causes are coronary heart disease, cancer and stroke.

Table 1.1 **Health and lifestyle**

		Men	Women
Percentage currently smoking cigarettes	Greater London	32	26
Percentage drinking over 21(M)/14 (W) units per week	North Thames	25	14
	South Thames	22	13
Percentage reporting:			
long-standing illness	Greater London	30	33
limiting long-term illness	Greater London	16	21
restricted activity in last 14 days	Greater London	13	17

Most commonly reported health problems	*Responses per*
North Thames (West)	*1,000 (M+W)*
Physical disabilities (including arthritis)	221
Skin problems (including allergies)	104
Chest/breathing problems	79
Severe heart problems/blood pressure	71
Stomach, liver and kidney problems	56
Difficulty seeing	41
Difficulty hearing	49
Depression	33

Sources: North Thames (West) Regional Health Authority (1994); Office for National Statistics (1997)

Fig. 1.2 **Mortality from selected causes of death in London 1995 compared to England & Wales (standardised mortality ratios under age 75)**

Standardised mortality ratio (<75) 1995

■ Outer London ■ Inner London
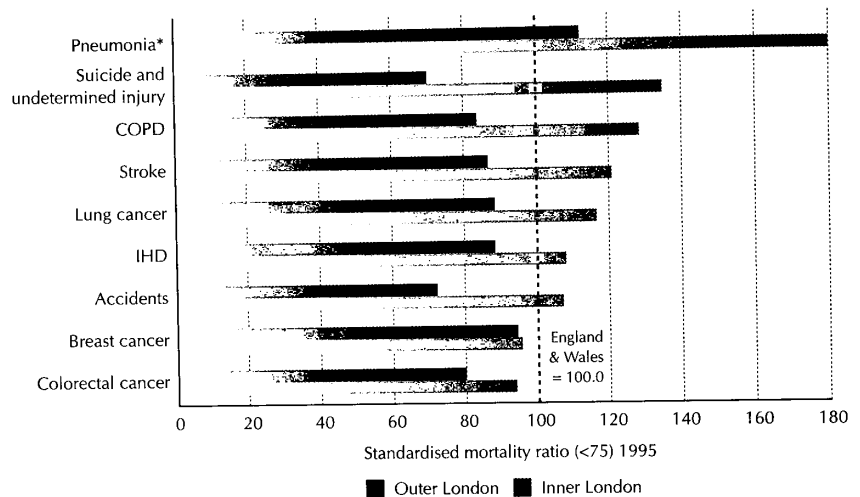
* Many deaths recorded as pneumonia will be HIV-related
COPD = chronic obstructive pulmonary disease
IHD = ischaemic heart disease
Source: The Health of Londoners Project (1997)

The most common forms of chronic ill health and disability are mental illness (see Chapter 10) and diseases of bones and joints. Among younger people, there are problems associated with unintended pregnancy (see Chapter 6) and sexually transmitted diseases, including HIV (see Chapter 5). The Green Paper *Our Healthier Nation* (Department of Health, 1998a) identified four major targets for health improvement: cardiovascular disease, accidents, mental health and cancers.

The distribution of diseases is not uniform throughout the population of London. Apart from age and gender, which are key factors, some diseases are more common in low income groups and among some minority ethnic communities. In particular, the poorest and most marginalised people in London have considerably worse health than the least deprived and most affluent (see Chapter 2). Moreover, it seems that London's death rates, although similar to the national average, have not

been improving as rapidly as the rest of England and Wales (Bardsley *et al.*, 1997b).

Among the factors that may be shaping health trends in London are issues such as:

- social selection – healthier people leaving the centre of London to live outside it, and less healthy people taking their place;

- the extent and distribution of poverty and deprivation, and the relative decline of London's economy;

- a lack of investment in public infrastructure for London, the most evident example of which is the public transport system of buses and the Underground; the increasing use of cars, without commensurate increase in road space, has led to chronic traffic problems, especially during working hours, and has substantially increased the hazards to cyclists;

- changing social structures along with rising unemployment, contributing to increased violence and drug and alcohol misuse; joint developments in 'community safety' between police and local authorities are valuable responses to these problems.

London: a Healthy City?

The principles underlying Healthy Cities, launched by the World Health Organization in 1985, are being increasingly recognised as important for public health action (World Health Organization, 1997). Camden, then as Bloomsbury Health Authority, was a founding member of the Project, along with three other cities from the UK (Belfast, Glasgow and Liverpool).

Being a Healthy City means a commitment to:

- partnerships between agencies (especially local authorities, health services and voluntary groups);

- health promotion as a distinct focus of health services work;

- working to develop primary care and community services;

- working through public participation and community involvement.

The idea of London becoming a Healthy City is being actively promoted by the Association of London Government working with local and health authorities. Other capitals – Copenhagen, Athens, Tokyo – are already Healthy Cities. However, the present arrangements for the government of London makes it harder to fulfil the basic criteria for membership. One of these criteria is that each Healthy City must produce a Health Profile (World Health Organization, 1995), setting out the main health issues locally, a health plan showing how to meet these issues, and health indicators showing progress towards achieving targets. The present report of The Health of Londoners Project provides

an important basis for such a health profile on which to build towards a Health Plan for London.

A new strategy 'Health for All in the 21st Century' is currently being developed by the World Health Organization.
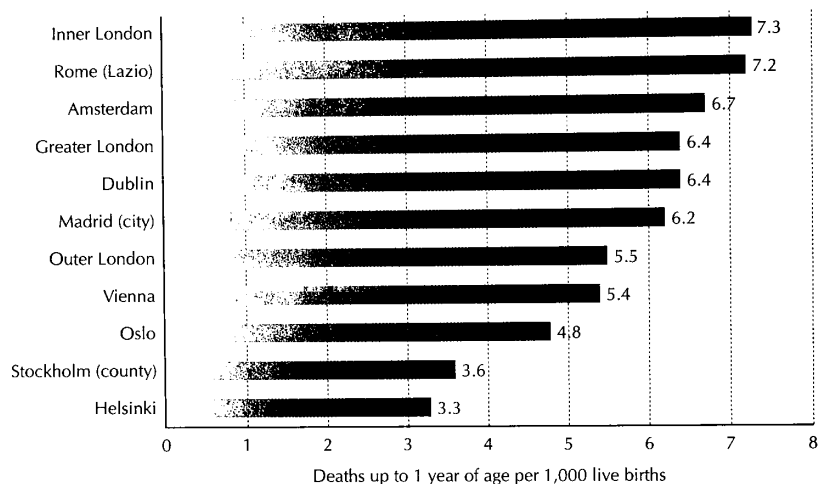
The White Paper on proposals for an elected mayor and a Greater London Authority (GLA) marks a potentially important step in developing health policies that apply across the whole city (Department of the Environment, Transport and the Regions, 1998). Although the detailed shape and scope of the GLA is still uncertain, the proposals suggest roles in transport, economic development, the environment, planning, police and fire services, culture and health. The White Paper states: 'The Mayor would look at the effect on health of all his or her policies and functions, and would have a duty to promote the health of Londoners.' However, the ways that health is explicitly considered within the role of the proposed authority is still unclear. It is important that the GLA be able to assess the health impact of a wide range of policies (Association of London Government, 1997a; Health of Londoners Project, 1997).

Local Agenda 21

The United Nations Earth Summit in Rio de Janeiro in 1992 reaffirmed the importance of nations and local governments taking responsibility for sustainable development – that is, economic progress within the limits of renewable resources and equitable societies. The UK Government is one of six European nations piloting National Environmental Action plans, and has encouraged local authorities to lead Agenda 21 processes, creating plans and implementing policies for sustainability. To date, 12 London boroughs have signed the charter.

At borough level, Healthy Cities and Local Agenda 21 are very similar in approach, both emphasising the importance of social as well as environmental improvement, collaboration between sectors and

Fig. 1.3 **Infant mortality rates in western European capital cities**

City	Deaths per 1,000
Inner London	7.3
Rome (Lazio)	7.2
Amsterdam	6.7
Greater London	6.4
Dublin	6.4
Madrid (city)	6.2
Outer London	5.5
Vienna	5.4
Oslo	4.8
Stockholm (county)	3.6
Helsinki	3.3

Deaths up to 1 year of age per 1,000 live births

Source: Project Mégapoles (1998, work in progress)

the involvement of local people. In 1997 the London Borough of Merton was awarded a commendation in the European Sustainable Cities and Towns campaign, and activity in this borough shows that innovation is possible within existing political and financial frameworks. Other London boroughs have also made important contributions to environmental improvement. Although Agenda 21 initiatives are focused on local areas, there is also some recognition of their significance for London as a whole. The Association of London Government (1997b) has worked to examine common themes across the city and proposes developing some elements of monitoring and surveillance for the entire capital.

London in Europe

The role of the European Union (EU) in promoting common health goals has become increasingly important since the Maastricht Treaty of 1992. The influence of European directives is important in areas such as drug control, tobacco and the Common Agricultural Policy (World Health Organization, 1996). In addition, there are ways in which EU development funds are spent on particular areas of health and social issues.

In developing an understanding of health in London, it is important to draw comparisons with other major conurbations, and in particular with comparable cities across Europe. Figures 1.3 and 1.4 give some indications of how health status indicators for capital cities are being explored by The Health of Londoners Project as part of a Europe-wide network looking at public health improvements in capital cities – Project Mégapoles. This work is funded by the European Union (Agren *et al.*, 1997) and is separated into three sub-networks examining children and young people, older people, and disadvantaged groups.

Health care services in London

London's health needs have characteristically been expressed through high use of hospitals, of which there have been a relatively large number (Tomlinson, 1992). At the same time a number of reports have pointed to the relative underdevelopment of primary care in parts of London (King's Fund, 1992; Department of Health, 1993; Leese & Bosanquet, 1995). Access to good primary and community care services is especially important for the most vulnerable groups in the population (Watt, 1996).

Fig. 1.4 **Premature mortality rates (below age 65) in some European capital cities/regions**

Standardised mortality rate (ages under 65) per 100,000
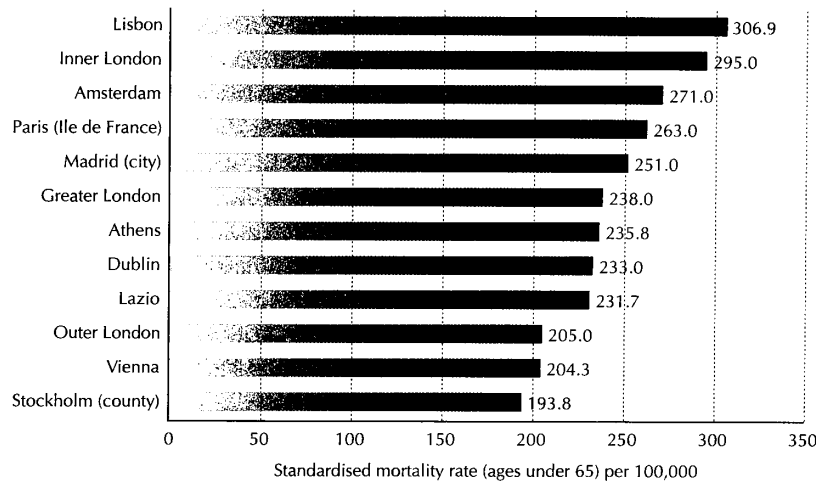
Source: Project Mégapoles (1998, work in progress)

One of the consequences of the national approach to aligning the allocation of health service resources to targets based on population need has been that a number of London health authorities currently receive more than the target allocation. These areas can therefore expect proportionately less money for new development, even though they may have a deprived population with a high level of health needs. Moving towards a better balance of services linked to health needs is complicated by a number of factors, such as:

- the recurring health problems of people suffering multiple deprivation, augmented by the arrival of new groups with high levels of health need who are under-counted in population estimates;

- the problems associated with closing hospitals and capping expenditure on secondary care such as local consultation processes, additional transitional costs involved, and the availability of alternatives to hospital services;

- the underdevelopment and variable quality of primary care;

- local authorities that may be in deficit with reduced expenditure on community care.

The recent NHS White Paper (Department of Health, 1997) proposes consolidation of the two funding streams, hitherto kept separate – and presumably of the approach to calculation of 'fair shares'. The complexity of the transition of London's health services to being firmly underpinned by a strong primary care sector makes such a proposal welcome.

In February, the latest review of London's health services (Department of Health, 1998b) was published, together with a response from the Government. As well as discussing specific issues concerned with the configuration of acute services, this review emphasised the importance of planning across *all* of London and the importance of partnerships with bodies outside the NHS.

Emerging policy issues

Following the publication of the NHS White Paper (Department of Health, 1997), the National Health Service is embarking on another period of change, with a new emphasis on primary care-led commissioning and the development of Primary Care Groups. Health authorities have been given a role of, among other things, producing Health

Improvement Programmes in consultation with local health care providers and in partnership with other organisations. There is a strong emphasis on partnership within the NHS and with other sectors, including some statutory duties. Nationally there are now 11 pilot Health Action Zones, which have the potential to break down further barriers between organisations and require local groups to develop joint health strategies that target inequalities. These should work across the public, private and voluntary sectors.

The Health of the Nation (Department of Health, 1992), a central government initiative, provided the first national strategy for health that focused directly on health and disease in the population and set health targets for achievement. This is to be replaced by the new strategy outlined in the Green Paper *Our Healthier Nation* (Department of Health, 1998a), which outlines health priorities for the future (see Box 1.2). This general strategy is to be followed by specific strategies about smoking, alcohol, teenage pregnancy, HIV/AIDS and drug misuse.

The Government is also developing 'healthy living centres' using £300 million from the National Lottery. These are intended to be local flagships for health in the community, with an important role in providing services for people who might otherwise be excluded, and are felt to be particularly important for deprived areas.

Looking across London

In the past year, the potential for looking at health across the whole of London has developed enormously. The proposals in the Turnberg Review (Department of Health, 1998b) to move towards a single NHS Region for London are to be welcomed, and the proposed Greater London Authority could have a key role in shaping health and regeneration in the capital. The next steps beyond this report are to engage with all participants who make a

BOX 1.2 KEY POINTS OF *OUR HEALTHIER NATION*

- Recognises the importance of the social and economic determinants of good health, as well as lifestyle factors.

- Explicitly has a reduction in inequality as one of the two key aims.

- Proposes a national contract for better health, in which government and local communities will 'join in partnership to improve health for all'.

- A key role for health authorities in developing Health Improvement Programmes that identify local needs and action.

- Identifies three settings for health action: schools, the workplace and neighbourhoods (focusing on older people).

- Identifies four broad health improvement targets for the year 2010:

  - to reduce death from heart disease and stroke by at least a third;

  - to reduce accidents by at least a fifth;

  - to reduce deaths from cancer by at least a further fifth;

  - to improve mental health (reducing deaths from suicide by at least a sixth).

contribution to health, and to define the resource input, policy actions and outcome measures that will promote London's health in the twenty-first century. Healthy City status for London, properly funded, could provide a positive contribution. Leadership is needed at the level of the new Greater London Authority, but there must be active collaboration from local agencies.

In the immediate future, it is important that *all* people involved in public health in London use the opportunities provided by recent government policy to formulate and implement not just local health strategies but also the interaction of these with a wider London agenda.

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Chapter 2

The people of London: social and economic factors in health

Martin Bardsley & John Flatley

Summary points

- Within London there is a diverse population that encompasses a wide range of social and economic circumstances. A strong and enduring relationship between health status and measures of deprivation can be seen in differences in health between areas, and reflects differences between communities and individuals. The health problems associated with deprivation are distributed throughout London and are not just found in the inner city.

- Inequalities in health status between rich and poor areas in London increased during the 1980s.

- London's population is generally younger than national averages. Many of the key health problems of Londoners are associated with a younger population, for example substance misuse, mental ill health, HIV/AIDS and teenage pregnancy.

- London is the most ethnically diverse of UK cities. This has implications for the health profile of London, for the ways health needs are expressed and how services identify and respond to them. London also has to develop services that cope with the problems of a mobile population, refugees and the homeless.

- Over the past 15 years, reductions in premature mortality in London have not kept pace with changes nationally. Although this is partly associated with HIV-related mortality, it is also likely to be a result of changes in social and economic conditions in London.

Implications for improvements in public health

- Health authorities must continue to work with local boroughs on reinforcing the importance of health issues and the determinants of good health. Such collaborative work needs to improve public health input into policies on social and economic regeneration generally, including community development, housing, education, refugees and anti-poverty strategies. Elected members as well as officers should be involved in this process as much as possible, including needs assessment.

- Health and other agencies must recognise the health problems associated with social exclusion and develop services that are accessible to the most vulnerable groups.

O Many of the most important health problems of London are shared between areas. Ways must be developed to look at strategic health themes at a city-wide level, based on co-operation between geographic areas and sectors of government. In particular, it is important that any Greater London Authority is able to look at public health issues and monitor health trends for the entire city.

O Tackling health inequalities across the capital requires a pan-London approach.

Introduction

This chapter is concerned with the general economic and social background that underlies health and health changes within the capital.

Building healthier communities means addressing issues such as income, employment, opportunities for healthy lifestyles, housing, education and the cohesion of the community itself. There is a wealth of evidence pointing to the critical effects of these factors on health (Department of Health and Social Security, 1980; Townsend *et al.*, 1988; Benzeval *et al.*, 1995). The associations between deprivation indicators and poorer health, and the consequent inequalities in health, are recognised nationally as a target for action (Department of Health, 1998).

The following sections examine the way that three features of London – the age distribution of the population, ethnic diversity and social disadvantage – affect the health profile of the city. These are not the only issues to consider, and they are not mutually exclusive, but they are important contributors to health in the capital.

The people of London

London has 14 per cent of England's population living in 1 per cent of the land area. With 7 million people resident in the 32 London boroughs and the City of London, swelled each day by some 670,000 commuting into the capital for work, London is the largest city in the European Union (Office of National Statistics *et al.*, 1996) (see Fig. 2.1). In population 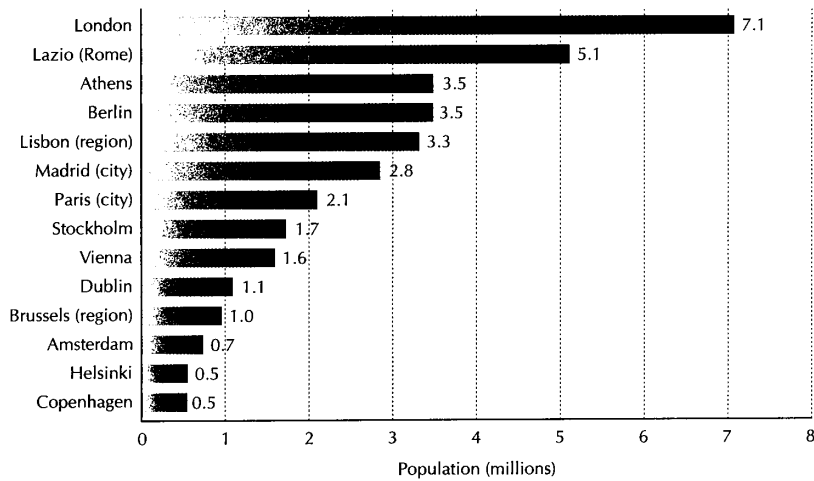size, London is comparable with a number of countries –for example, Austria (8 million) or Sweden (9 million) – and is bigger than the Republic of Ireland, Switzerland, Finland and Scotland.

The population of London has fallen since World War II (see Fig. 2.2), especially in Inner London, as people have tended to move to high growth areas and new towns around the capital. However, the decline stopped in the mid 1980s, and London's population has started to grow again (London Research Centre, 1997).

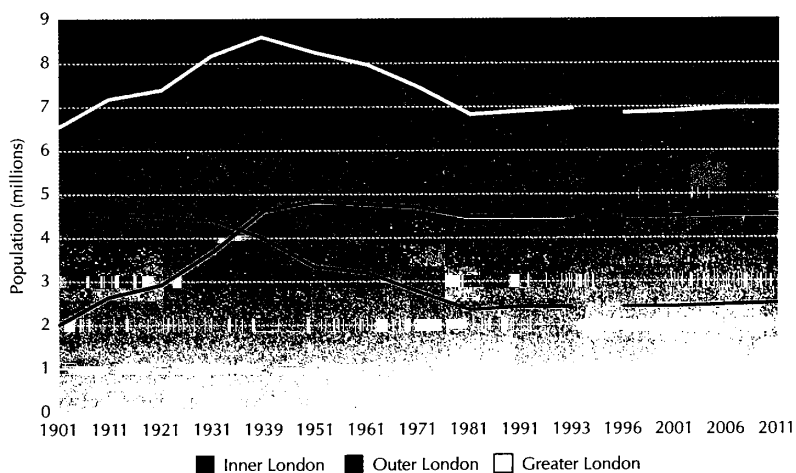### BOX 2.1 THE POPULATION OF LONDON

- With a population of 7 million, London is the largest city in western Europe.

- London's population is increasing again after 40 years of decline. Latest estimates suggest that London will grow by about 15,000 people per year over the next decade.

- London has proportionately more young people than UK averages, and more people aged 0–19 than the total population of most UK cities.

- London has relatively fewer people of retirement age than national averages.

- The proportion of people in London over 65 years of age is projected to decline slightly, although there will be a slight rise in the number aged over 90. Over all, the 'ageing' of the population in London will be less pronounced than in many other parts of the UK.

- London contains areas with the highest and lowest fertility rates in the country.

- London 'imports' younger people (from the rest of the UK and abroad) and 'exports' older people (mainly to the south-east of England).

Fig. 2.1 Populations of European Union capital cities/regions

Bar chart of Population (millions):

City/Region	Population (millions)
London	7.1
Lazio (Rome)	5.1
Athens	3.5
Berlin	3.5
Lisbon (region)	3.3
Madrid (city)	2.8
Paris (city)	2.1
Stockholm	1.7
Vienna	1.6
Dublin	1.1
Brussels (region)	1.0
Amsterdam	0.7
Helsinki	0.5
Copenhagen	0.5

Population (millions)

Source: Project Mégapoles (1998, work in progress)

Fig. 2.2 Actual and projected changes in the population for London 1901–2011

Population (millions) plotted for years 1901 1911 1921 1931 1939 1951 1961 1971 1981 1991 1993 1996 2001 2006 2011

■ Inner London ■ Outer London □ Greater London

Source: Travers & Minors (1995)

Table 2.1 **Age profile of London and other cities**

	Population	0–15	15–25	25–45	45–64	65+	Fertility rate
England & Wales	52,010,160	19%	12%	30%	23%	16%	5.9
England	49,089,085	19%	12%	30%	23%	16%	5.9
Greater London	7,074,265	19%	13%	34%	20%	13%	6.2
Inner London	2,998,221	19%	13%	37%	19%	12%	6.2
Outer London	4,076,044	20%	13%	33%	21%	14%	6.1
Highest borough		26% Newham	15% Tower Hamlets	41% Hammersmith	24% Havering	17% Bromley	8.4 Tower Hamlets
Lowest borough		14% Westminster	12% Sutton	29% Havering	16% Tower Hamlets	10% Newham	4.4 Westminster
Manchester	430,818	22%	17%	29%	17%	14%	6.1
Liverpool	467,995	20%	15%	29%	20%	15%	5.7
Sheffield	530,375	18%	14%	30%	22%	17%	5.6
Birmingham	1,020,589	22%	14%	30%	19%	15%	6.8

Source: Office of Population Censuses and Surveys (1993)

Like many cities, London has a high proportion of younger people (Table 2.1), particularly children (see Chapter 8) and those aged 25–35 years. There are also proportionately fewer people of retirement age. This demographic structure is most marked in Inner London.

The age distribution in London is partly a consequence of the migration of younger people into the capital in search of education, work and entertainment. Very often, as these migrants grow older, obtain settled work, and perhaps start a family, they move to Outer London and the suburbs beyond (Hollis, 1995). In addition, the birth rate in London is slightly higher than national averages and equivalent to levels in some other UK cities such as Bradford and Birmingham. Yet within London, birth rates range from among the highest in the country (in Newham) to the lowest (in Westminster) (Department of Health, 1997).

Age and health

Many of the most important health issues in the capital are more common among younger people. These include the higher levels of acute mental illness (see Chapter 10), HIV/AIDS (see Chapter 5), unplanned pregnancy (see Chapter 6) and substance misuse (see Chapter 7). Figure 2.3 shows the mortality rates in London at different ages, expressed relative to the national averages, and indicates the much higher mortality rates associated with Inner London at ages up to 65.

Infant mortality rates are often regarded as a fundamental indicator of health status in the community. Rates have declined throughout the century, and Greater London averaged 6.4 deaths per 1,000 live births in 1996 (Department of Health, 1997). For London's boroughs, values ranged from 2.6 in Hammersmith & Fulham to more than 8.0 in Lambeth and Lewisham. The differences between Inner and Outer London have remained relatively stable over the past 10–15 years (Bardsley et al., 1997). The current values in Inner London are at the level seen in Outer London about eight years ago. A comparison with Stockholm, where the average is 3.6, indicates the potential for further improvement in infant mortality rates (see Chapter 8). Although both cities have a gradient between rich and poor areas, the most affluent areas in London have rates that are comparable with the poorest areas in Stockholm (Bardsley & Bremberg, 1997).

Between 20 and 50 years of age, mortality rates in Inner London are significantly higher than national

Fig. 2.3 **Difference between London's mortality rates and national average by age, 1991–95: (a) men; (b) women**

(a)

Inner London ☐ Outer London ■

(b)

Inner London ☐ Outer London ■
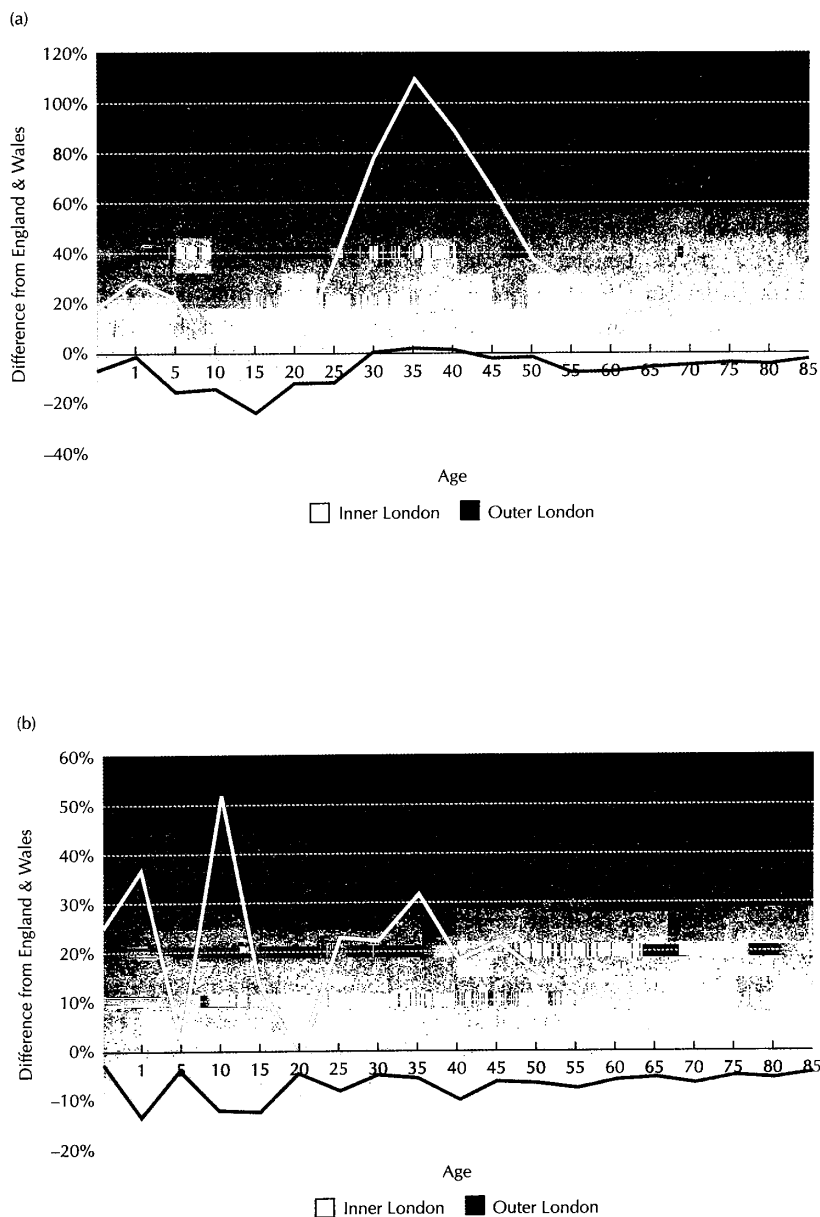
Values above zero indicate that at that age local mortality rates are higher than national averages.
Source: Bardsley *et al.* (1997)

averages, especially among men. Part of the explanation for this is linked to the excess burden of HIV/AIDS seen in Inner London (Hickman et al., 1997) (see Chapter 5). However, there is also an excess among women and men outside the age range associated with HIV-related mortality. Among these groups, deaths from cardiovascular disease are particularly important (Bardsley et al., 1997) – and are probably associated with Asian and African/Caribbean communities in parts of London, in whom the mortality from coronary heart disease (among Asians) and stroke (among African/Caribbeans) is high (Balarajan, 1995). Reducing mortality from cardiovascular disease was an important part of the Health of the Nation initiative (Department of Health, 1992) and has also been proposed for the new national health strategy, Our Healthier Nation (Department of Health, 1998).

Finally, in the oldest age groups, mortality rates in London are at or below national averages (Bardsley & Morgan, 1997; Warnes, 1997). This phenomenon of apparently relatively healthy older people in the capital, even in the most deprived areas, is surprising. Although no definitive explanations are available, it seems that this is linked to the migration of people – particularly the older and sicker – who have tended to move out of Inner London to Outer London or south-east England (Bebbington & Darton, 1996; Boyle & Hamblin, 1997; Warnes, 1997). There are relatively fewer residential and nursing home places for older people in Inner London, and London boroughs tend to place considerably more supported residents outside their own area than do local authorities elsewhere in the country (Flatley et al., 1998). Changes in the pattern of community care and in the number of nursing and residential homes in London may affect the numbers of local placements and the observed health status among older residents in future.

Ethnicity

London is the most ethnically diverse of all UK cities (Storkey, 1994). The 1991 Census recorded over 20 per cent of London's population as being from black and minority ethnic groups. At borough level, the proportion of the population from black or minority ethnic groups ranged from 5 to 45 per cent. Almost half of all the UK's minority ethnic population live in London, and half were born in the UK. In the 1991 Census every borough recorded at least one minority community of more than 2,000 people from one of the nine major ethnic groups, many boroughs having seven or eight such communities (Bardsley & Hamm, 1995). These summary statistics took no account of a number of other important ethnic groups (e.g. Turks and Orthodox Jews).

A growing number of refugees and asylum seekers settle in London. There are estimates of about 43,000 applicants granted refugee status since 1989, and a further 54,700 were awaiting a Home Office decision in 1995 (Atkins & Flatley, 1996). These groups are perhaps the most disadvantaged of any, and present a major challenge for health and welfare services. London Research Centre estimates suggest that asylum seekers make up around 9 per cent of all homeless people housed by local authorities in London (Atkins & Flatley, 1996). New entrants to the country are especially vulnerable, and may have existing health problems that need addressing. For example, in one Inner London area, over half the new cases of tuberculosis were among people who had arrived in the UK comparatively recently (Bhatti et al., 1995; East London & The City Health Authority, 1997) (see also Chapter 11). Moreover, these groups can become isolated from mainstream health and welfare services (Bariso, 1997) and suffer some of the most extreme social and economic problems when settling in a new country.

Although the age structure of black and minority ethnic populations tends to be younger than that of the white population, the proportion of black and minority ethnic elders will rise sharply over the next decade. The London Research Centre (1996a) has projected that the population aged over 65 in many minority ethnic groups will increase by 100–200 per cent over the next 15 years, as the total size of this age group declines.

Ethnic diversity is significant in terms of health in London, for a number of reasons:

- Indicators of social disadvantage are more common in minority ethnic groups; for example, rates of unemployment are about twice as high in non-white groups (Flatley, 1996). In many instances it is difficult to disentangle the effects of ethnicity from material disadvantage.

- Some patterns of ill health are more prevalent in particular ethnic groups; for example, thalassaemia, stroke, coronary heart disease, diabetes and schizophrenia (Balarajan, 1995; Nazroo, 1997).

- It is important to maintain the accessibility and appropriateness of health and welfare service interventions for different and constantly changing cultural groups (Ahmed, 1993).

- The problems of recording and linking health problems and ethnicity make it difficult to assess levels of need in some communities.

Deprivation and social disadvantage

The 1980s saw some major changes in the social and economic profile of London (Simmie, 1994; Congdon, 1995), including a rise in unemployment and a decline of manufacturing industry. Replacing manufacturing was a growing service sector – but one with a high proportion of low-paid part-time jobs. The banking and finance sector grew during this time and, with it, the incomes of a better paid

managerial class. Not surprisingly, the past two decades have seen a growth in income inequality throughout the country, which has been exemplified in London (Joseph Rowntree Foundation, 1995; Anderson & Flatley, 1998).

Although average earnings in London are among the highest in the UK, the capital has seen a growth in the proportion of adults receiving Supplementary Benefit or Income Support from around 10 per cent in 1983 to 17 per cent in 1995, the rates in some boroughs reaching more than 30 per cent. The numbers of people 'living in poverty' in London is estimated to have increased from 14 to 24 per cent between 1983 and 1992 (Edwards & Flatley, 1996). Unemployment rates, which in London had been lower than national averages, showed a sharp rise during the late 1980s and early 1990s, such that parts of Inner London had some of the worst figures in the country (Fig. 2.4). The increase in unemployment in London was not restricted to Inner London but affected almost all boroughs. Among the 260,000 unemployed in Greater London in July 1996, almost 43 per cent had been unemployed for more than 52 weeks (Flatley, 1996). Unemployment is also significantly higher in non-white ethnic groups, particularly in younger age groups. For example, between the ages of 16 and 24, unemployment in 1995 among non-white groups was 40 per cent compared with 17 per cent among white groups (Flatley, 1996).

There have been also been major changes in the provision of housing in the capital (see Chapter 3). The 1980s saw a massive growth in homelessness in London, particularly among young people (London Research Centre, 1996b; Pleace & Quilgars, 1996).

It is perhaps not surprising to find that composite indicators of social and material deprivation, such as those developed by Townsend, Carstairs and Jarman (Morris & Carstairs, 1991; Dolan et al., 1995), show that between 1981 and 1991 the position of London boroughs tended to become worse relative to the rest of the country.

Fig. 2.4 **Trends in unemployment in London, 1990–96**
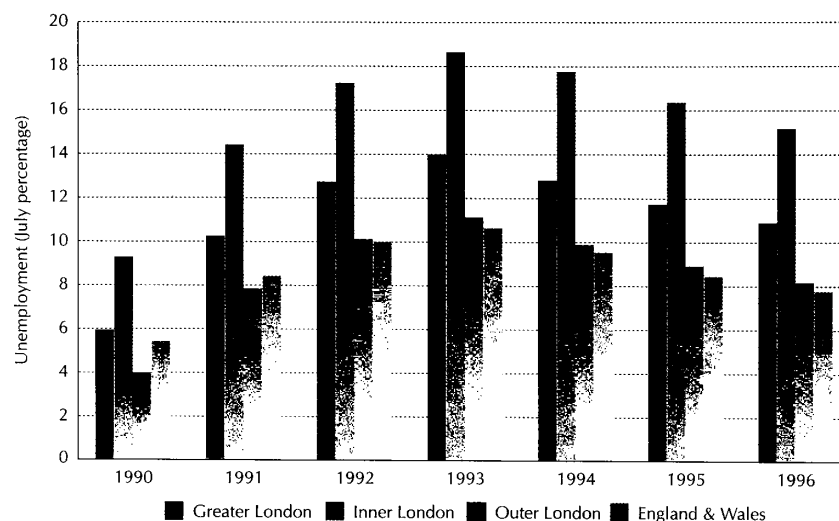
Source: Travers & Minors (1995)

Table 2.2 **Indicators related to social exclusion**

	Greater London	Range between lowest and highest boroughs	England
Unemployment (July 1997)	7.9%	3.4–17.9%	5.6%
Unemployed >1 year (July 1997)	39.8%	29.3–47.4%	No data
Full-time employees earning below £4.26 per hour 1995	4.8%	2.8–12.2%	No data
Households statutorily accepted as homeless by local authority, per 1,000 1995/6	9.6	1.8–22.9	6.0
Children in non-earning households	22.9%	9.7–39.5%	15.6%
Exclusions from school 1995/96	2,251 children	29–119	12,400
Eligible for free school meals (secondary schools) 1996	34%	9–66% (excl. the City of London)	18%
Adults in receipt of Income Support 1995	16.9%	7.4–32.4%	12.3%

Sources: Edwards & Flatley (1996); Euteneuer (1997), Flatley et al. (1998)

There are growing concerns for groups who suffer multiple disadvantage and who are increasingly excluded from mainstream participation within their communities. There is evidence of increasing polarisation within London, and a concern for those who suffer multiple disadvantage with regard to health, housing, income, employment and education (Edwards & Flatley, 1996).

The extent of social exclusion is difficult to describe in one statistic. Table 2.2 summarises some of the more commonly used indicators. It is important to remember that, although the extent of these problems may be greater in one borough than another, they exist in some form throughout London. Analysis by the London Research Centre suggests that London contains proportionately more

Fig. 2.5 **Standardised mortality ratios (under the age of 75; 1995) compared with deprivation (Jarman UPA score), London boroughs**
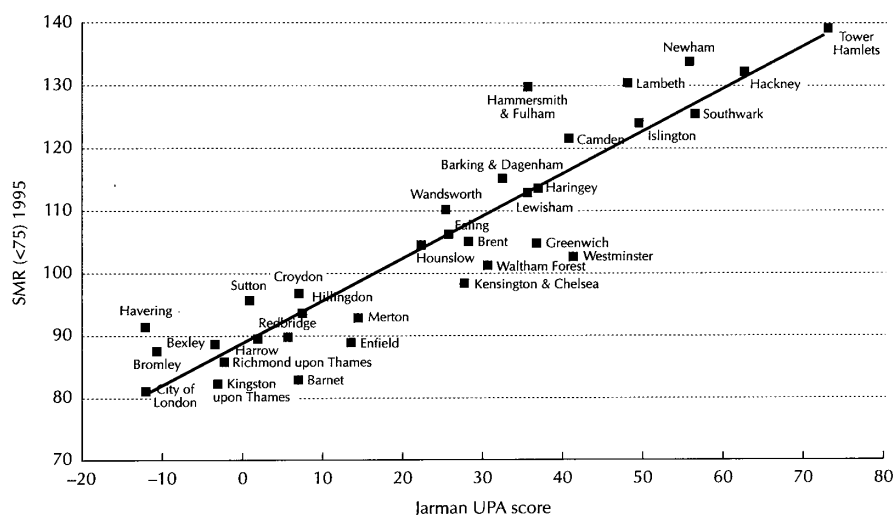
The Jarman UPA score is based on census variables selected to indicate need for primary care. Higher values indicate greater deprivation and more need. England & Wales average value is zero.

young unemployed (21 per cent of the England total) and long-term unemployed (25 per cent of the England total) – two groups that have been targeted in the government's Welfare to Work programme (Flatley, 1997).

Deprivation and health

Although there are a number of views on the different mechanisms that link social disadvantage with poorer health (Department of Health and Social Security, 1980; Townsend et al., 1988; Strong, 1990; Benzeval et al., 1995), the relations between deprivation indicators and health status are strong and enduring (Eames et al., 1993). There is also some evidence that the extent of inequality itself is associated with health status (Wilkinson, 1994; Davey-Smith, 1996). Figure 2.5 exemplifies the basic health profile across London boroughs,

comparing premature mortality rates (under 75 years of age) with a measure of deprivation. (In this case the Jarman UPA score is used, but other deprivation indices show the same picture.) The areas with the greatest levels of social disadvantage have the worst health record.

The chances of dying before the age of 75 in areas of east and south London are almost twice as high as in the least deprived parts of the capital. Such variations also exist within boroughs and, even where people are on average relatively affluent, there are areas of significant deprivation with associated health problems. Similar gradients exist for a whole series of health indicators. They underpin the links between health and the wider social and economic environment of the city (Bardsley & Morgan, 1997).

BOX 2.2 CHANGES IN RELATIVE MORTALITY 1950–92

Dorling's analysis (1997) of changing mortality in Britain provides an interesting view on how London has changed over the past 40 years (see Fig. 2.6). The areas used in the analysis are based on 1950 boundaries and enable a comparison of relative mortality rates. A value of more than 100 indicates that an area has a higher mortality rate than the national average at that time. Over this period absolute rates have been falling. For most of the areas, which are mainly in what we now consider Inner London, relative mortality rates are worse in 1990–92 than in 1950–53. Throughout this period, areas such as Shoreditch, Stepney and Southwark have consistently been among those with the highest rates in London. For some areas (e.g. Battersea, Hackney, Hammersmith, West Ham, Bermondsey and Lambeth), the relative mortality in 1990–92 is markedly worse than 40 years earlier. Other areas have shown a relative improvement; for example, St Marylebone, Woolwich and Chelsea. On the whole, however, the values in London on all age mortality rates are better than the record in Glasgow, where the standard mortality ratio increased from 125 to 131 over these 40 years.

Fig. 2.6 **All age standardised mortality ratios in London, 1950–53 and 1990–92**
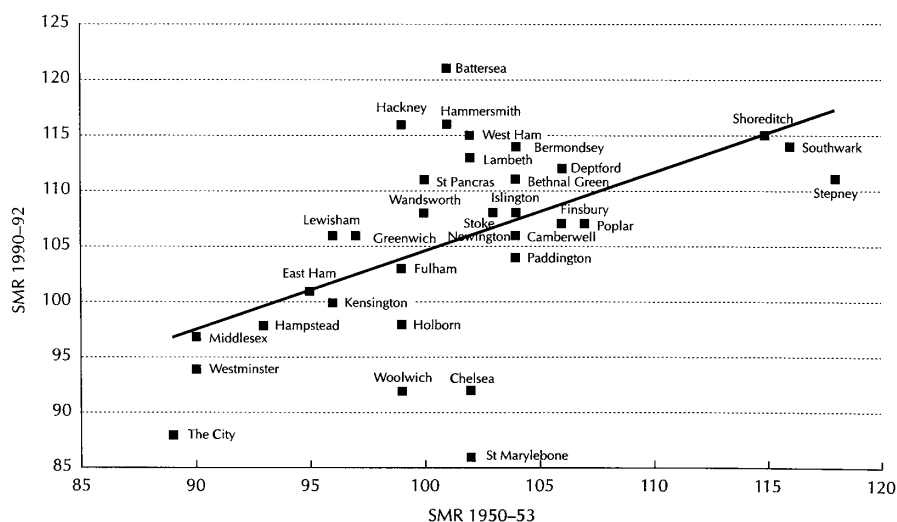
Source: Dorling (1997)

Increasing inequalities in health in London

In addition to the wide cross-sectional inequality in health between rich and poor areas, this divide is widening in London and the UK as a whole (McLoone & Boddy, 1994; Phillimore *et al.*, 1994; Bardsley & Morgan, 1996; Dorling, 1997).

Standardised mortality ratios (SMRs) in 1981 and 1991 relative to England and Wales were analysed for 724 electoral wards in London (excluding the

City of London and Enfield where there were no comparable data over the time period). When sorted according to the levels of deprivation, figures for SMR under the age of 75 show how the wards with the lowest deprivation scores in 1981 (in this case based on Department of Environment Index of Local Conditions) had improved slightly by 1991, whereas the wards with the highest deprivation scores in 1981 show a large deterioration by 1991 (Table 2.3). Thus, the gradients in mortality rates between the most and least deprived wards in London seem to have increased during the 1980s.
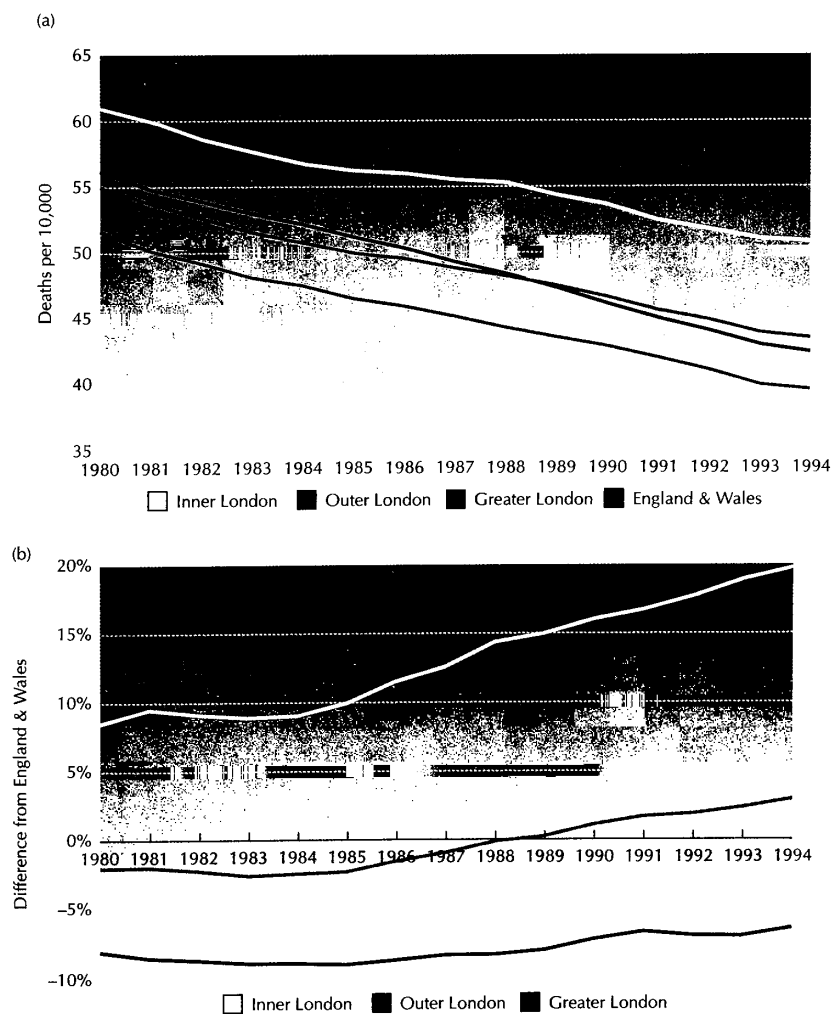
Table 2.3 **Standardised mortality ratios (under the age of 75) in 1981 and 1991: London wards by deprivation quintile**

Deprivation category (quintiles)	SMR 1981	95% Confidence intervals			SMR 1991	95% Confidence intervals			Change
		Lower		Upper		Lower		Upper	
Least deprived	80.6	79.2	–	82.0	80.0	78.4	–	81.6	–0.7%
2	88.7	87.2	–	90.2	91.2	89.5	–	92.9	2.8%
3	97.1	95.5	–	98.7	100.1	98.3	–	102.1	3.2%
4	106.6	104.9	–	108.3	115.5	113.4	–	117.6	8.4%
Most deprived	115.3	113.5	–	117.1	125.0	122.8	–	127.3	8.4%

* Excludes City of London and Enfield
Source: Bardsley & Morgan (1996)

Fig. 2.7 **(a) Absolute (age-standardised) mortality rates in people aged under 75. (b) Difference in age-standardised mortality from averages for England & Wales**

(a)

□ Inner London ■ Outer London ■ Greater London ■ England & Wales

(b)

□ Inner London ■ Outer London ■ Greater London

The change in SMR among the least deprived fifth of ward values was from 80.6 to 80.0, whilst for the most deprived fifth of ward values increased significantly from 115 to 120. The absolute mortality rates (under the age of 75) in the most deprived wards seem not to have changed to any great extent during this decade.

A similar divergence between rich and poor areas has been observed at borough level in relation to a number of other indicators based on mortality rates, including some key national health targets (Hamm et al., 1996).

Recent analyses of trends in London's mortality rates reveal that rates in London are not keeping pace with change at a national level, particularly in Inner London (Camden & Islington Health Authority, 1996; Charlton, 1996; Bardsley et al., 1997) (see Fig. 2.7). Although absolute rates in most age and sex groups continue to fall, in many they are not falling as fast as national averages. Whilst part of this effect seems to be associated with HIV-related deaths in younger men in Inner London, it is also apparent in older age groups. The effects of social and economic circumstances are probably an important factor in these adverse trends in London (Bardsley et al., 1997).

Conclusions

This chapter has emphasised the ways that the health of Londoners is bound up with the economic and social conditions in the capital. In particular, it has shown the relevance of London's age and ethnic profile to its health status and the significance of increasing inequalities in health across the capital.

It is important to recognise when and where a view of the whole capital is important to understanding and dealing with health problems. For some health problems, the underlying causes are linked with change across the whole of London and individual local issues are almost impossible to disentangle. In some cases, we see problems that are common to broad swathes of the capital and are a product of the

way the city itself works – for example, indicators linked to sexual behaviour are indicative of the social interactions among young people in London.

Most important is the fact that health and welfare services have to recognise the ways in which wider social and economic change affect health in the capital. Solutions require collaborative work with other organisations in the local authority, education, housing, transport, voluntary and private sectors. Initiatives that work across organisational boundaries to address the causes of ill health and reduce inequalities must be encouraged (Department of Health, 1998). We also need to improve ways of recognising the health dimensions of other aspects of economic and social developments. Some elements of the picture of social and economic change in the past two decades have not been encouraging, particularly in London where it is clear that existing inequalities in health are increasing. At the extreme are problems of polarisation and social exclusion whereby groups of people are falling behind on a whole series of social indicators; not surprisingly, these groups show the poorest health and the least improvement in health over time. Improving the health of the most disadvantaged groups is a critical factor in the overall well-being of the capital.

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Chapter 3

Housing and health

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Summary points

Access to good quality housing is essential for good health. London has a number of distinctive problems in the housing sector that have major health implications. These include the problems of the homeless, the effects of poor quality and overcrowded housing, a shortage of affordable housing for people on low incomes and problems in the local environment.

�‍O Housing and health in London are showing signs of increasing polarisation between the rich and the poor. Social housing (local authority and housing association dwellings) is increasingly becoming associated with low income and social disadvantage and, as a consequence, is being recognised as an indicator of poor health.

O Although levels of homelessness have declined in recent years, it is still a major problem for London. Much evidence points to the severe health problems that can arise in homeless people and, therefore, the need to provide appropriate health and welfare services.

O Poor quality housing and homelessness have a direct impact on the demands for NHS treatment services.

The extent to which health is considered as an explicit goal in housing and urban regeneration programmes is limited. Although the bulk of housing management is best suited to a local level, there are issues of concern regarding the links between housing and health across all London that would benefit from a wider strategic view.

Implications for improvements in public health

Health agencies must promote existing arrangements and develop new relationships with housing agencies as part of their broader health strategies. Improvements in housing can potentially lead to better health and reduce the burdens on the NHS. Local Health Improvement Programmes can provide a vehicle for:
– emphasising housing as a focus for joint planning involving community and primary care groups;
– implementing measures to complement national health strategies, particularly in relation to accident prevention and mental health;
– promoting better alignment of housing provision for people with special needs and improving discharge planning.

The NHS needs to continue work to improve access to primary and preventive services for people who are homeless or in temporary accommodation. This must be co-ordinated with other agencies, notably local authority social services, education and housing departments. Successful work in existing pilot schemes could be built upon.

Mechanisms for resource allocation in the NHS in London must take account of the size of and special problems associated with the homeless population. Ways of measuring the numbers of homeless need to be improved.

Areas where housing and health need to relate at a pan-London level include:
- assessment of how the Single Regeneration Budget process affects inequalities in housing and health across the capital;
- development of common information and expertise linking housing and health;
- a better understanding of strategic plans and priorities.

Introduction

Among the many factors determining health, access to good quality, affordable housing is one of the most important. This chapter describes some of the ways in which the housing market in London exacerbates health problems and creates further inequalities in health (Table 3.1). It includes sections looking at the links between housing and health, and a discussion of the roles that the health service can play. There are a number of useful reviews of the literature (see, for example, Ineichen, 1993; Ambrose et al., 1996; Hunt, 1997; National Housing Federation, 1997; Pollard et al., 1997).

Table 3.1 **Health manifestations of poor housing**

Feature of housing	Health manifestations
Homelessness	
including temporary accommodation	Increased risk of mental illness, including stress, alcohol/drug problems
	Respiratory disease, including tuberculosis
	Perinatal health (e.g. low birthweight, infant mortality)
	Child development
	Access to health promotion/primary care
Quality of housing	
Damp	Respiratory disease (e.g. asthma, bronchitis), infections
Cold	Hypothermia, heart disease and stroke, excess winter deaths
Lacking amenities	Gastrointestinal infections, associated with cold and damp
Infestation	Mental health problems, stress, loss of sleep
Overcrowding	Infectious disease (e.g. tuberculosis)
Design	Accidents, including fires and falls
Noise insulation	Carbon monoxide, nitrogen dioxide poisoning
Air quality	Passive smoking
Urban environment	
High rise	Accidents, road traffic accidents
Access to services	Mobility, social integration, mental health
Transport	Access to disease prevention/primary care
Recreation/leisure	General fitness (e.g. cardiovascular disease)
Crime (fear of)	Mental health, stress, violence

Table 3.2 **London's housing compared to other cities in England**

	Percentage of people in accommodation that is not self-contained (i.e. shared amenities)	*Percentage of people living in overcrowded accommodation (more than 1 person per room)*	*Percentage of people renting purpose-built flats in residential buildings*
Inner London	2.7	11.3	36.3
Outer London	1.2	7.1	13.1
England & Wales	0.6	4.6	9.9
Metropolitan districts	0.4	5.6	11.4
Manchester	0.8	7.3	17.2
Birmingham	0.5	10.2	14.3
Sheffield	0.5	3.9	15.1
Liverpool	0.7	5.6	12.7
Leeds	0.6	4.5	12.0
Highest in England	4.7	27.0	65.1
	Kensington & Chelsea	Tower Hamlets	Tower Hamlets

Source: Department of Health (1997a)

Table 3.3 **Housing stock in London**

		Proportion of all households	*Range across London boroughs*	
	Greater London		*Highest*	*Lowest*
Local authority	620,698	21%	51% Tower Hamlets	0% Bromley
Housing association	211,083	7%	14% Bromley/Kensington & Chelsea	1% Havering
Other public sector	23,938	1%	3% Hillingdon	0% (17 boroughs)
Private sector	2,155,161	72%	89% Harrow	40% Southwark

Source: London Research Centre (1997a)

Patterns of housing in London

The 7 million residents of London occupy just under 3 million dwellings (London Research Centre, 1997a). The average household size in London is smaller than the national average and is declining – a product of higher divorce rates, more lone parent families and the in-migration of young people. The latest estimates indicate that the demand for housing in London outstrips supply. Household projections suggest that London will grow by an average 26,300 households per year (London Research Centre, 1997a).

Although London is not homogeneous, there are some over-riding issues affecting the general quality of housing in London that distinguish it from the rest of the country (see Box 3.1 and Table 3.2). These indicators point to some of the key challenges for housing provision in London.

The past decade has seen radical changes in the housing market with the sale of council houses and the growth of housing association (now known as registered social landlord or RSL) properties (Merrett, 1994; Atkins & Flatley, 1996). Over all, these changes have led to a marked reduction in new house building (see Fig. 3.1). Controls on local authority expenditure have also placed limitations on the amount of maintenance carried out, and there are serious problems in some areas with houses in need of renovation.

BOX 3.1 DISTINCTIVE CHARACTERISTICS OF HOUSING IN LONDON

- London has fewer owner-occupiers (57 per cent) and more social housing tenants than other areas in England.

- The proportion of flats is high and houses low, compared to other cities in the UK – although not necessarily continental Europe. In Inner London, 71 per cent of all households are in flats and about 50 per cent of these are in blocks over five storeys.

- House prices and rents in London are the highest in the country. In addition, some of the poorest areas of the capital have very high house prices and rents. The average price for a terraced house in London in 1996 was £101,000, with an average in central London of £256,800. In 1995/96, average advertised private sector rent for a one-bedroomed house or flat was £148 per week.

- London has a particularly large number of households (115,000 or 4 per cent) that are overcrowded. The proportion of people living in overcrowded housing is as high as 27 per cent in Tower Hamlets. Rates are higher than national averages in both Inner and Outer London.

- A significant number of properties in London (65,917 at the 1991 Census) lack basic amenities such as an exclusive WC. These are normally associated with older private properties, often with relatively poor occupants.

- A relatively high number (over 230,000) of dwellings are unfit or in need of renovation, reflecting the age of the housing stock and building systems used.

- With a relatively young and mobile population, private sector flats (including houses in multiple occupation) are important; 21 per cent of all privately rented households in England are in London.

- There are estimated to be 125,000 vacant properties in London, most being in the private sector.

Fig. 3.1 **New housing completions in London, 1977–95**
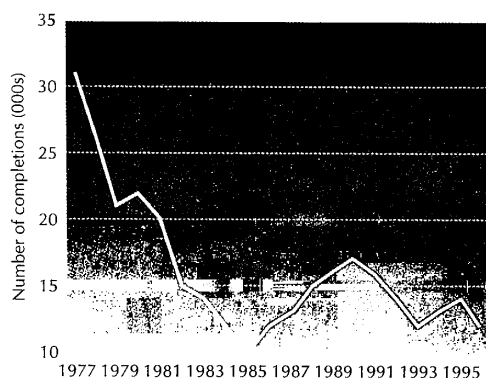
Source: London Research Centre (1997b)

Two adverse consequences of housing policy have become apparent over the past 10–15 years. The first is the growth of homelessness and the use of temporary accommodation (Fig. 3.2). The second is a growing gap in income, and other social indicators, between people in social housing and owner-occupiers. As wealthier tenants in council estates opted to buy their own homes (following the 1980 Housing Act), those still renting were on lower incomes and often in the less desirable properties. Social housing has increasingly become the sector for those claiming benefit or who are most vulnerable. The 1992 London Housing Survey (London Research Centre, 1994) revealed that tenants in the social rented sector were getting poorer relative to people living in the private sector. Tenants in the social rented sector also represented a higher proportion of the unemployed, people in black and minority ethnic groups, and those with low incomes. The social housing sector also caters for 70 per cent of London's lone parents and for half of the pensioners who live alone and are disabled. A recent London Research Centre report highlights the growth in the proportion of new housing association tenants in London eligible for housing benefit, which rose from 54 per cent in 1989/90 to 75 per cent in 1995/96 (Atkins & Flatley, 1996). There have also been changes in eligibility for benefits among young people and asylum seekers, which have tended to increase problems for some groups.

Fig. 3.2 **Statutory homeless acceptances and use of temporary accommodation in London**
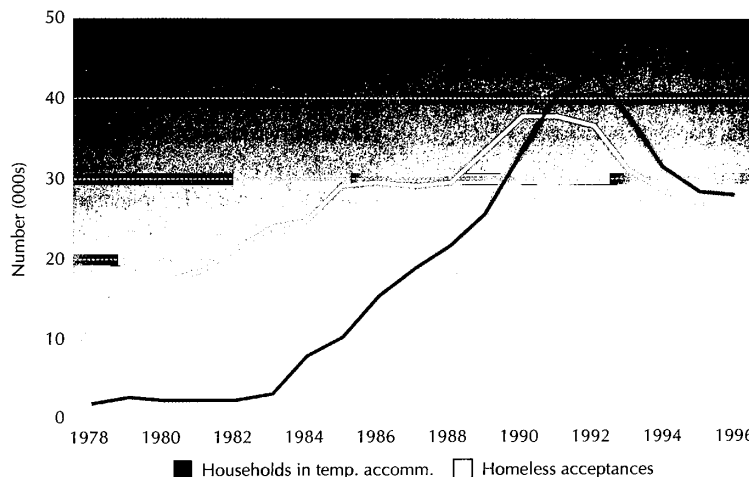
Source: London Research Centre (1997a)

For many people on low incomes but with high rents there is an increasing dependence on Housing Benefit support (London Research Centre, 1997a). There can also be a 'benefit trap', whereby a reduction in Housing Benefit can interact with other taxes and benefits, so there is little increase in net income. Moreover, the effect of increases in rents in excess of general inflation seen in London in the late 1980s has been to intensify this benefit trap (Edwards & Flatley, 1996).

Homelessness

Homelessness is a problem for many large cities. Estimates of the number of homeless in London vary from 100,000 (Pleace & Quilgars, 1996) to 237,000 (Logan, 1996). This range is indicative of the different ways that homeless people can be defined and counted.

The term 'homeless' can encompass a number of different groups. The Housing Acts of 1985 and 1996 impose statutory duties on local authorities to house people who are 'vulnerable' (excluding those who are intentionally homeless) such as pregnant women, those with dependent children, and those who are 'vulnerable' due to old age or their mental health. Yet to these must be added the large numbers in temporary accommodation and hostels and the large groups of concealed homeless – often single people living with others, sleeping on floors or in squats. Figure 3.2 charts the rise in the number of people accepted as homeless by local authorities in London (statutory homeless 'acceptances'), showing the peak of 38,000 in 1990 and subsequent decline to around 27,000 in 1996. The rise in the number of people in temporary accommodation is even more marked and indicates how the amount of social housing limits the ability to move people from temporary accommodation. Figure 3.3 shows the distribution of homeless people across London boroughs in 1995 as a percentage of all residents. The highest values are around 2–3 per cent and tend to be in the inner city north of the river.

There are many studies that point to the greater risk of mortality and morbidity among the homeless (Shanks, 1988; Scott, 1993; Connelly & Crowe, 1994). Conditions in temporary accommodation are often very poor, with little privacy or security, shared kitchens and/or bathrooms, and they may be damp, cold and overcrowded. Poor quality

temporary housing has been associated with a number of health risks, including respiratory and gastrointestinal infections, poorer perinatal outcomes and mental health problems linked to stress (Conway, 1988; Paterson & Roderick, 1990). Rates of long-term illness among homeless people are 2.5 times higher than among the general population (Victor, 1992).

For people who are roofless, hostel dwellers or using night shelters, there is a characteristic pattern of health needs that includes tuberculosis, chronic respiratory disease and trauma. Such people also suffer from problems associated with alcohol or drug misuse and mental health. Historically, these people have tended to be older men, but recent years have seen growing numbers of women and younger men. Problems such as mental illness are probably important contributory factors in becoming homeless

in the first place, and, once homeless, make obtaining appropriate housing that much harder.

In addition to a greater level of ill health, homeless people may also experience problems in getting access to health services – in particular primary and community care. For example, it has been estimated that 28 per cent of homeless people are not registered with a GP, compared to 3 per cent in the housed population (Moore *et al.*, 1996). One of the key issues for the health service is to improve access for the homeless. This may require the development of specialist services, as for example in Enfield and Haringey where there are specialist health visitors for homeless people (Enfield & Haringey Health Authority, 1997) and in Tower Hamlets where there is a special multi-disciplinary team that offers outreach services for single homeless people.

Fig. 3.3 **Proportion of the population who were homeless, by London borough, in 1995**
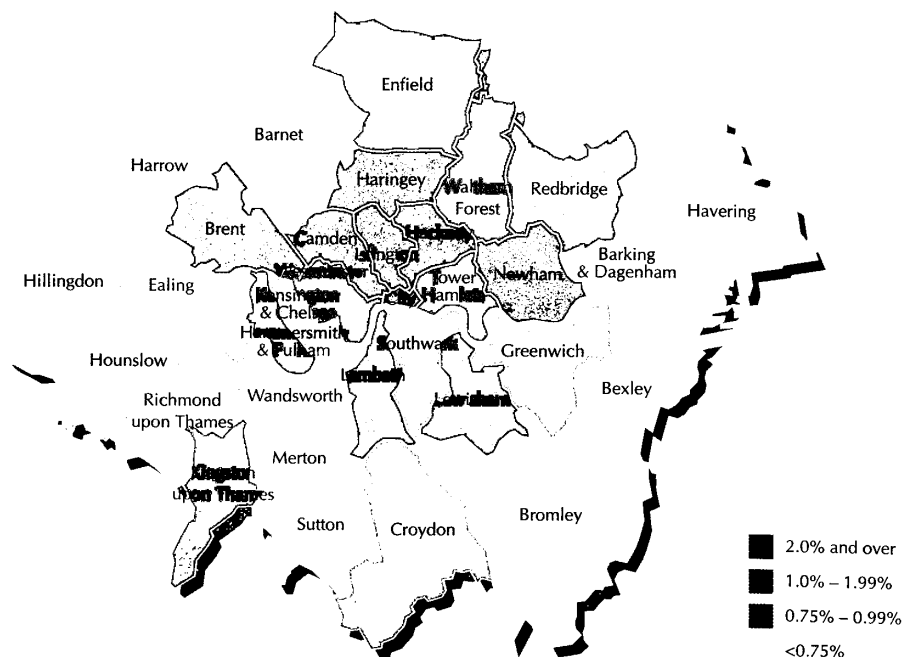
Data include people in temporary accommodation, squatters, hostel dwellers, travellers and those sleeping rough.
Source: Health Action for Homeless People (1995)

Quality of housing

Poor quality housing may be a direct cause of ill health, an additional risk factor or exacerbate the effects of pre-existing conditions. Although it is not always easy to separate the effects of poor housing from other social and economic factors, there is a growing body of evidence that points to the specific importance of good quality housing to good health.

The effect of cold and damp in the home is one of the most commonly explored areas and there is evidence to link these factors with a wide range of health conditions, in particular respiratory problems, infections and allergic disease (Marsh et al., 1985; Ineichen, 1993; Burridge & Ormandy, 1996; Hunt, 1997). For people on low incomes, the effects of cold and damp housing may be compounded by the high costs of adequate heating, leading to the problems of fuel poverty. Overcoming these problems requires investment in housing with good heating, ventilation and insulation. This involves developing adequate building standards for new properties or conversions and renovating older, poor quality housing (Ambrose et al., 1996).

Similarly, design and maintenance within a dwelling can reduce the incidence of accidents, an important cause of ill health both in children and in older people. Estimates based on national data suggest that in any one year in London there are 300,000 accidents in the home that require either GP or hospital treatment, and over 400 deaths (Department of Trade and Industry, 1995). It has been estimated that 11 per cent of accidents to children were associated with unsafe architectural features (Leather et al., 1994). Such accidents could be reduced by improving design features in housing such as L-shaped flights of stairs, no doors or windows opening onto stairways and good lighting (Towner et al., 1993). Design aspects are especially important in houses of multiple occupation, where there may be problems due to inadequate fire escapes (Dugdale & Draper, 1993; Leather et al., 1994).

Poor quality housing has been shown to affect the needs for other services such as education, police and social services (Ambrose, 1996). Various estimates of the costs to the health service have been attempted. Studies by Carr-Hill suggested that people in damp housing incurred health service costs that were 50 per cent higher than those of comparable groups, matched for income (Carr-Hill et al., 1993). It has been estimated (cited in National Housing Federation, 1997) that the health service costs for treating ill health resulting from substandard housing are £2.4 billion per year. London's share of this would be at least £280 million per year, the equivalent of about 5 per cent of the total London NHS budget.

Within London, it is possible to see a relationship between housing conditions and admissions to hospital for respiratory disease. In particular, The Health of Londoners Project (1998, unpublished) has found that overcrowding is significantly associated with higher levels of hospital admission when standardised for other census variables and provider characteristics.

The urban environment – outside the home

Factors outside the home can also affect health, though the causal relationships are especially hard to demonstrate. The history of both urban planning and public health has recognised the ways that the environment outside the home affects the quality of life and health. The range of factors may encompass specific issues, such as air quality or distance from local facilities, to the less tangible but still important factors, such as the degree of community interaction and cohesion, community safety and the visual appearance of a neighbourhood. Some key concerns for London are listed in Box 3.2.

The uneven spatial distribution of criminal offences and of victims of crime is well established, and some housing estates have much higher levels of crime

Box 3.2 The urban environment: key concerns for London

- The effects of high-rise blocks have been shown to be linked to levels of mental stress in the UK, and the idea that housing needs to be surrounded by defensible space has come to be accepted as the norm.

- Access to play facilities and open spaces is important for children and adults alike, and can contribute to physical fitness and the levels of social interaction within a community.

- Access to local facilities such as shops, GPs, public transport etc. is important.

- Road traffic continues to be a major threat to health, and accidents are a particularly important issue for children and for older people.

- Crime and fear of crime can affect health by reducing social interactions and increasing stress. Surveys of people's quality of life invariably identify crime as the most important concern.

than others. There are a number of ways that the design and management of housing estates can reduce the problems of crime (Hope & Foster, 1992). The work of police liaison officers can be important in the practical application of these ideas, as can local community safety officers (Home Office, 1997).

Urban regeneration programmes

The association between poor housing, poor health and a whole battery of other social indicators means that health improvements are most likely to come from wide-ranging intersectoral developments such as those seen in various urban regeneration schemes.

In 1995/96, 19 London boroughs had access to Single Regeneration Budget (SRB) resources for housing. In all, £100 million (14 per cent) of the total capital budget for housing was allocated to London (London Research Centre, 1997a).

To date, the extent to which health-related criteria have been used in developing and assessing SRB proposals has been limited. Health authorities have not tended to be major partners in the process and there are no formal links between the NHS Regional Offices and the Government Office for London. For example, from the last round of major London-wide proposals in 1997, only 8 out of 101 bids had a significant health partner (North Thames Regional Office, 1997, personal communication). This compared with previous years when there was no NHS involvement. Even when health authorities are involved, the bids tend not have explicit health-related elements.

The SRB bidding process inevitably favours the areas with the best bids and the greater capacity to draw in private sector funds, rather than the areas that might have the most need. Moreover, the requirement for substantial matched funding may preclude investment in some of the most deprived areas. So, for example, although some successful SRB bids have been in more deprived parts of Outer London, there have been few in Inner London.

The focus of the SRB programme is on economic regeneration, and there seems to be a lost opportunity for developing parallel systems of health impact assessment that show the added value of the investments and explicit objectives to reduce inequalities. There have been discussions about the nature of inter-agency working arising from the recent White Paper on the NHS (Department of Health, 1997b) and the proposals for a new health policy (Department of Health, 1998a), together with a review of pan-London issues in relation to health (Department of Health, 1998b) and the links between the NHS and the proposed Greater London Authority (Department of the Environment, Transport and the Regions, 1997). These may present an opportunity for such approaches to develop in future.

Housing for special needs

For some people, the design and style of their housing affects their ability to cope with existing health problems. Local authorities were first urged to target housing resources explicitly towards a

group of people with 'special needs' in 1969, and, throughout the 1970s, experience of any one of a fairly wide range of medical conditions secured applicants some degree of priority in most council house queues.

There are two broad mechanisms for matching specific housing provision for people with particular health needs, discussed below.

General medical need

People can apply to their local authority for priority status on medical grounds, and such applications are usually supported by their GP. Local authorities have varying mechanisms for designating medical priority – sometimes using their own advisers, sometimes seeking the advice of public health professionals in the health authority. However, the ability of local authority housing departments to select in favour of people with medical needs has become limited as demands on the grounds of medical priority have grown and the available council stock has decreased. A relatively large proportion of people with medical priority fail to get rehoused or have to endure long waits. Evidence about the outcomes of rehousing on health grounds are variable, with improvement linked more to mental health problems (Elton & Packer, 1986) than to physical illness (Golding, 1987). It has been argued that these mixed results are indicative of the importance of providing social support and medical intervention to people in their own homes, which can be more effective and less costly than rehousing (Smith, 1990).

Special needs groups

Increasingly, medical priority rehousing is giving way to policies targeted at groups categorised as having a special need, including the 'elderly', the 'physically disabled' and those who have mental health problems. As Chapter 10 discusses, mental health problems pose particular problems for London. Responding to these special needs can include a variety of measures, ranging from building adaptations through to special packages of care in

amenity and sheltered housing projects. Although there has been criticism that the creation of 'special provision' can be segregating and stigmatising (Arnold et al., 1993), the distinction has been taken up by many housing associations and in the Housing Corporation funding mechanisms. Many of the 11 special needs groups defined by the Housing Corporation (1997) are those in which London has particular problems (as documented in other chapters), including people with mental health problems, people infected with HIV, those with substance misuse problems, refugees, and frail elders (for whom there are fewer residential and nursing home places in London than elsewhere). Together with the shift from institutional to community-based living, this has led to an increasing number of architecturally and spatially distinct dwellings that are focused on specific groups of people.

Housing is obviously an essential part of all aspects of community care strategies. Alternatives to institutional care require flexible combinations of housing and specific support services if they are to be successful. These also require a degree of co-operation between different agencies in health, social services and housing. For example, discharge planning from hospital must anticipate the accommodation and levels of support that people will need when they return home.

In addition to these operational links, it has been argued that there must be stronger links between housing applications and community care strategies. For example, research has shown that rehousing not only improves health and welfare but can also secure better access to close relatives for their social support networks (Smith et al., 1993).

There is considerable experience in joint working between health and local authorities – mainly with social services although there is some with housing departments. Work across organisational boundaries will never be straightforward and there can be problems such as conflicting priorities, different planning and bidding cycles, and the fears of inter-agency 'cost-shunting' by shifting the financial

burden of collaborative working to one partner (Goss & Kent, 1995; Molyneux & Palmer, 1997). As the NHS moves towards new organisational forms based on primary care groups of commissioners of health care, it is important to consider how these relationships with local authorities will develop. The government's Health Action Zone initiative might be expected to tackle some of these difficulties.

Housing and health working together

The preceding sections have outlined how housing affects health. Box 3.3 outlines some of the different ways that health services in London are engaging with housing issues and developing inter-agency working, and gives some examples of the type of work that health authorities in London are involved in at local level. Although there are undoubtedly many examples of good practice across London in relation to housing and health (Association of Metropolitan Authorities, 1997), there is a view that more work needs to be done.

Additional NHS resources are required to deal with health problems associated with poor quality housing or homelessness. In some instances, small improvement grants for housing have been used by health authorities as a means of avoiding less desirable and more costly treatments, such as longer hospital stays. However, between the different agencies involved there are 20 different sources of funds for equipment and adaptations. At least one area in the country (Kirklees) has sought to pool these resources. In more general terms, there must be a more strategic view of how investments in one sector can reap benefits in another (Molyneux & Palmer, 1997).

BOX 3.3 HEALTH SERVICE ROLES IN PROMOTING BETTER HEALTH THROUGH BETTER HOUSING

Joint co-ordinating strategic planning groups linking housing, health and community care
Kensington & Chelsea has a joint housing and social services strategy developed in consultation with health agencies, with health authority representation on the steering group. Barking & Dagenham has published a joint strategy with housing and health as a key action area.

Partnerships for housing investment
Lambeth, Southwark & Lewisham Health Authority, working with the London Boroughs of Lewisham and Southwark, has linked urban regeneration funds to improve some estates to the development of primary care premises.

Investing in housing modifications
Ealing, Hammersmith & Hounslow Health Authority are funding improvements to some local houses for residents with mental health problems.

Focused health information/intelligence and needs assessment for housing, including annual reports
Mental health needs assessment work has been undertaken by MIND and the London Boroughs of Merton and Sutton, with funding from the London Housing Federation.

Joint work on prioritisation of housing and health needs
Hillingdon Health Authority and the London Borough of Hillingdon have undertaken joint funding of a scheme for people with severe physical and sensory impairment.

Health promotion work relating to accidents, energy efficiency etc
In Waltham Forest, a community health development project has been working on some estates to provide advice, domiciliary support and training.

Promoting healthy housing standards
Croydon Health Think-Tank drew up action plans for improving the safety and security of housing.

Projects for groups with special needs
A dedicated housing social worker in Bexley co-ordinates housing need for people with mental health problems.

There is a need for health services to develop more appropriate responses according to housing status. In particular, helping people who are homeless or in temporary accommodation to access important preventive services and primary care is a priority. A number of innovative schemes around London, including several Primary Care Act pilots, have developed new and better ways of improving access for certain groups. They include schemes that encourage GPs to register people in housing need (Hinton, 1994). Better access to primary care services requires changes in policies and attitudes, as well as funding the development of outreach services, health education, training, advocacy and inter-agency collaboration (Pleace & Quilgars, 1996).

Maintaining and improving the well-being of people whose special housing needs have arisen as a result of health problems can include work on developing medical priority systems to deliver the greatest benefit and liaison with local authorities on community care and discharge from hospitals (see Box 3.4).

Information on the extent of local health problems, which often resides in local public health departments, can be used with housing agencies to identify joint priorities. It is also important to recognise the links between housing issues and local health promotion work – for example, home accident prevention and energy efficiency.

BOX 3.4 APPROACHES TO IMPROVING MEDICAL PRIORITY SYSTEMS

- Develop better communications and joint working between health authorities, NHS trusts, primary care and housing providers.

- Recognise that a range of interventions (other than rehousing) may be appropriate.

- Encourage more standardised systems of assessment.

- Promote ways of incorporating medical assessments fairly in housing waiting lists/priority systems, and improve monitoring of medical priority allocations.

- Accountability and consistency in how 'health needs' are built into access and allocation procedures.

Finally, there is a need to develop a clearer strategic view, both locally and across London, of how health improvements flow from better housing and to emphasise the development of inter-agency approaches to health improvement.

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Chapter 4

Transport and health

Jake Ferguson & Mark McCarthy

Summary points

O Transport policy in London has a major impact on the health of the population. Adverse effects include injury from accidents; cardiovascular, respiratory and malignant disease; and psychological distress associated with noise and community severance (disruption of communities by traffic flowing through them).

O The adverse effects of transport on health are felt most by poorer communities, older people and people with physical or other disabilities.

Patterns of travel in London have become increasingly unhealthy: car use in London increased by 45 per cent between 1981 and 1991. Changes to transport patterns could produce significant positive health benefits; for example, from more cycling and walking, and from minimising the harm that traffic causes.

O London has a uniquely complex system for planning transport in the capital.

Implications for improvements in public health

O There must be a more coherent strategic view and mechanisms for assessing the impact on health of various transport options. The Greater London Authority (GLA) should set an early precedent by requiring health improvement and assessment of the impact on health to be explicit objectives of all local transport policies.

O There should be a shift towards the development and promotion of healthier forms of transport, including walking and cycling, and reducing the dominance of cars in land-use planning. Local Health Improvement Programmes could focus on assessing the impact of local transport policies on health, with an emphasis on more effective and sustainable ways to use the NHS's own transport and ensuring more accessible transport for disabled and elderly people.

O Local authorities and health authorities must promote measures to ameliorate the adverse effects of traffic on health, especially by reducing car use.

The health service has a role to play both in the way it organises its own transport and in advocating the use of healthy forms of transport. There should be better sharing of information among pan-London health and local authority bodies on transport and health.

○ Employers, including the NHS, local authorities and local education authorities should consider the adverse impact of car use in their own organisations and review policy accordingly; for example, penalising users of high emission cars, rewarding those who reduce mileage and subsidising the use of public transport rather than providing parking spaces.

Introduction

This chapter looks at the ways that transport policy in London is related to health, and briefly considers some of the key policy changes needed at both national and local level. There is also review of what the NHS can do, with respect to transport, to improve health. A more detailed analysis of the health problems linked to transport in London is available in a report by The Health of Londoners Project (1996).

Transport is fundamental to the efficient functioning of a city and its economic, social and cultural development. It also has a major effect on the health of its residents and the people who work there. The associated economic cost of road transport is high. Estimates for the UK are £23–£26 billion per year (Pearce, 1994), which includes costs linked to congestion (£13.5 bn), pollution (£2.8 bn) and accidents (£4.7–£7.5 bn).

Transport systems have to balance the conflicting interests of residents, commuters, commerce, long-distance journeys and the contribution of the public and private sectors. A number of European and UK cities have made admirable attempts to develop innovative transport solutions and develop a broad strategic view of how transport should evolve.

Transport policy should enable people to use healthy and sustainable forms of transport, but London has lacked the unified and political control required to oversee such developments. The consultation paper *Proposals for the Greater London Authority* (Department of the Environment, Transport and the Regions, 1997) suggests that a unified London authority will offer strategic action, leadership and enhanced protection for the environment and in transport planning. These proposals also offer the potential to bring health assessments into transport planning.

Developments in transport policy

Although the Government has made a strong commitment to improve transport policy, it is important for health to be linked with this; for example, the recent Green Paper on transport did not talk explicitly about health. On a more positive note, the old Departments of the Environment and of Transport have been merged to form the Department of the Environment, Transport and the Regions, which will allow greater integration of transport policy. There are a number of national policies that will have an impact on transport (see Box 4.1).

The Green Paper on transport policy has sought views on how to achieve a better, more integrated transport system. The key features are:

- a safe and efficient transport system that will maintain and enhance the UK's competitiveness;

- a better, more integrated public transport system, together with better arrangements for walkers and cyclists;

- a more environmentally sustainable transport system;

- better and more strategic integration of transport and land-use planning.

Other important legislation includes the Road Traffic Reduction Bill. This is 'landmark' legislation because it requires local (but not national) traffic authorities to develop plans and targets for reducing the volume of traffic. Another Bill is being prepared that will give the Secretary of State responsibility for developing national road traffic reduction targets.

BOX 4.1 OTHER EMERGING TRANSPORT-RELATED LEGISLATION

● Developing an Integrated Transport Policy (August 1997).

● Proposals for a Greater London Authority: A consultation paper (July 1997).

● Road Traffic Reduction Act (21 March 1997).

● Revised Traffic Management and Parking Guidance for London.

● Carbon dioxide reduction targets – a pledge to cut carbon dioxide emissions by 20 per cent by 2010. (Road traffic contributes over a fifth of the total carbon dioxide emissions in London.)

● The UK Sustainable Development Strategy – reducing traffic volumes will become a key national indicator.

● The National Air Quality Strategy – requires local authorities, through partnership with other areas, to develop Local Air Quality Action Plans and to declare Air Quality Management Areas.

● National Cycle Strategy targets – a commitment to double the proportion of journeys made by bicycle by 2002 and doubling them again by 2012. The national walking strategy is currently being developed.

● Reduction in permissible maximum blood alcohol levels.

Figure 4.1 **Main modes of travel in London, 1981 and 1991**
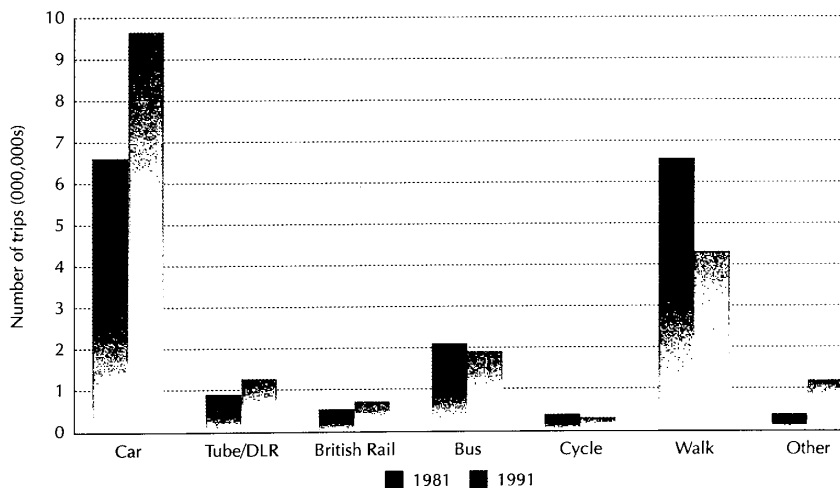
DLR = Docklands Light Railway
Source: London Research Centre (1994)

Transport patterns in London

During the working day, London's population of 7 million residents is swelled by 670,000 commuters. More jobs are located in the centre, so people typically have to travel from outside the borough to get to work. Patterns of travel in London are becoming less healthy, and car journeys continue to dominate (see Fig. 4.1).

The most common mode of transport in London for trips over 200 metres (about 180 yards) is the car (London Research Centre, 1994). Between 1981 and 1991 the number of trips by car increased by 45

per cent (Fig. 4.1). More than a quarter of all trips by car are under 2 miles (3.2 km), and over half under 5 miles (8 km) (London Research Centre, 1994). A consequence of the increase in traffic in central London has been a reduction in average speeds from 12.7 mph in 1968–70 to just over 10 mph in 1990–94.

Models predicting future traffic patterns indicate that, by 2001, there will be increases in the numbers of cars entering central London (up by 11 per cent) and Outer London (16 per cent), as well as a 5 per cent rise in rail use. Such models have to be treated with caution: there is a danger that they become self-fulfilling prophecies by assuming that patterns of transport use will not radically change in future.

Londoners make over 4 million trips on foot each day and a further 4.3 million to or from other forms of transport. Over the period 1985/86 to 1992/93 the average number of walk journeys per person per year fell by 3 per cent. The most marked decline (50 per cent) was in commuting trips. There were also increases in the number of trips driving children to and from school (doubling) and for shopping to be done by car (Government Office for London/ Department of Transport, 1996).

Each weekday, 140,000 Londoners make around 330,000 bicycle trips – only about 1.6 per cent of all trips. However, there are about 1.2 million bicycles available to London residents, which implies that only about one in ten is used on any given day (Government Office for London/Department of Transport, 1996).

Experience in a number of European cities shows how radical rethinking of patterns of use and corresponding switches in transport resources can bring about positive changes (see Box 4.2).

Health implications of transport

Transport affects health in a variety of ways both directly and indirectly (Health of Londoners Project, 1996). The following sections document some of the more obvious ways that transport and heath are linked.

Accidents

Road traffic accidents are an evident link between transport and health – in London in 1996 there were more than 250 fatal accidents, more than 6,500 serious injuries and more than 38,500 slight injuries (London Accident Analysis Unit, 1997).

Box 4.2   Base study of good practice: Gröningen, Netherlands

Twenty years ago, Gröningen decided on a different approach to traffic problems. Schemes for several ring roads to cope with increasing traffic were dropped, and instead emphasis shifted to improving accessibility for public transport, pedestrians and cyclists. The new plan focused on:

- *vehicle restraint* – the city centre was divided into four sections; cars and lorries were not allowed to cross from one sector to another;

- *easy access for cyclists* – cyclists are exempt from most one-way regulations; at the train station there is secure parking for 3,000 bicycles;

- *better public transport* – unlike cars, buses can move freely around the city centre;

- *bringing shops and other facilities back to the city centre* – out-of-town shopping centres are banned; markets that had been pushed out by the spread of car parks have returned to the centre; and an urban renewal programme has led to an increase of about 20 per cent in the number of city centre dwellers.

Between 1977 and 1984, traffic in the city centre dropped by 50 per cent, and cycling increased by 20 per cent; bus travel increased by 12 per cent.

Source: Transport 2000 (1995)

Table 4.1 **Road accident injuries by mode of travel, London 1996**

	Fatal (%)	Serious (%)	Slight (%)	Total
Pedestrian	122 (1.3)	1,931 (21.1)	7,095 (77.6)	9,148
Pedal cycle	20 (0.5)	573 (13.3)	3,707 (86.2)	4,300
Powered 2-wheeler	35 (0.6)	876 (14.9)	4,959 (84.5)	5,870
Car	66 (0.3)	2,724 (12.3)	19,295 (87.4)	22,085
Taxi	0 (0)	36 (8.5)	389 (91.5)	425
Bus or coach	2 (0.1)	249 (11.2)	1,964 (88.7)	2,215
Goods vehicle	6 (0.6)	146 (13.4)	934 (86.0)	1,086
Other	0 (0)	33 (16.9)	162 (83.1)	195
Total	251 (0.6)	6,568 (14.5)	38,505 (84.9)	45,324

Source: London Accident Analysis Unit (1997)

Although London constitutes about 12 per cent of the UK population, in 1993 it accounted for 20 per cent of all UK pedestrian casualties, 17 per cent of all UK motorcycle casualties and almost 20 per cent of all UK cycle casualties.

Over the past decade there has been a reduction in the total number of casualties, though interpretation of these trends is complicated by changes in transport patterns. For example, casualties to car occupants have shown little decline, although the number of trips by car has increased substantially. Although the number of pedestrian casualties fell by about 27 per cent up to 1993, the number of trips also declined during this time. In terms of severity, pedestrians have proportionately more severe or fatal accidents (see Table 4.1) than other groups. Relative mortality rates from road traffic accidents are linked to traffic speed, so overall rates in London tend to be lower than national averages, with higher values in Outer than Inner London.

Accident rates should be interpreted with caution. Most road deaths in London are recorded as accidents, but many non-fatal accidents go unreported, especially among vulnerable road users (e.g. pedestrians, cyclists) who are not subject to insurance claims. Falling accident rates do not imply increased safety: few people would regard London's streets as 'safer' than 30 years ago. Mortality rates have fallen partly because of better emergency services and hospital care. But the increased number and speed of cars in London have led to fewer people cycling and greater restrictions on pedestrians. A study of over 100 cyclist deaths in London showed that the majority were from being run over by heavy lorries, especially turning left corners (Gilbert & McCarthy, 1994). There is, as yet, very little political concern for cyclist safety in London (McCarthy, 1997).

Air and noise pollution

Outdoor air quality remains an important public health issue. The pollutants of 50 years ago, mainly generated by coal burning, have been superseded by those caused by motor vehicle emissions. Air quality monitoring in London is improving and a new public information system on air pollution was announced by the Department of Health in 1997. The new system features new bandings that cover a wider range of pollutants, are more understandable and are widely available to the public.

Poor air quality is a danger to health and different pollutants have differing health effects. Poor air quality alone does not cause asthma, but does exacerbate symptoms for some people with pre-existing respiratory problems. Small particulates (known as PM10 or PM2.5), largely produced by diesel engines, seem to be associated with increased mortality rates in the elderly or those with pre-existing respiratory disease. It has been estimated that there are over 4,000 respiratory and 1,500 cardiovascular admissions to hospital in London each year due to traffic pollution (Health of Londoners Project, 1996). Recently, the British Medical Association (1997) indicated that 1 in 50

heart attacks in London may be precipitated by air pollution.

Noise pollution can also affect health yet its effects are very difficult to quantify. It is believed that persistent exposure to noise, especially at night, may lead to psychological distress. It is likely that road traffic is the largest single cause of noise pollution in London (London Planning Advisory Council, 1994). Transport noise is associated with productivity losses caused by an inability to concentrate at work or disrupted sleep (Pearce, 1994).

Exercise

Cycling and walking have a positive effect on health by increasing cardiovascular fitness and reducing the risk of obesity and cardiovascular disease (National Forum for Coronary Heart Disease Prevention, 1995). Given that cardiovascular disease is still the biggest cause of death in London, and obesity is reported to be increasing, the promotion of cycling and walking is clearly an important part of a transport policy. It has been argued that exercise is much more likely to be sustained if it forms part of regular daily activity, is habit-forming and easily affordable (National Forum for Coronary Heart Disease Prevention, 1995).

An important way to encourage walking and cycling is to reduce the hazards posed by motor vehicles: motorised traffic is frequently mentioned as a reason for not walking or cycling. However, the British Medical Association (1992) has concluded that there is likely to be a net health benefit from cycling and that that improved fitness outweighs the risk of accidents. Measures such as safer roads or separate cycle lanes will encourage the greater use of safer and healthier transport options. In addition, public health services can play an important role in changing attitudes to travel, including the promotion of the benefits of alternative forms of transport.

Community severance

Heavy traffic through residential areas can affect access to local facilities, cause traders to leave because of hazards to shoppers and effectively immobilise people with a physical disability (Hine & Russell, 1993). Traffic flows can also make areas less desirable as places to live and work, resulting in people and businesses moving out and dereliction setting in (Royal Commission on Environmental Pollution, 1994). In particular, fear of accidents has meant that parents are increasingly reluctant to allow children to walk or cycle to school; more parents drive their children to and from school, which in turn means more traffic (London Research Centre, 1995). There is very little information about the extent of community severance in London, although the decline in walking is probably a good indication of what is happening to communities in the capital.

Making transport healthier

There is a growing list of initiatives and programmes aimed at reducing car use or harm and increasing the use of healthier forms of transport (see Box 4.3).

Local authority road safety plans are important in improving safety on the roads, and have helped to overcome cyclists' fears and encourage greater use of the bicycle. More recently, ideas such as 'Green Commuter' plans have targeted organisations and businesses to help them develop strategies that encourage staff to choose more environmentally friendly ways of getting to work – with much success. Transport 2000 has developed a Healthy Transport Network for health authorities and NHS trusts, and 111 have signed up to schemes since its creation in 1997.

Along with reducing car use, the capacity and quality of public transport systems must be developed. Public transport needs to be efficient as

Box 4.3 Approaches to reducing traffic or the harm it causes

Unitary Development Plans (UDPs)
Many London boroughs are beginning to include sustainable transport concepts as part of their UDP. UDPs have a vital role for the future and it is important that transport and health are integral to their content.

Road safety legislation
Seat belts, motorcycle helmets and drink–driving limits, for example, are common across the world and have been cited as major factors in reducing vehicle occupant casualties (Adams, 1995).

Traffic restraint
Speed-reduction measures such as road humps, chicanes and road closures have become an accepted part of the urban landscape and are effective in reducing accidents.

Car-free zones, 'clear' zones and car-free housing   Many cities – notably Cambridge, Norwich and York – have implemented significant areas of 'pedestrianisation'. Many Inner London boroughs, such as Camden in its Green Transport Strategy, are developing similar plans. Proposals for such measures in central London, particularly around Trafalgar Square, have been suggested.

Road pricing and taxation
This is a possible option for reducing the number of cars entering central London and providing a source of investment for public transport. Such ideas might be difficult to implement and do not address the need for adequate alternatives. Reducing the benefits of using a company car, tightening local parking controls and reducing access for cars can have a cumulative effect in persuading people to use the car less.

Vehicles using alternative fuel
Technological developments such as electric vehicles and catalytic converters may help to reduce the impact of road traffic on air pollution, but continue to perpetuate the dominance of cars in land-use planning and as a means of transport.

Accessible transport
Some Inner London boroughs have developed projects to alleviate the difficulties faced by people who are less mobile. The ASTI Project in Camden, part funded by the European Commission, combines accessible transport with low-pollution vehicles.

Parking
There are currently proposals for 93 new car parks in London for 123,000 car parking spaces (London Council for the Protection of Rural England, 1998) – mainly for shopping and leisure facilities. Local authorities must impose much more stringent parking controls on large commercial developments.

well as affordable and accessible to all groups of people. Substantial investment will be required to improve public transport in London. One example of an innovative approach is the Tramlink scheme in Croydon, which aims to reduce traffic congestion and car use by creating a network of trams in south London.

Local bus services should be improved for people who live in rural areas, rather than developing 'park-and-ride' schemes which increase car use and, therefore, environmental pollution

Role of the health service

As a health-improving agency, the NHS must set a precedent for transport and health concerns. To date, organisations with a role in primary health have been slow to take up traffic reduction, and key documents such as *The Health of the Nation* (Department of Health, 1993) paid little or no attention to the benefits in terms of fewer accidents and improved fitness. Some of this reluctance may be because there is a feeling that the issue is too big for the NHS to make an impact. However, there are a number of areas where the NHS can play an important role.

Health transport in the NHS

NHS transport in London is significant, with an estimated 8 million trips per year to and from hospital for attendance at accident and emergency or outpatients alone. To this we can add staff travel and visits to people in hospital. The siting and accessibility of health service facilities is obviously important. Health services can, through Green Commuter plans and patient transport strategies, build healthy alliances with local authorities and business to encourage healthier alternatives to car travel. Finally, the health services, like any employer, can encourage flexible and home-based working as a way to reduce avoidable travel.

Promoting exercise

Health agencies have an important role in promoting exercise throughout the population. Encouraging more walking and cycling as a regular means of transport is one important step. For example, some simple measures to encourage cycling include providing adequate showers, secure bicycle racks, a recognition of cycling mileage in expenses claims and even, perhaps, free access to a pool of bicycles.

Health impact assessments of transport

Working closely with local authorities, health agencies can play an important role in providing information about the health consequences of local transport options. At present, pan-London planning groups such as the London Planning Advisory Committee or the Association of London Government have little formal input from the health sector. There must be a greater emphasis on the public health advocacy role in relation to transport policy. Local health improvement programmes may provide a catalyst for this in future.

Accident prevention and public awareness issues

Health authorities can play an important part in reducing the number of casualties on the roads by working closely with local authorities in the development of road safety plans, educating drivers on speed reduction and respecting other road users, promoting cycling and walking, and generally raising the awareness of the ill-effects of car travel through campaigns such as 'Don't Choke London' and as part of Local Agenda 21 initiatives. Health and local authorities can also promote healthier travel for children to and from school, improve access to public transport for disabled and vulnerable people, and work with police to reduce driving after drinking alcohol in pubs and restaurants.

The way ahead?

The problems of transport systems in London affect all of us who live and work there. The trends over the past decades have not been in the right direction and there is an urgent need for us to re-think the way we travel. Although individual motor transport is necessary for some people, public transport remains the only sustainable approach for most long journeys, while cycling or walking are best for short journeys. The challenge is to create public and political acceptance of these facts. The NHS has the challenge to lead – from the top down – especially in promoting exercise and reducing car use. Equally, the new Greater London Authority will provide a vital opportunity to promote health through the co-ordination and planning of transport across London.

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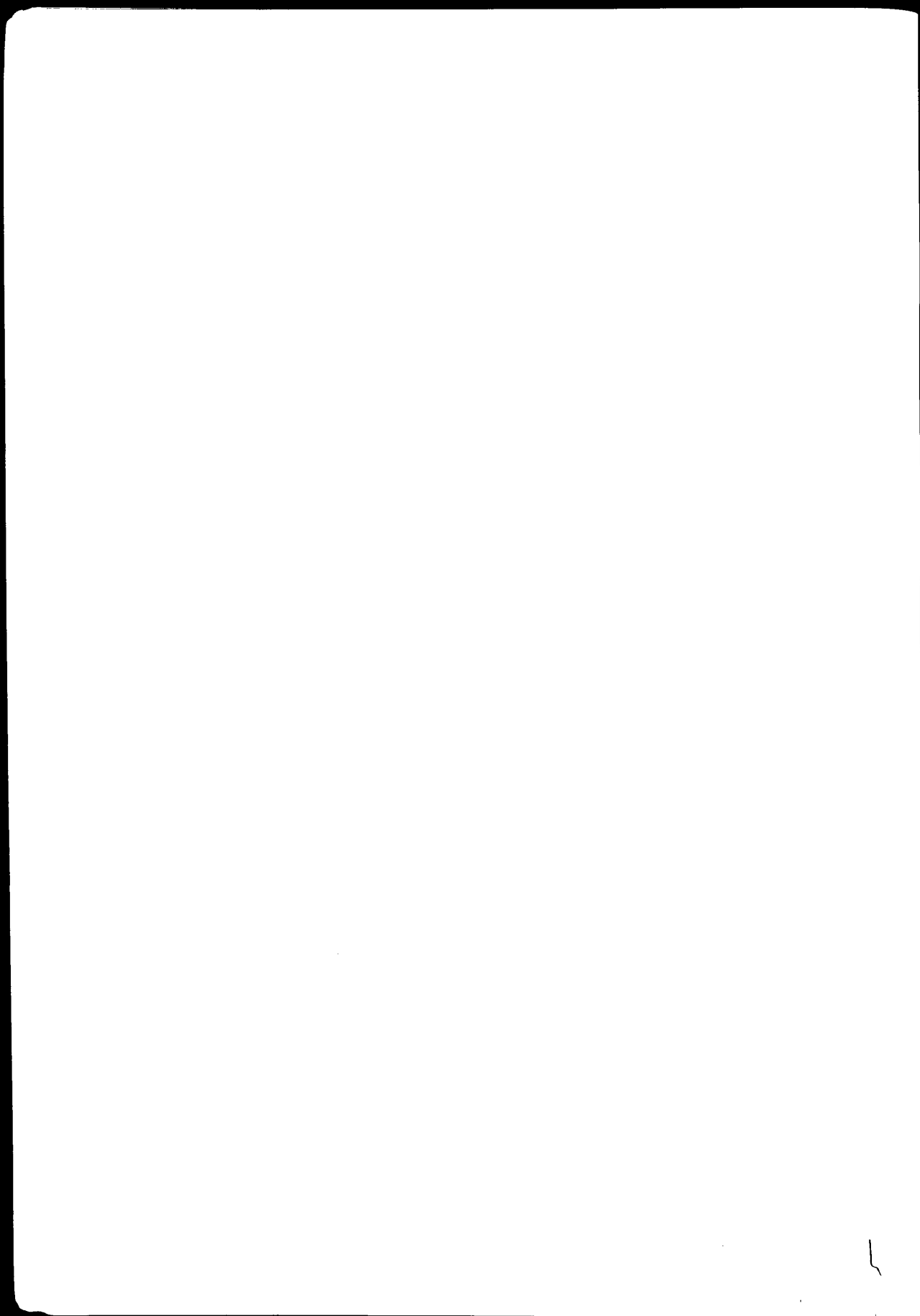
Chapter 5

HIV and AIDS

Matthew Hickman & Will Huxter

Summary points

☐ London, and particularly Inner London, is the focus of the national HIV epidemic in relation to homosexual men, heterosexuals and children, and the focus of the epidemic among injecting drug users in England and Wales. It is estimated that, in 1996, 10,000 adults with HIV infection were living in Inner London, and 2,000 in Outer London.

☐ Indicators of adult risk behaviour in relation to HIV and sexually transmitted diseases were considerably higher for Inner London than for the rest of the country.

☐ At least a third of all HIV infections acquired heterosexually in the UK were among residents of Inner London, with a further quarter resident in Outer London.

☐ Estimates suggest that HIV-related deaths were the most common cause of mortality in men aged between 15 and 54 in Inner London. In women of the same age group in Inner London, HIV was estimated to be one of the second most common causes of death (along with suicide and accidents) after breast cancer. In Outer London, HIV was estimated to be the fourth most common cause of death in men aged 15–54, behind heart disease, accidents and suicide.

☐ Because of the lack of reliable data that can be extrapolated for London's minority ethnic communities, it is not possible to highlight areas of major or growing risk. A pan-London focus would better address the issues of surveillance, prevention, treatment and care among black and minority ethnic people.

☐ It is important to manage the shift of the balance of care from hospital inpatient departments to outpatient settings across Greater London, if combination therapies continue to be successful in keeping patients well.

Implications for improvements in public health

☐ Future public health surveillance of HIV/AIDS should be undertaken on a pan-London basis with a view to using resources in health authorities, NHS regional offices and the Communicable Disease Surveillance Centre (CDSC) more effectively.

☐ More comprehensive monitoring of access by minority ethnic people to all HIV services is essential for all providers.

O Joint work and strategies on the commissioning of HIV services need to be expanded to encompass all of Greater London. London-specific HIV and sexual health targets will need to be considered in the light of the new national HIV strategy. This should include targets for the uptake of antenatal screening for HIV.

O A pan-London approach to antenatal testing for HIV is needed urgently.

O Needle-exchange schemes must at least be maintained at the current level to ensure that

HIV prevalence among injecting drug users remains low.

O Health strategies must ensure that all groups of the population have equal access to free HIV testing and to treatment.

O Planning for HIV services over the next few years must be undertaken on a pan-London basis and incorporate emerging intelligence about the cost-effectiveness of combination therapies. This may require a review of the number and location of specialist HIV centres.

Introduction

This chapter looks at HIV infection and HIV-related mortality in London. It uses data on adult risk behaviours from the National Survey of Sexual Attitudes and Lifestyles (Johnson et al., 1994) and estimates of the prevalence of HIV and AIDS in the capital to inform the work of health and local authorities in assessing the health needs of their populations and in planning their services.

It is estimated that there have been nearly 30 million HIV infections and 8 million AIDS cases world-wide, with over 90 per cent of new infections likely to occur in developing countries. In western Europe, the incidence of HIV seems to have stabilised, though there are different patterns between countries. In southern Europe, where injecting drug use is a major public health problem, the growth and number of HIV infections have been higher than in northern Europe where most infections are among homosexual men (to prevent confusion, the term 'homosexual men' is used here to denote the behaviour of 'sex between men' as well as the target population 'gay men'/'homosexual men'/'men who have sex with men'). However, most recently the largest relative increase in HIV and AIDS cases has been attributed to heterosexual transmission (Public Health Laboratory Service, 1997a).

In the UK, nearly 15,000 AIDS cases and 30,000 HIV diagnoses had been reported by the end of December 1997, 11,000 of whom have died (Public Health Laboratory Service AIDS Centre, 1998). Standard tables published by CDSC reveal that almost 70 per cent were reported from the two Thames Regions. However, the geographical pattern and focus of the HIV epidemic is even more extreme when the data are reported separately for London (Hickman et al., 1997).

London, particularly Inner London, is the focus of the overall HIV epidemic in England and Wales. Moreover, because of its demography and the concentration of 'at risk' groups and 'risk' behaviours, London is the focus of HIV infection for injecting drug users, heterosexuals and children, as well as for homosexual men.

HIV infection in London

It is estimated that at the end of 1996 there were over 23,000 adults in England and Wales infected with HIV, with a further 1,200 or more infections transmitted through blood transfusion or treatment with other blood products. Nearly 10,000 (42 per cent) lived in Inner London, 4,000 (17 per cent) in Outer London and 2,000 (9 per cent) in the rest of south-east England (Table 5.1). By contrast, the proportion of the England and Wales population

Table 5.1 **Estimates of HIV prevalence in people aged 16–59 in 1996, by area**

Area	Estimated number infected with HIV			Population prevalence (ages 16–59)		
	Men	Women	Total	Men	Women	Total
Inner London	7,870	1,920	9,790	0.93%	0.22%	0.58%
Outer London	2,520	1,390	3,910	0.19%	0.11%	0.15%
Rest of Thames	1,670	420	2,090	0.09%	0.02%	0.05%
Rest of England &Wales	6,060	1,590	7,650	0.04%	0.01%	0.03%
Total	18,120	5,320	23,440	0.10%	0.04%	0.08%

aged 16–59 resident in Inner London is less than 5 per cent, 7 per cent living in Outer London and 10 per cent in the rest of the south-east.

The prevalence of HIV infection in Inner London was almost 1 per cent for men aged 16–59 (about 1 in 100) and 0.2 per cent (about 1 in 500) for women of the same age. In Outer London, it was estimated that fewer than 0.2 per cent of men and 0.1 per cent of females were infected. In the rest of south-east England, excluding Brighton and East Sussex, the prevalence of HIV was only slightly higher than for the rest of England and Wales (Hickman et al., 1997).

Estimates for individual health authority areas in the North and South Thames regions are available elsewhere (Hickman et al., 1997), but they involve a further set of assumptions and are much less reliable than data attributed to Inner and Outer London. Inner London is also a net importer of people with HIV seeking treatment (i.e. more non-residents come into London for HIV treatment than Londoners go out of London). Some health authorities have as many non-residents as residents in contact with services, increasing the pressure and burden for the planning of treatment and care services.

Indicators of risk behaviour in London

Surveillance data have shown a consistent picture of the epidemic over the last ten years, the burden of HIV infection falling on three main groups:

- homosexual men

- injecting drug users

- black Africans.

They comprise the priority population for prevention and services, along with heterosexuals at greater risk – that is, people infected with sexually transmitted diseases and/or those engaging in unprotected sexual intercourse with multiple partners (Unlinked Anonymous Prevalence Monitoring Programme, 1997).

The National Survey of Sexual Attitudes and Lifestyles (Johnson et al., 1994; Wadsworth et al., 1996) suggests that adult risk behaviour in relation to HIV and sexually transmitted diseases is considerably greater in Inner London than in the rest of the country (Table 5.2). For instance, as a proportion of the whole population of England and Wales, Inner London has:

- 33 per cent of homosexual men and 20 per cent of homosexual women;

- 20 per cent of women with high numbers of heterosexual partners;

- 33 per cent of all men and 17 per cent of women who report ever having injected illicit drugs;

- 15 per cent of women who have had an abortion in the last five years

- 25 per cent of all women and 17 per cent of men who attended a sexually transmitted disease clinic in the last five years.

Table 5.2 **Sexual behaviour indicators, by area**

Men		Inner London	Outer London	England & Wales
Sample	16–59	450	670	7,650
	16–20	50	70	950
Homosexual partner	Estimate	8.6%	1.9%	1.5%
in past 5 years	Plus/minus	2.6%	1.0%	0.2%
Injecting drug user	Estimate	4.7%	0.3%	0.8%
(ever)	Plus/minus	2.1%	0.5%	0.2%
3 or more heterosexual	Estimate	10.9%	8.4%	5.5%
partners in last year	Plus/minus	2.9%	2.1%	0.5%
30 or more heterosexual	Estimate	8.8%	7.9%	5.4%
partners in lifetime	Plus/minus	2.7%	2.1%	0.6%
Sex before 16	Estimate	15.8%	23.1%	28.8%
(for ages 16–20)	Plus/minus	9.7%	10.1%	2.9%
Used condom in last	Estimate	45.8%	40.0%	35.5%
year	Plus/minus	4.9%	3.8%	1.1%
Used condom in last	Estimate	30.4%	25.3%	23.5%
heterosexual sex	Plus/minus	4.6%	3.5%	1.0%
Changed sexual risk	Estimate	40.1%	25.6%	19.5%
behaviour	Plus/minus	4.5%	3.3%	0.9%
Attended STD clinic in	Estimate	10.4%	4.9%	3.4%
past 5 years	Plus/minus	2.9%	1.7%	0.4%
Women				
Sample	16–59	580	740	9,430
	16–20	60	80	1,110
Homosexual partner	Estimate	2.2%	0.4%	0.6%
in past 5 years	Plus/minus	1.2%	0.4%	0.1%
Injecting drug user	Estimate	1.2%	0.5%	0.4%
(ever)	Plus/minus	11.2%	2.9%	1.7%
2 or more heterosexual	Estimate	11.8%	7.4%	6.7%
partners in last year	Plus/minus	2.7%	1.9%	0.6%
3 or more heterosexual	Estimate	6.7%	2.1%	2.0%
partners in last year	Plus/minus	2.1%	1.0%	0.3%
10 or more heterosexual	Estimate	19.8%	8.8%	6.9%
partners in lifetime	Plus/minus	3.4%	2.0%	0.5%
Sex before 16	Estimate	20.2%	11.5%	18.9%
(for ages 16–20)	Plus/minus	10.1%	6.8%	2.3%
Used condom in last	Estimate	30.4%	29.1%	24.2%
year	Plus/minus	3.8%	3.5%	0.9%
Used condom in last	Estimate	21.1%	23.7%	17.7%
heterosexual sex	Plus/minus	3.6%	3.3%	0.8%
Changed sexual risk	Estimate	34.4%	16.0%	14.3%
behaviour	Plus/minus	3.9%	2.6%	0.7%
Attended STD clinic in	Estimate	10.8%	2.9%	2.5%
past 5 years	Plus/minus	2.7%	1.2%	0.3%
Abortion in past 5	Estimate	11.2%	6.7%	4.6%
years	Plus/minus	2.7%	1.8%	0.4%

Table 5.3 **Estimates of live AIDS cases, number of HIV-infected persons in contact/not in contact with services and planning estimates of HIV infections by exposure category and geographical area**

Exposure group	Area	Live AIDS	HIV in contact with services	Not in contact	Planning estimates – HIV Central	Lower	Upper
Homosexual men	Inner London	1,100	3,410	1,650	6,160	4,620	7,700
	Outer London	280	830	320	1,430	1,070	1,790
	Rest of England & Wales*	900	2,150	2,870	5,920	4,440	7,400
Injecting drug users	Inner London	90	360	670	1,120	840	1,400
	Outer London	20	80	80	180	130	230
	Rest of England & Wales*	80	370	380	830	630	1,030
Heterosexual	Inner London	280	1,030	1,200	2,510	1,880	3,140
	Outer London	170	540	1,550	2,260	1,700	2,800
	Rest of England & Wales*	220	730	2,080	3,030	2,270	3,810
Total	Inner London	1,470	4,800	3,520	9,790	7,340	12,240
	Outer London	470	1,450	1,950	3,870	2,900	4,820
	Rest of England & Wales*	1,200	3,250	5,330	9,780	7,340	12,240

*Including the rest of the Thames Regions.
1. Estimates of the number of injecting drug users and heterosexuals resident in Outer London were derived by multiplying estimates for England and Wales by the proportion of people reported with HIV resident in Outer London.
2. Estimates of the number of people infected with HIV but who had not progressed to AIDS in contact with services were derived from the National Survey of Prevalent Diagnosed HIV Infections (SOPHID), which may under-estimate the total number who have been in contact with services. For estimates of the number of people with HIV infection 'in contact', add columns 3 and 4 of the Table ('Live AIDS' + 'HIV in contact with services').

Sexual behaviour indicators in Outer London and the rest of the south-east resemble those for the rest of England and Wales. However, the number and proportion of black Africans (who are at greater risk of HIV infection) resident in Outer London as well as those living in Inner London are considerably higher than national averages. The 1991 census recorded nearly 110,000 black Africans (55 per cent of the national total) as resident in Inner London and more than 54,000 black Africans (27 per cent of the national total) as resident in Outer London (Office of Population Censuses and Surveys, 1993).

Inner and Outer London

Table 5.3 shows estimates of the number of people with AIDS and HIV infection by exposure category, the pattern of which differs between Inner and Outer London. In Inner London most infections were among homosexual men, but there were also high numbers of people with HIV infection contracted heterosexually and through injecting drug use. In Outer London there were comparatively few injecting drug users with HIV infection, and the number of infections among heterosexuals was roughly equal to or higher than the number in homosexual men.

Homosexual men

The overall pattern of HIV and AIDS in England and Wales is dominated by infections among homosexual men and infections in residents of Inner London. Most AIDS cases (70 per cent) and diagnosed HIV infections (58 per cent) are in homosexual men, nearly half of whom live in Inner London. Unlinked anonymous surveys of people attending genitourinary medicine clinics suggest that, in 1996, the prevalence of HIV infection among homosexual men was 10 per cent in London and 2.9 per cent elsewhere (Unlinked Anonymous Prevalence Monitoring Programme, 1997).

Fig. 5.1 **Back-calculation estimates of HIV incidence (median and pointwise 95 per cent credible interval) and cumulative incidence in homosexual men in Inner London, 1979–96**
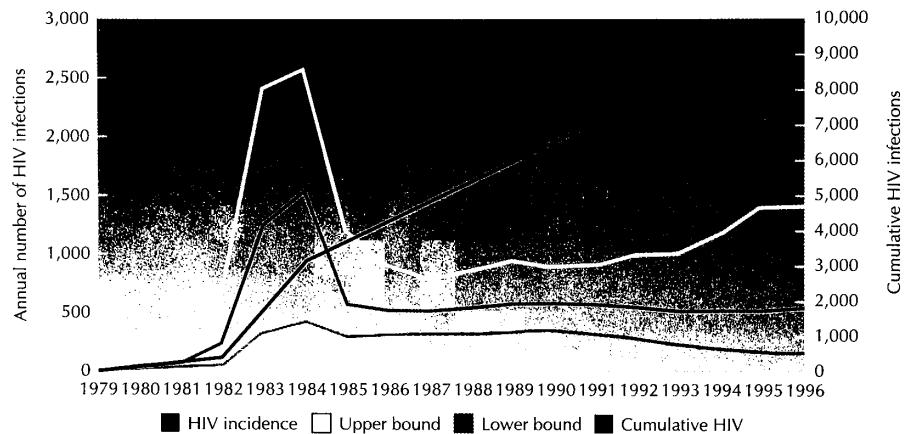
Source: Hickman et al. (1997)

Figure 5.1 illustrates the pattern of the HIV epidemic in homosexual men in Inner London, the shape of which is similar to that of England and Wales generally (Day, 1996). This suggests that incidence increased rapidly during the early 1980s, peaking between 1983 and 1984 and then declining to a stable level of about 500 new infections per year (95 per cent certainty interval 200 to 1,200). Unlinked anonymous surveillance also provides evidence of continued endemic transmission, suggesting that around 1 in 200 homosexual men is being infected with HIV each year (Unlinked Anonymous Prevalence Monitoring Programme, 1997). Clearly, when the prevalence of HIV infection among homosexual men is so high, small changes to more risky sexual behaviour will have dire consequences. Homosexual men remain a key priority group in London for maintaining changes in behaviour and emphasising the need for safer sexual behaviour.

Injecting drug users

About half the estimated number of HIV infections among injecting drug users in England and Wales were in residents of Inner London. Unlinked anonymous surveys suggest that new infections among drug users are low. The prevalence of HIV infection in the Public Health Laboratory Service (PHLS) studies at London drug agencies varied from 1 to 6 per cent between 1990 and 1996 (Unlinked Anonymous Prevalence Monitoring Programme, 1997), and a recent sero-prevalence study of women injectors recruited in the community (rather than from those presenting to services) in London found that HIV prevalence was 1 per cent. The low rates of HIV infection are attributed to a change in the behaviour of drug users, and particularly to the success of the provision of clean injecting equipment through needle-exchange schemes and the promotion of other harm-minimising activities. Rates of sharing syringes and other equipment, however, remain relatively high and injecting drug users are still vulnerable to HIV infection and other blood-borne viruses – especially hepatitis C, which seems to have been unaffected by the prevention initiatives that led to a fall in HIV infection.

Heterosexual infections

London is also the focus of HIV infections acquired heterosexually: 33–40 per cent of these HIV infections in England and Wales are in residents of Inner London, a further 25–29 per cent living in Outer London. The estimates of the prevalence of HIV among heterosexuals derived through back-calculation models do not yet separate ethnic groups or take account of changes in migration and are therefore much less reliable (De Angelis et al., 1998). The proportion of HIV infections presumed to have been acquired in the UK is small. Over 75 per cent of diagnosed infections were associated with exposure abroad.

The number of undiagnosed infections is likely to be substantial. In 1996, HIV prevalence among pregnant women in London was 0.19 per cent – about 1 in 500 (Unlinked Anonymous Prevalence Monitoring Programme, 1997). This is close to the estimates shown in Table 5.3, which assume that over 1,000 women who acquired HIV infection heterosexually may not be in contact with services, plus a further 1,000 men. Outside London, HIV infection among pregnant women was found to be 0.016 per cent – 1 in 6,000 (Nicoll et al., 1998). Over all, 75 per cent of infections among pregnant women are undetected at the time of the birth. This is a significant failure in the implementation of earlier advice recommending that all pregnant women be offered HIV testing (Department of Health, 1994). If more mothers had been diagnosed and offered anti-viral therapy and avoided breast-feeding, fewer children might have been infected with HIV. Several hospitals in London, however, have managed to increase uptake of HIV testing to more than 50 per cent (Duffy et al., 1998).

The risk of further transmission of HIV infection through heterosexual intercourse is higher in London than elsewhere in the UK because of the higher proportion of people with multiple partners, the higher rates of sexually transmitted disease infection in the south-east of England, and the higher background prevalence of HIV within the population. The surveillance of sexually transmitted diseases (STDs) in London is hampered by the lack of residence-based data, apart from one-off surveys (e.g. Low et al., 1997); this will change with the introduction of regional STD surveillance (Maguire et al., 1997).

There are no estimates of the total number of children infected with HIV in the UK, though it is likely to be comparatively small. Some 90 per cent of HIV infections in children under 15 are due to vertical (mother-to-child) transmission. The majority of reported cases were resident in London – where a large proportion of pregnant women are HIV-positive, compared with elsewhere – most of which were associated with the mother's heterosexual exposure abroad.

HIV-related mortality

Premature mortality is a key measure of the public health importance of a disease. It has been difficult to confirm the impact of HIV on mortality using routine mortality statistics alone, because HIV-related deaths are often hidden for reasons of confidentiality and classified under a number of different codes from the International Classification of Diseases (Bardsley et al., 1997). Instead, estimates of the number of HIV-related deaths were derived from surveillance data and combined with routine mortality statistics. It was shown that the increase in HIV-related deaths matched the rise in 'excess' deaths in males aged 15–54 in Inner London from 1985, suggesting that HIV was largely responsible for reversing the decline in mortality rates for this age group in Inner London (Fig. 5.2).

In Inner London, HIV has been estimated to be the leading cause of death in males aged 15–54, and close to accidents and suicide as the second (to breast cancer) leading cause of death in females of the same age group (Fig. 5.3). In Outer London, HIV infection was estimated to be the fourth most common cause of death among males aged 15–54 (Bardsley et al., 1997; Hickman et al., 1997).

Fig. 5.3 **Age-standardised mortality rates by cause of death in Inner London, 1979–95: (a) men aged 15–54; (b) women aged 15–54**

(a)

(b)
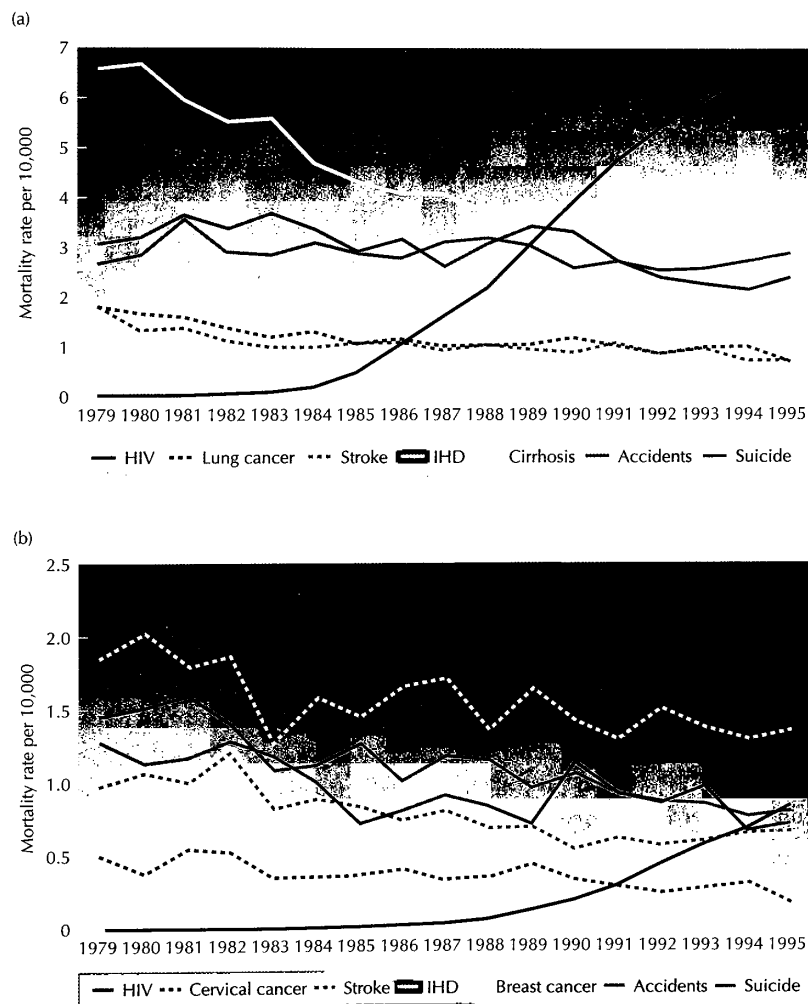
IHD = ischaemic heart disease
Source: Hickman *et al.* (1997)

Clearly, HIV is a major public health problem in London, especially in Inner London, making public health priorities in the capital different from those for the rest of England and Wales.

Projections

The estimates of HIV prevalence and HIV-related mortality presented here were derived from models that did not include a 'treatment effect' (De Angelis *et al.*, 1998). The advent of combination therapy has changed the basis for these estimates: AIDS reports and HIV-related deaths have recently fallen by a third (Public Health Laboratory Service, 1997b). Although the estimates of mortality and prevalence up to 1995/96 here will not be unduly affected, projections of AIDS cases and deaths are now difficult to make with precision.

Treatment has two potential effects (assuming that the number of new infections remains at the current, relatively low, levels). First, progression to AIDS is slowed, so more people are being treated for severe HIV infection. Secondly, survival is prolonged, leading to a greater number of live AIDS cases. Both these effects will increase the financial pressure on the treatment and care budget, already stretched by the increased cost of combination therapy for current patients.

Planning HIV and sexual health services for London

HIV care is an area in which pan-London collaboration is well established, for both commissioners and providers of services. Health services for people with HIV are 'open access' (i.e. open to anyone, regardless of where they live) and, until 1 April 1998, were purchased by health authorities based on the number of people treated in their area. Consequently, there are large flows of people being treated for HIV across administrative boundaries. It is important, therefore, to develop a collaborative approach that considers long-term strategic issues as well as managing effectively the short-term needs of people using the services.

The last two years or so have seen enormous changes in HIV care in London, presenting a number of challenges to those who commission, provide or use HIV services in the capital. These include:

- Managing the introduction of combination therapy into clinical practice, which, as well as creating cost pressures for London health authorities, has changed patterns of service use and placed a new emphasis on patient compliance.

- Maintaining continued investment in effective, targeted prevention interventions with the groups who are most at risk (including homosexual men, people from African communities and injecting drug users).

- Increasing the identification of HIV-positive women through antenatal testing programmes in all London hospitals, in order to reduce mother-to-child transmission by offering treatment before and during birth.

- Ensuring that services are appropriate to the needs of women and families, particularly those from African communities.

- Reviewing the make-up of HIV services in London by making explicit the respective roles that can be played most appropriately by specialist centres, local services, primary care and the voluntary sector.

- Managing the shift in resource allocation from host purchasing to residence-based funding (i.e. in which health authorities receive an allocation for the number of residents with HIV infection, rather than for the number treated in their area). This was partially introduced on 1 April 1998 and will bring the funding of HIV services more closely in line with that of other NHS services.

All of these issues were highlighted by the 'Developing the Agenda' project, which aimed to bring together stake-holder groups in the HIV field from across London to develop a shared understanding of the key issues and dilemmas, and to establish a framework for exploring and resolving them. The project emphasised the need for a collective, multi-agency strategic process to manage change (Luger & Carrier, 1997). A number of initiatives emerged from the project, including a review of the organisation of acute HIV care in London, a project to develop standards for HIV care and a more strategic pan-London approach to the commissioning and provision of HIV prevention work.

These are pan-London issues. Although commissioners of HIV services have worked together successfully across London, public health surveillance – which should provide the key evidence base for decision making – has lagged behind. One of the aims of the Unlinked Anonymous Surveys programme is to monitor the prevalence of HIV in London, but it

does not routinely separate or distinguish between Inner London, Outer London and the rest of south-east England, which have very different levels of HIV infection (Hickman et al., 1997).

Counts of the number of AIDS cases or diagnosed HIV infections can be provided by the health authority of residence. These reveal differences in the burden experienced by health authorities in Inner and Outer London, reflecting variation in the composition of populations (e.g. in terms of the numbers of homosexual men, black Africans and

injecting drug users). However, estimates of the prevalence and incidence of HIV infection, the monitoring of the impact of HIV on mortality, surveys of sexual and drug-taking behaviours, and forecasts of future caseloads require larger populations. These can be derived for London and, crucially, for both Inner and Outer London. Furthermore, to change the way public health surveillance data are presented – to truly match the evidence base with policy – requires a greater amount of decision making and public health action on a pan-London basis.

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Chapter 6

Contraception and abortion

Mark Newman, Martin Bardsley & David Morgan

Summary points

- Conception rates in London are higher than nationally. Inner east and south-east London in particular have rates that are among the highest in the country. There are wide variations in teenage conception rates across London, the highest rates again occurring in the most deprived areas.

- Abortion rates are markedly higher in London than elsewhere in the UK, including other urban areas. In 1995, 31 per cent of all pregnancies to women living in London ended in an abortion, compared with 20 per cent in England and Wales.

- It is estimated that 48 per cent of women between the ages of 16 and 49 in Greater London are using at least one method of non-surgical contraception, and that about 36 per cent of those in London obtain contraception services from their GP or a family planning clinic or both. NHS contraception service coverage varies greatly across London, from below 30 per cent in some boroughs to more than 50 per cent in others.

- There is no apparent complementary relation between levels of contraception service coverage from GPs and from family planning clinics –

  areas with high GP coverage do not necessarily have low family planning clinic activity, and vice versa.

- Strategic frameworks for commissioning contraception and abortion services in London, services for specific client groups (e.g. minority ethnic groups, men) and the availability of some methods of contraception (e.g. hormonal intra-uterine systems, implants, emergency contraception) are greatly variable across the capital.

Implications for improvements in public health

In view of London's distinctive position in terms of sexual health behaviour and indicators of sexual health need, a pan-London approach to monitoring outcomes and auditing services is needed. This should complement local work. Key areas for analysis could include:

- A further audit of London's contraception and abortion services, using national criteria, undertaken in 2000 to assess progress since The Health of Londoners Project study in 1996.
- An audit of the coverage and quality of sex education in London's schools.

Proposals to widen access to contraception services, including provision by nurse practitioners and pharmacists, should be actively encouraged.

A joint pan-London approach to general public education and information about sexual health and access to effective contraception should be actively considered by London's health and local authorities and contraception agencies. Key areas for such work include:

– emergency contraception;
– ethnic minority groups.

Targets should be set to reduce inequity in access to free contraception and abortion services across London. In particular:

– a minimum of 70 per cent of contraception

services for Londoners should be provided by the NHS by 2010.
– 90 per cent of abortions for Londoners should be funded by the NHS by 2005.

O Greater co-operation in community contraception services for young people across health authority boundaries in London should be considered.

O Primary care in London needs to give priority to further training and education for GPs and community services in contraception provision for young people.

O London's commissioners of contraception services should review the local provision of contraception services from GPs and community clinics, with the aim of their greater integration.

Introduction

This chapter looks at the need for, and the level and quality of, contraception and abortion services across the capital. It is estimated that 870,000 women in London are using some form of contraception (Newman et al., 1997). Every working day, GPs and family planning clinics in London provide about 4,000 women with advice about contraception. Every day some 400 women resident in London will conceive. In some parts of London, 50 per cent of these conceptions will be unintended and will end in abortion. Every day, about 330 women resident in London obtain post-coital emergency contraception (the 'morning-after pill') and about 170 have an abortion.

The prevention of unintended pregnancy and the ability to terminate an unwanted pregnancy are issues that affect most people in London directly or indirectly at some time in their lives. Meeting these needs involves the NHS as well as the education, voluntary and local authority sectors. In addition to

the importance of high quality local service provision, a pan-London perspective is also required because:

• many women may choose to access services in areas where they are not resident, particularly some specialist services for young people;

• some of the patterns of need for contraception are common across broad areas within the city;

• some of the initiatives to prevent unwanted pregnancy (e.g. health promotion work) may be more appropriate for a wider area than a single authority.

The public health rationale for the provision of contraception and abortion services is well recognised. Appropriate, skilled, effective contraception services can help individuals make a personal risk–benefit analysis, choose from the available methods and become motivated to use them (Health Education Authority, 1994).

Although the effectiveness of any particular method of contraception is difficult to determine accurately, there is good evidence of the cost effectiveness of the public provision of contraception and abortion services (Lee & Stewart, 1994; Trussell et al., 1995; Hughes & McGuire, 1996; NHS Centre for Reviews and Dissemination, 1997).

The need for contraception is basically determined by three factors: sexual activity, knowledge of fertility and a desire not to become pregnant. These in turn are affected by factors such as culture, age, parity, employment status and marital status (Guilleband, 1989; Tameside Family Health Services Authority et al., 1992). Translation of need into use is determined by a range of factors (see Box 6.1).

Box 6.1 FACTORS AFFECTING THE NEED FOR CONTRACEPTION SERVICES

- Patterns of sexual activity.

- Social and cultural differences in views on contraception and desired family size.

- The proportion of residents who have been sterilised.

- Ethnicity.

- Religious beliefs.

- Levels of affluence (which can affect people's attitude to having children).

- Education.

- The number of people working in the borough.

- The size of non-resident populations (e.g. numbers of temporary residents and students).

Conception rates

There are wide variations in teenage conception rates across London, the highest occurring in the most deprived areas (see Table 6.1). Inner city areas such as East London and Lambeth, Southwark & Lewisham experience conception rates in girls under 16 that are three to four times higher than those in the outermost parts of London such as Bromley and Barnet. Nationally, conception rates at

Table 6.1 **Conceptions at ages under 16 in the London boroughs, 1993–95**

London borough	Number of conceptions at ages 11–15 during 1993–95	Rate per 1,000: average for 1993–95
City of London	1	12.8
Barking & Dagenham	72	8.9
Barnet	63	4.0
Bexley	64	5.6
Brent	111	8.5
Bromley	72	5.0
Camden	63	8.4
Croydon	162	9.5
Ealing	88	5.9
Enfield	89	6.6
Greenwich	136	11.5
Hackney	137	13.3
Hammersmith & Fulham	69	11.8
Haringey	119	11.9
Harrow	40	3.5
Havering	76	6.0
Hillingdon	91	7.4
Hounslow	84	7.8
Islington	82	10.6
Kensington & Chelsea	27	5.1
Kingston upon Thames	44	6.7
Lambeth	220	19.2
Lewisham	147	13.2
Merton	60	7.8
Newham	141	10.6
Redbridge	57	4.6
Richmond upon Thames	29	3.9
Southwark	166	15.9
Sutton	40	4.7
Tower Hamlets	72	7.1
Waltham Forest	98	9.2
Wandsworth	124	12.9
City of Westminster	30	4.6
Inner London	1,398	11.7
Outer London	1,476	6.7
Greater London	2,874	8.5
England & Wales	23,031	8.3

Source: Office for National Statistics (1997a)

ages under 16 fell by 14 per cent from 1989–91 to 1993–95 (significant at the 5 per cent level). Health authorities in Outer London noted a similar fall, but the rest of London (Inner London and a group of 'mixed status' health authorities spanning the Inner/Outer London divide) have seen little significant change.

Table 6.2 **Conception rates (1995), abortion rates (1996) and percentage of conceptions ending in abortion (1995) in the London health authorities**

Health authority	All age conception rate, 1995	All age abortion rate, 1996	Conceptions ending in abortion, 1995
Barking & Havering	79.2	14.6	21.4%
Barnet	81.2	18.7	27.4%
Bexley & Greenwich	79.7	15.5	20.7%
Brent & Harrow	96.2	26.5	33.2%
Bromley	75.1	13.4	18.7%
Camden & Islington	92.2	32.2	40.4%
Croydon	81.6	19.7	26.4%
Ealing, Hammersmith & Hounslow	89.5	21.8	30.4%
East London & The City	118.1	28.9	28.9%
Enfield & Haringey	99.4	24.8	32.3%
Hillingdon	79.0	15.4	21.8%
Kensington, Chelsea & Westminster	82.6	30.2	43.2%
Kingston & Richmond	71.7	13.6	21.6%
Lambeth, Southwark & Lewisham	102.9	33.3	36.3%
Merton, Sutton & Wandsworth	81.0	19.0	25.8%
Redbridge & Waltham Forest	89.4	20.5	26.4%
Inner London deprived	101.6	31.3	36.3%
Mixed status	90.3	22.2	29.9%
High status	78.4	15.9	23.1%
Greater London	90.1	23.0	31.2%
England & Wales	73.7	12.1	19.7%

Source: Office for National Statistics (1997a, 1997b)

The wide differences within London are not unduly surprising given the evidence that teenage mothers are more likely to come from lower socio-economic groups (Department of Health, 1993) and live in underprivileged areas (Garlick *et al.*, 1993). It is important that health and local authority planners are mindful of the potential for such differences even within comparatively small areas.

Conception rates for all ages are higher in London than nationally. Lambeth, Southwark & Lewisham and East London & The City have rates that are higher than the rest of the capital. Comparison with rates in other cities in England suggests that Greater London has higher conception rates in older age groups.

Abortion rates

Issues relating to abortion often loom large in debates on contraception. However, they are a

highly unreliable indicator of the effectiveness of contraception services. Abortion rates in any one area will be the product of a number of factors (see Box 6.2). Despite these shortcomings, the Department of Health (1993) concluded that there was some value in considering information about abortion rates when looking at the overall objective of reducing unwanted births.

Abortion rates are markedly higher in London than elsewhere in the UK, including other urban areas –

Box 6.2 Factors affecting local abortion rates

- The effective use of contraception services in relation to patterns of sexual activity.

- Accessibility of abortion services.

- Differences in knowledge and attitudes towards abortion.

equivalent to twice the national rate. If all the health authorities in England are ranked by abortion rate in 1996, the highest 11 are in London and 15 of London's 16 health authorities are in the top 25. Even when rates in London are standardised to account for the capital's younger population, aggregate rates in Greater London are about 2.4 times higher than for England and Wales. In 1995, 31 per cent of all pregnancies to women living in London ended in an abortion. This is higher than any other urban area in the country and compares with just under 20 per cent in England and Wales in the same year (see Table 6.2).

Some of the excess is probably related to selective migration of people at higher risk of unintended pregnancy and of those more likely to have an abortion. Although data should be strictly resident-based, it may be that some of the recorded cases are people treated in London who are, in fact, temporary residents who have come from Ireland or areas elsewhere in the UK where it is more difficult to obtain a legal or NHS abortion.

Do NHS contraception and abortion services meet Londoners' needs?

Contraception services in London are provided by 1,800 GP practices, 300 family planning clinics run by NHS trusts and a number of independent clinics. Additional services are provided by health promotion departments, schools, voluntary agencies and social services. The provision of non-prescription methods of contraception (mostly condoms) also continues to be an important source.

The balance between family planning clinic and GP provision has changed over the past 20 years, as the total number of women using family planning clinics has declined, but there has been a marked growth in use among younger people. Funding levels for providers have been reduced and as a result the number of sites and number of clinics provided have fallen. Despite these apparent reductions in provision, activity figures for family planning clinics

seem to have increased slightly since 1991. GPs tend to see older clients and women using the pill as their main method (Ashton et al., 1992). Family planning clinics see a higher proportion of younger women.

The General Household Survey (Office of Population Censuses and Surveys, 1995) suggests that about 48 per cent of women aged 16–49 will be using at least one non-surgical method of contraception. Around 36 per cent of London's women in this age group will be attending their GP or a family planning clinic, or both, for contraception. The other 12 per cent represent the proportion buying over-the-counter methods of contraception from pharmacies, etc., and therefore not appearing in the activity figures. In some areas, the estimate of combined GP and family planning clinic coverage falls below the expected 48 per cent, sometimes as low as 30 per cent. In these areas, it is likely that there is low use of contraception services and greater use of less reliable over-the-counter methods.

Figure 6.1 shows that the pattern of contraception service coverage in the NHS varies greatly in relation to need. In some areas with very high need, such as Hackney and Newham, there is poor coverage; but some parts of London, for example Camden and Southwark, meet such high levels of need more effectively.

The alleged duplication of provision by family planning clinics and GPs has often been used as a justification for reductions in family planning clinic services. However, the evidence suggests that GPs and family planning clinics provide services to women at different stages of their reproductive careers and with different contraceptive requirements. Comparing across boroughs, there is no apparent complementary relation between levels of coverage by GPs and by family planning clinics. Areas with high GP coverage do not necessarily have low family planning clinic activity, and vice versa. The implication is that these two elements of

Fig. 6.1 **Percentage of women aged 16–49 attending family planning clinics or seeing their GP for contraception services, by London borough in 1995/96**

Source: Newman et al. (1997)

provision are not interchangeable, and a reduction in one will not result in a positive response from the other.

London has long been a centre for the development of innovative and responsive contraception and abortion services. However, recent research by The Health of Londoners Project, including surveys of all health authorities and NHS trusts in London, highlighted a number of issues that need to be addressed in both the purchasing and the provision of these services for Londoners (Newman et al., 1997). They are outlined below.

Access to NHS abortions

Access to a free NHS abortion varies across London (see Fig. 6.2). In 1996, 34 per cent of all abortions were paid for by the NHS in Redbridge & Waltham Forest compared to more than 70 per cent in East

London & The City and Croydon. This difference is further illustrated by the fact that in some areas of London there are comparatively high levels of late abortions, suggesting delays in access to the service – in 1996, 54 per cent of all abortions to women resident in London were performed after 9 weeks and 11 per cent after 12 weeks. It is also clear that, even where the percentage of abortions funded by the NHS is high, the rate of abortions per 1,000 women that the NHS does not fund can also be high.

Commissioning contraception and abortion services

Most health authorities in London had underdeveloped their roles as commissioners of quality contraception and abortion services on the basis of local need. Few (5 of 16) had developed a strategic framework for commissioning these

Fig. 6.2 **Percentage of abortions paid for by the NHS, by London health authority, in 1996**
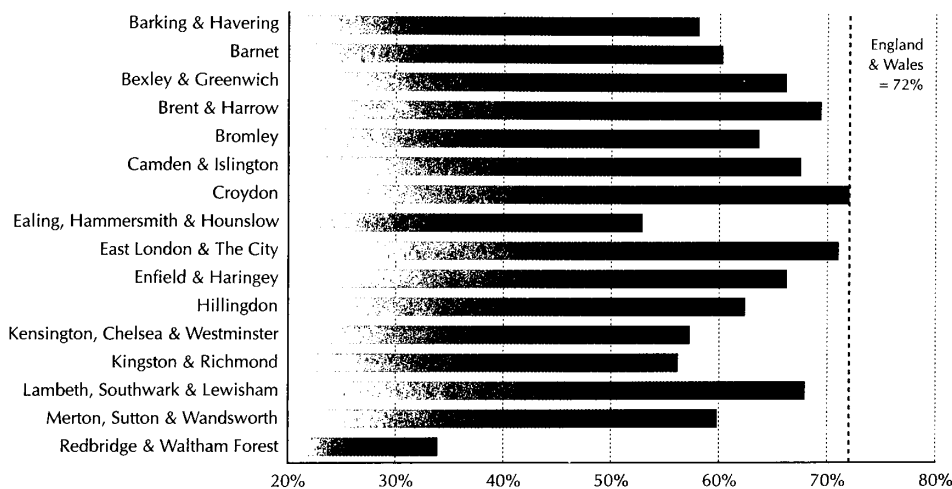
Source: Office for National Statistics (1997b)

services, and few had co-ordinating mechanisms or well-developed arrangements for joint planning. Most had service specifications for abortion services, but fewer had similar specifications for contraception services, even for young people's services. However, even where specifications were in place, monitoring arrangements sometimes seemed haphazard or absent.

Accessibility of NHS contraception services

The vast majority of general practices in London offered contraception advice and, although limited by the opening hours of surgeries, were distributed widely and evenly across the capital. The network of family planning clinics across London showed greater variability. There were clear differences between providers in the choice of either concentrating activity on a few sites or dispersing activity to a range of smaller clinics. In terms of clinic hours per 1,000 women aged 16–49, London's family planning clinics averaged 0.9 per week (ranging from 0.3 to 2.5 at borough level). Of these, about 46 per cent were on Saturdays or after 5:00 p.m. on weekdays.

NHS trust provision of family planning clinics and analysis of GP claims for contraception provision suggested unequal access to contraception services generally, particularly for certain sub-groups of the population. Accessibility to contraception services seemed likely to be especially difficult for minority ethnic groups and for men. Only one health authority had a formal strategy relating to contraception services for such groups. Although most family planning clinic providers take some steps specifically for minority ethnic groups, in general the capacity to deal with non-English speakers seemed limited. The level of use of family planning clinics by men was very low; most clinic contacts with men were as part of a couple where the woman was registered as the contact. GPs did not seem to offer contraception services to men. Relatively few general practices in London had free condom schemes.

Access to a full range of methods of contraception

Most effective methods of contraception were widely available in London. However, variations in the use of some methods indicated limited access.

For example:

- There was an almost fourfold difference across the London boroughs in the rate of intra-uterine contraceptive device insertion by both GPs (from 24 to 97 per 10,000 women aged 16–44) and family planning clinics (from 34 to 133 per 10,000 women aged 16–44).

- Hormonal intra-uterine contraceptive devices were available in only a limited number of trusts and, within these trusts, at a limited number of sites.

- Hormonal contraceptive implants were available at only a few sites, and not available at all in 11 trusts.

- Estimates of the numbers of sterilisations in London were far lower than if national rates (as in the General Household Survey) are applied. The limited information available suggested that activity in London was about half of that needed to maintain a 'steady state'.

Conclusions and implications for health policy

Sexual health is one of the areas where there has been a failure to achieve the national Health of the Nation targets (Adler, 1997). London is no exception to this trend and, to the extent that conception and abortion rates are useful indicators, things seem to be moving in the wrong direction in many areas. The Green Paper *Our Healthier Nation* (Department of Health, 1998), which sets out proposals for a new national health strategy, does not propose any specific targets for a reduction in unintended pregnancy. However, there is scope for their inclusion in local strategies and the separate national HIV strategy yet to be announced.

London's diverse, highly mobile and, in many areas, socio-economically deprived and multi-cultural population presents a particularly tough challenge to all who are interested in promoting sexual health and preventing unintended conception. Effective responses will require action on a number of levels, taking account of local needs within a framework of local Health Improvement Programmes but also linking to pan-London factors.

Such moves require fresh attempts at co-operation, effective sharing of information and a willingness to learn on the part of all providers (including GPs – who sometimes seem to forget that they are significant providers), health and local authorities. This approach must go beyond the traditional parochial concerns of individual providers, boroughs and health authorities with 'their own' residents. In some areas there needs to be more co-ordination and planning of services across local boundaries. Recent government announcements on Health Action Zones, the Department of Health task force on teenage pregnancy, the appointment of a Minister for Public Health and ideas being mooted for the remit of the planned Greater London Authority are all steps in the right direction.

There are, however, further issues for policy makers. First is the question of sex education and sexual health promotion: there are strong arguments for sexual health to be developed as a national curriculum subject. A second issue is that of who pays. It is important to reinforce the principle that access to effective methods of contraception and to an NHS abortion should not be dependent on ability to pay or where people live in London. There is of course a consequent obligation on the government to make sufficient funds available for the NHS to provide high quality services to meet need, and to put in place policy and financial arrangements that protect confidential provision for all rather than for residents only.

Finally, it is important that policy makers recognise that effective sex education and contraception services are inextricably linked to other aspects of sexual health, especially HIV/AIDS. A strategic approach to policy, planning and funding arrangements should take this into account.

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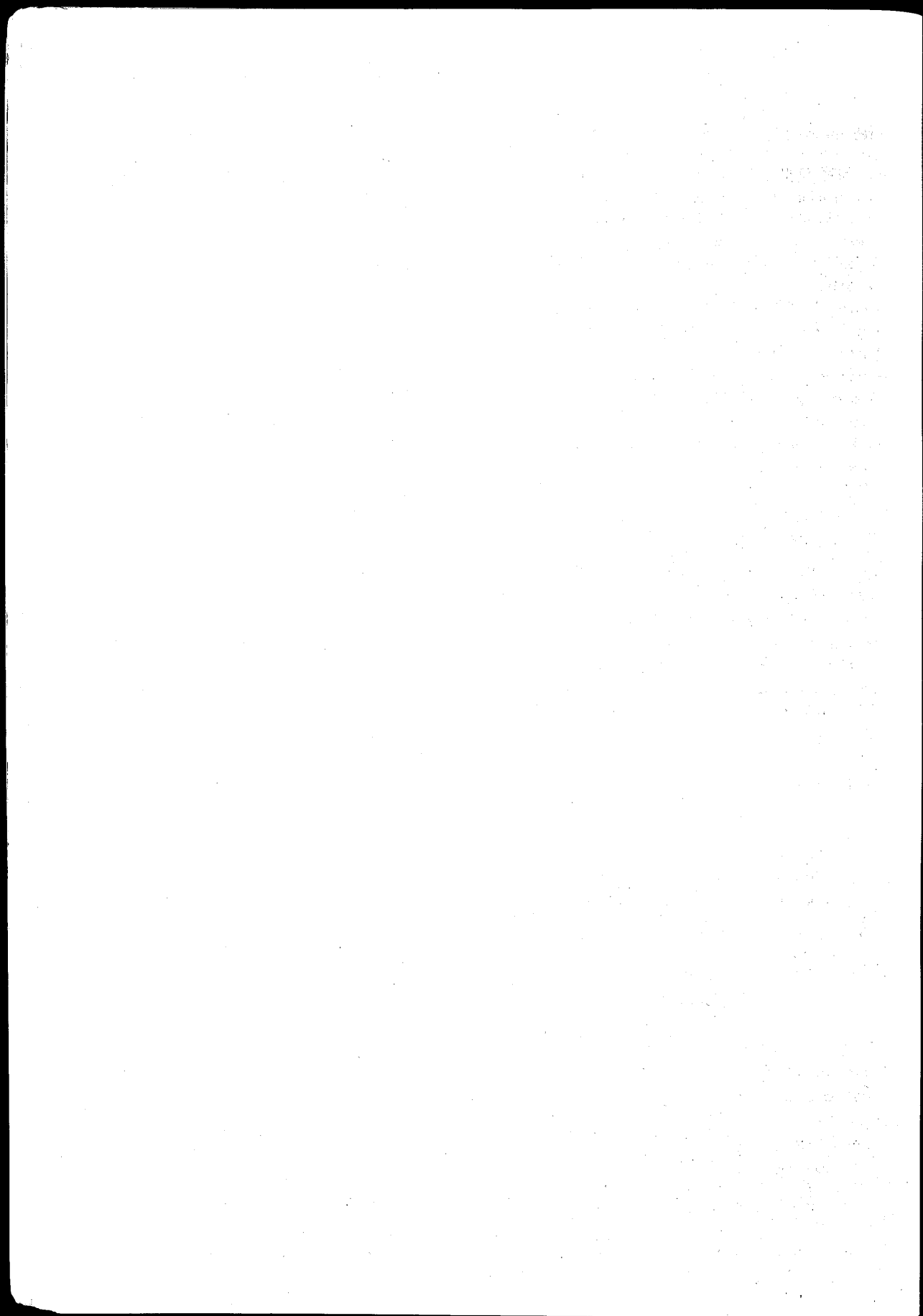
Chapter 7

Drug use

Gerry V. Stimson, Ali Judd & Chris Fitch

Summary points

Drug use among young people (ages 16–29) is common: 30–40 per cent have taken drugs in the past year and 20–25 per cent in the past month.

Drug misuse is a major problem for London, especially Inner London. One estimate suggests that 4.7 per cent of men aged 16–59 have injected drugs at some time, a value that is higher than other regions in the UK. In London there were 8,985 notifications to the Home Office Addicts Index in 1996, 21 per cent of the total for the UK.

The information available on drug-related harm at a London level is limited and tends to be biased towards the more serious kinds of drug use such as injecting and opiate use. London has higher rates of HIV and hepatitis C among injecting drug users than the rest of England and Wales.

Public health measures such as the distribution of sterile needles and the availability of methadone treatment are felt to be successful in minimising levels of risk behaviour.

Although HIV prevalence among injecting drug users in London is low by international standards, it is still high compared to the rest of England and Wales, and Inner London contains about 46 per cent of all cases of injecting-related HIV.

Problem drug use is generally higher in the most deprived areas of the capital.

There are many groups in London trying to tackle drug-related problems. It has been estimated that there are 150 specialist agencies in the London area offering a range of interventions at a variety of sites. There are also a number of pan-London co-ordinating groups.

Implications for improvements in public health

There must be better pan-London co-ordination and planning across areas and agencies involved in reducing harm from problematic drug use.

London needs an effective public health drugs surveillance system that includes information on drug users in contact with services and indicators of drug-related harm, and provides an early warning system for new drug problems. Existing local monitoring systems could be modified and brought together to facilitate this.

P Drugs services in London need a stable funding base if they are to work effectively. They will then be established elements within local Health Improvement Programmes and strategies for tackling drug-related problems.

Introduction

This chapter focuses on drug use in the capital. On many counts, London has higher levels of drug use and drug problems than the rest of England and Wales. Reducing the harm from problem drug use in London, both to individuals (e.g. through sharing needles and dirty injecting paraphernalia) and to the community (e.g. through drug-related crime and violence), is a complex issue owing to the multiplicity of organisations that are involved and the difficulties in developing a pan-London public health strategy and response.

Prevalence of drug use

Many people in all age groups in the UK have tried illegal drugs, and London is no exception. Some 50–60 per cent of young adults in London have taken drugs at some time in their lives (Fig. 7.1) (HEA/BMRB International, 1996; Percy, 1997,

personal communication). Indeed, it is now more common for young people to have taken drugs than to not have taken them. About 30–40 per cent of young adults have taken drugs in the last year, and 20–25 per cent have taken drugs in the last month. Males of all ages are more likely to take drugs than females, both in London and elsewhere.

Cannabis is the most commonly used drug, half of 16- to 24-year-olds in London having smoked it at some time in their lives, decreasing to a quarter in the last month. Generally, more young people in London report ever having used cannabis than their counterparts in the UK as a whole and in other European countries (European Monitoring Centre for Drugs and Drug Addiction, 1997). The use of more dangerous illegal drugs is much rarer: around 1 per cent of young people, and fewer older people, report ever having used heroin, methadone and crack, whereas even fewer people report the use of these drugs on a 'last month' basis.

Fig. 7.1 **Adults reporting they had ever used illicit drugs, solvents and steroids, by age and location (1994 and 1995)**
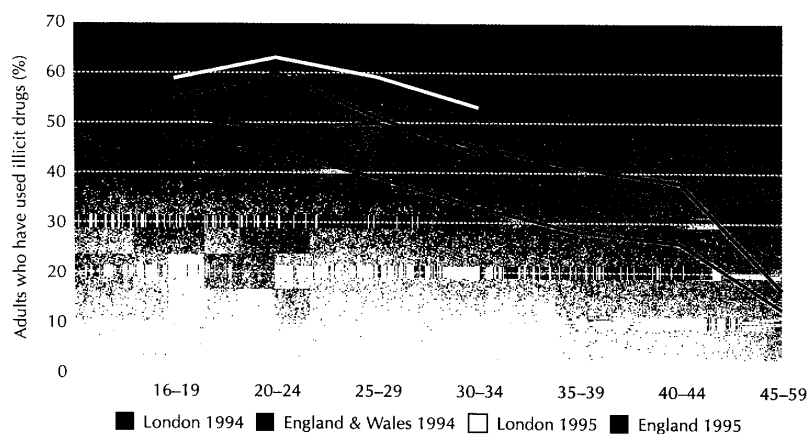
Sources: HEA/BMRB International (1996); Percy A (1997, personal communication)

As they get older, 11- to 16-year-olds are at a steadily increasing risk of being offered and having used drugs. They are most likely to have been offered or used cannabis, followed by amphetamines and LSD (Balding & Regis, 1996, personal communication; Congdon, 1996, personal communication). Some 3 per cent of 15- and 16-year-olds in London report having used glues and solvents. Two-thirds of 15-year-olds in London know a drug user.

With regard to injecting drug use, some 4.7 per cent of men aged between 16 and 59 years in Inner London report that they have injected drugs at some time. In no other area is the prevalence higher than 1.7 per cent, and for England and Wales as a whole (including London) it is 0.8 per cent (Wadsworth et al., 1996). The pattern is similar for women, although the proportion having injected is lower, at 1.2 per cent for Inner London and 0.4 per cent for England and Wales as a whole.

Adverse health consequences

Although drug use among Londoners is clearly widespread, most drug users probably do not experience problems related to it (though whether the current high levels of recreational drug use will be followed by higher levels of problem drug use in years to come is unknown). What is at issue is the extent of actual or potential health risks.

An overview of public health problems arising from drug use in London is necessarily partial, owing to the paucity and selectivity of the data. There are better data on the consequences of more serious kinds of drug use, such as injecting and the use of opiates, than on the consequences of more common forms. Thus, there are relatively good data on injecting risk behaviour and its consequences for HIV and AIDS, hepatitis B and hepatitis C. Data on the numbers of drug-related deaths and the mortality of drug users are inadequate. There are hardly any data on 'morbidity' associated with different kinds of drug use, i.e. the physical and mental health consequences over time. Some adverse

health consequences seem to have been averted so far by using public health approaches (as discussed below).

Injecting risk behaviour

Some evidence suggests that injecting drug users have made important changes in their injecting behaviour in response to the threat of HIV and AIDS. These changes have included reduction in the overall proportion sharing needles and syringes and in the frequency of sharing, and increased discrimination regarding sharing partners (Stimson & Hunter, 1996). This may not all be good news. Studies also indicate high levels of indirect sharing, i.e. of different items of equipment used in drug preparation and injection (Hunter et al., 1995), and some earlier studies may have under-estimated sharing levels.

Such reductions in risk behaviour have been attributed to the relatively swift introduction of public health initiatives, such as the distribution of sterile needles and syringes, media campaigns and increased availability of oral methadone treatment. The British response to HIV among injectors has been hailed as a 'public health success' (Stimson, 1995; 1996).

Number of reported HIV infections and cases of AIDS associated with injecting drug use

By international standards, the prevalence of HIV infection and AIDS among London injectors is low. However, in England and Wales as a whole, the HIV and AIDS epidemic among injecting drug users is concentrated in the Inner London health authorities.

Around 1,120 injecting-related HIV infections have been estimated for Inner London in 1996, accounting for 46 per cent of the total for England and Wales. Hickman and colleagues (1997a) have estimated that about 100 new HIV-1 infections occur each year from drug injecting in Inner London (about 2 a week), with a further 20 or so in England and Wales (see Chapter 5).

Taking the results of different studies, it is reasonable to assume that the proportion of current injectors with HIV infection in London is between 5 and 7 per cent, and probably much lower in more recent injectors. This is higher than the rest of England and Wales (which is less than 1 per cent), but low in international terms (Stimson *et al.*, 1996). In the UK, only Edinburgh and Dundee have been higher (Bath *et al.*, 1993).

The total number of people with injecting-related AIDS (including those who have died) to the end of June 1997 in the Thames regions is 355, which accounts for 64 per cent of cases in England and Wales, and 40 per cent of UK cases (Public Health Laboratory Service AIDS Centre, 1997).
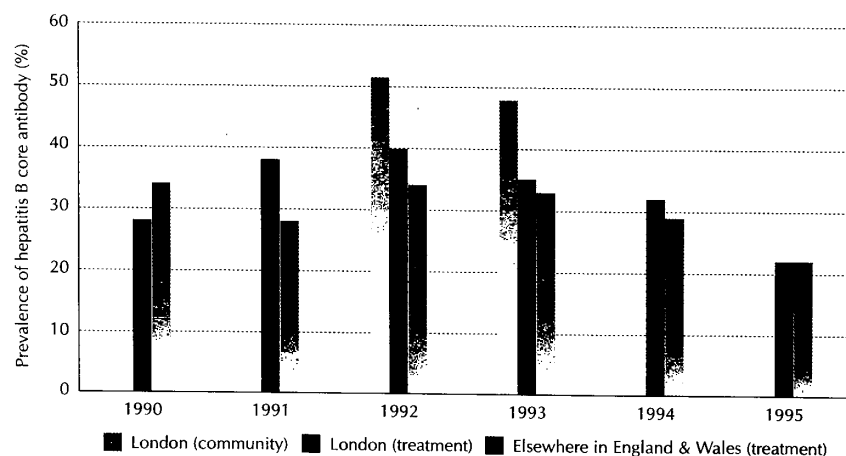
Hepatitis B and C

Between a third and a half of London's injecting drug users have been exposed to hepatitis B (Hart *et al.*, 1991; Rhodes *et al.*, 1996; Unlinked Anonymous Prevalence Monitoring Programme, 1997, reported in Stimson & Hunter, 1998). The prevalence of hepatitis B core antibody is generally higher among London's injecting drug

users than among their counterparts in other parts of England and Wales (Fig. 7.2). Furthermore, higher prevalence of hepatitis B core antibody has been found among injecting drug users recruited from community, rather than treatment, settings. Most acute hepatitis B infections are not clinically recognised, only 30–50 per cent of adults experiencing jaundice (Benenson, 1995). About 90 per cent of infected adults make a complete recovery. Around 10 per cent go on to develop chronic hepatitis B infection, of whom an estimated 10–25 percent will die prematurely from cirrhosis or hepatocellular carcinoma (Sherlock, 1990).

Results from the Unlinked Anonymous Prevalence Monitoring Programme (UAPMP) suggest that, among injecting drug users recruited at treatment settings, hepatitis B core antibody prevalence for all male injecting drug users peaked in 1992 and has since fallen, whereas the prevalence for female injecting drug users fell consistently from 1990 to 1995 (UAPMP, reported in Stimson & Hunter, 1998). It is unclear why this should be the case. The prevalence of hepatitis B core antibody is generally much higher among people who started

Fig. 7.2 Prevalence of hepatitis B core antibody among injecting drug users by location, 1990–95

Sources: Rhodes *et al.* (1996); Unlinked Anonymous Prevalence Monitoring Programme, reported in Stimson & Hunter (1998)

injecting prior to 1986. The lower rate of hepatitis B core antibody for those who started injecting from 1986 onwards supports the evidence for a decrease in injecting risk behaviour.

Both in London and in the UK, hepatitis C prevalence rates among injecting drug users are extremely high: 71 per cent and 60 per cent respectively in 1994 (Waller & Holmes, 1996). The high rates for hepatitis C, compared with the low rates for HIV and the generally declining rates for hepatitis B, need further investigation. They are likely to be linked to a variety of factors, including: the possibility that high levels of hepatitis C virus infection were already present among injecting drug users by the time harm-reduction measures were introduced among them; infectiousness; and viral transmissibility. Evidence suggests that parenteral infection is the most efficient mode of transmission of hepatitis C. Epidemiological studies indicate similarly substantial prevalence of hepatitis C in continental Europe, high rates of persistence of infection and high levels of morbidity in infected individuals. These findings support the view that hepatitis C represents a major clinical and public health challenge in Europe.

Drug-related deaths, and mortality of drug users

Drug-related deaths are currently a poor indicator of harms associated with drug use, because denominator populations (the total number of drug users) are unknown and there is likely to be considerable variation in the assignment of cause of death.

Every year there are about 350 deaths in London related to drug use (attributed to drug dependence; to non-dependent abuse of drugs; or from poisoning in which a drug was mentioned, including suicide by poisoning, accident or homicide), around 20 per cent of the total for England and Wales (Office for National Statistics, 1997, personal communication). The problem with interpreting such data is that

they cover all drugs (illicit, prescribed and over-the-counter medicines). Ecstasy deaths hit the headlines but account for only a small proportion of the total number of deaths, although official figures are currently unavailable. London generally has a higher number of drug-related deaths than other parts of Europe for which details are available by city: for example, 210 in Athens, 150 in Hamburg and 80 in Copenhagen in 1996 (Pompidou Group, 1997).

Co-morbidity ('dual diagnosis')

It is difficult to comment with any certainty about co-morbidity of mental illness and substance misuse. Much of the available literature on dual diagnosis originates from the USA and it is unclear how relevant it is to the UK. On current evidence, it is impossible to assess whether co-morbidity in London is similar to or different from the rest of England and Wales. A measurement of co-morbidity is a clear priority, as is an assessment of pathways to care, management strategies and liaison between agencies (see also Chapter 10).

Drugs and deprivation

There are no obvious links between drug use *per se* and deprivation. However, there are strong links between *problem* drug use and deprivation, as suggested by differences between health authorities in the number of reports to the Regional Drug Misuse Databases (RDMDs) and the high proportion of unemployed drug users seeking treatment. There is a high correlation between health authority reports to the Regional Drug Misuse Databases and Jarman deprivation scores ($R=0.776$, $p<0.001$, $R^2=0.605$) (see Fig. 7.3) indicating a link – at an aggregate level – between drug users attending services and the level of social deprivation (Sondhi, 1998).

Regional Drug Misuse Database data currently reflect only areas where services are based. Recent changes to data collection procedures for the databases will make it possible to look at place of residence and deprivation.

Fig. 7.3 **Drug episodes reported by services to London Regional Drug Misuse Databases 1996/97 vs Jarman Underprivileged Area score, by London health authority**
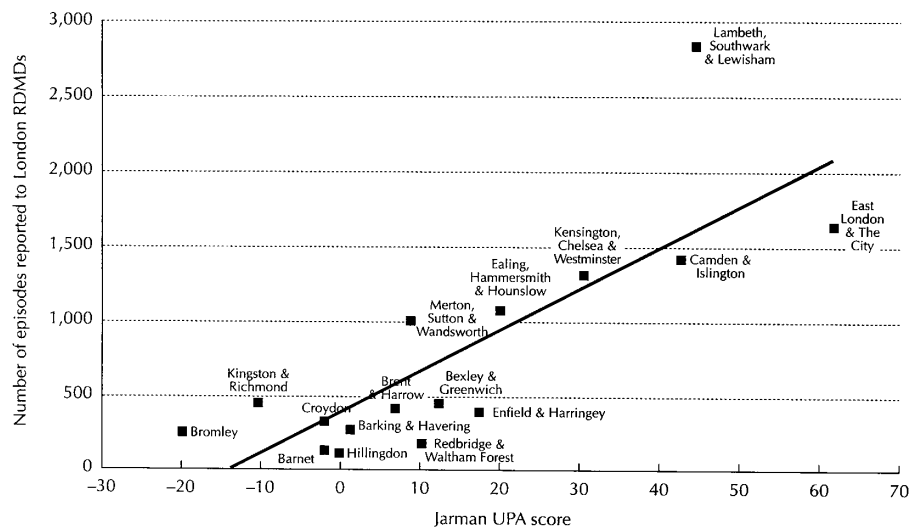
Source: Sondhi (1998)

Tackling problem drug use in London

London has a rich treasury of initiatives, projects and agencies working to reduce the harm caused by illegal drugs. However, in the absence of any London-wide co-ordination, the risks of duplication, competition, gaps in service and inefficiencies are great. Even describing the number of interventions and projects related to drug misuse in London should be easy: that it is not easy is in part because there is no single London-wide body that knows, or has responsibility for knowing, what is going on.

For example, estimating or categorising the number of drug services on offer in London is problematic. Drug services are located in the NHS, social services, the voluntary/independent sector, the courts and probation services, many community-based settings and the private sector. There is a diversity of funding base, service location and type of service delivery, many organisations providing a wide range of services for drug users and training for other health professionals from one site (Dale-Perera, 1998).

Similarly, an unknown number of organisations provide education and prevention initiatives to schools, youth clubs and other community groups, including the police, the drugs services themselves, the Drugs Prevention Initiative, youth projects and Theatre in Education.

The Standing Conference on Drug Abuse (SCODA) estimates that there are about 150 distinct services in the London area, many of which offer a range of interventions at a variety of sites. These include: over 65 community-based services (community drug teams and community-based 'street' agencies); 13 drug dependency units (some with in-patient units); 12 structured day programmes; 18 residential rehabilitation units; 53 needle-exchange schemes; 21 pharmacy needle-exchange schemes (with 229 outlets); and a number of specialist residential crisis intervention and respite care services.

More drug users present to services in London for treatment than in any other part of England and Wales. In 1996, London accounted for 8,985 of all

notifications to the Home Office Addicts Index, compared to a UK total of 43,372 (Home Office, 1997, personal communication). London has 21 per cent of addict notifications but only 12 per cent of the population.

For the six months to 31 March 1996, 5,867 individuals were reported to the Regional Drug Misuse Databases in London. This amounts to a quarter of all reports in England and a fifth of all reports in the UK (Department of Health, 1997a). However, database reports under-estimate the numbers of drug users in contact with services, and it is believed that the number of individual drug users who attend services in London is around 16,000 annually (Hickman et al., 1997b).

Table 7.1 shows the number of episodes reported by services to the Regional Drug Misuse Databases, by London health authority, for the financial year 1996/97. The ethnic profile of users attending London drug services is broadly similar to the wider London population, around four-fifths defining themselves as 'white' (Sondhi, 1998).

Planning a response to drugs across London

As these data suggest, problem drug use is a considerable public health issue in London. The extent and nature of the problem have only been touched on here, and there are currently inherent difficulties in providing a co-ordinated, community-wide response to a problem of such magnitude in the absence of a single strategic authority.

In the last five years, a range of organisations and professionals working in specific areas of the drugs field have joined forces on a voluntary basis in an attempt to improve pan-London planning in response to certain problems (Morley, 1998). The London Drug Policy Forum was established in 1991, and aims to promote greater co-ordination of strategies to deal with drugs. The Greater London Drugs and Alcohol Purchasers' Group, set up in 1993, attempts to provide some London-wide

Table 7.1 **Episodes reported by services to Regional Drug Misuse Databases by London health authority, 1996/97**

Health authority	Episodes
Barking & Havering	272
Barnet	136
Bexley & Greenwich	448
Brent & Harrow	416
Bromley	262
Camden & Islington	1,415
Croydon	323
Ealing, Hammersmith & Hounslow	1,065
East London & The City	1,632
Enfield & Haringey	396
Hillingdon	117
Kensington, Chelsea & Westminster	1,304
Kingston & Richmond	455
Lambeth, Southwark & Lewisham	2,829
Merton, Sutton & Wandsworth	1,006
Redbridge and Waltham Forest	182
Greater London	12,258
Number of individuals	10,972

Note Regional Drug Misuse Databases collect data on any drug user who presents in person for treatment at a service. The treatment *episode* may be either the first time that an individual has attended treatment or where an individual re-contacts the same service after a break of at least six months. Therefore, an individual can have more than one episode of contact with treatment services. The databases also count the number of different individuals who present for treatment and help.
Source: Sondhi (1998)

consistency in the purchasing of services for drug and alcohol misusers and in the assessment of their needs. The pan-London Drug Providers' Consortium enables providers to communicate with and support each other. Drug Action Teams, which were established as a result of the last Government's drug strategy 'Tackling Drugs Together' (Home Office, 1995), are charged with co-ordinating drugs strategies at local level. Of the 106 Drug Action Teams in England, 27 – almost one-quarter – are in London. Indications are that Drug Action Teams are now bringing together the disparate priorities and interests of the local agencies involved, but there is no mechanism for co-ordinating and concentrating their efforts. Purchasing guidance issued by the Department of Health (1997b) and guidance for providers of drug services issued by

SCODA (1997) aim to increase the quality, the range and the cost-effectiveness of services for problem drug users.

London-wide planning has improved as a result of such purchaser and provider forums, but fails through lack of overall pan-London co-ordination. There are about 150 specialist drugs agencies, 33 local authorities, 16 health authorities, 63 Metropolitan Police service divisions, 27 Drug Action Teams, 5 area probation services and 2 prison service operational areas.

London lacks an effective public health drugs surveillance system. Like the rest of England and Wales, it has no information strategy to inform policy development. Reporting systems and population surveys exist, but they are not sufficiently co-ordinated or developed to provide comprehensive data on the extent and nature of problem drug use in the capital that would facilitate evidence-based policy making. For example, the number of problem drug users in contact with drug services is not currently measured by the Regional Drug Misuse Databases. Early warning systems that could measure new epidemics of drug use, and new problems, are not in place. There are no reliable measures of mortality among drug users, nor estimates of the adverse health consequences that could result from recreational or problem drug use.

Good data on the nature and extent of drug use encourage effective policy making and help to deal with unmet needs. Some drug users continue to be marginalised from drug services. Community care marginalises drug users who are leaving prison (those in prison for less than six months are not served), and drug-using parents seeking placements with their children. Co-ordination through improved agency communication and collaboration would be a step in the right direction. Regional Drug Misuse Database statistics indicate that a large proportion of people using the London drug services are opiate

users. Those with stimulant problems often cannot find an appropriate response to their situation, despite the emergence of interesting models of service provision. Furthermore, evidence for the effectiveness of specific treatment modalities for this group is very limited (Department of Health, 1996). People with dual diagnoses and the most complex care needs, including substance misuse, mental health and homelessness, are often unable or unwilling to engage with drug services because of unrealistic or restrictive criteria.

Although the range of drug services across London is impressive on paper, the reality of provision is a little different. Local cohesion and partnership between service providers have often been compromised by the competitive nature of the 'provider market'; this may be helped by the abolition of the internal market, announced in the recent NHS White Paper (Department of Health, 1997c). A number of small non-statutory sector drug services based in the community have not survived this market during the past two years. Strategic planning and funding of drug services is sometimes undermined by the need to bid for funds for short-term non-core services at the expense of developing long-term core services.

Conclusion

London lacks a public health vision and approach to drugs. Public health activity has been reduced to commissioning services for individuals, rather than thinking about the totality of drug problems, and developing community-wide approaches to health promotion, prevention and harm reduction.

Acknowledgements

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Chapter 8

Child health

Sally Hargreaves, Martin Bardsley, Maggie Barker,
David Morgan & Doreen Kenny

Summary points

▶ Factors such as poverty, deprivation and social exclusion are critical in shaping child health. Disadvantage in childhood often compounds problems in later life. Within the capital, 23 per cent of dependent children live with non-earning adults, 19 per cent in overcrowded accommodation and 24 per cent in lone-parent families. On all of these indicators of social exclusion, values for Greater London are higher than national averages.

Social disadvantage results in a wide range of health problems that become apparent in children, including infant and childhood mortality, patterns of health-damaging behaviour, injury and accidents, and mental health problems.

▶ The children of London come from ethnically and culturally diverse backgrounds with many different first languages spoken in some schools. Projections suggest that the number from black and minority ethnic backgrounds will have increased by more than 25 per cent between 1991 and 2011.

▶ Good inter-agency working is critical to child health and must encompass pre-school and day care, schools, family support mechanism and community development.

The urban environment does not have to be a problem for children. Large cities, and especially London, offer great advantages for the young. It is important that we develop the ways that the health of children can be considered in all policies relating to the urban environment, employment and education.

Implications for improvements in public health

A comprehensive strategy to improve child health must reduce child poverty. This requires action by central government. The commitment to a Government contribution to the new contract in *Our Healthier Nation* must be backed by explicit policies to reduce child poverty.

▶ Inter-agency working is essential, particularly in the development of comprehensive Children's Service Plans that include health, social services and education. Particular attention needs to be paid to work on pre-school and day care, healthy schools, family support and community development.

▶ There should be a pan-London commitment to reduce -child poverty, with a target set over 10 years to reduce by 15 per cent the number of children living in poverty. The impact of London's future Single Regeneration Budget

(SRB) programmes should be assessed for their impact on child poverty.

Primary services should target support towards vulnerable families and away from a focus on mechanistic developmental screening.

Inequities in primary care premises and staffing (including community staff) should be tackled to ensure that areas of greatest need have easy access to more services than other areas.

Initiatives that are not based on general practices and which increase access to services for homeless families should be encouraged.

Employment practices (especially in the NHS and local authorities) that promote a better balance between home and work responsibilities should be encouraged, enabling parents who want to work to do so without jeopardising their children's well-being.

Health Improvement Programmes offer new opportunities to assess the impact of urban planning on child health.

Introduction

This chapter is divided into three sections. The first section illustrates the determinants of ill health among the capital's children, the second highlights some of the manifestations of ill health among children and young people in London, and the third section identifies priorities for improving child health.

The health of our children is an important indicator and predictor of the health of our city. Socially, physically and psychologically, children are among the most vulnerable members of any community. Disadvantage in childhood compounds problems later in life (Power & Matthews, 1997), so the future health of our communities is affected by the current social and physical well-being of our children. Above all else, the care of children involves most public sector organisations.

In 1996, more than a quarter of London's residents were aged 0–19 – a total of around 1.8 million, which is larger than the population of most other UK and European cities (Office for National Statistics, 1997a). This proportion varies significantly from borough to borough (see Table 8.1). Every year there are around 100,000 births to women in London. It is projected that the number of children under 15 in London will increase by 7 per cent by 2011 (London Research Centre, 1996), with the greatest increases in Inner London (13 per cent). In Inner London, 33 per cent of all dependent children live in lone-parent families, a figure comparable with Liverpool and Manchester (Forrest & Gordon, 1994). In areas such as Tower Hamlets and Lambeth, the proportion exceeds 40 per cent (see also Chapter 2).

London is the most ethnically diverse of UK cities (Storkey, 1994), and this is especially apparent among young people. The 1991 Census recorded that 31 per cent of Londoners under the age of 18 were from a black or minority ethnic group, with a range from 5 per cent in Havering to more than 60 per cent in Brent and Tower Hamlets (Office of Population Censuses and Surveys, 1993). Projections to the year 2011 suggest that the number of children under the age of 15 in some minority groups will increase markedly, particularly black Africans (75 per cent), black 'other' (57 per cent) and Bangladeshis (28 per cent), and especially in Outer London (London Research Centre, 1996). This is almost certainly an under-estimate, as many ethnic minorities – especially London's new arrivals and refugees – are inadequately recorded. The reasons for the increase include birth, migration and classification (e.g. increases in black 'other' may be because more people identify themselves as black British).

Table. 8.1 **Populations**

	Percentage of population aged 0–19 years	Projected increase in population aged 0–5 years 1993–2019	Residents aged under 18 years belonging to black & minority ethnic groups	Dependent children aged under 18 years in lone parent families	Dependent children living in overcrowded accommodation	Dependent children living in households with non-earning adults
National						
England & Wales	25.2%	–7.2%	10.0% (England)	17.2%	10.4%	17.0%
London						
Greater London	25.4%	–5.1%	30.8%	23.9%	18.6%	22.6%
Inner London	25.2%	–1.7%	36.5%	33.7%	25.5%	33.1%
Outer London	25.5%	–7.3%	27.5%	18.1%	14.9%	17.6%
Highest London borough value	Newham: 32.5%	Tower Hamlets: 12.1%	Brent: 61.3%	Lambeth: 42.3%	Tower Hamlets: 54.2%	Tower Hamlets: 45.6%
Lowest London borough value	Westminster: 19.3%	Brent: –15.5%	Havering: 4.7%	Kingston upon Thames: 12.7%	Bromley: 6.3%	Richmond upon: Thames: 9.4%
Other major English cities						
Manchester	29.9%	No data	20.0%	37.1%	15.9%	39.5%
Birmingham	28.7%	No data	35.4%	23.3%	22.0%	27.7%
Sheffield	24.1%	No data	9.8%	19.3%	9.8%	22.5%
Liverpool	26.8%	No data	5.8%	33.3%	11.6%	37.0%
Leeds	25.4%	No data	10.1%	19.4%	10.5%	18.6%
Sources:	Office for National Statistics (1997a)	London Research Centre (1996)	Office of Population Censuses and Surveys (1993)	Office of Population Censuses and Surveys (1993)	Office of Population Censuses and Surveys (1993)	Office of Population Censuses and Surveys (1993)

At present, 25 per cent of pupils in primary schools and 30 per cent of pupils in secondary schools have English as an additional language (38 per cent in Inner London), and about 18 per cent are reported as not being fluent in English (Euteneuer, 1997). A current study has identified 275 languages spoken by children in London, and languages other than English are regularly spoken in about 30 per cent of homes (School of Oriental and African Studies, 1997).

A large proportion of refugees and asylum seekers are resident in London (Atkins & Flatley, 1996). The number of people in London seeking asylum or entering the country as visitors and given leave to remain between 1991 and 1996 was estimated to be 149,000, around two-thirds of the total for England and Wales (Office for National Statistics, 1997a). In March 1997, London boroughs were assisting more than 2,000 asylum-seeking families with children and 526 unaccompanied asylum-seeking children (Association of London Government, 1997, unpublished data). Refugees and asylum seekers are some of the most disadvantaged people in London, particularly unaccompanied refugee children looked after by local authorities through the provisions of the Children Act. Changes in the law regarding eligibility for state benefits maintain this disadvantage.

Indicators of social exclusion

Children's social and economic background has important implications for their health and their need for health and welfare services.

Poverty

Despite having average incomes that are among the highest in the country, London has about twice the national proportion of children living in households with non-earning adults (Office of Population Censuses and Surveys, 1993). Of the ten areas in England and Wales with the highest percentage of children living with non-earning adults, seven are Inner London boroughs (Forrest & Gordon, 1994). Rates of unemployment among young people both generally and from minority ethnic communities are also high (London Research Centre, 1995). Eligibility for free school meals is often used as a proxy measure for low family income, eligibility being determined by parental receipt of Income Support or JobSeeker's Allowance. The Greater London average of 30 per cent of primary school pupils eligible for free school meals disguises a range of 8 per cent to 59 per cent across local education authorities (Euteneuer, 1997). Nearly 50 per cent of pupils in local authority maintained secondary schools in Inner London were eligible for free meals in 1996/97 (compared to 18 per cent in England), ranging from 8 per cent to 60 per cent at local education authority level (see Fig. 8.1).

Fig. 8.1 **Pupils in local-authority-maintained secondary schools eligible for free school meals, 1996/97**

Percentage eligible for free school meals
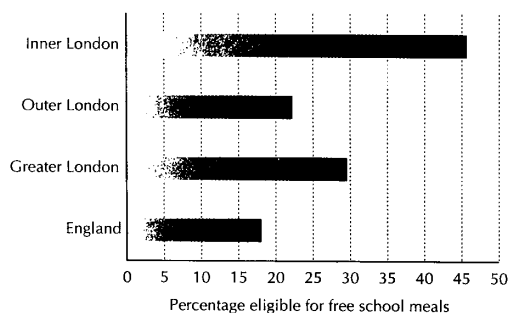
Source: Euteneuer (1997)

The health implications of poverty are many and varied. A child in the unskilled manual social class is twice as likely to die before the age of 15 as a child in the highest social class (Drever & Whitehead, 1997). The Green Paper *Our Healthier Nation* highlights that a child in the lowest social class is also five times more likely to die from an accident than one in the highest social class (Department of Health, 1998). Similar class gradients can be seen for a range of indicators such as low birthweight and infant mortality (Morris & Carstairs, 1991), accidental injury (Department of Health, 1993), congenital anomalies and behavioural problems (Woodroffe et al., 1993).

There is mounting evidence about the importance of income inequality (*per se*) as a cause of poorer health in babies and children (Davey-Smith et al., 1990; Wilkinson, 1994). For example, infant mortality has been identified as one of the health markers that worsens in communities where the degree of inequality is high or rising.

Housing and the home environment

London has a relatively large proportion of children living in overcrowded and temporary accommodation (see Table 8.1 and Chapter 3). Poor quality or temporary housing has implications for the short-term health of children – for example in relation to accidents and infectious diseases (Victor, 1992; Hunt, 1997) – and also for their emotional, behavioural and educational development in the longer term. Temporary accommodation and greater mobility also present problems in terms of continuity and access to health and welfare services: 10 per cent of children aged under 18 in Inner London had lived at a different address one year before the 1991 Census (Office of Population Censuses and Surveys, 1993).

Children looked after by local authorities

The numbers of children looked after by the local authority are higher in Inner London than in the rest of the country: 56 per 10,000 aged under 18 compared to 46 per 10,000 in England (Department

of Health, 1997a) (see Table 8.2). Such children are more likely to have experienced physical and emotional problems that can last into their adult lives (Bebbington & Miles, 1989). Recent years have seen a shift towards the use of foster homes rather than institutional care for these children (Commons Health Committee, 1997a), and the proportion in foster homes in London has now reached national levels – around 65 per cent in March 1996 (Department of Health, 1997a).

Although a stable home environment is especially important in early life, some children may embark on a long period of moving in and out of institutions and foster homes (Woodroffe et al., 1993). The life chances of children being looked after by the local authority may be further impaired by poor education, uncorrected health problems and maladjustment. Moreover, these children tend to be over-represented in statistics on homelessness, later unemployment and crime (Audit Commission, 1994). For example, 38 per cent of young prisoners and 30 per cent of young single homeless people in England and Wales had been looked after by a local authority at some time (Social Services Inspectorate, 1994).

Children on local authority protection registers comprise a category separate from, but sometimes overlapping, that of children being looked after. An inter-agency agreement is drawn up to protect a child who is considered to be at risk of abuse and placed on the register. Table 8.2 shows that the number of children on the child protection register in 1996 was highest in Inner London (49 per 10,000), with the value for Outer London (27 per 10,000) close to the national rate (29 per 10,000 in England) (Department of Health, 1997a). The most

Table 8.2 Social services and education

	Children looked after per 10,000 aged under 18 years	Children looked after placed in residential accommodation	Children and young people on protection register per 10,000 aged under 18	Year 11 pupils gaining 5 GCSE grades A to C	Unauthorised absence from secondary schools: average half days missed per absent pupil
National					
England	46	16%	29	44.5%	21
London					
Greater London	56	No data	34	38.3%	22
Inner London	88	No data	49	30.7%	26
Outer London	39	No data	27	43.6%	20
Highest London borough value	Lambeth: 117	Hammersmith & Fulham: 33%	Islington: 82	Kingston upon Thames: 59.9%	Barking & Dagenham: 39
Lowest London borough value	Barnet/Bexley: 25	Merton & Sutton: 9%	Kingston upon Thames: 9	Tower Hamlets: 23.9%	Croydon: 10
Other major English cities					
Manchester	104	10%	31	27.0%	16
Birmingham	56	23%	34	32.9%	11
Sheffield	47	15%	52	37.2%	13
Liverpool	94	22%	62	27.6%	14
Leeds	71	15%	62	36.6%	12
Sources:	Department of Health (1997a)	Department of Health (1997a)	Department of Health (1997a)	Department for Education and Employment (1997)	Department for Education and Employment (1996)

common categories on child protection registers are 'neglect' and 'physical abuse' – nationally about one-third of all registrations each in 1995 (Department of Health, 1997a). Registrations for 'neglect' in Inner London form a higher proportion of all registrations – 49 per cent in 1995.

Transport

Transport can have both positive and negative effects on children's health. Road traffic accidents are a major cause of childhood morbidity and mortality, although rates in London are relatively lower than elsewhere in the country (Health of Londoners Project, 1996). Walking and cycling are good ways to improve general fitness and provide health benefits at all ages, but congested city streets are not conducive to either. The number of trips by private car is increasing, particularly journeys taking children to or from school (London Research Centre, 1994). Although traffic-calming measures have been introduced, we need to go further and promote a healthier and more sustainable urban environment that is safe for children to play in (Millard & Wheway, 1997) and better for us all to live and work in (see Chapter 4).

Offending behaviour

In 1996 about 35,500 teenagers were accused of a crime in London, a rate of about 55 per 1,000 aged 10–19 (Metropolitan Police Information Bureau, 1997, unpublished). The most common offences were for theft (37 per cent), particularly from shops or of motor vehicles, possession of illegal drugs (11 per cent) and criminal damage (11 per cent). Crime and the fear of crime are part of life in the city, and inter-agency efforts to improve community safety are recognised as important (Home Office, 1997). Fear of crime can have widespread effects on the lives of children and young people and on the way that local communities operate, including social cohesion and the impact on health.

Children as victims of crime

About 15 children per 1,000 aged 1–18 were victims of crime in 1997 (Metropolitan Police Information Bureau, 1997, unpublished), mostly crimes of violence against the person (7.2 per 1,000). It has been estimated that 1 in 4 women living in Inner London has experienced domestic violence (Mooney, 1993), and children who witness domestic violence are more likely to suffer from physical and psychological health problems. There is also evidence to suggest that perpetrators of domestic violence are more likely to physically and sexually abuse children (Hughes, 1989). Bullying in school is also an area of increasing concern and can have a major impact on children's physical and mental well-being, but this and other aspects of violence against children (even some that can lead to children being placed on protection registers or being looked after by a local authority) are not represented in traditional 'crime' statistics.

Education

Education is important for the current and future well-being of children, and *Our Healthier Nation* (Department of Health, 1998) cites schools as a key health setting. Although health-related education is obviously a key factor, general educational attainment is also fundamental because it opens the door to being able to make healthy choices, gain employment and achieve a good standard of living. League tables show that, as a whole, London does not fare well in terms of educational attainment (Table 8.2), although deprivation and poverty do increase the burden on schools. In 1996 only 9 London boroughs exceeded the national average of 45 per cent of Year 11 pupils gaining 5 GCSEs at grades A–C (Department for Education and Employment, 1997).

In 1996/97, more than 2,000 children were permanently excluded from schools in Greater London – 0.2 per cent of local authority-maintained and 0.3 per cent of grant-maintained school pupils (Euteneuer, 1997). As an indirect result of national policy in education, exclusion from school seems to have increased, and black children seem to be disproportionately affected (Commission for Racial Equality, 1996). Some level of exclusions may be unavoidable because the school has to balance the

interests of the majority of pupils against those of the individual. Unauthorised absence from schools (truancy) is also a significant problem, the average number of half days missed per absent pupil in both Inner and Outer London being higher than in other metropolitan areas (Department for Education and Employment, 1996).

Manifestations of ill health

A number of standard indicators of child health are available from routine data sources, but they do not give a complete picture. Childhood mortality is still relatively uncommon, and indicators of morbidity are generally not sufficiently well developed to be part of routine information systems.

In considering which areas of child health present the biggest challenges and opportunities, we have chosen to concentrate on four areas: the health of babies, childhood accidents, health-related behaviours, and child and adolescent mental health. There is not room to cover all areas of ill health and there are some important issues that are not examined here, such as asthma, diabetes and children with disabilities. Other chapters of this report deal with some health problems in children and younger people (e.g. Chapter 6 on teenage conceptions; Chapter 9 on oral health; Chapter 11 on immunisations and vaccinations).

The health of babies

Stillbirth, perinatal mortality and infant mortality rates are used as standard indicators of the health status of a community (see Table 8.3). All have shown a consistent decline throughout this century as general health has improved. Average values for London are comparable or better than other UK cities, although still some way behind some other European capitals, particularly those in Scandinavia (Bardsley & Bremberg, 1997).

Although infant mortality rates continue to decline, values in the deprived Inner London boroughs remain three times higher than the most affluent Outer London areas. This is against a background of a narrowing in the national health divide in infant mortality rates by social class (Drever & Whitehead, 1997).

All else being equal, babies with a low birthweight have an increased risk of illness or death during their early months of life. Trends in this indicator are not so reassuring as others – the national trend is upwards and some Outer as well as Inner London boroughs (e.g. Harrow, Croydon and Ealing) have levels considerably higher than the national average (Table 8.3). Associated factors include maternal smoking and increased rates of caesarian section and forms of assisted delivery (e.g. forceps).

Childhood injury

After the age of 1 year, injury and accidents to children are the most significant cause of death (32 per cent of the total), of which about one-third are road traffic accidents.

Road accident statistics reveal that children are more likely to be injured as pedestrians than as passengers. In 1996, 2,600 child pedestrians were injured on London's roads, a rate of 169 per 100,000 children. About a quarter of child pedestrian casualties occur on the way to or from school and the peak age is 12 years. The severity ratio (the proportion of fatal and serious injuries to all injuries) for child pedestrian casualties increased between 1981 and 1988, but has generally decreased since 1989 (see Chapter 4). This decrease in the total number of child pedestrian casualties and accidents from 1981 to 1996 (37 per cent reduction for casualties and 36 per cent reduction for accidents) may be explained partially by a reduction in walking (especially to and from school) and by the introduction of traffic management schemes including traffic calming and zones restricting speed to 20 mph (London Accident Analysis Unit, 1997).

Childhood injury shows a strong class gradient, the mortality in non-manual classes being five times higher than in manual classes. Moreover, the differences by class seem to be widening (Roberts & Power, 1996).

Table 8.3 **Health indicators**

	Births under 2,500 grams	Stillbirths per 1,000 total births	Number of deaths to infants aged under 1 year per 1,000 live births	Number of deaths to infants aged under 1 week per 1,000 live births	Number of deaths to children aged 1–14 years per 100,000
National					
England & Wales	7.6%	5.4	6.1	8.6	17.5
London					
Greater London	8.2%	6.3	6.4	9.6	17.3
Inner London	8.7%	7.1	6.9	10.6	19.1
Outer London	7.7%	5.5	6.1	8.6	16.6
Highest London borough value	Hackney: 10.1%	Newham: 9.7	Lewisham: 10.8	Newham: 13.4	Waltham Forest: 30.3
Lowest London borough value	Richmond upon Thames: 5.7%	Bexley/Richmond: 2.5	Hammersmith & Fulham: 2.6	Richmond upon Thames: 5.1	Camden: 3.5
Other major English cities					
Manchester	9.6%	7.9	7.2	11.8	12.1
Birmingham	9.6%	7.2	9.0	12.7	17.7
Sheffield	8.4%	5.7	6.2	9.5	20.1
Liverpool	8.8%	5.0	6.5	8.1	25.8
Leeds	8.4%	4.4	6.0	6.9	19.2
Other European capital cities					
Amsterdam	No data	No data	6.7	No data	No data
Helsinki	No data	No data	3.3	No data	No data
Madrid	4.0%	No data	6.2	No data	No data
Stockholm	4.0%	No data	3.6	No data	No data

Source: Department of Health (1997b)

There are about 13,500 accidents in the home every year among London's children aged under 15, the most common being falls (Department of Trade and Industry, 1997). Incidence can be affected by design within the home and outside. Death and injury from fires are particularly significant, and are linked with overcrowded and temporary accommodation (see Chapter 3).

It has been argued that 'most deaths are preventable, and injuries can be reduced through a mixture of environmental, engineering and educational interventions' (Child Accident Prevention Trust, 1996). The types of intervention are many and varied: they can include measures to reduce traffic or slow its speed, safer cycle routes, use of crash helmets, installation of smoke alarms, improved house design, teaching children to swim etc. For the health services, there is an important health promotion role, including working with health professionals to develop their awareness of the issues and possible preventive measures. For all sectors it is important to recognise the importance not just of preventing specific injuries but also of how we shape and develop a healthier urban environment and how different policies help or hinder progress towards that goal.

Health-related behaviour

Indicators of health-related behaviour are important signs of the current health status of children and affect their future health as adults.

Smoking

It is estimated that 1 in 2 teenagers starting to smoke now will die from tobacco-related disease if they continue to smoke steadily. Although smoking is declining in most age groups, rates among teenagers are not and there seems to have been a slight increase in smoking among girls. In 1994, about 12 per cent of children aged 11–15 were regular cigarette smokers (National Audit Office, 1996). Smoking is more common among children whose parents smoke.

Substance misuse

Substance misuse among teenagers over the past 30 years has increased substantially (Commons Health Committee, 1997a) (see Chapter 7). The results of a 1994 survey of 16- to 19-year-olds in Croydon suggest that 46 per cent of young men and 33 per cent of young women had used cannabis at some stage (Croydon Health Authority, 1995). Some 6 per cent of individuals presenting to London drug agencies in 1993/94 were under 20 years of age (Regional Drug Misuse Databases, 1995). It is estimated that one-third of 15- to 16-year-olds drink alcohol on a weekly basis (Parker & Measham, 1993) and that 10 per cent of teenagers are frequent, possibly heavy drinkers (Adelekan *et al.*, 1994). Studies of alcohol and young people have highlighted – in addition to longer term alcohol-related chronic illness such as cirrhosis – accidents (road traffic, occupational and home/leisure) and assault/vandalism as more immediate adverse health consequences (Hayden, 1995).

Sexual health

There are a number of indicators of sexual risk behaviour that point to concentrated problems in London. The incidence of sexually transmitted diseases in teenagers is higher in the two NHS Thames Regions than elsewhere (Connor *et al.*,

1997) and, as Chapter 5 illustrates, HIV is of particular concern in London. Trends in teenage pregnancy in Inner London are not declining (see Chapter 6), and are among the highest in the country. The death rates of babies born to teenage mothers are 50 per cent higher than the national average (Office for National Statistics, 1997b).

Exercise

Physical activity is an important factor in building healthy bones, helping to maintain good mental health and preventing specific conditions such as heart disease. Children in inner city areas may have fewer opportunities for physical exercise, both in and out of school. For example, a survey of more than 2,000 secondary schoolchildren in Hackney (MORI, 1991) found that, although 88 per cent stated that they were fit, 14 per cent had no physical exercise while at school and 21 per cent had no physical exercise outside of school. Both of these proportions are higher than those seen nationally and, unlike the national picture, the proportion having no physical activity at school increased with age (from 9 per cent of boys aged 12 years to 43 per cent of boys aged 16 years, and from 22 per cent to 32 per cent of girls of the same ages). Proportions having no physical exercise were highest among children from the lowest socio-economic groups. Asian children were significantly more likely to see themselves as 'very' or 'fairly' unfit.

Mental health

Mental health problems in children are usually manifest as conduct or emotional disorders. It is thought that early intervention in childhood and adolescent mental health problems can be important in preventing adult mental ill health (Light & Bailey, 1993). In children, problems can vary greatly in terms of their severity and persistence, and may present as difficulties in personal relationships, education and social functioning. As such they are of concern to health, education and social services.

There are no precise data on the extent of child and adolescent mental health problems for London. Using surveys, we can roughly estimate prevalence rates for some of the more common conditions. Emotional disorders (e.g. phobias and depression) and conduct disorders (e.g. stealing and defiance) are the most common problems and may be found in around 10 per cent of children and 20 per cent of adolescents (Hargreaves et al., 1998).

A recent review of child and adolescent mental health in London concluded that:

> High levels of social disadvantage, a large refugee population, growing numbers of young people among the homeless, and high rates of children looked after by local authorities or on child protection registers indicate that needs for child and adolescent services in London are likely to be at the upper end of the spectrum.

> Bailey (1997)

Priorities for developing the health of London's children

This section outlines the most important issues that London needs to address in improving child health.

Improve inter-agency working

For children's services, the need to work across organisational boundaries is paramount. Key actors include health, local authority social services, education, housing, the criminal justice system, the voluntary sector and community groups. In some instances, significant barriers exist between departments in the same sector, including the NHS.

A recent Commons Health Committee concluded that:

> It is clear that the effective provision of services to children continues to be impeded by failures of liaison and co-ordination between the various agencies involved, and that further measures to encourage them to work together are required.

> Commons Health Committee (1997b)

For some health-related problems, geographic boundaries may present difficulties, such as in the treatment of those with complex needs, severe mental health problems or services for children with special educational needs. In these cases, services may be provided some distance from the borough of residence and it is important for the relevant authorities to have clear communication channels and recognise their respective responsibilities.

At a more local level, recent reforms of the health service have developed local commissioning, particularly around populations defined by GP practices. Potential problems may arise when practice populations do not match exactly to local communities. In such cases, communication between agencies can become more difficult and it is important that contact between different sectors recognises the community as the population of concern.

In terms of inter-sectoral working, the following four areas are especially important.

Pre-school and day care

Pre-school and day care have been shown to have beneficial effects on behavioural development and school achievement (Zoritch & Roberts, 1997). The interventions that have been studied in trials combine day care with some element of parental education and training – in both parenting and work skills – mostly targeted at mothers. Day care services are especially important for people on the lowest incomes, but at present the lack of affordable services means that many mothers cannot seek work. It remains to be seen if the Welfare to Work proposals will make a major difference to this.

Schools

Schools have the potential to provide most school-age children with sustained health messages. They provide supportive and enabling environments for children

with pre-existing health problems, which can have a positive influence on mental and physical health and help to develop children's understanding and beliefs about their own health. Initiatives such as the Healthy Schools programme aim to make the most of the school environment for better health and to develop positive health promotion, across a wide range of issues such as sexual health, substance misuse and diet (National Foundation for Educational Research, 1997). They can also provide a base for more specific initiatives aimed at certain groups, such as out-of-school clubs, which are particularly important in areas of social disadvantage, and education about issues such as bullying, racism, weapons, gangs and offending behaviour and juvenile justice. The Green Paper *Our Healthier Nation* (Department of Health, 1998) identifies the school as one of the key settings for health promotion.

Family support

Measures to improve child health are as much about the family as about the child. Services need to recognise the links between child and family health, especially for socially excluded groups and those with mental health problems. Projects with family support as the focus can also enable collaborative working between different agencies. Public consultation in Croydon revealed that many parents felt unable to support their children effectively, and wanted more parenting training for 15- and 16-year-olds in schools, more community-based schemes (like 'community mothers', who visit parents experiencing difficulties, in an informal and non-professional capacity) and more professional input through health visiting, day care for infants from 0 to 4 years old, and in schools through the curriculum, informal activities and wider use of school premises (Croydon South-East Health Think-Tank, 1995). Appropriate support services must also be provided for families in which the children themselves are carers.

Community development

Initiatives that address the wider health and social concerns are important for child health and should be encouraged. They have the potential to empower individuals, as well as the wider community, and to promote ways of increasing child and community participation in decision making. For example, the Somali Women and Children Health Project in Wandsworth aims to break down social isolation among this group, to discuss health needs and develop health-promoting interventions to address them, to highlight gaps in current services and to empower Somali women to develop the confidence and skills needed to take greater control over their own health.

Improve the quality of services (appropriateness and accessibility)

Children must have access to a range of effective preventive and health promotion services in primary care. In order to target and provide appropriate support for disadvantaged and vulnerable families, a broad approach is needed in which primary care practitioners work closely with social work, education and housing departments. The dangers of an over-mechanistic emphasis on developmental screening of children in primary care is not justified by the evidence and will miss opportunities for more effective inter-agency action to support vulnerable families. Children of families in temporary accommodation are among the most needy in society yet are often excluded from health and social services. Some of the problems could be addressed on a pan-London basis, with more emphasis on housing families near their natural community support, better social services for families housed out of their borough, more timely information for health and social services about families moving between boroughs, and the provision of specialist voluntary sector services for families (particularly refugees) who are cautious about dealing with 'government agencies'.

Promote a child-friendly employment policy, especially in the NHS

The workplace can have a role in promoting healthy children and families. Two-thirds of mothers now return to work following maternity

leave and more than half of all mothers of under-5s are economically active. Employers vary in the extent to which they have developed employment practices that help rather than hinder parents with young children. Some of the options include:

- help with costs of childcare;

- workplace nurseries;

- work leave for family reasons;

- emergency childcare services;

- flexible work time.

Such policies provide benefits to the employer by reducing staff turnover and, therefore, training and recruitment costs, absenteeism and staff stress. The benefits to the family are that such measures may enable parents (primarily mothers) to do more work with a higher income and in a way that is least disruptive to their relationship with their children. In a more general sense they can also help people towards a more even balance of work and domestic life.

The NHS is the largest employer in London and should lead the way in child-friendly and child-healthy employment. Although public sector providers tend to do better than the private sector, only 9 per cent of public sector establishments offer workplace nurseries. The number of NHS schemes is thought to be declining.

Increased recognition of health in urban regeneration

Policies for economic development, housing, education and transport are all important in relation to the health of London's children. However, our ability to assess the impact of these different sectors on health is limited. For example, although the links between transport and health are well established, the most recent Green Paper on transport does not mention health at all. Similarly, important areas such as bids for urban regeneration and Local Agenda 21, in which the improvement of

health is a key product, have little explicit discussion on states of health (see Chapter 3). The education, training and future employment opportunities via Single Regeneration Budgets are critical in the promotion of child health in the capital.

Conclusions

London is large and heterogeneous. The number of children and adolescents in Greater London is greater than the total population of most other UK cities. For those growing up in London there are some distinct advantages – its cultural diversity, access to museums, theatres, concerts etc. and, for the majority of children, a safe and healthy environment.

Concerns over child health focus particularly on the most disadvantaged. In the wealthy and privileged parts of London are some of the most deprived areas, and families, in the country. At the extremes are those who are or feel excluded from society and suffer multiple social disadvantage. Indicators of high levels of childhood poverty, poor quality of housing and high numbers of lone-parent families are all pointers to the areas that are of most concern with regard to the children and young people of London. Developing measures to reduce the current and future burdens of ill health for children must depend on strong and effective action by central government and co-ordination between agencies within the capital, particularly in enabling access to services for the socially excluded.

The role of central government in reducing child poverty in the capital and elsewhere is clear:

- better resourced education in the inner city;

- better vocational training and preparation for work;

- wider employment opportunities for young people;

- social family policy that reduces child poverty.

The multiplicity of factors that influence child health mean that an understanding of health should become part of the thinking on every major policy area in the capital, whether about economic development, land use, transport, urban regeneration or waste disposal.

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Chapter 9

Oral health

Jenny Gallagher

Summary points

Improvements in the oral health of children have slowed or levelled off, and in very young children there is some evidence that oral health may be worsening in certain areas. High levels of untreated decay remain, particularly among 5-year-olds.

There are inequalities in oral health within London, and levels of tooth decay are lowest in the most affluent and highest in the least affluent parts of the capital. The social determinants of oral health must be recognised – many of them lie outside the realm of the health services.

Targets laid down for the oral health of children in the Oral Health Strategy for England are unlikely to be met by most areas in London.

London's primary dental care provision is very different from that in the rest of the country. In parts of London there are special problems of low registration rates among children in areas with greatest need.

Implications for improvements in public health

London should lead the way in introducing water fluoridation, which is the most effective public health measure to tackle inequalities in tooth decay and provides the most likely means for London to reach national targets for oral health. This work could be facilitated by a Greater London Authority.

Local commissioning of primary dental care services through new pilot schemes (Personal Dental Service Pilots) must address local oral health needs and ensure effective, efficient and appropriate use of resources.

There needs to be wider inter-sectoral collaboration, with the aim of promoting oral health as part of general health. This is particularly important when targeting the needs of the most deprived communities.

Research is required into the prevalence of oral cancer, particularly among minority ethnic groups from the Asian sub-continent. Ethnic status must be included as part of routine information reporting.

Local Health Improvement Programmes must identify the benefits to oral health when developing local treatment and prevention strategies.

Introduction

This chapter examines oral health problems in London and in the wider national context. It focuses on the most prevalent disease in children, that is 'dental caries' or tooth decay, and the most serious in older adults, oral cancer. Thus the chapter concentrates on the oral health needs of the more vulnerable sections of society.

Oral health has been defined in *An Oral Health Strategy for England* as:

> A standard of health of the oral and related tissues which enables an individual to eat, speak and socialise without active disease, discomfort or embarrassment and which contributes to general well-being.
>
> Department of Health (1994)

This definition encompasses all oral and facial tissues, not just teeth. It is much wider than merely an absence of disease and echoes the World Health Organization definition of health. In the UK there is a wealth of useful data on oral disease from local and national surveys. The latter are mainly surveys of children, such as those carried out by the community dental services as part of oral screening in schools.

An Oral Health Strategy for England was published in July 1994, and has helped to focus the thoughts of health care workers and the general public on health, rather than merely the treatment of disease. The Oral Health Strategy was launched in tandem with a Green Paper *Improving NHS Dentistry*, which focused on the future provision, and particularly the remuneration for, primary dental care. Having highlighted the major decline in tooth decay, the strategy suggest a number of 'ways to better health' (see Box 9.1).

Both the strategy and the accompanying Green Paper saw the local commissioning of current general dental services as the way forward to ensure that services were needs-led rather than just demand-led, and that appropriate primary dental care should be remunerated appropriately.

Box 9.1 Ways to better health outlined in the national Oral Health Strategy

- A healthy personal lifestyle – reducing the consumption and especially the frequency of intake of sugar-containing food and drink; cleaning the teeth and gums thoroughly every day with a fluoride toothpaste; drinking fluoridated water; and attending for regular dental check-ups.

- Food and drink manufacturers and the pharmaceutical industry reducing the sugar content of products and providing clearer labelling.

- Fluoridation of water supplies to be taken forward by health authorities.

- Health authorities to target primary and secondary dental care services to meet established needs and to promote oral health along with closer collaboration between dental and other health professionals.

The Strategy set a series of targets for the oral health of children and adults (see Box 9.2), which are to be monitored through national and local surveys. Local objectives could be set where appropriate, and several health authorities in London have taken the opportunity to develop an oral health strategy, or are in the process of doing so.

The state of London's teeth

Variations in oral health exist between and within health authorities in London (Table 9.1). In general, if tooth decay is present in young children, much of it will be untreated by the time they start school at 5 years of age. The key health indicator is therefore the number of decayed, missing or filled teeth (dmft) at the age of 5. The average figure for London is 1.52 decayed, missing or filled teeth per child, with higher values in Inner London. This value compares quite favourably with the national average of 1.68 and the highest values in England over 3 in Manchester (Department of Health, 1997), whilst the lowest in England is 0.56 in Solihull.

BOX 9.2 TARGETS SET IN *AN ORAL HEALTH STRATEGY FOR ENGLAND* (DEPARTMENT OF HEALTH, 1994)

• By 2003, 70% of 5-year-old children should have had no caries.

• By 2003, 5-year-old children should have, on average, no more than one decayed, missing or filled primary tooth.

• By 2003, 12-year-old children should have, on average, no more than one decayed, missing or filled permanent tooth.

• By 1998, the proportion of dentate adults over 45 years old with at least one periodontal pocket (over 6 mm) should be reduced to 10%.

• By 1998, 50% of 30-year-olds should have more than 20 teeth that are sound and unfilled.

• By 1998, 75% of 50-year-olds should have more than 20 teeth.

• By 1998, 33% of adults over 75 years old should have (some) teeth.

• By 1998, 10% of adults over 75 years old should have more than 20 teeth.

In London, there is most oral disease among 5-year-olds in Kensington, Chelsea & Westminster (dmft = 2.39), East London & The City (2.32) and Camden & Islington (2.27). Generally, scores are worse in north London and in the least affluent areas.

The average dmft scores present only part of the picture. As Table 9.1 shows, only about half of 5-year-olds have caries at all (ranging from 27 per cent in Kingston & District to 53 per cent in Kensington, Chelsea & Westminster). For these children, the dmft scores average about 4 teeth

Table 9.1 **Dental caries experience in 5-year-old children in 1995/96**

Health authority/area	Percentage with dmft score > 0	Average dmft all aged 5	Average dmft those with caries	Care index (%) (filled/dmft)
Kingston & District	26.6	0.97	3.65	29
Merton & Sutton	30	1.09	3.63	25
Croydon	33.1	1.18	3.56	12
Bromley	35.4	1.28	3.62	24
Bexley & Greenwich	35.8	1.30	3.63	19
Lambeth, Southwark & Lewisham	36.1	1.36	3.77	19
Richmond, Twickenham & Roehampton	36.4	1.38	3.79	20
Enfield & Haringey	37.9	1.39	3.67	28
Barking & Havering	41.1	1.55	3.77	17
Wandsworth	41.3	1.65	4.00	24
Brent & Harrow	43.9	1.65	3.76	13
Redbridge & Waltham Forest	44.1	1.79	4.06	20
Hillingdon	45.2	1.89	4.18	18
Barnet	46.8	2.11	4.51	20
Ealing, Hammersmith & Hounslow	48.8	2.11	4.32	19
Camden & Islington	49.3	2.27	4.60	16
East London & The City	49.8	2.32	4.66	21
Kensington, Chelsea & Westminster	53.1	2.39	4.50	15
London	40.4	1.52	4.01	19
England	41.4	1.68	4.06	13

Oral Health Strategy for England target for 2003: 30%

dmft = decayed, missing, filled teeth

Source: Pitts & Evans (1997)

each, with a range across London from 3.65 to 4.5. The difference in scores between affluent and deprived areas is less marked among these children, an indication that even in the most affluent suburbs there are groups of children with relatively severe problems at the age of 5 years.

Data specific to London are available for only two of the national targets outlined in Box 9.2. In 1995/96, 60 per cent of children in London had had no caries, against the target of 70 per cent by 2003. The lowest value of 47 per cent was in Kensington, Chelsea & Westminster, whereas Kingston & District and Merton & Sutton were already above target. For 12-year-old children, data suggest that, in 1996/97, the average dmft score in London ranged from 0.6 in Bromley to 1.2 in Camden & Islington.

Trends in tooth decay

Over the past three decades we have seen major improvements in oral health, greater awareness of the ability to prevent oral disease in general and tooth decay in particular, individuals placing greater emphasis on their oral health, and developments in the techniques and materials for treating disease (Department of Health, 1994). Improvements in the oral health of children and young adults have been well documented (Todd & Lader, 1991; Downer, 1994, 1995; O'Brien, 1994; Nugent & Pitts, 1997).

Tooth decay in the UK peaked in the 1960s and has fallen since then. The decline started before the introduction of fluoride toothpaste in the 1970s, though the rate of fall accelerated from that point. Other factors that have contributed to these changes probably include dietary changes, more dental health promotion, increased dental awareness, changes in the micro-organisms that are normally present in the body and in the saliva, increased use of antibiotics and a more preventive approach adopted by practitioners.

Downer (1995) highlighted that much of the dramatic improvement in the oral health of 5-year-olds had already taken place and was levelling off.

Fig. 9.1 **London 5-year-olds with decayed, missing or filled teeth (dmft), compared with those in England, 1989–95**
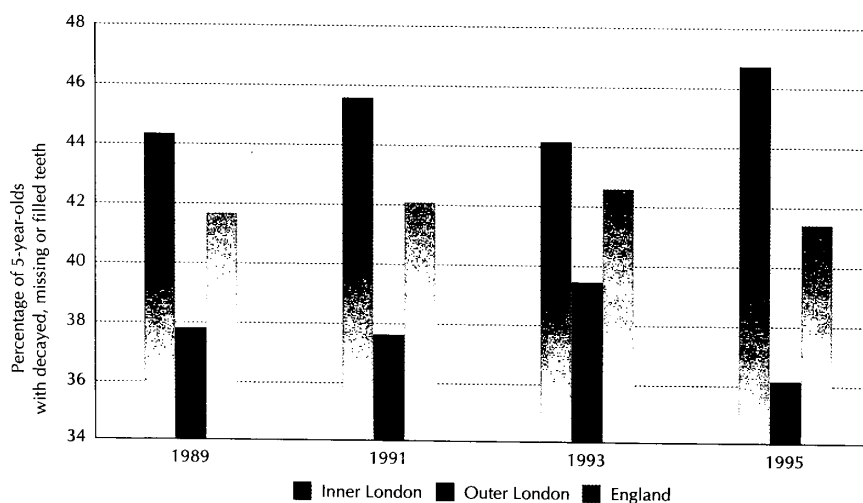
Source: Nugent & Pitts (1997)

Pitts and Evans (1997) recently reported that the oral health of 5-year-olds had reached a lower plateau and that recent years had seen some variation around that mean.

Data for London since 1989 (comparing areas where data have been available) suggest that there has not been a significant change in the proportion of children without tooth decay (see Fig. 9.1), whether in Inner London, Outer London or England as a whole.

Inequalities in oral health

There are pronounced differences in oral health between geographic areas and social groups in the UK (between north and south) and in London. Jones et al. (1997) have shown the correlation between rates of tooth decay and measures of social deprivation. This analysis also confirmed evidence of the effectiveness of water fluoridation, which halved the amount of tooth decay in 5- and 12-year-old children in the north-west of England.

A national nutritional, dietary and dental survey carried out in 1992/93 (Hinds & Gregory, 1995) revealed that tooth decay was the most prevalent oral disease in pre-school and young children and found that 'dental decay was most strongly related to social background'. The factors most strongly related to decay prevalence were:

- receipt of state benefits by the parents of the 1.5- to 2.5-year-old children;

- the educational status of the mother in the 2.5- to 3.5-year-old children;

- social class of the head of household in the 3.5- to 4.5-year-old children.

Oral cancer

In the UK, there are estimated to be 3,000 new cases of oral cancer per year, affecting the lips, tongue, floor of the mouth and the upper pharynx (Health Education Authority & British Dental Association, 1996). Most cases (85 per cent) occur in people over the age of 50 years. The cancer may appear as a painless ulcer or lump in the mouth (most commonly on the tongue) that does not heal. A relatively large proportion seek medical help late, presenting with large lesions and regional spread. Although there are a number of risk factors for oral cancer, the most important are tobacco use in various kinds (Johnson & Warnakulasuriya, 1993).

In some parts of Asia (India, Sri Lanka, Pakistan, Bangladesh), oral cancer is the most common form of cancer and accounts for about a third of all new cases (Johnson & Warnakulasuriya, 1993). This is of particular relevance in London, where there is a significant Asian population among whom cultural and lifestyle factors are linked to the key risk factors for oral cancer. Risk factors have been associated with a comparatively higher incidence of oral cancer among people from southern Asia (Warnakulasuriya & Johnson 1996). Data from the Thames Cancer Registry (1995) reveal that the incidence of oral cancer is related to the proportion of the population who are Asian.

In 1996 there were 439 cases of oral cancer in London, the rates in men being about three times higher than those in women (Thames Cancer Registry, 1998). The trends in age standardised incidence rates across south-east England have shown an 18 per cent increase in men and 9 per cent in women between 1987 and 1996. The age-standardised rate in London is higher than that for south-east England, and in the capital there are three-fold differences, with the highest rates in Kensington, Chelsea & Westminster, East London & The City and Merton, Sutton & Wandsworth (see Fig. 9.2).
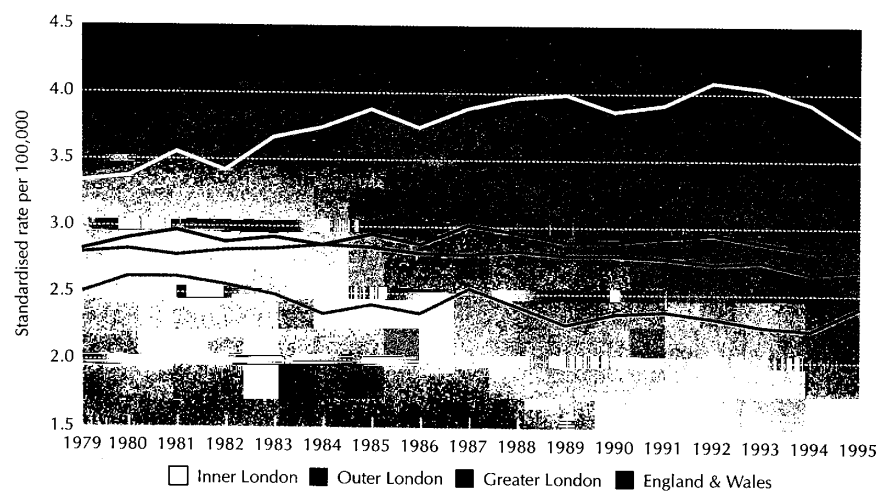
The age-standardised mortality rate for oral cancers in Inner London (3.5 deaths per 100,000 in 1995) is significantly higher than the average of 2.5 for England and Wales (see Fig. 9.3).

Fig. 9.2 **Registrations of oral cancer in the London health authorities, 1996**

Age-standardised rate (world) per 100,000

■ Females   ■ Males
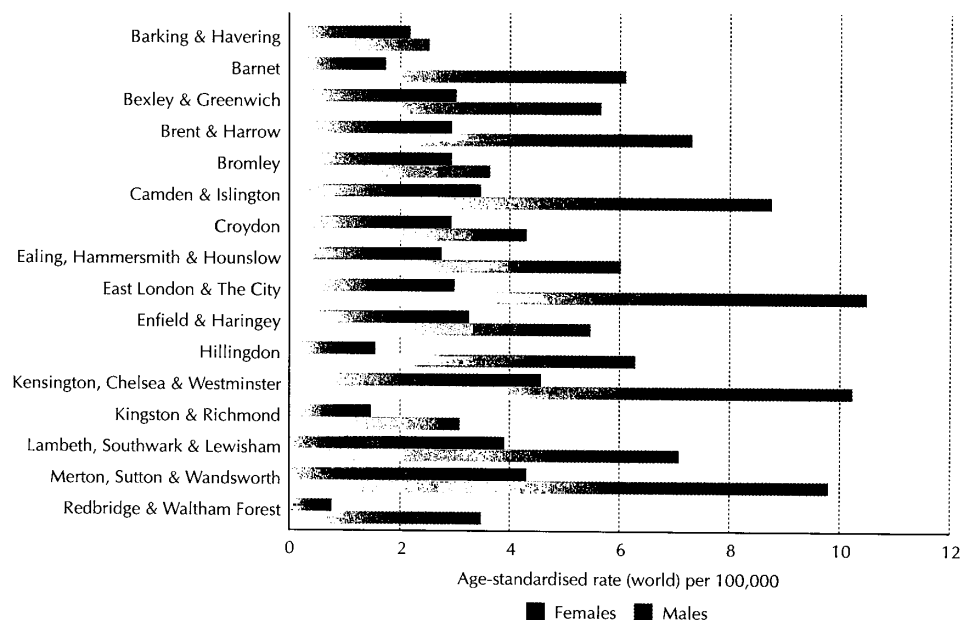
Source: Thames Cancer Registry (1998)

Fig. 9.3 **Mortality from oral cancer in London, compared with England and Wales, 1979–95**

1979 1980 1981 1982 1983 1984 1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995

☐ Inner London ■ Outer London ■ Greater London ■ England & Wales

Data from Office for National Statistics (1996a, 1996b, 1996c, 1996d)

There is a need for greater public awareness of oral cancer – the associated risk factors and the benefits of early diagnosis and treatment. Schools, community education, pharmacists and GPs have an important role to play in the prevention and early detection of the disease.

Primary dental care services in London

General dental services in London are very different from those nationally. In particular, services in the capital are characterised by:

- a high level of private dental care in some, though not all, parts of London;

- a lower uptake of dental services than nationally, most marked among children;

- a greater amount of treatment per patient;

- a high turnover in dentists, particularly at associate or assistant level;

- many people seeing a dentist in the area where they work rather than where they live, making needs assessment for residential populations more complex; unlike medical services, dental services are not necessarily addressing 'very local' need and therefore are better viewed at a macro (i.e. health authority) level.

The higher costs of living in the capital act as a disincentive to practices, as only part of these additional costs are covered in reimbursement rates (i.e. those for business rates).

Although the past decade has seen an improvement in oral health, there has also been a decline in the proportion of decayed teeth that that are being

Fig. 9.4 **General dental practice registration rates for those under the age of 18 in London, September 1997**
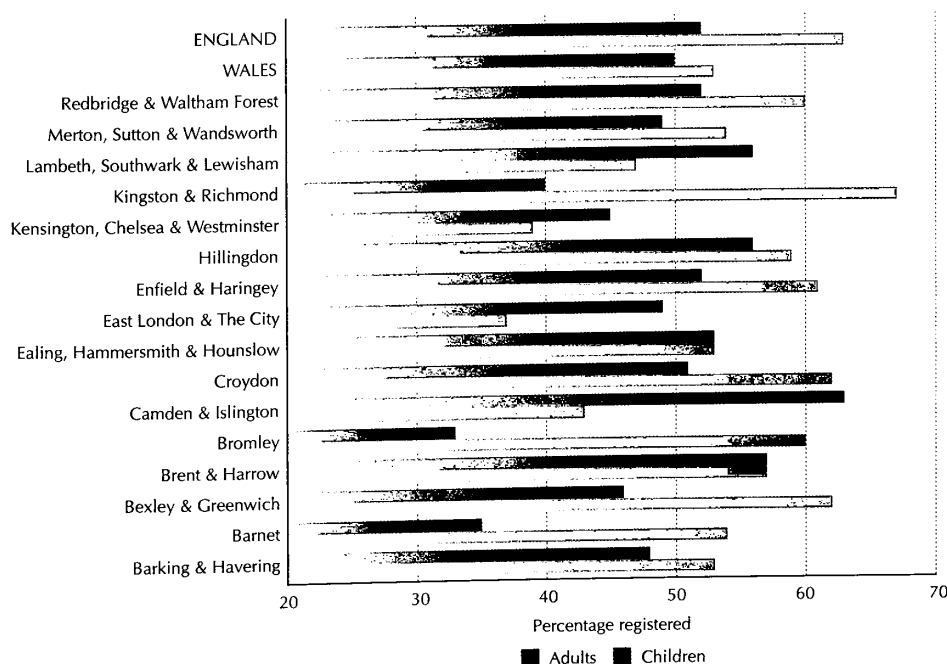
Source: Dental Practice Board (1997)

treated, especially among children (usually expressed as the 'Care Index', see Table 9.1). In 1987, around 24 per cent of decayed teeth in 5-year-olds had been filled; in 1996 the equivalent value had fallen to 13 per cent (Nugent & Pitts, 1997). One of the factors behind these changes has been the system of reimbursing dentists. It is hoped that the latest changes – effective from September 1996 and moving back towards a fee-for-service approach – will rectify this anomaly.

In London there are marked differences in the extent of registration with a general dental practitioner and in levels of treatment (as assessed by the proportion of decayed teeth that are actively treated). The patterns we see in London are that registration (Fig. 9.4) and treatment (see Table 9.1) in children tend to be lower in the areas with the greatest level of oral health problems. Such differences point toward the need to fund oral health services by specifically targeting groups in most need.

The most recent approach to funding, Personal Dental Services Pilots, offer some hope of allowing sufficient local discretion to commission services on the basis of perceived needs (NHS Executive, 1997). There are outline proposals for 25 such pilots across England. Three schemes in London have been working up full proposals to become Personal Dental Services Pilots. If they are successful, it is anticipated that the pilots will come into operation on 1 October 1998. The advantages lie in their ability to target resources more effectively to groups with the greatest need, and so help to reduce inequalities in services. However, the pilots do not come with additional funding, rather they must seek to allocate existing resources more equitably.

Meeting the targets for oral health

Persisting inequalities in oral health across London mean that only certain, more affluent, areas are close to meeting national targets for children's oral health. To reach these targets, there must be further

sustained action at all levels. Water fluoridation would have the most radical impact on oral health, particularly for those in social groups who have the most disease and are least likely to access services for regular and timely treatment. The potential benefits of fluoridation have recently been reinforced in the Green Paper *Our Healthier Nation* (Department of Health, 1998) along with a recognition of the difficulties involved. The Inner London Chief Executives have been taking the initiative to push this matter forward on a pan-London basis. The proposed Greater London Authority may provide a vehicle for developing this work further in the capital – although it has to be recognised that London's water supplies also serve other areas in the home counties.

The other important strand for improving oral health relates to nutrition and the importance of reducing the volume and frequency of sugar consumption, especially among children (Health Education Authority, 1996). This can range from action at a local level, such as work on oral health promotion, to wider regional and national issues such as the clear labelling of food. It also involves an important element of inter-sectoral work, particularly with education and schools and with local business – including food shops and restaurants. It is important to recognise that messages about food and good oral health are usually the same as those for general health, but there are also specific issues such as encouraging the use of fluoride toothpaste, effective cleaning techniques and regular dental check-ups.

These strategic themes will need to be supported by a range of local initiatives. However, health authorities have little or no ability to direct the services of general dental practitioners, the major providers of primary dental care, so options for change are currently limited to commissioning community dental services and some oral health promotion work. Initiatives such as the Personal Dental Service Pilots may offer a way ahead.

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Chapter 10
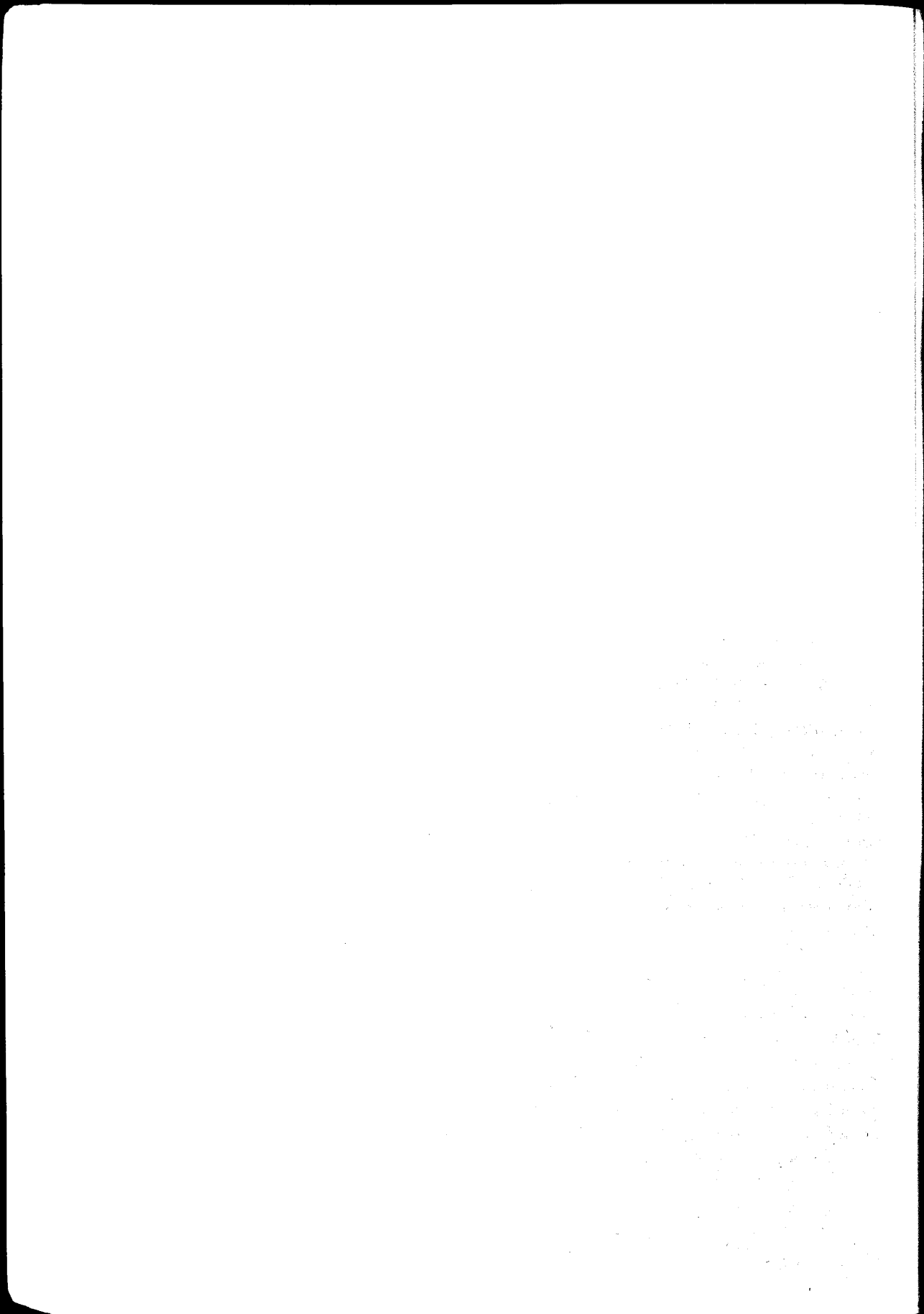
Mental illness

David Goldberg & Mike Gill

Summary points

- The capital has higher levels of serious mental illness than any other city in the UK. Demand for health services is rising, at least among young men and for in-patient services. The service response to this increased demand is inadequate.

- Although a broader public health response tackling the causes of mental illness will have some impact on moderate mental illness, this will be in the distant future. There is an urgent need now to address the rising demand for services for those with severe mental illness in the capital.

- There is evidence that many patients treated at present in hospital wards can be treated more cost-effectively in the community in facilities with 24-hour nursing care. This, in addition to assertive outreach teams to deal with small caseloads of clients with very severe mental illness who are hard to engage, can provide a cost-effective option which will, over time, reduce the need for in-patient capacity. Currently, there is a severe shortage of such 24-hour facilities. However, there will continue to be a need for in-patient beds in any future pattern of mental health services in London.

- There are excellent examples of integrated health and local authority community mental health teams in other metropolitan areas, but such teams are still not fully established or integrated in many parts of the capital.

- All the evidence points to major inequalities in mental health services. The resources allocated to deprived inner city areas are insufficient, resulting in serious inequity of access in the face of rising demand.

- More services are needed urgently, both in the community (particularly supported accommodation and assertive outreach in the inner city) and in the acute care sector.

- The needs of minority ethnic groups and refugees are not being met satisfactorily, and the alienation, felt particularly by people of Afro-Caribbean origin, require special attention.

Implications for improvements in public health

- A prime requirement for the development of equitable mental health services is a review of how resources are allocated. This review should include particularly the level of resources made

available to support mentally disordered offenders, and adequate ring-fenced resources for mental health within social services and housing. The newly created Mental Health Challenge Funds and the Mentally Disordered Offenders Strategic Assistance Fund have been helpful in temporarily reducing inequalities across London. As a minimum, it is essential that the additional resources for mentally disordered offenders are maintained if they are to be effective in the longer term.

The opportunities presented by commissioning services on a joint or single basis between the NHS and social services need extension, potentially to the stage of a common budget and, where possible, involving housing departments. Health Action Zone status potentially offers a fast-track opportunity to develop partnerships and evaluate their effectiveness.

Targets to cover the whole population by community mental health teams should be set as part of the pan-London mental health strategy recommended by the Turnberg Review.

A strategy for mental health in London must ensure that primary-care-led commissioning and the creation of primary care groups preserve the inter-agency/population focus of community mental health teams, which cover registered as well as non-registered patients, and that the activity level needed for some specialist mental health services to be effective is not fragmented further.

A pan-London strategy should prioritise the development of a firmer evidence base to support good practice to treat patients with personality disorders and 'dual diagnoses' (i.e. those with mental health and substance misuse problems).

Solutions are required to the problem of shortages of staff of all types to run the service. Such solutions include better training, improved conditions of work, and the employment of non-professional staff and mental health nurses to assist with the task of caring for the mentally ill people in the community and in hospital. The Welfare to Work scheme may provide a vehicle for this.

Improved management of beds in in-patient facilities for people with mental health problems and a centralised emergency bed service may have a positive role in the prevention of large numbers of distant placements, often to the independent sector. This needs further evaluation.

Means must be found to remove the obstacles to the provision of supported residential accommodation of various kinds in the community: this would free up between a quarter and one-third of acute beds that are currently occupied by patients ready to be discharged. Health Action Zone initiatives offer an opportunity to pool resources more effectively to fund this.

Initiatives should be developed in partnership with minority ethnic communities, to include training in cultural sensitivity for all mental health professionals, more comprehensive ethnic monitoring, changes in the environments provided in mental health facilities, and community-led public information campaigns. Health Action Zones offer an opportunity to pilot the effectiveness of some of these initiatives.

Health Improvement Programmes in London should actively seek to establish targets and resourcing mechanisms for bridging gaps identified in local mental health services.

The safety and effectiveness of local services should be explicitly underpinned in a system of clinical governance that crosses agency boundaries. The development of a pan-London strategy as recommended in the Turnberg Review offers an unrivalled opportunity for an agreed London-wide, evidence-based set of criteria for audit and cross-district comparison.

Introduction

This chapter highlights the distinctive features of mental health in the capital and the challenges faced by services trying to meet these needs. The evidence presented focuses primarily on severe mental illness in adults. The chapter goes on to identify priorities for tackling severe mental illness among adults in the capital.

London is different

Levels of serious mental illness in London are higher than in any other large city in the UK. The capital has the highest rates of factors known to increase the risk of mental illness – unemployment, the proportion of single-person dwellings, the proportion of the population aged 15–30 (the highest risk years for psychotic illness), and the proportion of people from Afro-Caribbean communities (double the risk for psychosis). London also includes some of the most socially deprived areas in the country (see Chapter 2).

The high rates of mental illness result in high use of psychiatric services. Inner London has higher hospital admission rates than have other large cities, especially among people aged 16–64, and particularly for men. Rates have increased throughout the UK, but particularly in London (a 26 per cent increase in London compared with 18 per cent elsewhere between 1989 and 1994). People in the 16–64 age group in London are discharged at almost twice the rate elsewhere to local authority or independent residential services (Fig. 10.1), reflecting the high rates of social exclusion – for example, being single, widowed or divorced (Fig. 10.2).

London has experienced a bigger increase in the prevalence of mentally disordered offenders compared with other deprived UK inner cities, and in response has more than four times the number of medium secure places (11.5 per 100,000 population in Inner London compared with 2.9 per 100,000 in other deprived UK inner cities). National policy to shift the care of mentally disordered offenders from the criminal justice system into the health sector, although rational and humanitarian, has increased pressure on London's mental health services because there has been no associated transfer of resources from prisons to the health sector. The creation of the Strategic Assistance Fund to address the rising demand from mentally disordered offenders is welcome, but its continuity is not guaranteed. This problem has been highlighted in the recent Turnberg Review of London's health services (Department of Health, 1998a).

Once admitted, patients in London wards are more severely mentally ill than elsewhere, as measured by Health of the Nation Outcome Scales ('HoNOS'), a tool for measuring the health and social functioning of those with mental illness (Wing et al., 1996). More of those admitted in London have a diagnosis of schizophrenic illness – 37 per cent of 16- to 64-year olds, compared with 26 per cent in the rest of the UK. Almost twice as many patients in London are detained under the Mental Health Act than elsewhere, and more than twice are defined as 'new long stay' (i.e. they have in-patient stays of more than 18 months). In London, about 80 per cent of the population are classified as white, but represent only 51 per cent of mental health admissions. Most of the over-representation of this non-white population in mental health admissions in London is among young men of Afro-Caribbean origin.

Fig. 10.1 **Proportion of all discharges of mental health patients from hospital to NHS, local authority or independent residential services in 1994/95: (a) men; (b) women**
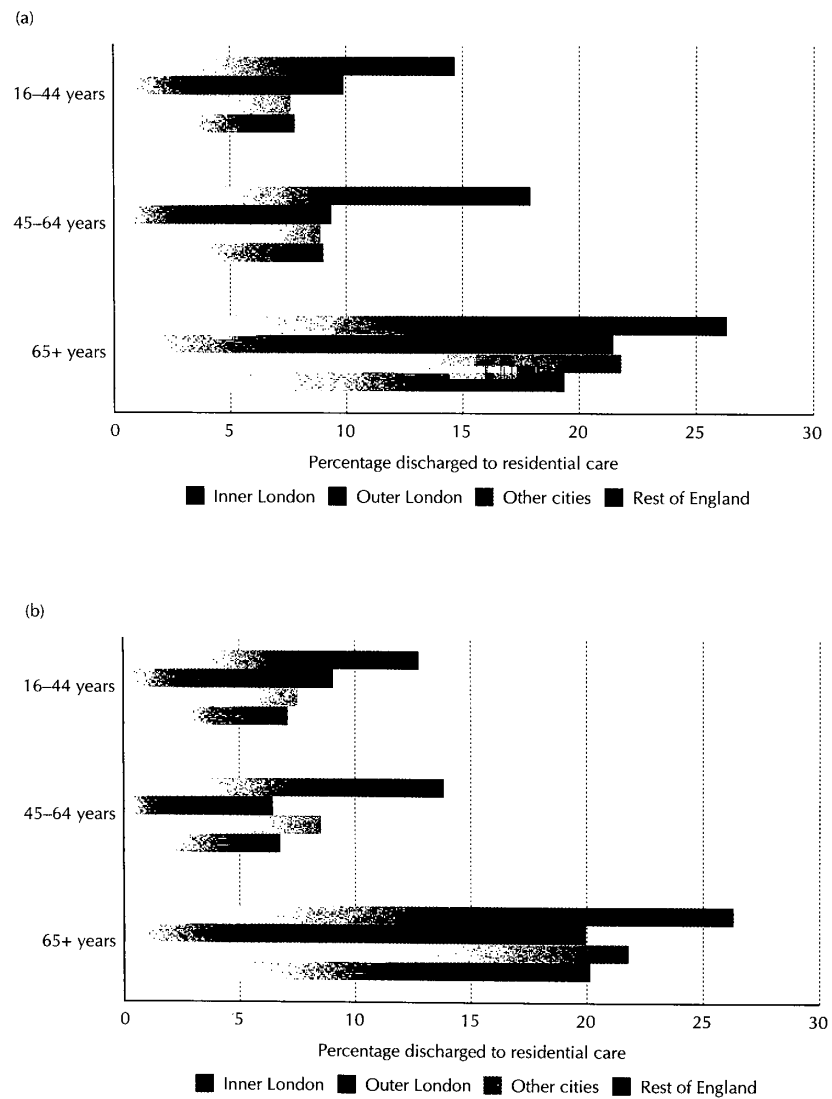
(a)

Percentage discharged to residential care

■ Inner London ■ Outer London ■ Other cities ■ Rest of England

(b)

Percentage discharged to residential care

■ Inner London ■ Outer London ■ Other cities ■ Rest of England

The other cities are Birmingham, Bradford, Gateshead, Leeds, Liverpool, Manchester, Newcastle, North Tyneside, Salford and Sheffield
Source: Johnson *et al.* (1997)

Fig. 10.2 **Proportion of all mental health 'finished consultant episodes' which are of people who are single, divorced or widowed, 1994/95**
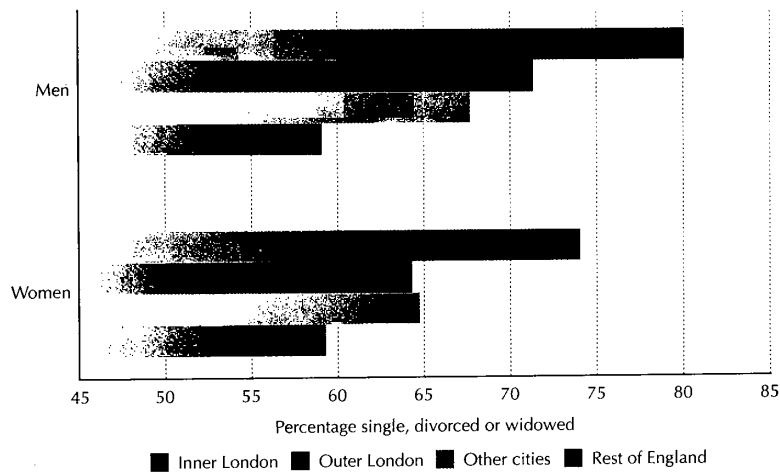
The other cities are Birmingham, Bradford, Gateshead, Leeds, Liverpool, Manchester, Newcastle, North Tyneside, Salford and Sheffield
Source: Johnson *et al.* (1997)

A public health approach?

In the face of these and other data, the King's Fund London Commission (1997) recommended that a broad-based public health approach be adopted to improve the mental health of Londoners. Community and borough development and regeneration programmes needed

> *consciously to include measures to support the mental health of Londoners – in particular the reduction of poverty and its causes (unemployment, social and cultural isolation, poor living conditions etc.) should reduce the overall vulnerability to mental illness from which many in the capital suffer.*
>
> King's Fund London Commission (1997)

On the other hand, there is a real problem *now*: mental health services in London and deprived inner cities across the country are experiencing severe problems and cannot cope with the level of demand placed upon them. The situation in London is worse than anywhere else (Johnson *et al.*, 1997). The Tomlinson Report (1992) recommended that

urgent efforts be made to develop fully resourced community mental health teams in the Inner London areas that lacked them, and that there should be a review of the number of acute psychiatric beds, of which there were too few. Since then, matters seem to have become worse, not better, with a growing gap between demand and supply.

Will a public health approach solve the capital's mental health problems?

There might be a good argument for intervening in the way recommended by the King's Fund London Commission – to improve health in the medium and longer term, and at the level of service provision – potentially for more immediate effect. What is the evidence?

An assault on the social and economic factors underlying mental illness may have some effect. For serious mental illness, the size of the effect is difficult to predict. Although there are many and complex factors underlying the expression of mental illness through criminal behaviour, there is evidence of a clear correlation between social

deprivation and the prevalence of mentally disordered offenders, and also suicide and parasuicide rates (King's Fund London Commission, 1997).

Reducing London's rates of mental illness to less than the current rate of twice that of anywhere else in the country could release significant resources from a service that has expanded enormously in the last few years. But there is little evidence that any reduction in the incidence or prevalence of major psychiatric disorders will be realised in the short term. In the case of common disorders such as anxiety and depression, the likely effect of a public health approach will be more significant. This is supported by two recent studies (Weich *et al.*, 1997; Weich & Lewis, 1998), both of which have attempted to identify the effect on self-perceived mental health (as measured by the General Health Questionnaire) of poor housing, low income and other markers of a poor standard of living. The proportion of mental health problems detected in this way, which could be ascribed to a poor standard of living, was 10 per cent or more. The potential to reduce the incidence of moderate mental illness by at least 10 per cent across the whole population implies a significant long-term benefit to health.

However, the time required for this approach to have any effect on the incidence and prevalence of major mental illness is likely to be long, and may be attenuated as long as substance misuse among people with psychoses continues to increase (see Chapter 7), and as long as young men, particularly from minority ethnic backgrounds, continue to experience community services as alienating (Wilson, 1993). Like the well established approach to other major public health issues such as coronary heart disease and alcohol misuse, it seems clear that the long-term approach must be complemented by an effective service for people who are already mentally ill. In London, the rising level of severe illness requires a comprehensive, inter-agency programme.

Stretched specialist mental health in-patient services

In the face of the rising tide of demand in London, how well are mental health and other services coping? In particular, is the burden of mental illness in the capital likely to be affected by increasing the amount and/or altering the balance of services?

The evidence points to specialist mental health services still being unable to meet demand. They provide only for those with severe mental illness, such as schizophrenia, other psychotic illness and the dementias. There is little support for people with so-called moderate mental illness, such as depression and chronic anxiety. The extent of this pressure in London's in-patient services is manifested by:

- Rising bed occupancy rates: these have been increasing steadily, at times reaching levels as high as 125 per cent (i.e. more than one person per day). Figures for London are much worse than those for other inner city areas in England. Although occupancy has fallen recently in some parts of the capital, it is still too high at around 100 per cent.

- Among London's in-patients, the numbers of assaults and cases of sexual harassment are unacceptably high. Levels of violence are high in national terms and are above those seen among in-patients in other urban areas. Nearly three times as many London patients are compulsorily detained than in other inner cities.

- The available evidence suggests significant inequalities in service provision in London compared with other parts of the country. There are people with serious mental disorders in London who would certainly benefit from admission, but do not reach the very high threshold for hospitalisation in London. Such people would be admitted in other areas of the country.

- In-patient facilities are being used inefficiently because inappropriately placed 'new long-term' patients and patients with housing support needs remain in hospital. There is a five-fold variation in the provision of such facilities across London. The inefficiency is compounded by reliance on the private sector for 'extra-contractual referrals' (usually distant placements), which add to the difficulties of ensuring continuity of care.

- The concentration of resources on attempting to meet the needs of the most acutely ill has been associated with limited and patchy provision of other important elements in long-term care, such as day care, family and carer support services, and schemes offering sheltered or supported open-market employment.

Services in the community are not sufficient to deal with the demand

A major factor contributing to the inability of services in the community to stem in-patient pressures is that there are not enough 24-hour staffed residential places to which patients can be discharged. Across London there is a five-fold variation in the provision of these facilities, and a ten-fold variation in the provision of less intensively staffed residential care facilities. In addition, high-intensity 24-hour community services, which can substitute for hospital admission when patients are in crisis, are almost entirely absent in London. Home treatment of moderate intensity, with daily visits available on working days, is available in only a few areas of London.

Community mental health teams are effective in preventing re-admission to hospital and reducing lengths of stay, but their development is far from comprehensive across London. In some areas, community mental health teams are now fully integrated and jointly managed via pooled resources with local authorities, and reductions in hospital bed occupancy and length of stay are beginning to be seen. However, in too many parts of London coverage of the whole population is still incomplete, and integration with social care is a long way off. In addition, the workload of these teams is very high, and additional resources may be needed to ensure that they have as beneficial an impact as elsewhere.

There is strong evidence supporting the cost-effectiveness of assertive outreach teams in providing an alternative to hospital for some patients with very severe problems and who are largely disengaged from society and services (Seymour, 1998). Yet such key elements in the service spectrum are largely missing in the inner city, where they are needed most.

The development of effective community mental health teams also depends on adequate resources being made available by social services. The lack of a ring-fencing mechanism for mental health funds within most housing and social services departments exacerbates difficulties in their development. More difficulties arise in the face of the service pressures, which inevitably have been felt at local level following closure of long-stay hospitals and the financial pressures experienced by both the NHS and local authority partners. Even people who have been resettled from the old long-stay hospitals and have come with their own ring-fenced financial support have added pressure to already over-stretched services.

There is also the issue of a shortage of specific provision for the management of people with a dual diagnosis (i.e. those with mental illness and substance misuse problems), as well as a lack of any integrated approach between the mental health and drug services (see Chapter 7).

The main conclusion from this evidence is that, however strong the case for maintaining – and in some areas possibly increasing – the total in-patient provision, the capacity of the capital to provide for people with serious mental illness is hampered more significantly by the inadequacy of a range of services in the community (Johnson et al., 1997). If the gaps

in community and supported housing services could be bridged, the pressure on in-patient services would fall.

Serious incidents

London has had more than its fair share of serious mental health 'incidents', and they are becoming more frequent, although it must be said that reporting procedures and action have changed in recent years (e.g. since 1994, health authorities have been advised to carry out independent inquiries into all homicides in which the offender has had contact with specialist mental health services). There was only one homicide inquiry involving an individual with mental illness in the UK in the decade before 1985, but between then and 1996 there have been 26 such inquiries in the UK, of which no fewer than 11 were in London (Johnson et al., 1997). Similar themes emerge in these London inquiries: shortage of resources (9/11), poor communication between agencies (7/11), poor assessment of the risk of violence (6/11), problems with discharge from hospital (5/11) and poor liaison with police or the probation service (5/11). Despite the seriousness of such incidents, the consequences of the excessively high political and media profile created by successive public inquiries needs to be questioned.

Some of these problems are related to the change from a custodial service to a community service, and may be expected to improve as better training is taken up more widely. However, it will be necessary to employ less intensively trained personnel if the service is to be fully staffed, and this increase in numbers of staff will continue to impose a heavy burden of training on the service.

It is difficult to resist the conclusion that some London services have fallen well below a minimal safety level. Urgent remedial action must be taken if further disasters are to be averted.

The contribution of primary care

Whilst GPs and primary care practitioners manage high levels of moderate mental illness without much support from specialist services, it is unlikely that an improved service in primary care will do much to reduce the burden on London's mental health services in the next few years. There are a number of reasons for this.

In contrast to most other types of health care, the proportion of patients for whom general practice acts as 'gatekeeper' to specialist mental health is very variable. In some Inner London mental health units, up to 80 per cent of patients are referred from outside general practice: for example, from the criminal justice system, social services and housing departments, and the voluntary sector. Most seriously ill patients find their way to specialised mental health services via accident and emergency departments, social services or the police.

Much specialist mental health work requires particular clinical skills, techniques and facilities that are not available in primary care. Some types of disorder cannot be properly treated in an exclusively primary care setting: for example, the actively suicidal, the homicidal, many with acute psychoses and those requiring supportive day care. GPs and the primary care team need the support of social services and the voluntary sector as well as that of the specialist health services. This requires a great deal of organisation and liaison.

There is room for much improvement in the management of severe mental illness between primary care and specialist services. Shared care plans and good practice protocols can help (Goldberg et al., 1996), but their development and ownership require time and effort from two services that are already severely stretched, especially in the inner city.

Improved patterns of working between primary and secondary services will require increased staffing levels if they are to be successful, as well as retraining for existing counsellors in more effective forms of psychotherapy (Goldberg & Jackson, 1992; Goldberg & Goumay, 1997).

Differences in London

There are great differences in expenditure on mental illness in London. These differences remain great when actual levels of service are compared with estimates of need derived from the Census

Table 10.1 **Difference between actual and predicted ('MINI' model) levels of mental health service provision in Inner and Outer London**

	Category 1 Medium secure unit	Category 2 Intensive care/local secure unit	Category 3 Acute ward
Inner London	Difference	Difference	Difference
City of London	0.6	0.4	0.1
Camden	NK	−9.5	−22.0
Hackney	21.3	15.4	−16.1
Hammersmith & Fulham	NK	0.5	−15.7
Haringey	NK	1.9	−28.7
Islington	NK	−3.4	−26.6
Kensington & Chelsea	NK	−3.2	−2.9
Lambeth	4.3	3.7	−63.1
Lewisham	−0.7	−6.2	−49.7
Newham	0.3	−7.7	−61.3
Southwark	−0.8	3.6	−39.8
Tower Hamlets	NK	−4.4	−2.6
Wandsworth	−2.1	−11.3	−70.0
Westminster	NK	1.2	−52.7
Total	**22.9**	**−19.0**	**−451.1**
Outer London	Difference	Difference	Difference
Barking & Dagenham	−3.5	−4.0	−24.7
Barnet	−9.4	8.9	−2.2
Bexley	1.0	−2.7	17.4
Brent	−7.2	−2.2	−40.2
Bromley	−2.2	−8.6	−29.0
Croydon	−14.8	−2.2	−43.7
Ealing	9.8	10.0	−29.3
Enfield	11.4	−6.1	−15.1
Greenwich	−5.3	−6.5	−17.0
Harrow	−7.2	−6.3	−13.2
Havering	−0.6	−3.1	−12.2
Hillingdon	−7.6	−6.8	−15.7
Hounslow	−6.6	−8.7	−20.9
Kingston upon Thames	NK	3.1	−11.3
Merton	10.4	−2.3	−7.9
Redbridge	−7.6	1.6	2.2
Richmond upon Thames	−7.2	−6.1	−14.0
Sutton	−6.1	9.7	−16.0
Waltham Forest	−13.3	−0.8	−36.6
Total	**−66.0**	**−33.1**	**−329.4**

A negative score indicates a shortage of actual places compared to need estimated by MINI. NK = not known

Note Classification of Inner and Outer London has been changed from the source document to the Office for National Statistics definition.

Source: Johnson *et al.* (1997)

indicators used in the 1996 version of the Mental Illness Needs Index, 'MINI' (Glover, 1996). This is particularly true of acute beds. In general, discrepancies between actual and predicted figures are greatest for socially deprived areas in Inner London, such as Camden, Lambeth, Southwark, Lewisham, and boroughs in east London. In some of the outermost parts of the capital, such as Kingston upon Thames, Barnet and Bexley, levels of service provision are close to need predicted by the MINI model. Although there are some inaccuracies in the data collected on actual levels of services, Table 10.1 gives a strong indication of unmet need in the inner city.

These figures underline the impossibility of providing services adequate for the needs of deprived areas with the resources that are at present available to health authorities.

If present trends continue, socially deprived areas will experience mounting difficulties in providing an adequate mental health service, and there will be progressive difficulties in recruiting staff at all grades and in all professions.

The needs of minority ethnic communities

In London, almost half of mental health admissions to hospital are people from minority ethnic communities or those who were not born in the UK. On the whole, ethnic monitoring is poor within mental health services, yet minority ethnic groups – especially those of Afro-Caribbean origin – are relatively over-represented among patients who are compulsorily detained and under-represented among those who access 'talking therapies'. Within the constrained resources in inner city NHS trusts, it is usually not possible to provide a special service for all such patients, nor would it be desirable to do so. A large number of refugees arrive or live in London, and many do not speak English. The prevalence of mental health problems among refugees is relatively high. Special attention is

necessary to ensure that they can access the services they need, and that they can make use of them.

Four issues urgently need to be addressed:

- Ethnic and cultural sensitivity training needs to be more widely available to all staff who come into contact with patients.

- A concentrated effort must be made to recruit staff from minority ethnic communities into responsible positions in the NHS, especially mental health services.

- A clear strategy for minority ethnic users supported by mental health and bilingual advocates should be a fundamental part of an accessible service.

- People from minority ethnic communities themselves need to be encouraged to seek care from their GP earlier in the course of their illness. Available evidence suggests that delays in seeking care are longer, so illnesses are more severe by the time they come to the attention of the mental health services.

The prospect before us

The Government's response to the Turnberg Review (Department of Health, 1998b) has improved the situation in some respects: the announcement of a single Regional Office of the NHS Executive for London, with a high profile for mental health, and a review of the formula for allocating resources. The review should result in more money being made available to socially deprived inner city areas, of which many parts of London are prime examples.

As primary care groups develop towards trust status, they will acquire mental health purchasing powers from health authorities. Such a change seems certain to draw mental health resources into primary care. This would be a desirable

development if the resources at present devoted to community mental health teams were adequate, but this is far from being the case in London. It seems quite possible that well-intentioned changes led by primary care groups could result in a worsening of an already precarious situation.

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Chapter 11

Communicable disease

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Summary points

- Communicable diseases continue to present major health problems for Londoners. Standardised mortality ratios for infectious disease are higher in London than the rest of the country.

- Notifications of sexually transmitted diseases, food poisoning and tuberculosis are increasing in Inner London.

- Notifications of tuberculosis are concentrated in areas of high deprivation and where there are large black and minority ethnic communities. Tuberculosis is also a particular problem among the capital's homeless population.

- There are still gaps in the prevention, surveillance and treatment of tuberculosis, and also in fully understanding its links with ethnicity and poverty.

Implications for improvements in public health

- London needs a coherent city-wide strategy for dealing with communicable disease, closely linked with local preventive work.

Better integration of the responsibilities for prevention, surveillance and control of communicable disease is required between local authorities, health authorities and London-wide organisations and groups. There is, at present, duplication and fragmentation of effort, and a review is needed to highlight where these occur. There is also a need for better integration of the responsibility for prevention, surveillance and control of communicable disease within health authority boundaries, such as between the consultants in communicable disease control, acute and community NHS trusts, and community and general practitioners.

Links between those responsible for the prevention, surveillance and control of communicable disease and primary care must be improved to enhance surveillance and to improve uptake of immunisation.

Particular attention must be given to London-wide surveillance and control of tuberculosis, including universal BCG immunisation. Opportunities for enhancing local and regional surveillance resources should be explored.

- The prevention of tuberculosis and its appropriate treatment must remain at the local inter-agency level, but there should be more

effective collaboration; for example, twinning of like populations and cross-borough multi-agency audit against agreed standards.

Policy for tuberculosis detection and control in immigrants and refugees must be reviewed to ensure cost-effectiveness. London-wide co-ordination, and possibly surveillance, is needed. Recognition should be given to the need for additional resources to support any change in policy on screening of new arrivals for tuberculosis.

Health Improvement Programmes in areas with a high prevalence of tuberculosis should prioritise this as a key area and set targets for change.

Introduction

This chapter examines four of the key communicable disease issues affecting the capital: food poisoning, tuberculosis, sexually transmitted diseases, and childhood immunisation.

Although the distribution and nature of communicable diseases have changed dramatically this century, they remain a major source of ill health and mortality world-wide. The recent emergence of drug-resistant infectious diseases and the continuing challenges from diseases such as meningitis and food poisoning mean that effective services for the surveillance, prevention and control of communicable disease are essential.

Illness and disability caused by communicable disease are not simply the result of contact with a particular micro-organism, but are also influenced by a broad range of factors that affect the likelihood of getting an infection, and the degree of illness that follows. These factors, which are especially relevant in London, include:

- The physical and social environment, which may make the likelihood of transmission of disease between individuals greater – for example, the effects of overcrowding, homelessness or cold and damp housing (see Chapter 3), all of which are particular problems in parts of the capital.

- Poverty and deprivation, which increase the likelihood of infectious disease and the severity of illness, and are associated with greater problems in access to and use of health services.

- Increased risk in black and minority ethnic communities, and there may be particular problems for people newly arrived in the UK, refugees and people seeking asylum. More mobile populations may also suffer from problems in accessing preventive and treatment health services, which require continuity.

- Links between lifestyle and behaviour and specific infectious diseases; for example, the distinctive patterns of sexual behaviour and high incidence of HIV in London, especially in Inner London (see Chapter 5).

These factors also increase the challenges of prevention and control of communicable disease in London. Given these factors, it is not surprising that mortality rates from infectious and parasitic disease in London are higher than national averages (see Table 11.1).

Pan-London surveillance

Effective surveillance and control of communicable disease require close collaboration between many different organisations and professionals. Although individual organisations have some specific statutory responsibilities, joint working between agencies is essential to ensure a co-ordinated and effective approach. In London, responsibility for communicable disease is divided between 33 London borough environmental health departments

Table 11.1 **Standardised mortality ratios for infectious and parasitic diseases, 1995**

SMRs	Under 65	Under 75	All ages
Inner London	396.1	361.2	298.4
Outer London	137.6	130.9	124.3
Greater London	237.8	218.4	187.8
England & Wales	100.0	100.0	100.0

Source: Office for National Statistics (1996)

and 16 health authorities (employing 19 consultants in communicable disease control). A recent survey to assess the adequacy of arrangements for communicable disease control in England revealed that there were areas, including parts of Greater London, where arrangements needed strengthening (Regional Services Division, PHLS Communicable Disease Surveillance Centre, 1997). This review observed that, whilst reactive work, such as the investigation and management of outbreaks, was well handled, there was scope for improvement in proactive, preventive activities and commissioning of appropriate services. Communicable disease control could be improved by a national restating of standards and status of work at regional and district level to address aspects needing further development.

Some of the problems of surveillance of communicable disease in the capital were addressed by the establishment of the London Communicable Disease Surveillance Project (LCDSP) in 1994. This successfully introduced a single electronic surveillance system across London. The Communicable Disease Surveillance Centre (CDSC) for the Thames area (which superseded LCDSP in 1996) has a pan-London role in surveillance and control by liaising – across both Thames Regions – with NHS and public health laboratories and local consultants in communicable disease control.

Food poisoning

Food poisoning is defined as 'any disease of an infectious or toxic nature caused by or thought to be caused by the consumption of food or water'. It is a 'notifiable' disease, which means that, when diagnosed, it must be formally reported to the health authority.

Vulnerable groups such as children, elderly people and those with immune disorders are particularly at risk of serious illness, and many days are lost in the workplace and in school because of food poisoning. The cost in terms of workload for primary care and hospitals is also an important consideration, and an increase in the numbers of individual cases and outbreaks also results in an increasing burden for those with responsibilities for communicable disease control.

There were 8,814 notifications of food poisoning in Greater London in 1996 (125 per 100,000 people). The number of notifications of food poisoning has increased steadily in London since the beginning of the 1980s (see Fig. 11.1), but the rate of the increase has slowed in the last three years. This increase is probably due to a combination of a number of factors:

- improvements in data collection;

- a growth in demand by the general public for 'fast food', and large increases in the number of outlets;

- insufficient training of food handlers;

- poor adherence to the Food Safety Act 1990, with particular reference to food hygiene practice in food outlets;

Fig. 11.1 Notifications of food poisoning in Greater London per 100,000 population, 1986–96
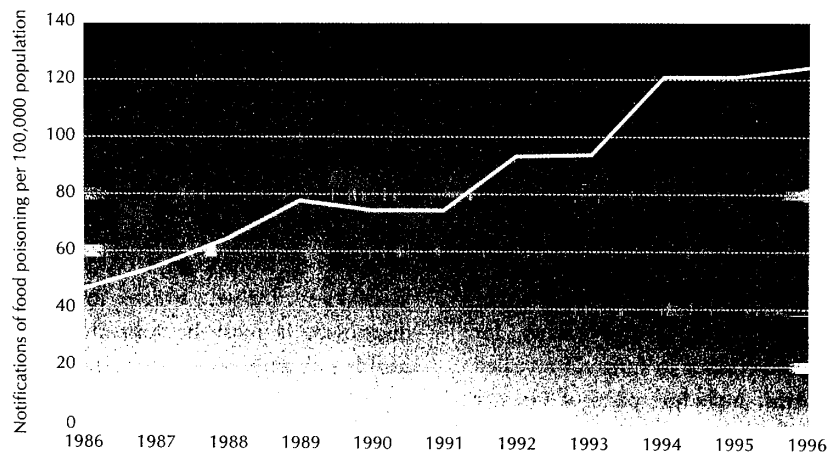
Source: Department of Health (1997)

- changes in food production, such as mass poultry farming, which increase rather than reduce food poisoning;

- changes in the pattern of disease and in the micro-organisms that cause disease, such as the increase in cases of *E. coli 0157* (responsible for the Scottish outbreak of food poisoning in 1997).

The interpretation of trends in notifications for any infectious disease, and for food poisoning in particular, is complicated by problems with the notification system. In some instances it is clear that a group of cases can be linked to one cause, so it is vital that surveillance systems are able to identify such outbreaks. However, the notifications have to be consistent for a system based on them to operate effectively.

Food safety and the prevention and control of food poisoning are key issues for London. The Food Standards Agency aims to 'promote high standards throughout the food chain', and may help in dealing with some of the problems. To reduce rates of illness from food poisoning in London, this initiative needs to be coupled with improvements in surveillance and control. Timely notification of cases of food poisoning is very important (agreed as within 48 hours in North Thames and within 72 hours in South Thames at an audit conference on food poisoning held at CDSC in February 1998). Public health would benefit from the development of a standard approach to the investigation of notifications of food poisoning, through audits of resources used and of outcomes in collaboration with environmental health colleagues.

Tuberculosis

Tuberculosis presents a major and growing public health challenge for London. Although its incidence declined throughout most of this century, rates began to rise again in the late 1980s in many areas of the world, including London (see Fig. 11.2).

Latest figures suggest that, in any one year in London, there are over 2,000 notified cases of tuberculosis (Department of Health, 1997), with around 1,300 hospital admissions and 95 deaths. Age- and sex-standardised notification rates for London are about three times higher than national

Fig. 11.2 **Notifications of tuberculosis in London per 100,000 population, 1986–96**
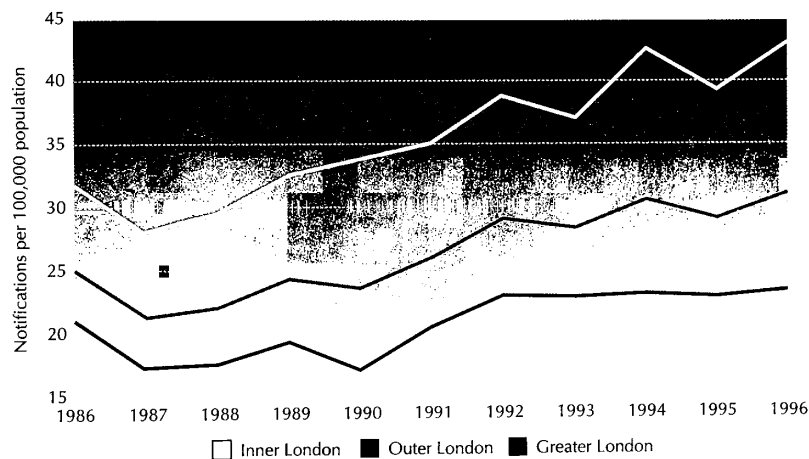
Source: London Group of Consultants in Communicable Disease Control (1995); Department of Health (1996, 1997)

averages, and more than six times higher in some London boroughs (e.g. Brent, Hackney and Newham) (Department of Health, 1997). In 1996, more than a third (39 per cent) of all notified cases of tuberculosis in England and Wales occurred in London.

The incidence of tuberculosis has been associated with poverty (Spence et al., 1993; Darbyshire, 1995) and ethnic origin (Docherty et al., 1995) and, perhaps most important, as an interaction between these factors (Lavender & Black, 1995). The relative risk of tuberculosis among minority ethnic communities has been shown to be highest in black African refugee groups (Bhatti et al., 1995; Docherty et al., 1995). Tuberculosis is also a particular problem among homeless people (see Chapter 3). Thus, notifications of tuberculosis are concentrated predominantly in areas of high deprivation or where there are major minority ethnic communities (Mangtani et al., 1995) (see Figs. 11.3 and 11.4).

London's rates are higher than any other city in England. The highest rates in London, and in England, in 1996 were in Newham (81 per 100,000), Brent (73 per 100,000) and Hackney (64

per 100,000). If all of the local authorities in England are ranked according to the standardised tuberculosis notification rate in 1996, 16 of the highest 20 values in England are from London boroughs.

The past few years have seen a growth in the number cases of tuberculosis resistant to standard treatments. A serious outbreak of this form of tuberculosis (which has happened in parts of the USA and in mainland Europe) would present even greater health problems, with more deaths and a wider spread of the disease. This situation therefore requires careful monitoring. At the moment, the proportion of multi-drug-resistant isolates of Mycobacterium tuberculosis (the organism that causes tuberculosis) is very small, but is rising both nationally and in London. In 1995, multi-drug-resistant tuberculosis accounted for 2.6 per cent of all cases in London, compared to 1.9 per cent for England and Wales as a whole (see Fig. 11.5).

A factor that might promote the development of multi-drug-resistant tuberculosis is patients not completing their anti-tuberculosis treatment course. Chest physicians are reporting (anecdotally) increasing problems with patients not taking the

Fig. 11.3 **Standardised tuberculosis notification rate vs Jarman Underprivileged Area score, by London borough, 1996**
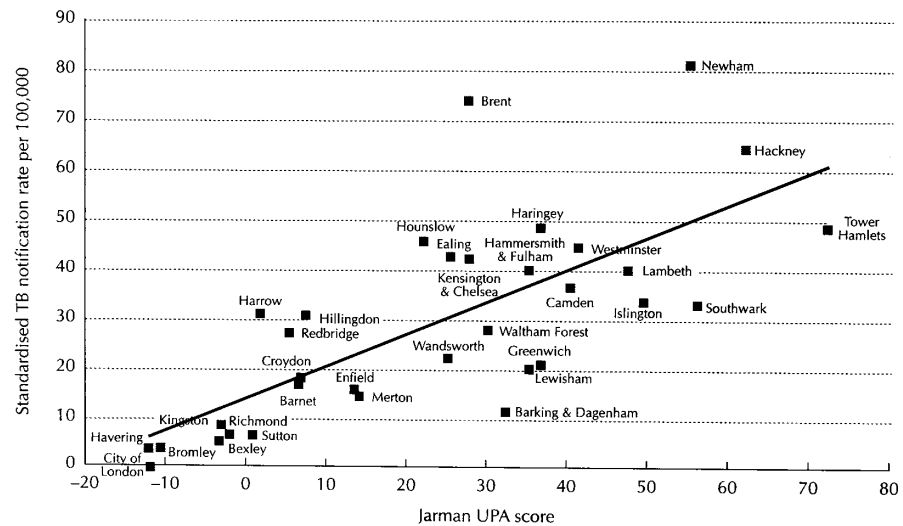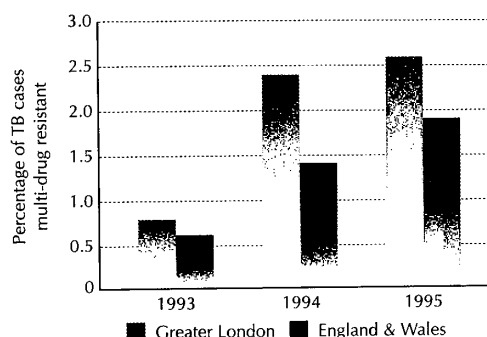

Source: Department of Health (1997)

Fig. 11.4 **Standardised notification rates of tuberculosis by London borough, 1996**
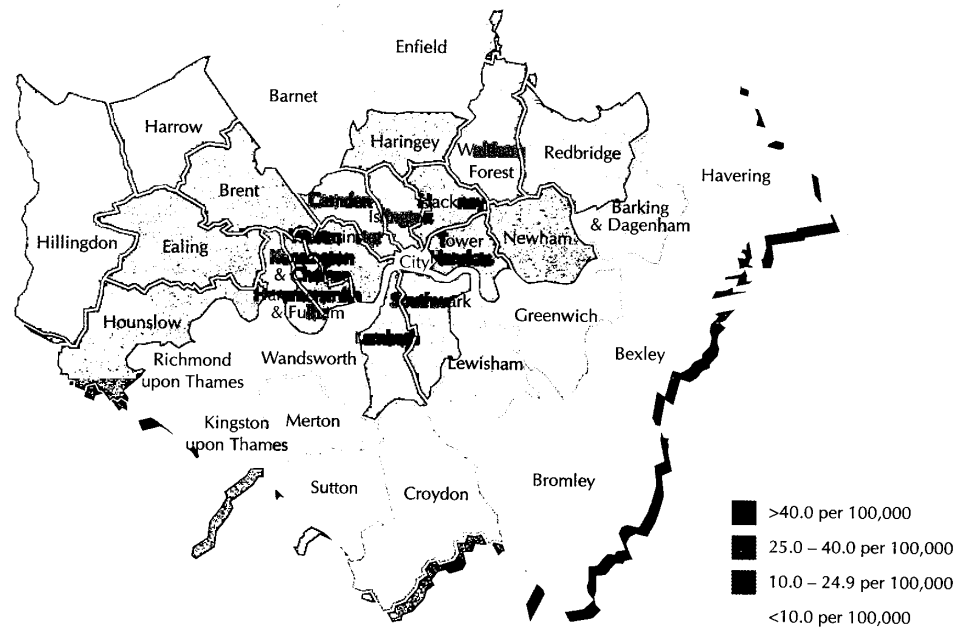
Source: Department of Health (1997)

Fig. 11.5 **Multi-drug-resistant *Mycobacterium tuberculosis* as a percentage of all cases in London and in England and Wales, 1993–95**

Source: Unpublished data from the UK Mycobacterial Resistance Network ('Mycobnet' 1997)

full course of treatment. Although we do not know the extent of this 'non-compliance', it is becoming increasingly necessary to supervise treatment more closely or to use 'directly observed treatment' (i.e. actually observing people take the drugs as prescribed to ensure that treatment is completed). Proper surveillance and assessment of the need for such measures are an important factor in planning services for tuberculosis and in estimating how poor compliance might contribute to multi-drug resistance.

Tuberculosis is curable if treated, and largely preventable. BCG immunisation offers good protection for young people, and, in areas designated by the World Health Organization/ Department of Health as having a high incidence (more than 40 cases per 100,000 population), BCG should be given at birth. Not only is there no routine information on BCG uptake across London, neither there is any policy coherence across the capital.

In combating tuberculosis, there must be systems for:

- surveillance to identify adverse trends and focus on priority groups;

- early identification of cases;

- treating those who have the condition, and ensuring that treatment is properly taken and completed;

- BCG immunisation, universally in schools and newborn babies where appropriate;

- tracing contacts and people at high risk of developing tuberculosis.

A report on the surveillance, prevention and control of tuberculosis in London in 1995 (London Group of Consultants in Communicable Disease Control, 1995) contained a number of recommendations for the control of tuberculosis (summarised in Box 11.1). However, it has proved difficult to implement these recommendations, partly because of a primary need to strengthen and co-ordinate surveillance and provision of services across London. Work is currently underway to look at the problems preventing the implementation of the recommendations, which include relatively mobile populations, large numbers of people coming from countries with high levels of tuberculosis and a shortage of community nurses and other staff in some areas of the capital. Moreover, there can be difficulties in immunising newborn babies in areas of high tuberculosis incidence (see 'Childhood immunisation', later), and inconsistent policies between London boroughs on following up new arrivals and refugees for tuberculosis add to the problems. The existing Port Health arrangements (welcome letters advising how to find a GP and utilise health services, sent to all new arrivals notified by London's Port Health Service in conjunction with the immigration authorities) seem to be inadequate in controlling tuberculosis in new arrivals and refugees from countries with a high prevalence of the disease. Surveillance and control are undertaken by too many agencies – 16 health authorities using information received from 33 local authorities. It has been proposed that control might be improved by a central register of cases and pan-London surveillance, as has been implemented in

Box 11.1 Summary of recommendations on tuberculosis control in the capital by the Working Party on Tuberculosis of the London Group of Consultants in Communicable Disease Control, 1995

- The present notification system should include additional information on ethnicity, country of birth, year of entry to the UK, travel history, and results of sputum smear tests.

- Surveillance and control of tuberculosis across London would be improved by a single register of named cases.

- Improved tuberculosis surveillance programmes are required for new entrants, refugees and people from minority ethnic communities.

- Collaborative initiatives are required to establish the extent of tuberculosis in the homeless, and the prevalence of co-infection with HIV.

- Special measures are required to improve the control of tuberculosis in people exposed to the above risks.

- Work is required to assess whether, in the London population, there is evidence of spread of *Mycobacterium tuberculosis* outside known risk groups.

- Agreed protocols, contracts and audit arrangements should be in place for the surveillance, prevention and control of tuberculosis.

- Early diagnosis and appropriate treatment are the key to prevention and control: awareness of tuberculosis should be improved among medical staff by regular feedback of surveillance and audit reports.

- The Working Party endorses the British Thoracic Society guidelines and standards of care, and recommends their incorporation into purchaser/provider contracts, with emphasis on the importance of ensuring that all cases of tuberculosis be referred to consultants experienced in treating the disease.

Source: London Group of Consultants in Communicable Disease Control (1995)

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other cities. The additional resource implications of the recent Department of Health pilot to change tuberculosis screening policy for new arrivals need to be taken into account, as a large proportion of this population is under-counted and thus not reflected in health and local authority allocations.

Guidance from the Department of Health, along with problems in implementing the recommendations of the 1995 report, have prompted re-examination of surveillance for tuberculosis and provision of appropriate services, by a number of health professionals in London.

Sexually transmitted disease

Patterns of sexual behaviour in London mean that the problems posed by sexually transmitted disease tend to be greater than elsewhere in England and Wales (see Chapter 5). In addition to the high prevalence of HIV infection in the capital, rates of other sexually transmitted diseases tend to be high in London – for example, the total number of new cases of gonorrhoea seen in genitourinary medicine clinics in London in the first half of 1996 was almost double the number seen in the rest of England, and showed a 43 per cent increase over the first half in 1995. Trends for other (non-HIV) sexually transmitted diseases over the same period also show rises in first-attack herpes simplex (up by 40 per cent) and uncomplicated chlamydia (up by 32 per cent). Surveillance data and recent research reveal that rates of gonorrhoea were six to seven times higher in Lambeth, Southwark & Lewisham in 1994/95 than for England and Wales in the previous year (Low *et al.*, 1997). Although data are not yet available by district of origin, this increase may explain some of the differences in London; for example, commuters using services near where they work rather than near where they live. Sexually

transmitted diseases cause illness and discomfort in themselves, but may also have an impact on the future fertility and health of the population.

Addressing the problems should include:

- education about primary prevention;

- an increase in the quantity and quality of sexual health promotion in schools and for young people in other settings;

- early diagnosis to reduce the chances of people passing on infections;

- prompt treatment to reduce the long-term effects of illness;

- improved tracing and treatment of contacts where appropriate.

The relative anonymity, deprivation and population movement within and into the capital encourage the spread of sexually transmitted disease. Targeting effective prevention initiatives to 'at risk' groups (homosexual men, young people and drug users) is essential if progress is to be made in reducing the incidence and prevalence of sexually transmitted diseases. It is important to understand the characteristics and networks of groups most affected by such diseases.

Surveillance of sexually transmitted diseases is an important aspect of their control, but there is no formal, single notification system. Surveillance relies on laboratory reports and numbers of new cases seen in genitourinary medicine clinics, which means that the geographic distribution of sexually transmitted diseases is difficult to determine, because people may be using services some distance from where they live. It is difficult therefore to plan diagnostic, treatment and preventive services to address the problems of sexually transmitted diseases and to target resources to the areas of greatest need. Development of a better surveillance system has already started through the Sexually Transmitted Infection Surveillance and Commissioning Information System (SCIS), based

at Imperial College. The aim of this project is to recruit all genitourinary medicine clinics in the North Thames Region to a surveillance initiative mirroring the one that has been running in South Thames (West) since 1995. A co-ordinated approach between districts and clinics would enhance the value of information throughout London and allow more informed prevention and control initiatives, provided that client confidentiality is retained.

Childhood immunisation

Immunisation and vaccination programmes have been one of the most important and effective tools in the prevention of infectious disease in childhood. It is important that existing programmes are maintained in order to prevent the recurrence of diseases such as polio (which, though common 50 years ago, is now virtually unknown) or diphtheria (which has returned to epidemic levels in parts of eastern Europe).

The success of these programmes is usually assessed by the number of 2-year-olds who have received each immunisation, for which there is a national target of 95 per cent. The BCG immunisation programme has already been mentioned as important in the prevention and control of tuberculosis, but the uptake of BCG immunisation across London is unknown.

For children, there are three major immunisation and vaccination programmes:

- measles, mumps and rubella (MMR);

- diphtheria, tetanus and polio (DTP);

- *Haemophilus influenza* (Hib).

While great efforts have been made in the Thames Regions to reach the national target uptake rate, levels in 1996 were below the 95 per cent target (Department of Health, 1997). For certain vaccines, rates of uptake have been falling over the last couple of years, largely as a result of adverse

Fig. 11.6 **Children immunised against measles, mumps and rubella (MMR) by their second birthday in the London health authorities, 1996**

Percentage of children immunised (MMR) by their 2nd birthday
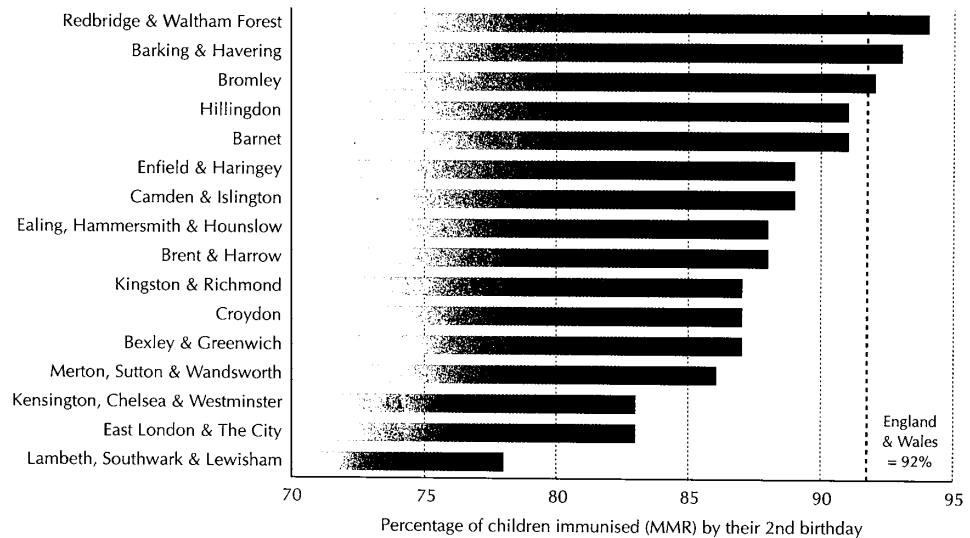
Source: Department of Health (1997)

media publicity. This is most marked for measles, mumps and rubella vaccination, recently in relation to autism and bowel disease.

Although uptake of immunisation varies between areas of London, there are very much lower uptake rates in Inner London (see Fig. 11.6), especially in Lambeth, Southwark & Lewisham (where DTP and Hib rates are 85 per cent and MMR rates 74 per cent at 24 months), in East London & The City (88 per cent for DTP and Hib, and 78 per cent for MMR at 24 months), and in Kensington, Chelsea & Westminster (83 per cent for MMR and 88 per cent for Hib at 24 months).

In some health authorities, low uptake rates may be associated with problems in data collection as well as a mobile and deprived population. The national MMR campaign in 1994 was particularly successful in London, with a marked reduction in the number of cases of measles being reported in the teenage population. If momentum is to be maintained and uptake rates improved, the accuracy of the data

needs to be improved. The difficulties faced are highlighted by the differences between information on child health computer systems and from GP target payments. Linking these information systems electronically may enable better surveillance to take place. In addition, improving co-ordination and communication between different professionals and agencies must be a priority. There also needs to be improved health education for all health professionals and parents to counter the adverse publicity about immunisation. Special attention must be given to the groups that are hardest to reach, such as travellers, homeless families and those whose first language is not English.

There is a need for continued London-wide efforts to ensure that the targets for immunisation are met throughout the capital. Pooling information, resources and examples of good practice help practitioners avoid duplication of effort, by addressing similar problems with the same approach in different areas of London.

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Appendix 1

About The Health of Londoners Project

Project background

The Health of Londoners Project was set up in early 1995 with funding from the two Thames regional health authorities, the London Implementation Group and seven London health authorities. This group has expanded and now funding is provided by all 16 London health authorities and the North and South Thames Regional Offices of the NHS Executive.

The Project arose from a recognition that health authorities need a London-wide perspective on health. This was fuelled in part by the Tomlinson Report and subsequent initiatives, but also by major issues affecting the health of the whole capital such as housing, air pollution and transport.

The Project has a core team based at the East London & The City Health Authority and works with specialists in public health departments across London. It is overseen by a Steering Group (see Appendix 2) with representatives from all London health authorities.

Project objectives

The Project's main objectives are:

- To provide policy makers with an informed view of how health is changing within London and the impact recent initiatives may have over time.

- To provide useful comparative information that health authorities and partner agencies can use to inform and support local analysis of health policy.

- To bring together and build on some of the many sources of data on health and its determinants in London.

- To develop a means of twinning like populations in London.

- To create the basis of a health network involving health authorities and associated local authorities and other London-wide umbrella groups.

A centre for London-wide health information and analysis

Much of the Project's work is concerned with reviewing and analysing basic health information, using data primarily at health or local authority level, but also some ward level analyses. The Project analyses and reviews key information on:

- health statistics, mortality and morbidity;

- population and census data;

- social and environmental indicators.

Examples of such studies are a review of key facts and figures on London's health and projections of Health of the Nation mortality indicators, both of which use a comparative framework to look at similarities and differences between geographical areas and provide a city-wide view of health. The data from these analyses have been provided to health authorities and other agencies, and have subsequently been used as part of local analyses for health reports, performance monitoring and strategy development.

Focused project work

Specific topics are examined in detail as small projects led by individual health authorities. An example is a report on transport in London. This examines the way that transport issues influence health and how securing change requires action beyond individual health authority and local authority boundaries. Other such work includes a study of HIV-related and sexual behaviour indicators in London and a major review of contraception and abortion services in the capital. Current work topics include analyses of housing and health in the capital, a review of child health in London and the health of refugees and asylum seekers.

Working with other agencies and networks

The Project maintains close contact with relevant groups outside public health, collaborating on important work such as the contribution of a chapter on health and deprivation to a major report on poverty and social exclusion by the London Research Centre. Contacts have also been consolidated with groups such as the Association of London Government, the King's Fund and other public and academic groups (e.g. South East Institute of Public Health).

Appendix 2

London health authorities

Barking & Havering Health Authority
The Clock House, East Street, Barking, Essex
IG11 8EY
Telephone: 0181 591 9595   Fax: 0181 532 6201
Chief Executives: Sue Osborn/Sue Williams
Director of Public Health: Chris Watts
The Health of Londoners Project Steering Group
Representative: Frances Haste

Barnet Health Authority
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London NW9 6QQ
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Chief Executive: Judy Hargadon
Director of Public Health: Stephen Farrow
The Health of Londoners Project Steering Group
Representative: Stephen Farrow

Bexley & Greenwich Health Authority
221 Erith Road, Bexleyheath, Kent DA7 6HZ
Telephone: 0181 298 6000   Fax: 0181 298 6001
Chief Executive: Michael Kerin
Director of Public Health: Luise Parsons
The Health of Londoners Project Steering Group
Representative: Luise Parsons

Brent & Harrow Health Authority
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Bessborough Road, Harrow, Middlesex HA1 3EX
Telephone: 0181 422 6644   Fax: 0181 426 8646
Chief Executive: Mary Whitty
Director of Public Health and Health Policy: Mike Gill
The Health of Londoners Project Steering Group
Representative: Mike Gill

Bromley Health Authority
Global House, 10 Station Approach, Hayes, Kent
BR2 7EH
Telephone: 0181 315 8315   Fax: 0181 462 6767
Chief Executive: Claire Perry
Director of Public Health: Jackie Spiby
The Health of Londoners Project Steering Group
Representative: Angela Bhan

Camden & Islington Health Authority
Insull Wing, 110 Hampstead Road, London NW1 2LJ
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Chief Executive: Simon Robbins
Director of Public Health: Maggie Barker
The Health of Londoners Project Steering Group
Representative: Maggie Barker

Croydon Health Authority
Knollys House, 17 Addiscombe Road, Croydon,
Surrey CR0 6SR
Telephone: 0181 401 3900   Fax: 0181 680 2418
Chief Executive: Terry Hanafin
Director of Public Health: John Shanks
The Health of Londoners Project Steering Group
Representative: Catherine Scott

**Ealing, Hammersmith & Hounslow Health
Authority**
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Director of Public Health: Mike Soljak
The Health of Londoners Project Steering Group
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East London & The City Health Authority
81–91 Commercial Road, London E1 1RD
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Director of Public Health: Bobbie Jacobson
The Health of Londoners Project Steering Group
Representative: Bobbie Jacobson (Chair)

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The Health of Londoners Project Steering Group
Representative: Keith Baker

Hillingdon Health Authority
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West Drayton, Middlesex UB7 7HJ
Telephone: 01895 452000   Fax: 01895 452108
Chief Executive: David Panter
Director of Public Health: Hilary Pickles
The Health of Londoners Project Steering Group
Representative: John Aldous

Kensington, Chelsea & Westminster Health Authority
50 Eastbourne Terrace, London W2 6LX
Telephone: 0171 725 3333   Fax: 0171 725 3398
Chief Executive: John James
Director of Public Health: Sally Hargreaves
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Chief Executive: Laura Noel
Director of Public Health: Lucy Moore
The Health of Londoners Project Steering Group
Representative: Cathy Shaw

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Regional Director of Public Health: Maureen Dalziel
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