

F BETTER HEALTH FOR ALL

Main messages

Average life expectancy for both men and women increased between 1981 and 1995. Healthy life expectancy also increased but not as fast as total life expectancy, so by 1995 men could expect to spend 8 years of their lives and women 11 years in poor health. Men in unskilled occupations have a 9-year lower total life expectancy than those in professional occupations.

Death rates from cancer, circulatory disease, accidents and suicides declined between 1970 and 1996.

Relevance

Life expectancies in GB have been increasing for many years and in 1995 were 74 years for men and 79 years for women. But it is not just overall length of life that matters; we want to live longer, but in good health; and we want to ensure that everyone has the chance to live a long and healthy life, not just those in certain social groups.

This means tackling the major causes of premature death such as heart disease, cancer, accidents and suicides. It also means looking at the reasons for ill health and health inequalities, to make sure that those who are ill have access to health care, wherever they live and regardless of their ability to pay, and that they do not have to wait too long for treatment.

The extent to which the key objectives identified in the Strategy are being achieved, as reflected by the indicators, is illustrated in the following table.

Key strategies

- *A better quality of life. A strategy for sustainable development for the UK (7.19-7.25)*
- *Our Healthier Nation: A contract for health¹*

Some other related indicators:

Indicators of success in tackling poverty and social exclusion (**H4**); Homes judged unfit to live in (**H7**); Days when air pollution is moderate or higher (**H10**); Proportion of people of working age out of work for more than two years (**C6**); People in employment working long hours (**C8**); Work fatalities and injury rates; Working days lost through illness (**C10**); Pesticide residues in food (**D12**); Index of local deprivation (**E2**); Truancies and exclusions from school/Teenage pregnancies (**E3**); How children get to school (**G2**); Access to services in rural areas (**J2**); Participation in sport and cultural activities (**J4**); Fear of crime (**K9**); Concentrations of persistent organic pollutants (**M1**); Dangerous substances in water (**M2**)

¹ July 1999, ISBN 0-10-143862-1

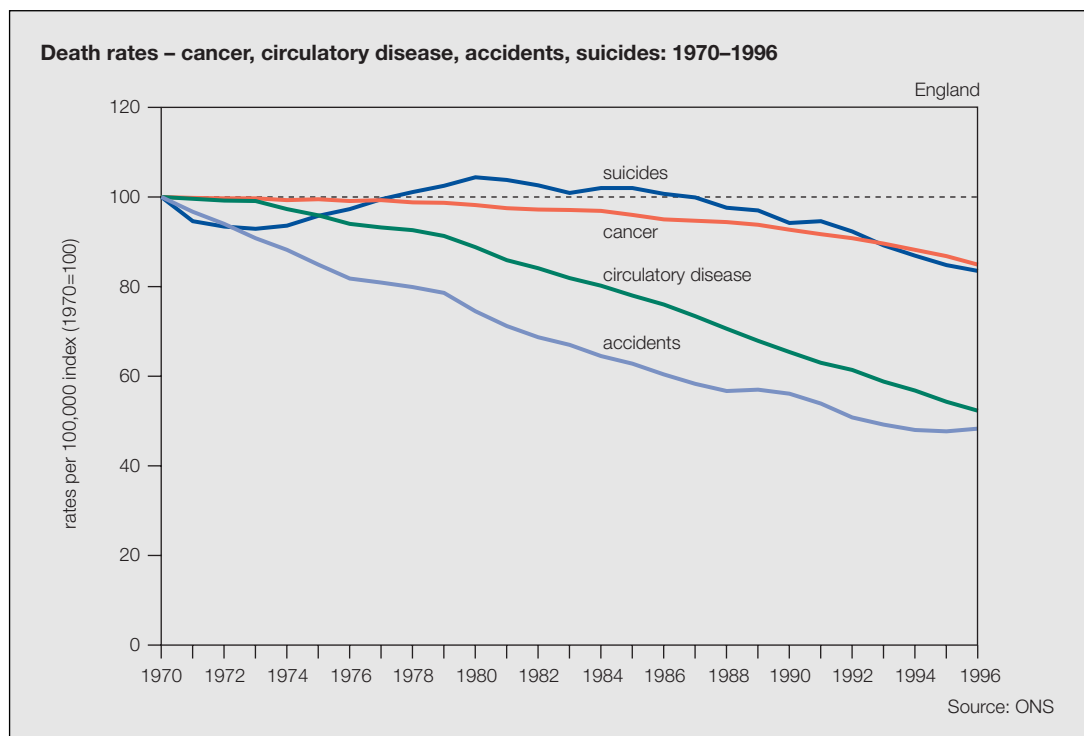
Objective	Ref no.	Indicator	Data used	Change since		Specific targets/goals
				1970	1990	
Improve health of the population overall	H6	Expected years of healthy life (headline)	1981-1995	✓	≈	An increase in healthy life expectancy at age 65, in England
Deliver key health targets	F1	Death rates from cancer, circulatory disease, accidents and suicides	1970-1996	✓	✓	Four national targets to reduce mortality from cancer, accidents, circulatory disease and suicide, and to reduce the rate of serious injury from accidents in England.
Environmental factors affecting health	F2	Respiratory illness	1995/96	
Address major factors leading to health inequalities	F3	Health inequalities	1972/76-1992/96	✗	✗	No national targets, but health authorities are expected to set local inequalities targets
Provide people with access to effective healthcare, based on patients' needs, and not on where they live or their ability to pay	F4	NHS hospital waiting lists	1993-1999	...	✓	Reduce NHS waiting lists to 1,058,000 by the end of this Parliament in England

Key	
✓ significant change, in direction of meeting objective	✗ significant change, in direction away from meeting objective
≈ no significant change	••• trend is uncertain or no quantitative data available
na not applicable, in cases where the indicator is for contextual purposes	

Objective Deliver key health targets

Indicator Death rates from cancer, circulatory disease, accidents and suicides

F1



Death rates from cancer, circulatory diseases (people under 75), accidents and suicides (all ages), have been declining – for cancer, circulatory diseases, and accidents, rates have been falling over the period 1970 to 1996, and for suicides the rate has been falling over the period 1981 to 1996.

Relevance Improving people's health is a key sustainable development objective and better health for everyone – for the worst off in society as well as the more affluent, for men and for women.

Targets and goals Targets have been set to reduce the death rates by the year 2010 (relative to 3 year average up to 1997), in England, in the following priority areas:

- circulatory disease: to reduce the death rate in people under 75 by at least 40 per cent
- cancer: to reduce the death rate in people under 75 by at least 20 per cent
- accidents: to reduce the death rate by at least 20 per cent
- suicides: to reduce the death rate by at least 20 per cent

Trends *Circulatory disease:* Circulatory disease death rates among people aged under 75 have been falling steadily over the period 1970 to 1996. However, among certain subgroups, for example stroke death rates in the under 65 age group, the rate of decline has slowed down in recent years.

Cancer: Death rates are falling, but the risk of developing cancer appears to be increasing. Approximately a quarter of a million cases of cancer are diagnosed in the UK each year and one in three persons is expected to develop cancer.

Accidents: Death rates from accidental causes for all ages have shown a fairly consistent decrease over the period 1970 to 1996. However, the picture is not the same for all age groups; for example, among older people (aged 65+) the rate of decline has slowed in recent years. The figures from the most recent years suggest that the trend is flat, but more years' data will be needed to confirm this.

Suicides: Suicide rates in the population rose during the 1970s, but generally declined over the period 1981 to 1996. Suicide among young men continued to increase during this time, though rates have recently shown signs of stabilising.

Background

Major lifestyle factors which increase the risk of developing circulatory disease ie heart disease, stroke or related illnesses, include smoking, poor diet, lack of physical exercise, high blood pressure, excessive alcohol consumption and excessive stress. Mortality rates from circulatory disease in working age men are higher in unskilled groups than in professional groups. Death rates are also higher in the North of England than in the South.

About a third of all cancer deaths in England are due to smoking. Poor diet is estimated to play a role in about a quarter. Exposure to infections, pollutants and radiation can all cause cancer. Mortality rates from cancer in working age men are higher in unskilled groups than in professional groups and much of the difference is due to a higher rate of smoking in the former. Many women from ethnic minority groups or deprived inner city areas do not come forward for screening. If the survival rates among the poorest matched those among the richest in England and Wales, 12,700 untimely deaths could have been prevented amongst those diagnosed between 1986 and 1990.

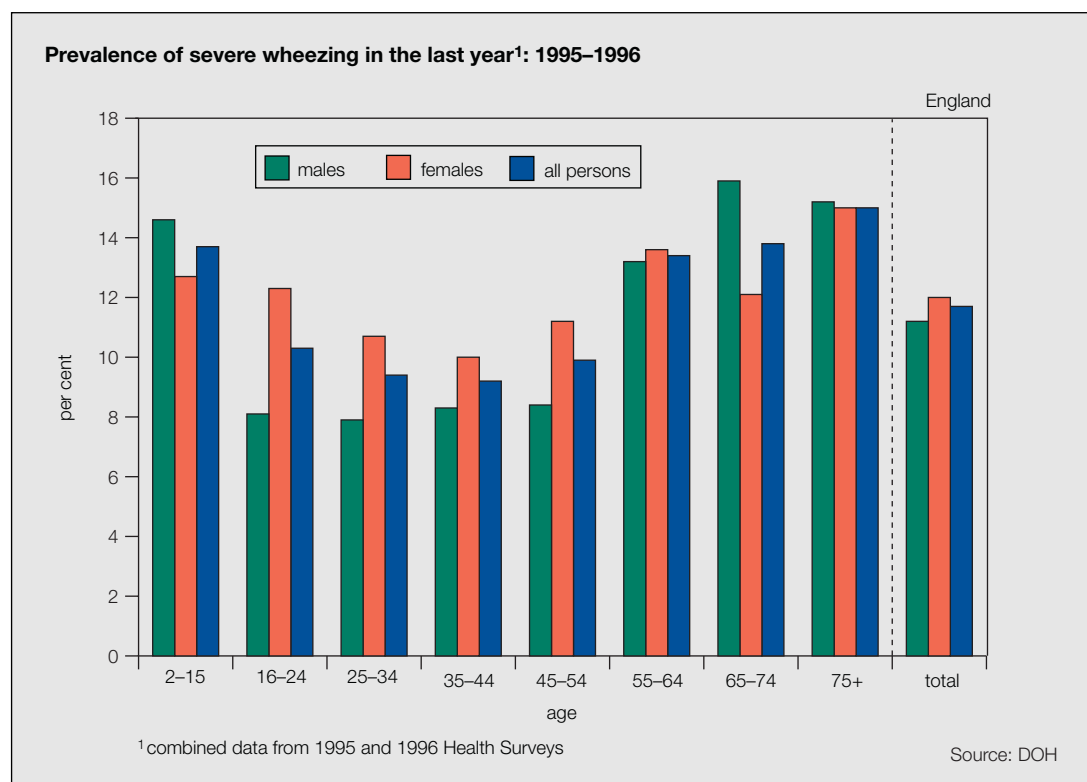
Children in families where the head of the household is in an unskilled occupation are five times more likely to die in accidents than children from families headed by a professional. The rate of fatal accidents among 15-24 year olds is higher in rural than in urban areas.

Suicide is often the result of severe mental health problems. The figures include official suicides as declared by the coroner and unofficial suicides or open verdicts are those where there may be doubt about the deceased's intentions. Research studies show that most open verdicts are in fact suicides. Recent figures show that 76% of suicide and undetermined injury deaths were males. Mortality rates from this cause in working age men are higher in unskilled groups than in professional groups. Certain occupations e.g. vets and doctors have high rates of suicide compared with the general working population. There are also high rates of suicide among young women born in the Indian sub-continent and living in England and Wales.

Objective Environmental factors affecting health

Indicator Respiratory illness

F2



In 1995-6, 12 per cent of the population overall, and 14 per cent of children, reported severe wheezing in the last twelve months. Unskilled men are twice as likely to report severe wheezing as professional men, and people living in urban areas are more likely to report severe wheezing than those in rural areas.

Relevance Severe wheezing resulting from respiratory illness such as asthma, is a major cause of acute and chronic morbidity in children. Asthmatic attacks can result in premature deaths in both children and adults.

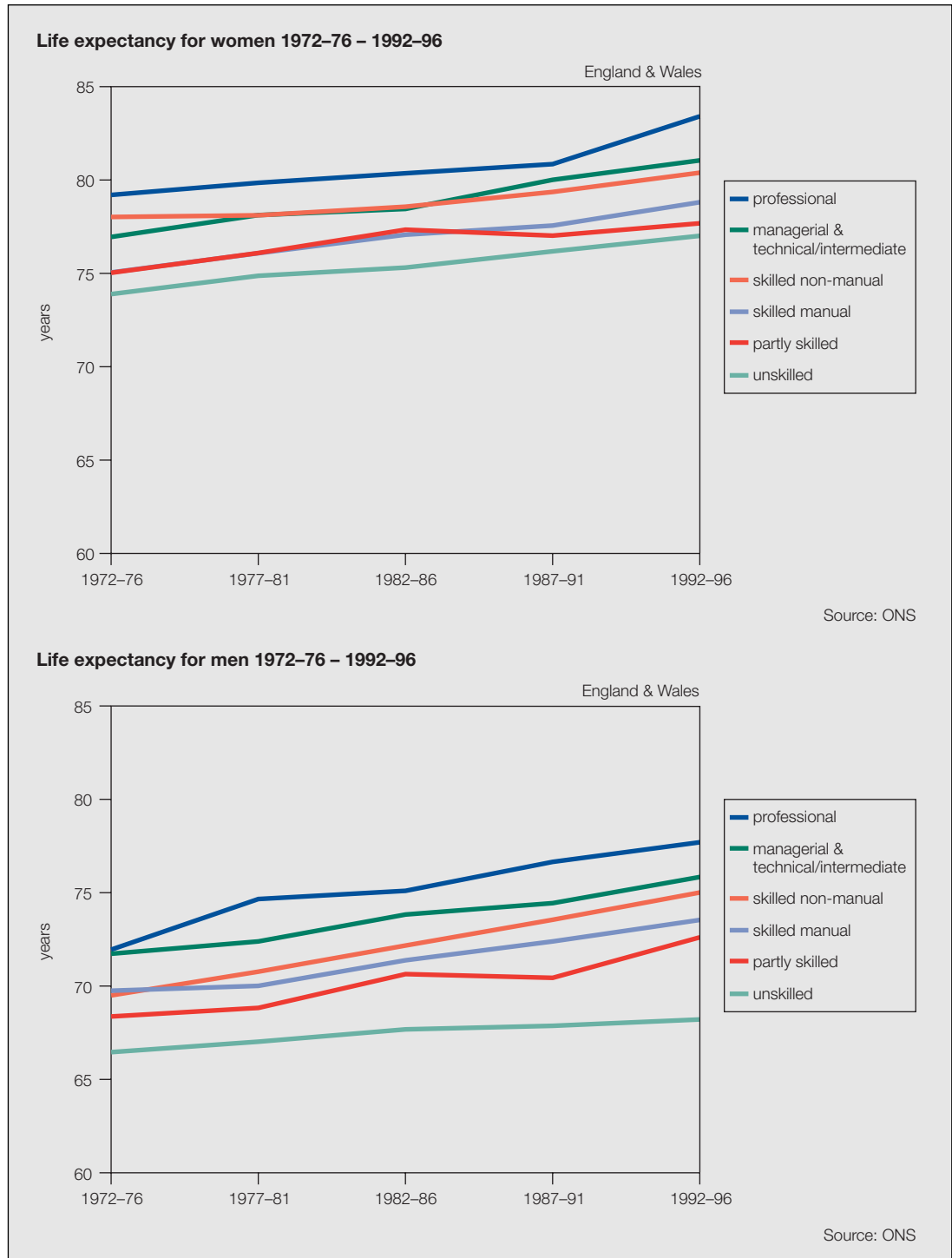
Trends Current evidence suggests an increase in the prevalence of asthma over the last several years. However, this may be due, in part, to changes in the uptake and provision of services.

Background Severe wheezing is defined as being of sufficient severity to either cause sleep disturbance, interfere with daily activities or cause absence from school/work. Air pollution can cause such breathing difficulties, particularly amongst people who are already asthmatic.

Objective Address major factors leading to health inequalities

Indicator Health inequalities

F3



Between 1972 and 1996 life expectancy in England and Wales has increased for all Social Classes, but those in professional and managerial occupations can expect to live longer than those in partly skilled and unskilled occupations.

Relevance Helping people in all walks of life to live longer healthier lives is a key sustainable development objective

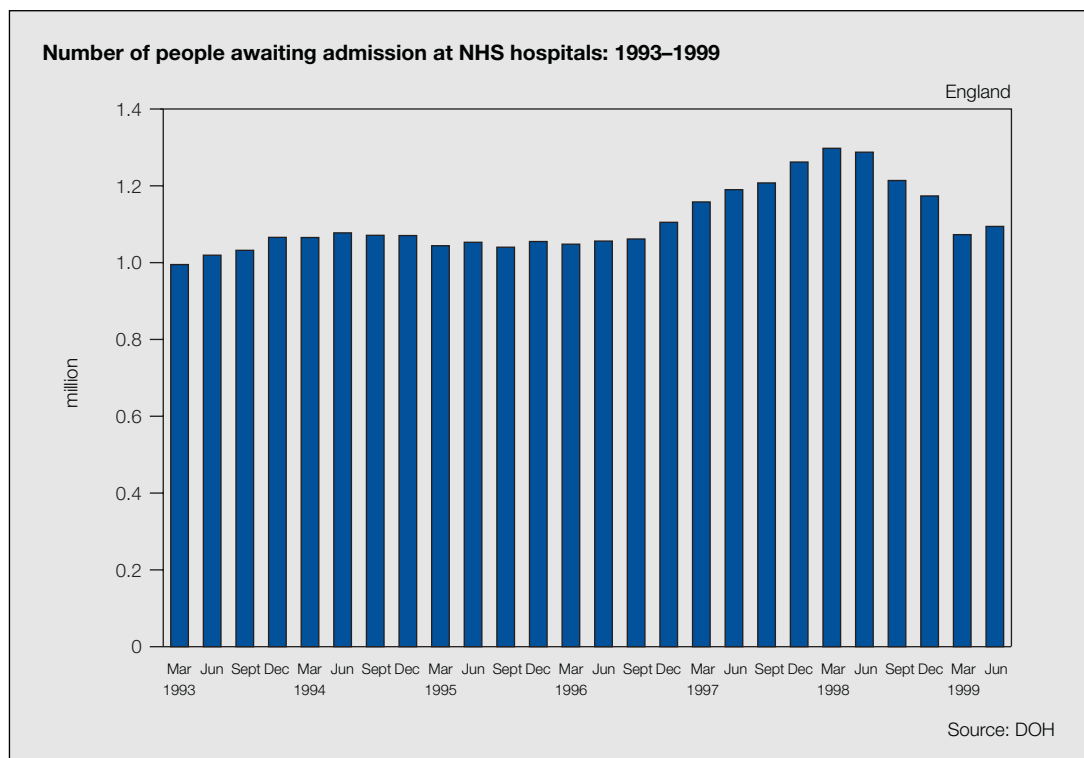
Targets and goals There is no national target but Health Authorities are expected to set local inequalities targets.

- Trends* There were clear inequalities in life expectancy by Social Class over the period 1972 to 1996. For men in 1992-96 there was more than a 9 year difference in life expectancy between those in professional occupations and those in unskilled occupations; for women the differential was over 6 years. The difference for men has increased reasonably consistently since the early 1970s, whereas for women initial narrowing of the gap has been followed by widening in recent years.
- Background* The Social Class variation in life expectancy of men and women is based on the ONS Longitudinal Study. Life expectancies are those at birth.

Objective Provide people with access to effective health care based on patients' needs, and not on where they live or their ability to pay

Indicator NHS hospital waiting lists

F4



NHS hospital waiting lists have fallen by 16 per cent over the period March 1998 to June 1999; but waiting lists in June 1999 were 10 per cent above levels in March 1993.

Relevance Providing people with prompt access to health care by reducing the number waiting for hospital treatment, which will also reduce the length of time people wait, is likely to have major benefits for people's health.

Targets and goals To reduce NHS waiting lists to 1,058,000 by the end of this Parliament, in England (ie 100,000 below the March 1997 figure of 1,158,000).

Trends The number of patients waiting for inpatient treatment at NHS hospitals remained at just over one million in the mid 1990s but increased sharply by around 140,000 between March 1997 and March 1998. The numbers have subsequently fallen to 1,094,000 in June 1999.

Background Patients are placed on the inpatient waiting list as soon as a consultant decides that the patient needs inpatient treatment and they stay on the waiting list until they are admitted for treatment or until they are removed from the waiting list, (for example because they no longer need the treatment or have received the treatment privately). Patients are not counted on the waiting list during periods when they are unavailable for treatment.