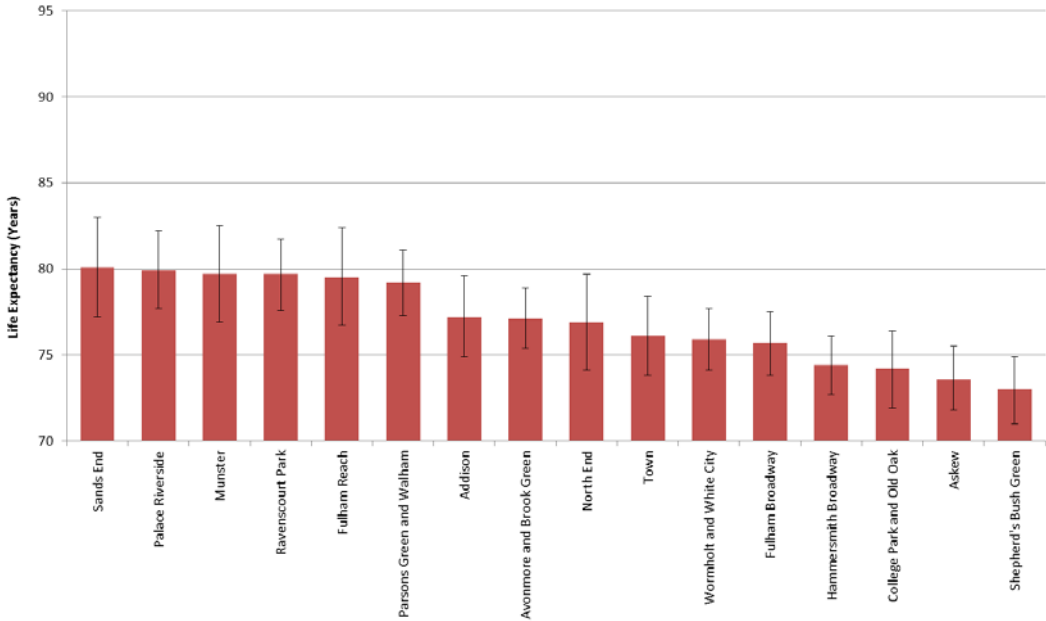


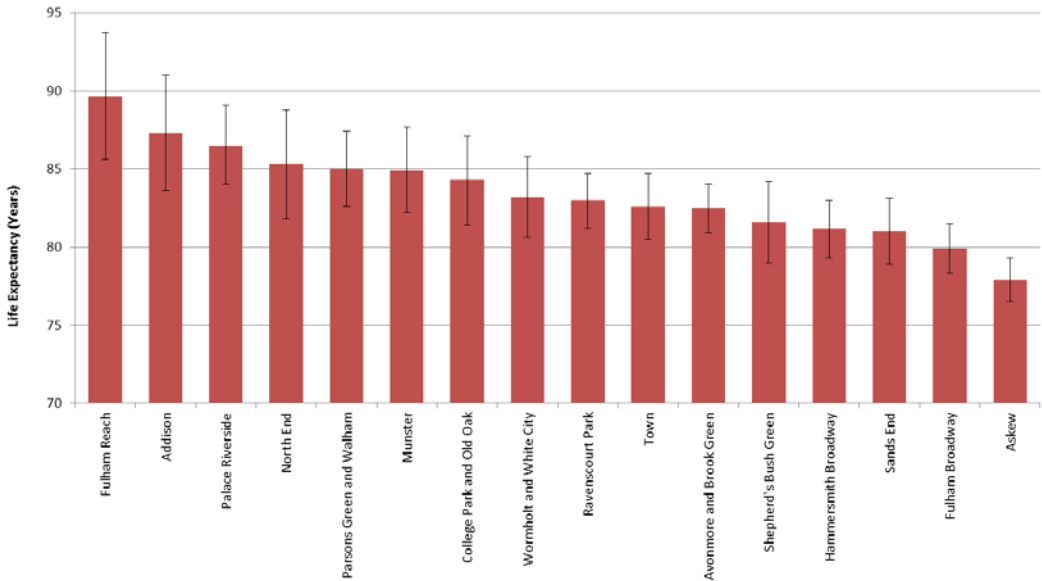
Unequal Life Expectancy in Hammersmith and Fulham

Inequalities in health are commonly described in terms of life expectancy variations. For example, in Hammersmith and Fulham, there is a 7.1 year gap in male life expectancy and a 11.7 year gap in female life expectancy between people living in different wards in the borough (see below).

Male Life Expectancy at Ward Level: 2003/07 (Source: London Health Observatory)



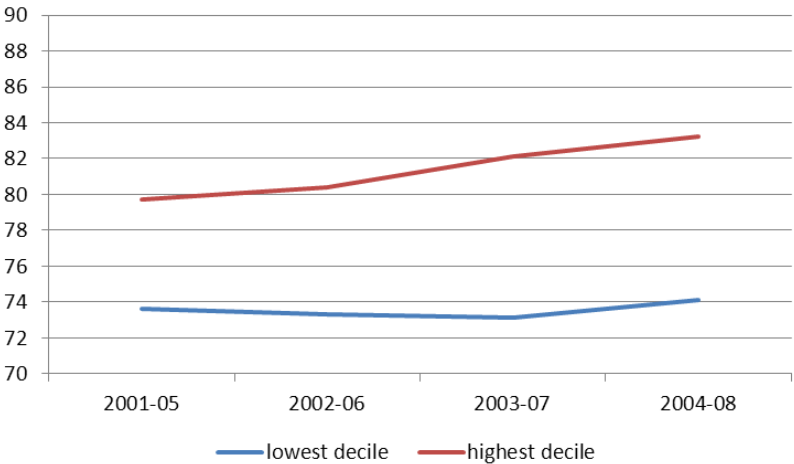
Female Life Expectancy at Ward Level: 2003/07 (Source: London Health Observatory)



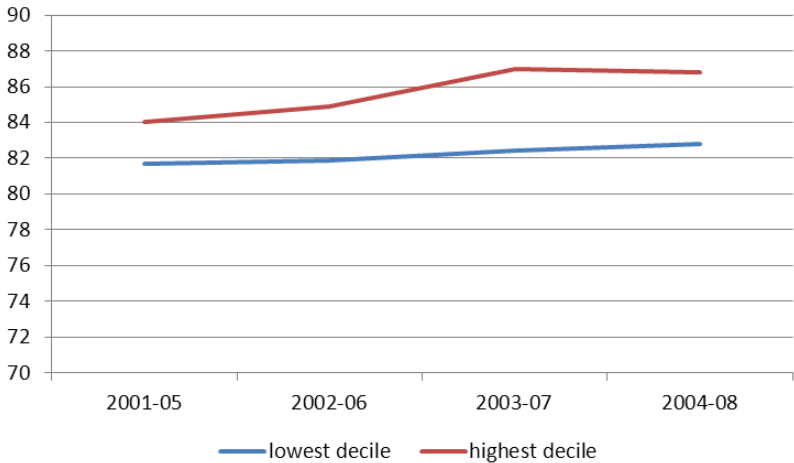
Interestingly, the fact that females in Hammersmith and Fulham have a larger gap in life expectancy across wards than males is not reflected across London, where male life expectancy ranges from 88 years in a ward in Kensington and Chelsea to 71 years in Lewisham Central (a gap of 17 years) and female life expectancy ranges from 76 years in a ward in Newham to 90 years in Knightsbridge (a gap of 14 years).

Although average life expectancy has risen in H&F, the gap between the poorer and richer segments of the population has grown, increasing from 6.1 years in 2001/05 to 9.1 years in 2004/08 for men, and from 2.3 years in 2001/05 to 4 years in 2004/08 for women. The two graphs below show the trends in life expectancy for men and women comparing people in the bottom and top tenth of the socio-economic spectrum.

Trend in Male Life Expectancy in Hammersmith & Fulham (Source: APHO)



Trend in Female Life Expectancy in Hammersmith & Fulham (Source: APHO)

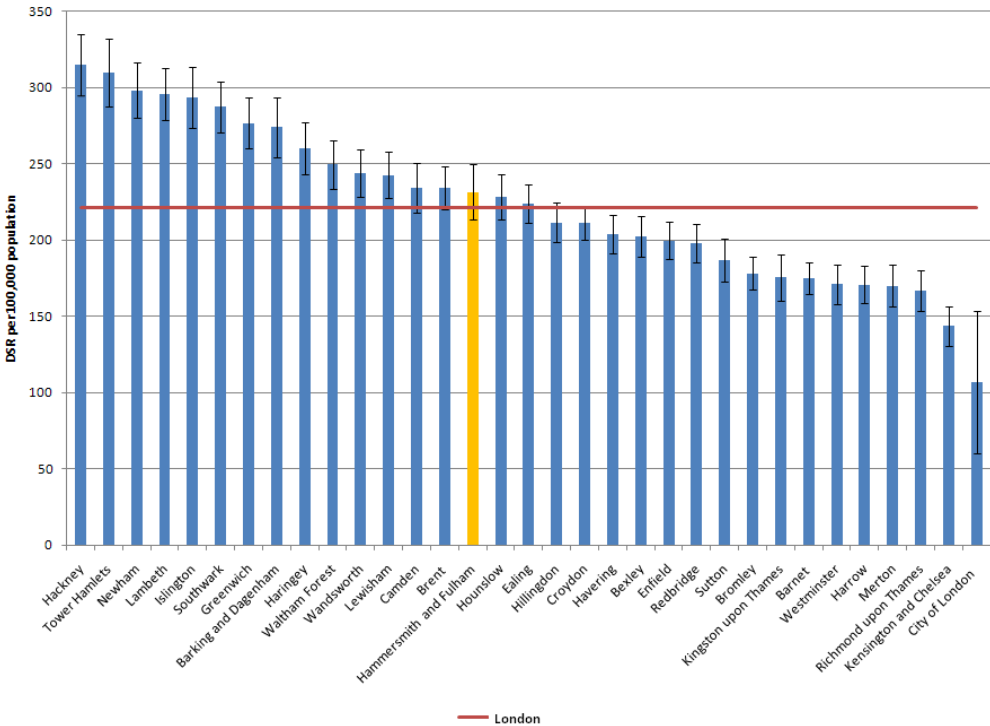


Premature mortality

Underlying the gap in life expectancy is the fact that some men and women, especially those from lower socio-economic status groups, die early. It is therefore worth looking at the causes of premature deaths.

In Hammersmith and Fulham, between 2006 and 2008, there were 643 deaths occurring to adults below the age of 65 years - 414 men (64%) and 229 (36%) women. This translates into a premature mortality rate of 231 deaths per 100,000 population per year which is above the London average. Two of the borough's six statistical neighbours⁵ (Tower Hamlets and Islington) have significantly higher premature mortality rates. If Hammersmith and Fulham had the same premature mortality rate as Kensington and Chelsea (which has one of the lowest rates of premature mortality), there would be approx. 50 fewer premature deaths a year in actual numbers.

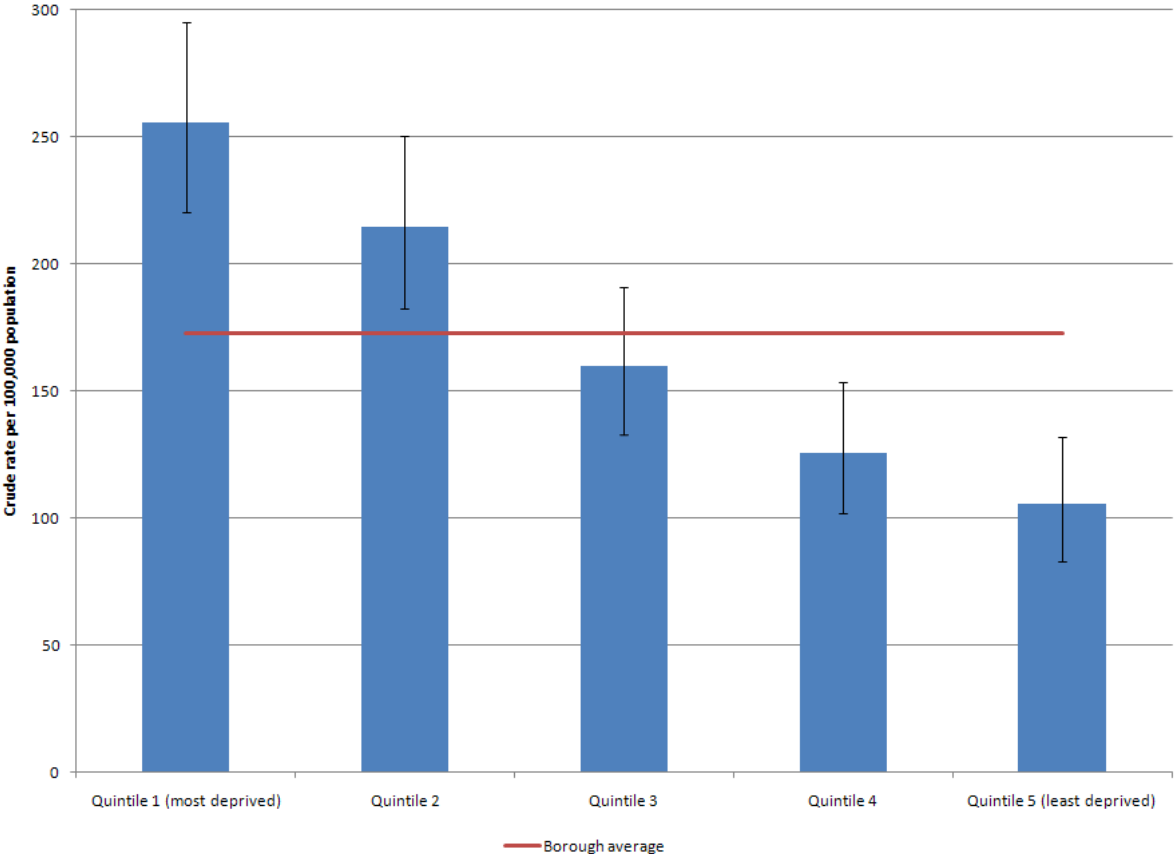
Directly standardised rate per 100,000 of premature mortality from all causes, ages 15-64, 2006-08 (Source: NCHOD)



⁵ ONS Cluster: Camden, Hammersmith and Fulham, Islington, Kensington and Chelsea, Wandsworth, Westminster and Tower Hamlets.

Within H&F, as one would expect, deprived residents have a significantly higher premature mortality rate compared to the least deprived residents as shown in the figure below.

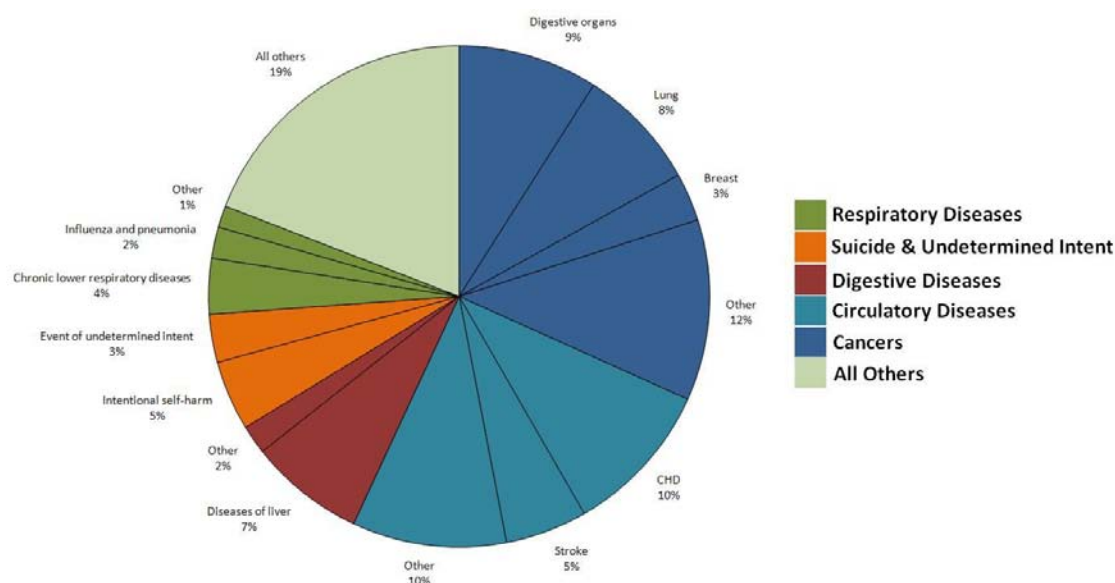
Crude rate per 100,000 of premature mortality from all causes by local deprivation quintiles, ages 15-64, 2006-08 (Source: ONS Mortality Files)



The main causes of premature mortality are: cancers (mainly bowel, lung and breast cancers), circulatory disease and diseases of the digestive system (mainly liver disease). These three sets of diseases make up about two thirds of all premature deaths. Both breast and bowel cancers are now the target of early detection screening programmes; and the risk for all of these diseases is increased by smoking and unhealthy levels of alcohol consumption.

Percentage of premature deaths by underlying cause: 2006-08

(Source: ONS Mortality Files)



While the early detection of disease and quick access to medical care can help prolong life and reduce mortality, social, behavioural and environmental factors that determine vulnerability and susceptibility to these diseases are what primarily determine the overall pattern of premature mortality and health inequalities across society.

Dying younger and suffering longer

Differences in life expectancy and premature mortality rates do not fully describe inequalities in health because they do not capture the severity and length of illness and disability prior to death. However, when health status is measured as a product of both longevity and quality of life, the disparity between the rich and poor is much greater.

For example, across England as a whole, although people in the poorest neighbourhoods die on average 7 years earlier than people in the richest neighbourhoods, the difference in *disability free life expectancy*⁶ is 17 years. This means that not only do poor people generally

⁶ Disability-free life expectancy is the average number of years an individual is expected to live free of disability if current patterns of mortality and disability continue to apply.

die earlier than their richer counterparts, but they live with sickness, illness and disability for a much greater proportion of their life.

In Hammersmith and Fulham the gap in terms of disability free life expectancy between the most deprived area and least deprived area has been estimated to be 9.6 years for males and 12.3 years for females. Across London, the gaps in disability free life expectancy are higher: between the most deprived small area (in Newham) and the least deprived area (in Bromley), it is 19.5 years for males and 15.5 years for females⁷.

Children are not exempt

While inequalities in adult health may provoke equivocal reactions, a decent society would find systemic, unfair and avoidable inequalities in child health to be unacceptable. The reality is that children demonstrate marked inequalities in their state of health.

The Income Deprivation Affecting Children Index (IDACI) is a measure of the percentage of children (under 16) who live in income-deprived families (i.e. in receipt of Income Support, Income based Jobseeker's Allowance, Working Families' Tax Credit or Disabled Person's Tax Credit below a given threshold). The index scores range from 0 (least deprived) to 0.99 (most deprived) and every lower super output area (LSOA) in England has been ranked from 1 (most deprived) to 32,482 (least deprived).

Scores in Hammersmith & Fulham range from 0.77 (Rank - 155) in the most deprived LSOA in the North End ward of the borough to 0.04 (Rank - 28,709) in the least deprived LSOA in Ravenscourt Park ward. The average IDACI score for H&F is 0.36, indicating a high number of children living in families that are income deprived.

Additionally, the Child Well-being Index (CWI) covers the major domains of a child's life that have an impact on his or her well-being. The seven domains are: material well-being, health, education, crime, housing, environment and children in need. By this index, H&F is the 23rd most deprived out of 354 local authorities in England. The relevance of this data is

⁷ ONS experimental stats 1999-2003. Available at <http://www.statistics.gov.uk/CCI/article.asp?ID=2562>

that there is a strong causal relationship between poverty (both in absolute and relative terms) and social deprivation with poor health. This is discussed more in Chapter three. But, what follows now, is a brief description of the state of health inequalities amongst children in H&F.

In H&F, there are about eight child deaths every year. With such small numbers, it is not possible to conduct any statistical analyses of differential rates of infant mortality within the borough. However, across England, where we can analyse much bigger numbers of child deaths, infant mortality rates vary. For example, Pakistani and Black Caribbean babies are twice as likely to die in their first year (9.8 and 9.6 deaths per 1,000 live births, respectively) compared to White British or Bangladeshi babies (4.5 per 1000 and 4.2 per 1000 respectively).

Within H&F, we need to look at other indicators to reveal the existence of child health inequalities. For example, low birth weight babies (<2500 grams) begin their lives at a greater risk of illness compared to babies of normal birthweight. In H&F about 7% of babies born are low birthweight, amounting to around 190 babies per year. The percentage of babies born with a low birthweight is significantly higher in the most deprived areas compared to the least deprived areas. If the low birthweight rate in the most deprived areas (8.1%) was reduced to that of the least deprived areas (4.9%), an estimated 21 fewer babies would be born with low birthweight in the borough each year.

A further illustration of child health inequalities is the difference in rates of 5 year old children with at least one decayed, missing or filled tooth (DMFT). This is a marker of poor dental health, which in turn is a marker of poor nutrition as well as poor child care. Hammersmith and Fulham has one of the highest rates of children with poor dental health, with an average of 1.91 DMFT per child. In one survey of two hundred 5 year olds, it was found that nearly half of all children (44.5%) had a DMFT with an average of 4.1 teeth affected.

Finally, we can also see health inequalities in the pattern of childhood obesity in Hammersmith and Fulham, where about 12% of children in reception (age 4-5) and about 23% in year 6 (age 10-11) are obese. Deprivation is a clear factor in the pattern of obesity. When child weights are analysed according to the 'Income Deprivation Affecting Children

Index' (IDACI), a clear gradient is seen with obesity being statistically more common among children living in deprived areas. Ethnicity is also a factor. Children of 'white' ethnicity have a lower prevalence compared to children in 'other ethnic groups.' In chapter four, we discuss the issue of child obesity in more detail, but before that, chapter three will discuss the challenge of tackling the upstream determinants of health which are necessary if real and sustainable progress is to be made in reducing health inequalities.