

## **NSMC Report 12**

**National  
Social Marketing  
Centre**

### **KEY HEALTH & LIFESTYLE AREAS**

(For Government PSA targets arising from 'Choosing Health'  
white paper priorities)

### **CURRENT RATES & PAST TRENDS**

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## INTRODUCTION – National Social Marketing Centre review work

*Dominic McVey and Clive Blair-Stevens*

The aim of the Centre:

*to help realise the full potential of effective social marketing  
in contributing to national and local efforts  
to improve health and reduce health inequalities.*

This paper is part of work contributing to the independent National Review of health-related programmes and social marketing campaigns that was first announced as part of the Public Health White Paper 'Choosing Health'. The work was undertaken by the National Social Marketing Centre and was published in June 2006.

The discussion and consultation that fed into the development of that White Paper had highlighted a number of concerns. Two of particular relevance to this work were:

- A growing realisation that continuing with existing methods and approaches was not going to deliver the type of impact on key health-related behaviours that was needed.
- Other comparable countries appeared to be achieving more positive impacts on behaviours by using and integrating a more dynamic customer-focused social marketing approach into their methods.

As a result, it was agreed that a National Review should be undertaken to examine the potential of social marketing approaches to contribute to both national and local efforts, and to review current understanding and skills in the area among key professional and practitioner groups.

The National Consumer Council was asked to lead this work as they had been key advocates for a more consumer-focused approach. It was also recognised that an independent aspect to the review would be important so that existing practice across the Department of Health could be considered and recommendations developed.

To inform the National Review a range of research methods and approaches were used. The overarching objectives of the research programme were as follows:

### Research programme – overarching objectives

- 1: To review the growing evidence-base for Social Marketing in some key priority areas
- 2: To examine current government practice and effectiveness in delivering health-related programmes and campaign interventions.
- 3: To better understand stakeholder understanding and perceptions of social marketing
- 4: To consider key behavioural trends and progress towards government health-related targets.
- 5: To consider and assess the costs to society of preventable ill-health and assess the potential of Social Marketing to contribute to reducing that cost.
- 6: To map current national capacity to utilise and deliver Social Marketing approaches.
- 7: To map key social and market research sources available to those developing health-related programmes or campaigns.

While the NSM Centre has a small core team, a larger number of external associates

have been actively contributing to developing work. These have included colleagues from a number of research organisations and individual consultants who have been commissioned to assist with developing aspects of the research programme.

This report is one of a range of research and review reports that have informed the National Review.

#### Summary of NSM Centre papers – currently being developed

|        |  |
|--------|--|
| NSMC1  | Effectiveness Review: Physical Activity and Social Marketing                           |
| NSMC2  | Effectiveness Review: Nutrition and Social Marketing                                   |
| NSMC3  | Effectiveness Review: Alcohol, Tobacco and Drug misuse & Social Marketing              |
| NSMC4  | Social Marketing Capacity in the UK: Academic Sector – initial selective review        |
| NSMC5  | Social Marketing Capacity in the UK: Commercial Sector – initial selective review      |
| NSMC6  | Social Marketing for Health in the European Union – initial selective review           |
| NSMC7  | National Health-Related Campaigns Review – selective review of 11 campaigns            |
| NSMC8  | National Stakeholder Research Findings – current understanding and views               |
| NSMC9  | Summary review of current use of Social Marketing across Government                    |
| NSMC10 | Health economic analysis: Initial look at the societal costs of preventable ill-health |
| NSMC11 | Social Marketing Research – compendium of social & market research sources             |
| NSMC12 | Overview of key behavioural trends and targets re: 'Choosing Health' priorities        |

#### Providing comments and views

The research programme is revealing invaluable insights into the use and effectiveness of social marketing related interventions and has provided a robust platform to inform the first National Social Marketing Strategy for Health.

The work however also has a much wider value and interest. Anyone working to elicit positive behavioural effects within different audiences, whatever the focus or topic, should find these reports of interest. It will be of particular relevance to those working on or contributing to health-related programmes and campaigns, whether in public health, health promotion, communications or as dedicated social marketers, at a national or local level.

To encourage debate about Social Marketing we would like to take this opportunity to invite readers to offer their views and feedback on the ways they think health-related programmes and campaigns might be improved, drawing on core social marketing principles.

As other work and material is developed it is being made available via the website on: [www.nsmcentre.org.uk](http://www.nsmcentre.org.uk). We welcome your comments and ideas which can be emailed to us at: [nsmc@ncc.org.uk](mailto:nsmc@ncc.org.uk).

Finally, we would like to thank particularly Roslyn Kane for undertaking this work and contributing to our national review.

Thanks are also due to our other National Social Marketing Centre colleagues and associates who have all helped ensure this work could contribute to the national review.

We look forward to receiving further comments and views.

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## Report content and layout

This report describes the Government's PSA targets in the key health and lifestyle areas addressed by the Choosing Health White Paper, published in 2004.

Data relating to each target are then presented. Current rates and past trends are examined along with separate analyses for adults and children where appropriate. Wherever possible future projections<sup>1</sup> and international comparisons are also examined.

Data are presented for England only, unless unavailable, when UK rates have been used.

### Report layout

The *Choosing Health* White Paper (2004) and its Delivery Plan (2005) highlight six key priority areas:

- Tackling health inequalities;
- Reducing the numbers of people who smoke;
- Tackling obesity;
- Improving sexual health;
- Improving mental health and well-being;
- Reducing harm and encouraging sensible drinking.

This priority area constitutes a section of this report.

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<sup>1</sup> Accessing data projections has been difficult. The Government Actuary Department publishes projections of general demographic data, some of which have been used in this report (Life expectancy and Infant Mortality Rates). Efforts have been made to identify specific projections of mortality rates by cause of death and prevalence of risk factors such as smoking, obesity and alcohol consumption. The Office for National Statistics only publish estimates for future all-case mortality rates and where some of the Public Health Observatories have published projections of cardiovascular disease and cancer, they only estimate rates to 2010. No further projections appear to be available at this time.





## Section 1: Tackling Health Inequalities

The issue of health inequalities has been raised in a number of Government documents, including: *Tackling Health Inequalities: A Programme for Action*<sup>2</sup>, launched in 2003 and the *Choosing Health* White Paper and its delivery plan launched in 2004 and 2005 respectively.

The Programme for Action laid the foundation for meeting the government's Public Service Agreement (PSA) targets to reduce the health gap on infant mortality and life expectancy by 2010 and this is reinforced in the *Choosing Health* White Paper. The target is to:

- reduce, by 2010, inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth

In the White Paper delivery plan, *Delivering Choosing Health* (2005) health inequalities are identified as the first of six priorities areas and the Government sets out its action to address them in England<sup>3</sup>. The focus is on narrowing the health gap between disadvantaged groups, communities and the rest of the country, and on improving health overall. A 'spearhead group' of 70 local authority areas have been identified to lead the work and pilot several of the key White Paper recommendations<sup>4</sup>.

In 2005 *Tackling Health Inequalities: Status Report on the Programme for Action* was published. It provides a review of developments since the publication of the Programme for Action in 2003. It considers progress against the Public Service Agreement (PSA) target, the national headline indicators and against government commitments<sup>5</sup>.

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<sup>2</sup> The Programme for Action developed a set of 12 national headline indicators to monitor intermediate progress towards the overall PSA inequalities target. These indicators provide a broad summary of the areas to be monitored and reflect data already collected. They cover: Death rates from cancer and heart disease; Teenage conceptions; Road accident casualty rates in disadvantaged communities; Numbers of primary care professionals; Uptake of flu vaccinations; Smoking among manual groups and among pregnant women; Educational attainment; Consumption of fruit and vegetables; Proportion in non-decent housing; PE and school sport; Children in poverty; Homeless families living in temporary accommodation.

<sup>3</sup> DoH. *Choosing Health: Making healthy choices easier*. 2004 (Chapter 2); DoH. *Delivering Choosing Health: Making healthy choices easier*. 2005.

<sup>4</sup> See <http://www.dh.gov.uk/assetRoot/04/09/54/13/04095413.pdf> for a full definition of the Spearhead Group

<sup>5</sup> Further recent DoH documents on Health Inequalities include: *Health Inequalities - rising to the challenge*, published in 2005, which explains some of the new initiatives to emerge from the *Choosing Health* White Paper, and *The Spearhead group of local authorities and primary care trusts*: This paper outlines the Public Service Agreement targets on Health Inequalities.

## PSA Targets<sup>6</sup>

### A: To improve the health of the population:

- By 2010 increase average life expectancy at birth in England to 78.6 years for men and to 82.5 years for women.

Detailed objective for life expectancy:

- Starting with Local Authorities, by 2010 to reduce by at least 10% the gap between the fifth of areas with the “worst health and deprivation indicators” (The Spearhead Group) and the population as a whole<sup>7</sup>.

### B: To substantially reduce mortality rates by 2010<sup>8</sup>

- from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole;
- from cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole;
- from suicide and undetermined injury by at least 20%.

### C: To reduce health inequalities:

- by 10% by 2010 as measured by infant mortality<sup>9</sup> and life expectancy at birth<sup>10</sup>.

<sup>6</sup> For further information see: <http://www.dh.gov.uk/assetRoot/04/09/61/80/04096180.pdf>

<sup>7</sup> This has been revised from the previous (PSA 2002) target in order to be consistent with the new inequalities aspects of the cancer and circulatory disease targets. The previous aim was to reduce the gap between the fifth of areas with the **lowest life expectancy at birth** and the population as a whole. The target is to narrow the **relative** gap between the “Spearhead” areas and the national average. (PSA Technical Notes Update 2005-2008 Annex A, DoH 2006)

<sup>8</sup> From the Our Healthier Nation baseline, 1995-97

<sup>9</sup> From a 1997-99 baseline

<sup>10</sup> From the Our Healthier Nation baseline, 1995-97

## Progress towards Targets

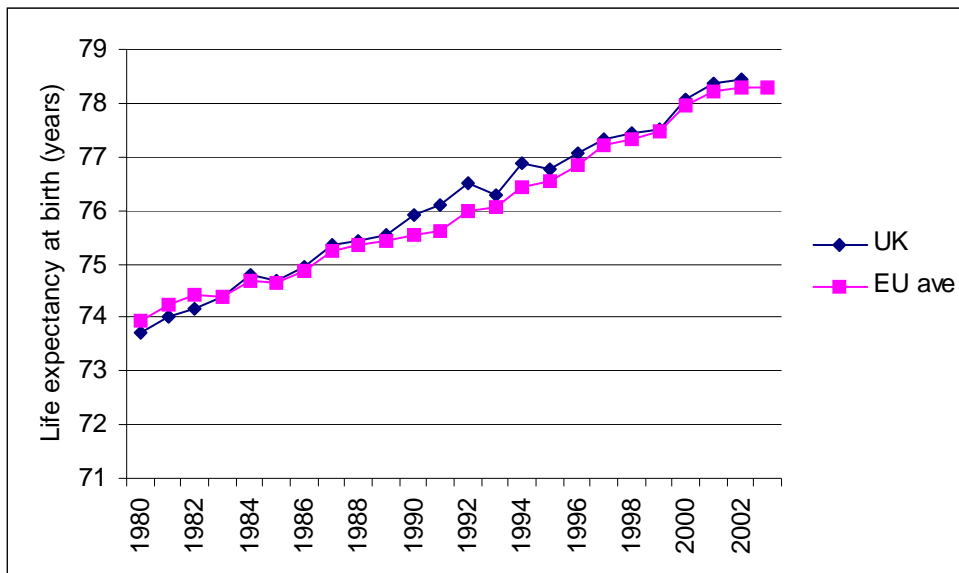
### A: Improve the health of the population:

#### Life expectancy

The latest data for 2002-2004 indicate that since the target baseline (1995-1997), the relative gap in life expectancy between England and the Spearhead Group has increased for both men and women, with a larger increase for women. For men the relative gap increased by 1%, for women by 8% (Health Inequalities Target Progress Report, DoH 2005).

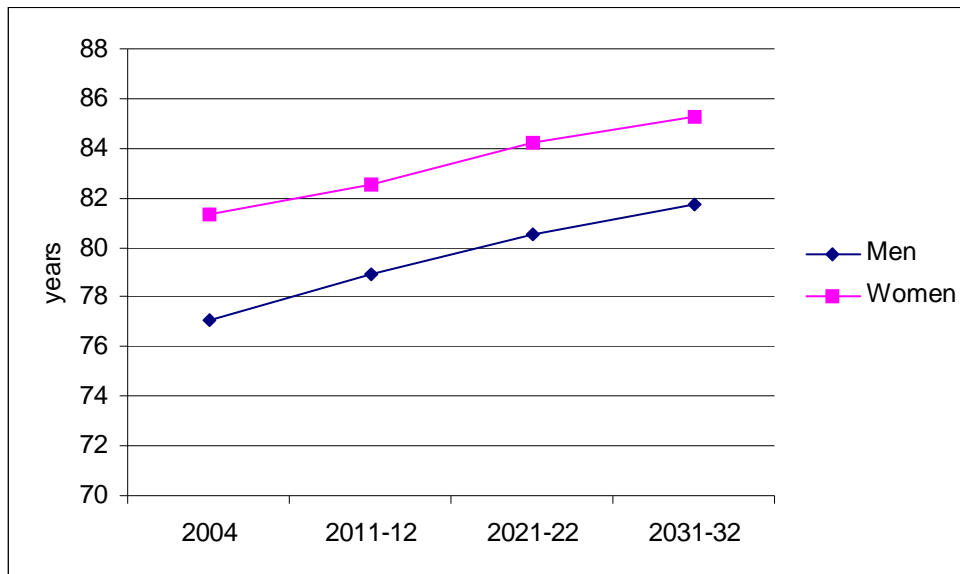
#### International comparisons

**Figure 1: Average life expectancy at birth, 1980-2002. UK and EU average.**



Source: WHO HFA database <http://data.euro.who.int/hfad/>. World Health Organisation Regional Office for Europe. Updated: June 2005

Figure 1 shows the average life expectancy in the UK compared to the EU average. Between 1980 to 2002 it increased in the UK from 73.7 to 78.5 years. The UK figure has been close to the EU average throughout this time but the gap was wider in the mid-90s than in more recent years.

**Future projections:****Figure 2: Life expectancy at birth according to mortality rates assumed for selected years, projected to 2031-32. England**

Source: <http://www.gad.gov.uk/Population/index.asp?v=Table&pic=2004|england|eol>

The Government's Actuary department makes projections for life expectancy in the future. It is predicted to rise steadily in England from 77.1 in 2004 to 81.7 in 2031 for men and from 81.3 to 85.3 for women.

## **B: Substantially reduce mortality rates by 2010<sup>11</sup>**

The targets on cancer and cardiovascular disease relate to Local Authority areas (LAs) with both the worst health and deprivation indicators. The following graphs therefore look at changes in death rates between areas in terms of their deprivation levels, and the relative level of their death rate, compared with the other areas.

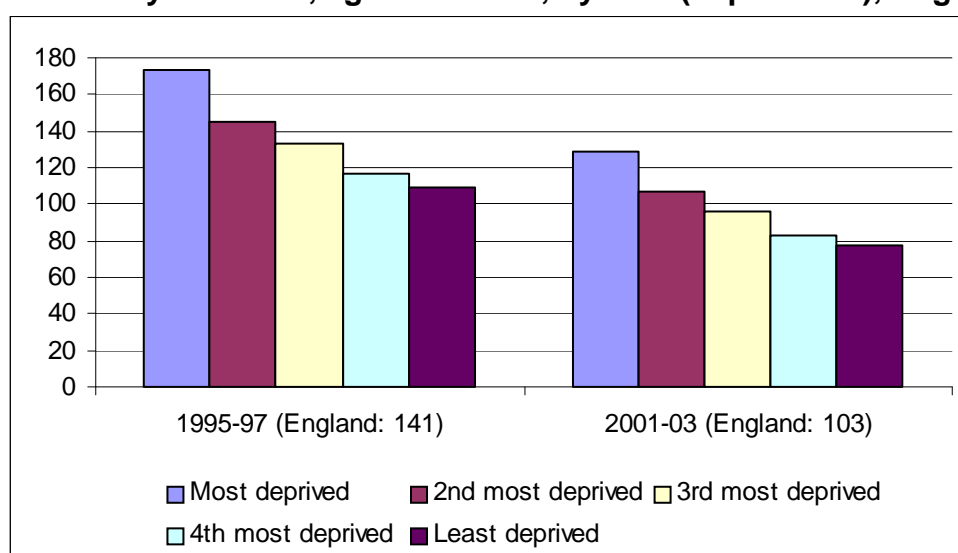
### **Cardiovascular Disease**

Circulatory diseases (which include heart disease and stroke) have remained the most common cause of death in England and Wales over the last 90 years among both males and females. Male death rates from circulatory disease are generally higher than those for females: 300 per 100,000 compared with 190 per 100,000 in 2003<sup>12</sup>.

There have been improvements in circulatory disease death rates since 1995-97 (including for the most disadvantaged areas), accompanied by a narrowing of inequalities in absolute terms, with signs of a widening of inequalities in relative terms (DoH. Tackling health inequalities: Status report on the Programme for Action 2005).

The circulatory disease mortality the gap has reduced significantly from a baseline absolute gap of 36.7 deaths per 100,000 population in 1995-7 to 27.6 deaths per 100,000 population in 2002-4. (The target for 2010 is to reduce the absolute gap to 22.0 deaths per 100,000 population or less). The gap has therefore reduced - by 24.7% - over this period as opposed to the required reduction of at least 40% by 2010. This trajectory is on-track for achievement of the target (DoH Health Inequalities Target Progress Report 2005).

**Figure 3: Age-standardised death rates per 100,000 population for circulatory diseases, ages under 75, by area (deprivation), England**



Source: ONS. Adapted from DoH: Tackling health inequalities: Status report on the Programme for Action 2005

<sup>11</sup> From the Our Healthier Nation baseline, 1995-97

<sup>12</sup> Source: ONS 2006. See <http://www.nationalstatistics.gov.uk/cgi/nugget.asp?id=1337>

### As summarized in the DoH Status report:

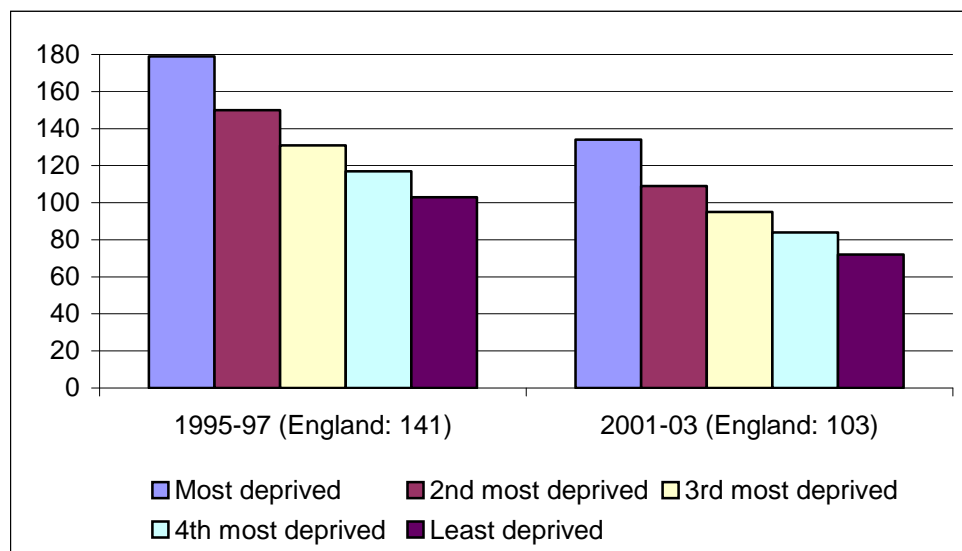
There is a gradient in circulatory disease death rates (ages under 75) by area deprivation, with the most deprived areas having the highest death rates and the least deprived, the lowest.

In 2001-03 the circulatory disease death rate (ages under 75) in the most deprived areas was 67% higher than in the least deprived areas.

Since 1995-97 the gap in circulatory disease death rates between the most deprived areas and the England average has decreased in absolute terms but increased in relative terms. This also applies to the gap between the most deprived areas and the least deprived.

Adapted from: DoH Status report 2005

**Figure 4: Age-standardised death rates per 100,000 population for circulatory diseases, ages under 75, by area (death rate), England**



Source: ONS. Adapted from DoH: Tackling health inequalities: Status report on the Programme for Action 2005

### As summarized in the Status report:

Since 1995-97 the gap in circulatory disease death rates between the areas with highest death rates and the England average has decreased in absolute terms but increased in relative terms. This also applies to the gap between the quintiles of areas with highest and lowest rates.

Between 1995-97 and 2001-03, the absolute gap between the spearhead group and the England average circulatory disease death rate narrowed by 22% but with no narrowing of the relative gap.

Adapted from: DoH Status report 2005

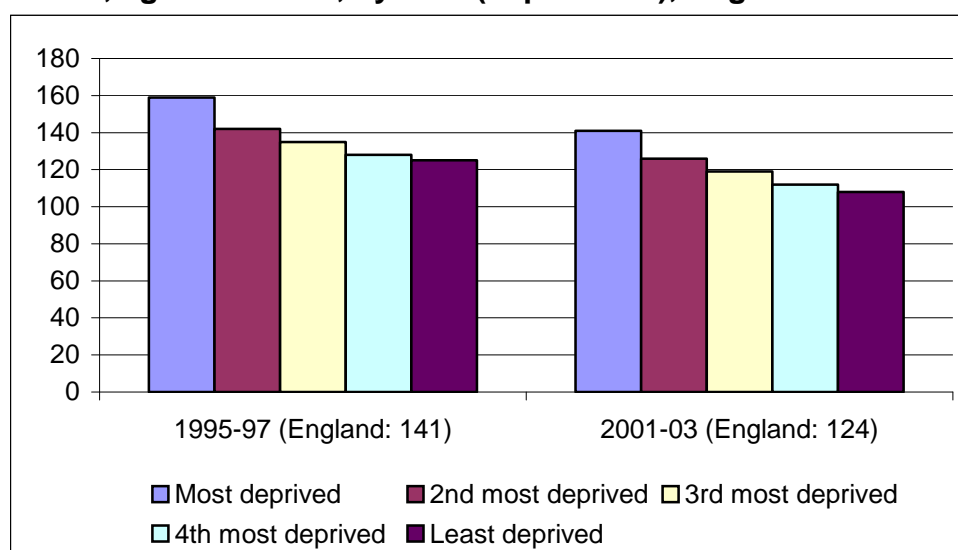
## Cancer

Cancers are now the second most common cause of death among both men and women. Female cancer mortality rates decreased during the 1940s and 1950s, then rose to a peak in the late 1980s, declining again during the 1990s. Among men the pattern was different. Rates increased substantially to the late 1970s and then declined more rapidly from the 1990s<sup>13</sup>.

There have been improvements in cancer death rates since 1995-97 (including for the most disadvantaged areas), and some signs of a narrowing of inequalities. (DoH Tackling health inequalities: Status report on the Programme for Action 2005). Indeed, the cancer mortality gap has reduced from a baseline absolute gap of 20.7 deaths per 100,000 population in 1995-7 to 18.8 deaths per 100,000 population in 2002-4 (DoH Health Inequalities Target Progress Report 2005).

The target for 2010 is to reduce the absolute gap to 19.5 deaths per 100,000 population or less). The gap has, therefore, reduced - by 9.4% - over this period as opposed to the required reduction of at least 6% by 2010. This trajectory shows early achievement of the target, but will need to be maintained.

**Figure 5: Age-standardised death rates per 100,000 population for cancer, ages under 75, by area (deprivation), England**



Source: ONS. Adapted from DoH: Tackling health inequalities: Status report on the Programme for Action 2005

<sup>13</sup> Source: ONS 2006. See <http://www.nationalstatistics.gov.uk/cgi/nugget.asp?id=1337>

## The Status report on Health Inequalities summarizes the improvements in cancer death rates in England since 1995-97. In brief:

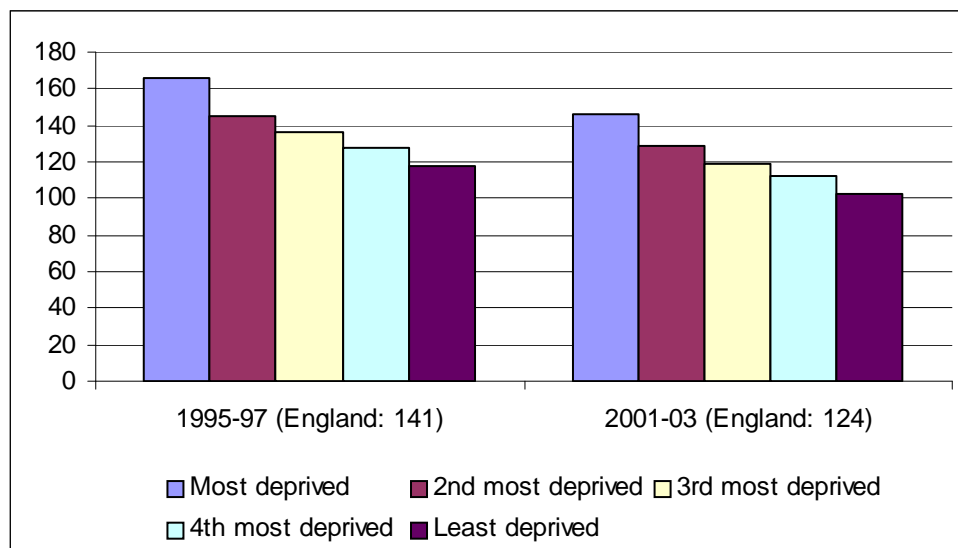
There is a gradient in cancer death rates (ages under 75) by area deprivation, with the most deprived quintile having the highest death rates and the least deprived the lowest death rates.

In 2001-03 the cancer death rate (ages under 75) in the most deprived quintile of areas was 31% higher than in the least deprived quintile.

Since 1995-97 the gap in cancer death rates between the most deprived areas and the England average has not changed significantly in absolute or relative terms. This also applies to the gap between the most and least deprived areas.

Adapted from: DoH Status report 2005

**Figure 6: Age-standardised death rates per 100,000 population for cancer, ages under 75, by area (death rate), England**



Source: ONS. Adapted from DoH: Tackling health inequalities: Status report on the Programme for Action 2005

### As summarized in the status report:

The gap between the quintile of areas with highest death rates and the England average has decreased slightly in absolute terms since 1995-97, but with no significant change in relative terms. This also applies to the gap between areas with the highest and lowest rates.

Between 1995-97 and 2001-03, the absolute gap between the spearhead group and the England average cancer death rate narrowed by 8% but with no narrowing of the relative gap.

Adapted from: DoH Status report 2005

Smoking is an important risk factor for both CVD and cancer. This is examined more generally in section 2 of this report and in relation to infant mortality, below.



## Future projections

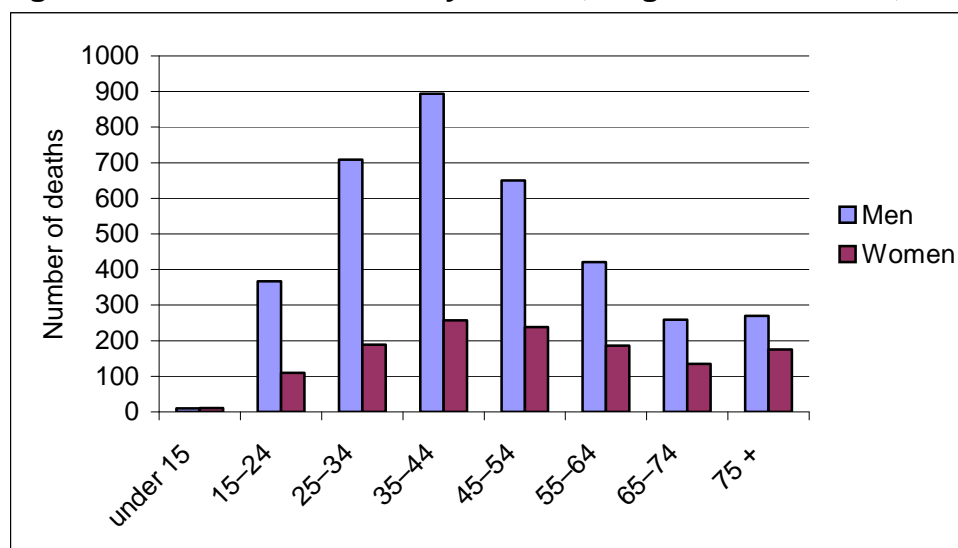
The Government Actuary's Department (GAD) produces national population projections for a number of demographic measures. However, projections of mortality rates by different causes are not provided because of various complications.

For example, deaths from separate causes are not always independent and the relationships are not always well understood. The underlying cause of death is not always clear so there is some uncertainty over whether the data on causes of death are reliable. Changes in the classification of causes of death, plus changing practices in diagnosis, can make analysis of trend patterns difficult<sup>14</sup>.

## Suicide

Figure 7 shows the total number of suicides amongst men and women in England and Wales. The majority of suicides occur in young men. The peak difference in the number of deaths to suicide between men and women is seen in the 25-34 age group where the total number of suicides is 4 times higher for men than for women.

**Figure 7: Number of deaths by suicide, England and Wales, 2004**



Source: ONS mortality data. 2005

Figure 8 shows the suicide rate in the UK from 1971 to 2003. There were 5,755 adult suicides in the UK in 2003, the lowest number since 1973.

In 2003 men accounted for three-quarters of all suicides. This difference between the sexes widened in the 1970s and 1980s. In 1971 men accounted for slightly over half of all suicides (56 per cent) (ONS 2005).

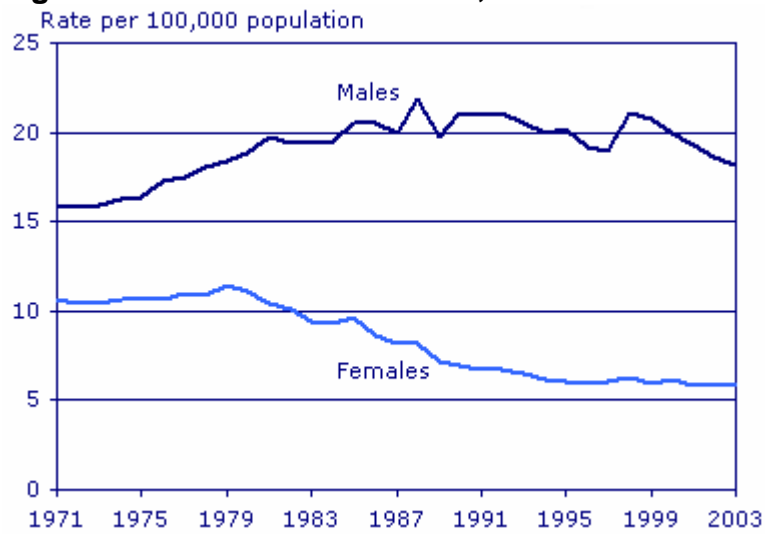
Suicide rates for men, which were rising through the 1970s and 1980s, have decreased steadily since 1998. The rate for 2003, 18.1 deaths per 100,000 population, was the lowest since 1978 (ONS 2005).

<sup>14</sup> For further detail, see:

[http://www.statistics.gov.uk/methods\\_quality/quality\\_review/downloads/QandAFinalB.pdf](http://www.statistics.gov.uk/methods_quality/quality_review/downloads/QandAFinalB.pdf)

Suicide rates for women, which fell steadily in the 1980s and early 1990s, have decreased only slightly since the mid-1990s. The rate for women remained around 5.8 deaths per 100,000 population in each of the years 2001 to 2003 (ONS 2005).

**Figure 8: Suicide rate in the UK, 1971 to 2003**



Source: ONS data 2005

<http://www.nationalstatistics.gov.uk/CCI/nugget.asp?ID=1092&Pos=3&ColRank=2&Rank=1000>

## C: Reduce health inequalities:

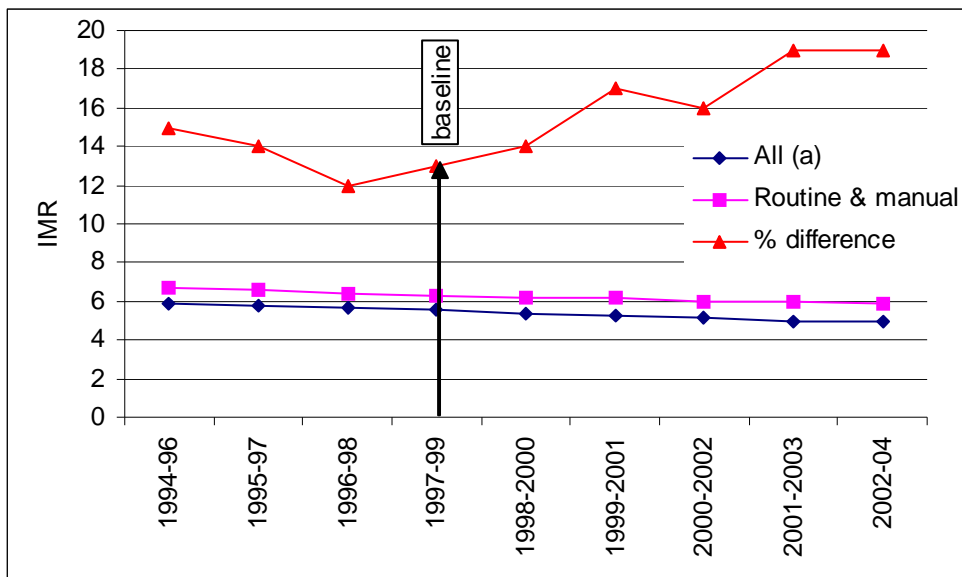
### Infant mortality

As described above, the overall PSA target is to reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth. Specifically in relation to infant mortality, the detailed objective is:

- Starting with children under one year, by 2010 to reduce by at least 10% the gap between “routine and manual” socio-economic groups and the population as a whole from the baseline year of 1997-99

Figure 9 shows infant mortality rates in England and Wales from 1994-96 to 2002-04 by social group. Rates have declined in the routine and manual group since the baseline period, however, the rate of decline has been faster in other groups. As a result, the trend shows a widening in the relative gap between infant mortality in the routine and manual group and the total population between the target baseline 1997-99 and the latest period 2002-04 (DoH 2005).

**Figure 9: Infant mortality rates per 1000 live births, by socio-economic group, England and Wales. 1994-2004**



Source: ONS 2005

(a): within marriage and joint registration.

Using NS SEC90 for data up to 2000 and NS SEC for 2001, 2002 and 2003 data.

Figures for live births are a 10 per cent sample coded for father's occupation. Information on the father's occupation is not collected for births outside marriage if the father does not attend the registration of the baby's birth.

### This widening of the infant mortality rate by social class is further detailed in the recent DoH Target update. In brief:

The gap between 'routine and manual' groups and the whole population has widened since the target baseline.

The infant mortality rate among the "routine and manual" group was 19% higher than in the total population in 2002-04, the same as for 2001-03. This compares with 13% higher in the baseline period of 1997-99.

The most recent figures therefore show no change in the gap between the "routine and manual" groups and the population as a whole, compared with last year. Over the period since the target baseline, the gap has widened, although there have been year-on-year fluctuations in intervening years.

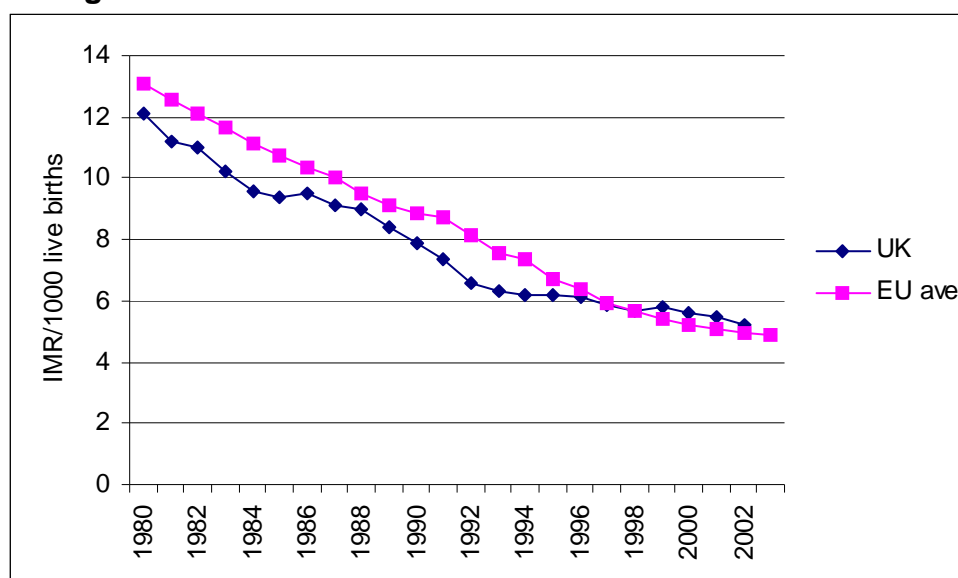
Adapted from: DoH 2005 Health Inequalities Target Update

### International comparisons

The infant mortality rate has fallen significantly in the UK since 1980, from 12.1 per 1000 live births to 5.2 per 1000 in 2002.

Throughout the 1980s and towards the end of the 1990s, there was a significant gap between the infant mortality rate in the UK and the EU average, with the former being lower than the latter. Around 1997, the gap closed and the rates have since reversed with the UK rate now slightly higher than the EU average. The UK rate is predicted to fall to 5.0 per 1000 by 2025<sup>15</sup>.

**Figure 10: Infant mortality per 1000 live births 1980-2002. UK and EU average<sup>16</sup>.**



Source. WHO Health for all database 2005 <http://data.euro.who.int/hfad/>.

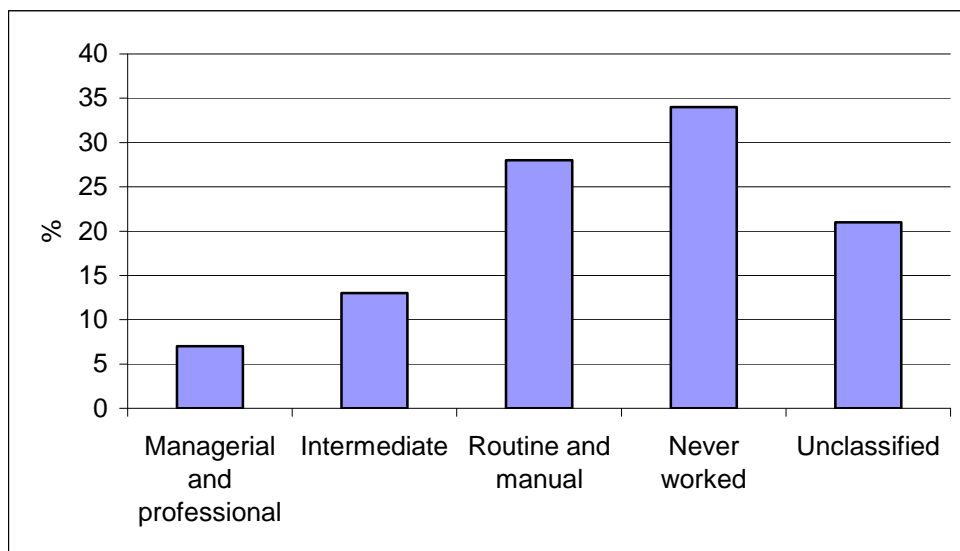
<sup>15</sup> Source: WHO World Health Report, 1998: [http://www.who.int/whr/1998/en/whr98\\_en.pdf](http://www.who.int/whr/1998/en/whr98_en.pdf)

<sup>16</sup> Current 25 Member States of the European Union

## Prevalence of smoking among pregnant women

Relevant to the infant mortality rate, is an examination in changes in patterns of smoking among women during pregnancy. In 2000 there was a strong gradient in smoking throughout pregnancy by socio-economic group, with managerial and professional groups having the lowest prevalence (DoH Status Report 2005).

**Figure 11: Percentage of women who smoked throughout pregnancy by socio-economic group, England 2000**



Source: Infant Feeding Survey 2000. Adapted from DoH Status report 2005

### As summarized in the Status report:

Data from the 2000 Infant Feeding Survey show a clear social gradient in the prevalence of smoking throughout pregnancy in England, with rates decreasing from the routine and manual group to the intermediate group, and from the intermediate group to the managerial and professional group. The 'never worked' socioeconomic group has the highest prevalence (34%).

Earlier data from the 1995 Infant Feeding Survey also showed a social gradient. The prevalence of smoking during pregnancy in social class V was 37%, 1.5 times the prevalence for all mothers (24%) and over 5 times the prevalence in social class I (7%)<sup>17</sup>.

Adapted from: DoH Status report 2005

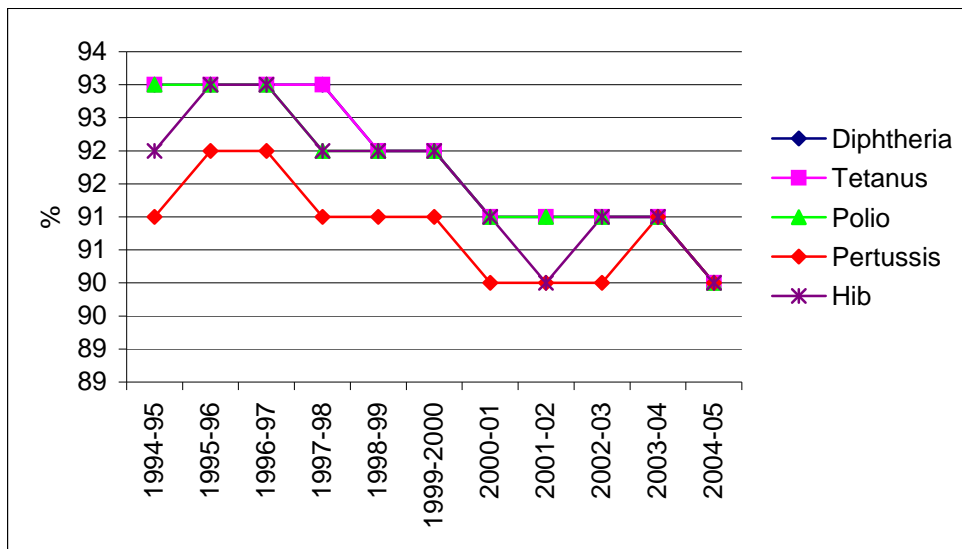
<sup>17</sup> The questions on smoking used in the 2000 Infant Feeding Survey were changed such that results from the 2000 survey are not robustly comparable with results from earlier surveys. (DoH Status report 2005).

## Immunisation

A further related issue is the uptake of infant and child immunisation. Figure 12 shows the percentage of children immunised against the main childhood diseases in England from 1994-95 to 2004-05.

Childhood immunisation rates in England are high. Immunisation rates against diphtheria, tetanus and polio are virtually identical as these are given as a combined injection. In 2004-05, 90% of children had completed primary immunisation courses by their first birthday.

**Figure 12: Percentage of children immunized by their first birthday. England 1994-95 to 2004-05**



NB Hib = Haemophilus influenzae b

Source: Form KC51: DoH 2005

See: <http://www.dh.gov.uk/assetRoot/04/11/96/50/04119650.pdf>

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## Section 2: Reducing the numbers of people who smoke

In December 1998 the Government published *Smoking Kills – a White Paper on tobacco*, which included targets for reducing the prevalence of cigarette smoking among adults in England<sup>18</sup>. In 2000 further targets were set out in the NHS Cancer plan:

- to reduce smoking rates among manual groups from 32% in 1998 to 26% by 2010
- to reduce adult smoking prevalence from 28 per cent in 1996 to 24 per cent by 2010.

### PSA Targets

Smoking was a priority area in The Choosing Health White Paper, 2004 and the Delivery Plan in 2005, which set out comprehensive proposals for action. In July 2004 the Government set a new target<sup>19</sup>:

- to reduce the overall proportion of cigarette smokers in England from 26 per cent in 2002 to 21 per cent or less by 2010 – with a reduction from 31 to 26 per cent or less among routine and manual occupation groups.

In relation to young people the 2004 target was:

- to reduce the number of children aged 11-15 who smoke regularly (defined as usually smoking at least one cigarette a week) from a baseline of 13% in 1996 to 11% by 2005 and 9% by 2010.

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<sup>18</sup> The Smoking Kills targets were:

1. To reduce smoking among children from 13% to 9% or less by the year 2010; with a fall to 11% by the year 2005.
2. To reduce adult smoking in all social classes so that the overall rate falls from 28% to 24% or less by the year 2010; with a fall to 26% by the year 2005.
3. To reduce the percentage of women who smoke during pregnancy from 23% to 15% by the year 2010; with a fall to 18% by the year 2005.

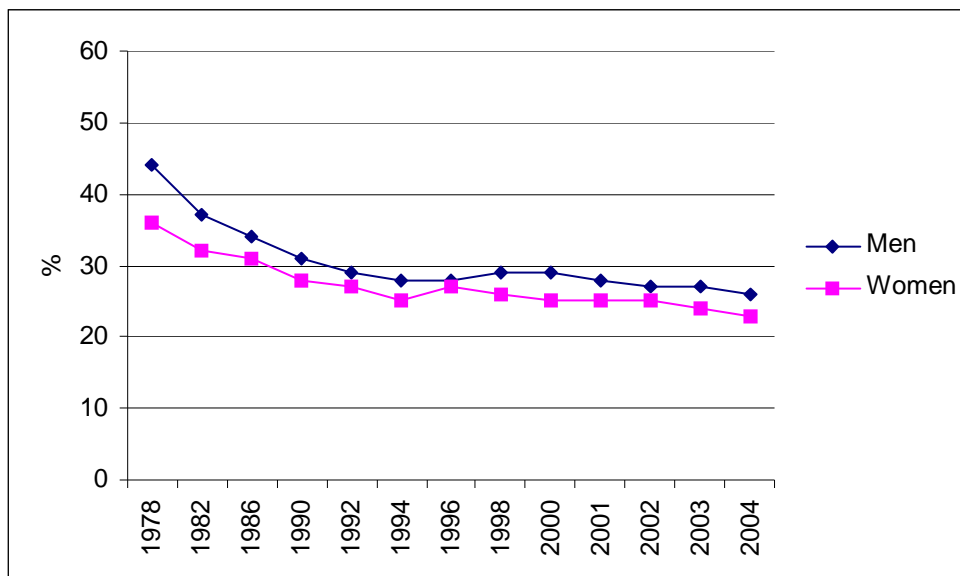
<sup>19</sup> See <http://www.dh.gov.uk/assetRoot/04/09/61/80/04096180.pdf>

## Progress towards targets

### Smoking Rates

As shown in Figure 13 below, the prevalence of cigarette smoking in adults fell from the late 1970s until around 1994, where it reached a plateau until 2000. Since then though it has fallen again from 29% to 26% for men and 25% to 23% for women. Although men are still more likely than women to smoke cigarettes, the gap has narrowed. In 1974 51 per cent of men and 41 per cent of women smoked (GHS 2004/05: DoH summary).

**Figure 13: Prevalence of cigarette smoking by sex: 1978 to 2004. Adults age 16 and over, England**



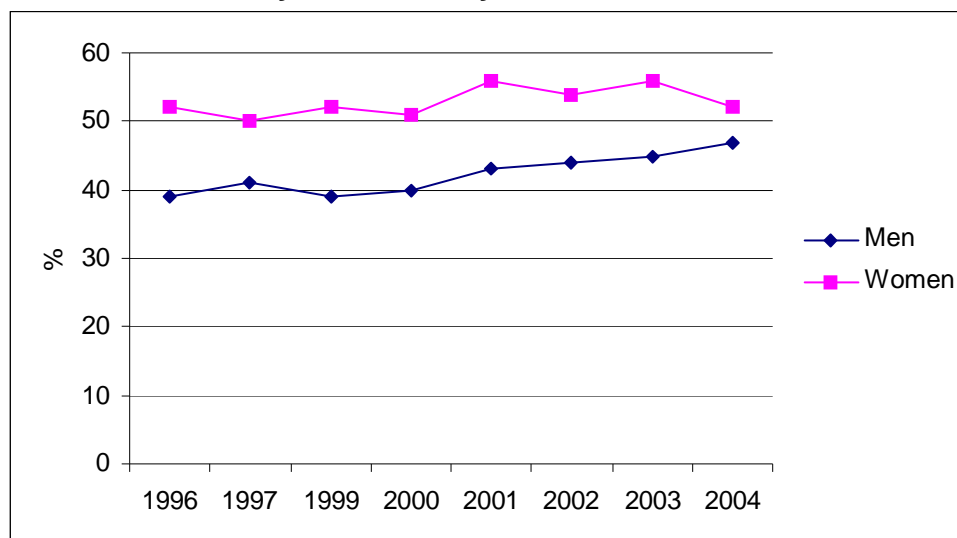
Source: GHS 2005

NB from 1998 onwards calculations were weighted

Weighted base for 2004: Men 19 561 000; women: 22 396 000

Looking at the percentage of adults who have never or only occasionally ever smoked, there has been gradual increase amongst both men and women since 2000. The current rate is 47% for men and 52% for women.

**Figure 14: Cigarette smoking status (percentage) among adults, 1996-2004: Never or only occasionally ever smoked**



Source: ONS Omnibus Survey 2004: Adapted from Lader & Goddard 2005:

**The Department of Health have produced a summary bulletin of the most recent findings from the General Household Survey (GHS). In brief:**

Cigarette smoking is still more common among adults aged 20 to 34 than other age groups. In 2003 36 per cent of adults aged 20 to 24 and 34 per cent of adults aged 25 to 34 were smokers compared with 15 per cent of those aged 60 and over.

The proportion of men who were heavy smokers (on average 20 or more cigarettes a day) fell from 14 per cent in 1990 to 10 per cent in 1998. Among women the proportion fell from 9 per cent to 7 per cent over the same period. Since then the proportions have remained virtually unchanged.

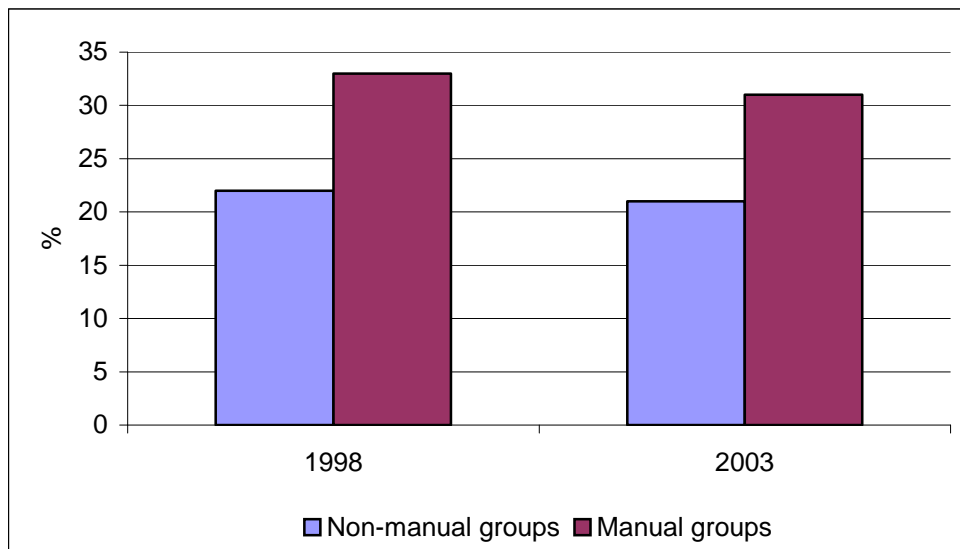
The proportion of light to moderate smokers (on average under 20 cigarettes a day) has been around 17 to 19 per cent of both men and women since 1998. Among men and women, on average men smoked 15 cigarettes a day and women smoked 13 a day in 2003/04.

In 2003/04 two thirds (66 per cent) of cigarette smokers in Great Britain said that they wanted to give up, though 55 per cent said it would be difficult to go without smoking for a whole day.

Adapted from: GHS 2004/05: DoH summary 2005

## Smoking prevalence by social class

**Figure 15: Smoking prevalence (aged 16 and over) by socio-economic group, England 1998 and 2003<sup>20</sup>**



Source: General Household Survey (ONS). Adapted from: DoH Status Report 2005

Since 1998 smoking prevalence among all adults has fallen (including a slight fall in prevalence among manual groups), but there has been no significant change in inequalities for manual groups compared with non-manual groups or all adults (DoH Status report 2005).

### As summarized in the Status Report 2005:

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Smoking prevalence among manual groups is consistently higher than in non-manual groups and in the adult population as a whole.

In 2003 smoking prevalence in manual groups was 10 percentage points higher than in non-manual groups, in relative terms, 48% higher.

Smoking prevalence fell steadily from 1974 to 1992, and remained broadly flat between 1992 and 1998. Since 1998 smoking prevalence among all adults has fallen, including a slight fall in prevalence among manual groups.

Since 1998 the gap in smoking prevalence between manual groups and the average for all adults has not changed significantly in absolute or relative terms. This also applies to the gap between manual and non-manual groups.

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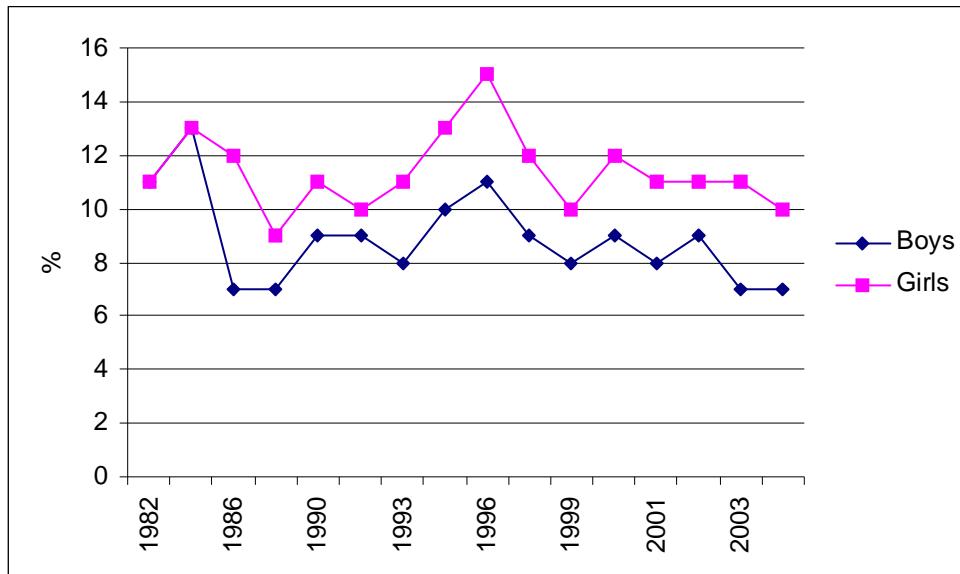
Adapted from: Status report

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<sup>20</sup> GHS data were weighted from 2000 onwards and retrospectively for 1998 for comparative purposes. Data were weighted to compensate for non-response in the sample and also to match known population distributions. Weighted data cannot be reliably compared with the unweighted data for 1998 and previous years. From 2001 onwards figures are based on the new NS SEC classification recoded to produce socio-economic groups (SEG) (ie manual/non-manual groups).

## Smoking prevalence amongst young people:

**Figure 16: Percentage of pupils age 11-15 who are regular smokers, England 1998-2004**



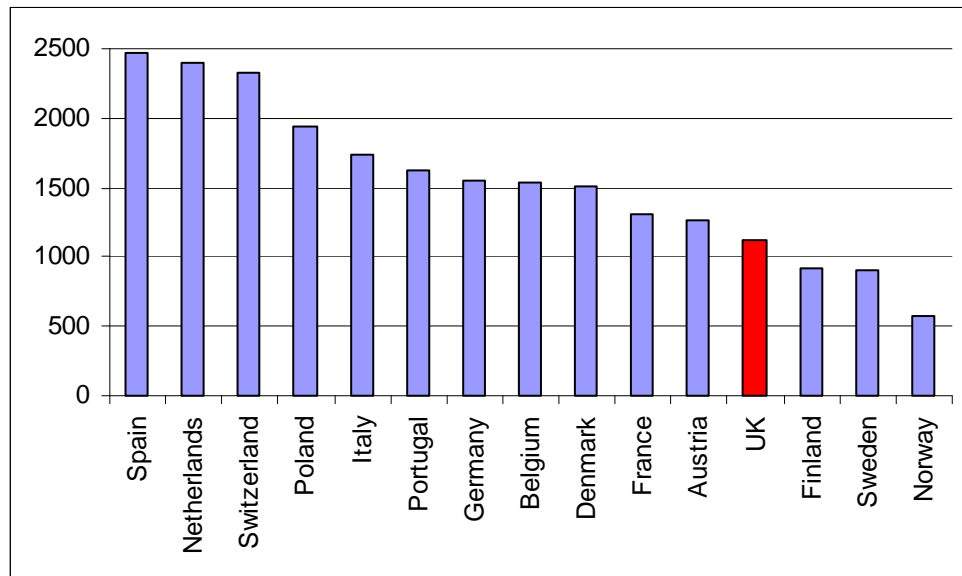
Source: Adapted from Fuller *et al* 2005.

A recent survey by National Centre for Social Research and the National Foundation for Educational Research was conducted to monitor smoking, drinking and drug use among secondary school children aged 11-15. Information was obtained from 9,715 pupils in 313 schools throughout England during the autumn term of 2004 (Fuller *et al* 2005).

The proportion of young people who are regular smokers (defined as those who smoke at least one cigarette a week) has fluctuated since 1982, but has remained stable since 1999 at between 9% and 10%. There are differences by gender however. In the early 1980s, equal proportions of girls and boys smoked regularly. Since the mid 1980s, girls have been consistently more likely to smoke than boys. In 2004, 10% of girls were regular smokers compared with 7% of boys (Fuller *et al* 2005).

## International comparisons

**Figure 17: Number of cigarettes consumed per person per year, selected European countries, 2000**



Source: WHO Health for all database. 2005 <http://data.euro.who.int/hfad/>.

When we look at the actual number of cigarettes consumed annually, the UK has lower rates than many other European countries. In Spain, The Netherlands and Switzerland annual consumption per person exceed 2000 where in the UK the rate is just over 1100.

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## Section 3: Tackling Obesity

Choosing Health and its delivery plan and the related documents, *Choosing a Better Diet: a food and health action plan*<sup>21</sup> and *Choosing activity: A Physical Activity Action Plan*<sup>22</sup>, published in 2005, propose a wide range of actions aimed at improving diet, reducing obesity, and increasing exercise, particularly amongst children. This section therefore covers information on obesity, diet and physical activity.

### PSA Targets

Department of Health/Department for Education and Skills/Department for Culture Media and Sport 2004/05 PSA Targets:<sup>23</sup>

#### Obesity:

- Halt the year-on-year rise in obesity among children under 11 by 2010 (from the 2002–04 baseline) in the context of a broader strategy to tackle obesity in the population as a whole

#### Physical activity<sup>24</sup>:

- Increase the percentage of the population who are reasonably active (taking at least 30 minutes of moderate exercise five times a week) from 30% to 50% in 2011 and 70% by 2020
- Increase the take-up of cultural and sporting opportunities by adults and young people aged 16+ from priority groups (women, black and ethnic minorities, lower socio-economic groups and those with physical or mental disabilities) by 1) increasing by 3% the number who participate in active sports at least 12 times a year
- Increase the uptake of sport by 5 to 16 year olds so that the percentage of school children in England who spend a minimum of two hours each week on high quality PE and school sport increases from 25% in 2002 to 75% by 2006 and to 85% by 2008

#### Diet<sup>25</sup>:

The DoH PSA targets do not refer directly to diet. However those related targets are presented in Section 1 (Tackling Inequalities) and the obesity target above.

*Choosing a Better Diet: a food and health action plan* does however set out its own objectives to improve the nutritional balance of the average diet in England:

<sup>21</sup> DoH 2005: <http://www.dh.gov.uk/assetRoot/04/10/57/09/04105709.pdf>

<sup>22</sup> DoH 2005: <http://www.dh.gov.uk/assetRoot/04/10/57/10/04105710.pdf>

<sup>23</sup> Source: <http://www.dh.gov.uk/assetRoot/04/10/57/13/04105713.pdf>

<sup>24</sup> Source: <http://www.dh.gov.uk/assetRoot/04/10/57/10/04105710.pdf>

<sup>25</sup> Source: <http://www.dh.gov.uk/assetRoot/04/10/57/09/04105709.pdf>

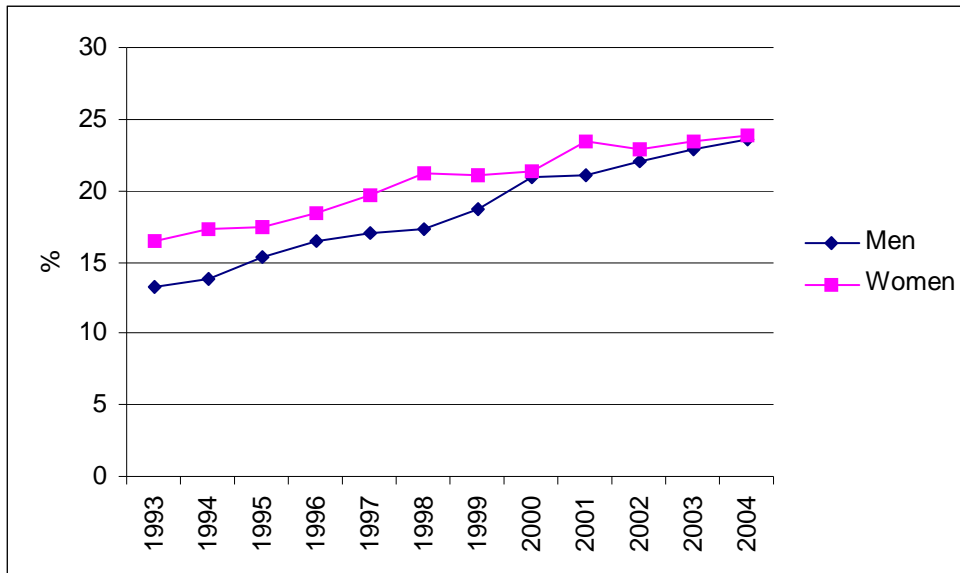
- To increase the average consumption of a variety of fruit and vegetables to at least five portions per day (currently 2.8 portions per day)
- To increase the average intake of dietary fibre to 18 grams per day (currently 13.8 grams per day)
- To reduce the average intake of salt to 6 grams per day by 2010 (currently 9.5 grams per day)
- To reduce the average intake of saturated fat to 11% of food energy (currently 13.3%)
- To maintain the current trend in the average total intake of fat at 35% of food energy (currently 35.3%)
- To reduce the average intake of added sugar to 11% of food energy (currently 12.7%)

## Progress towards targets

### Obesity

#### Obesity rates in adults

**Figure 18: Percentage of adult population (aged 16 +) with a BMI>30 kg/m<sup>2</sup> England 1993-2004**

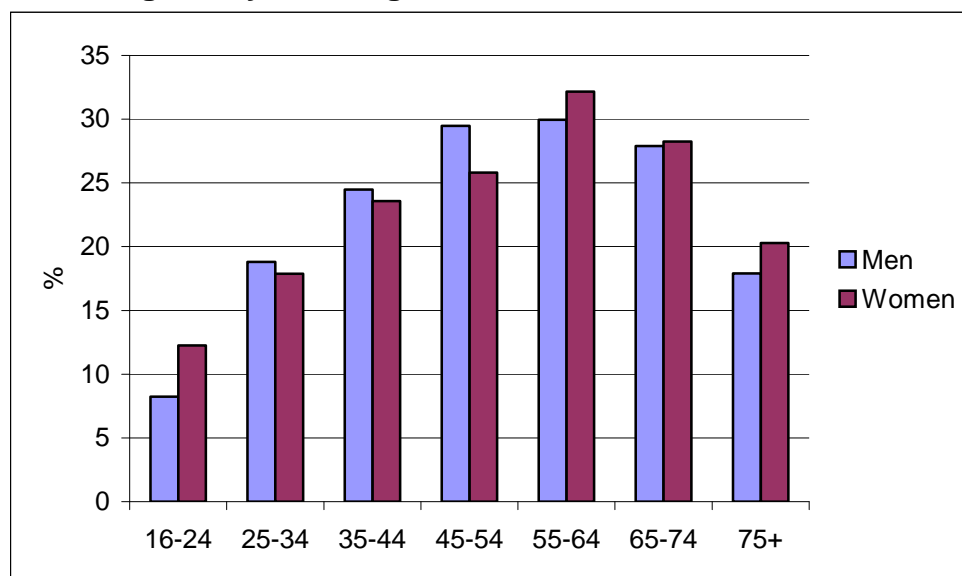


Source: HSE 2005

The proportion of adults in England with a body mass index over 30kg/m<sup>2</sup> has been increasing in recent years. The figure has generally been higher for women, but the gap has now narrowed. In 2004 the percentage of the population considered obese was almost equal between the sexes (23.6% for men and 23.8% for women).

There are significant differences by age group with the highest rates of obesity for both men and women being seen amongst the 55-64 year group (30% for men and 32% for women). Interestingly, excluding the youngest people, male obesity rates exceed those of women up until age 45-54. After this time the proportions are reversed with higher obesity rates being seen amongst women.

**Figure 19: Percentage of adult population (aged 16 and over) with a BMI>30 kg/m<sup>2</sup>, by sex. England 2004**

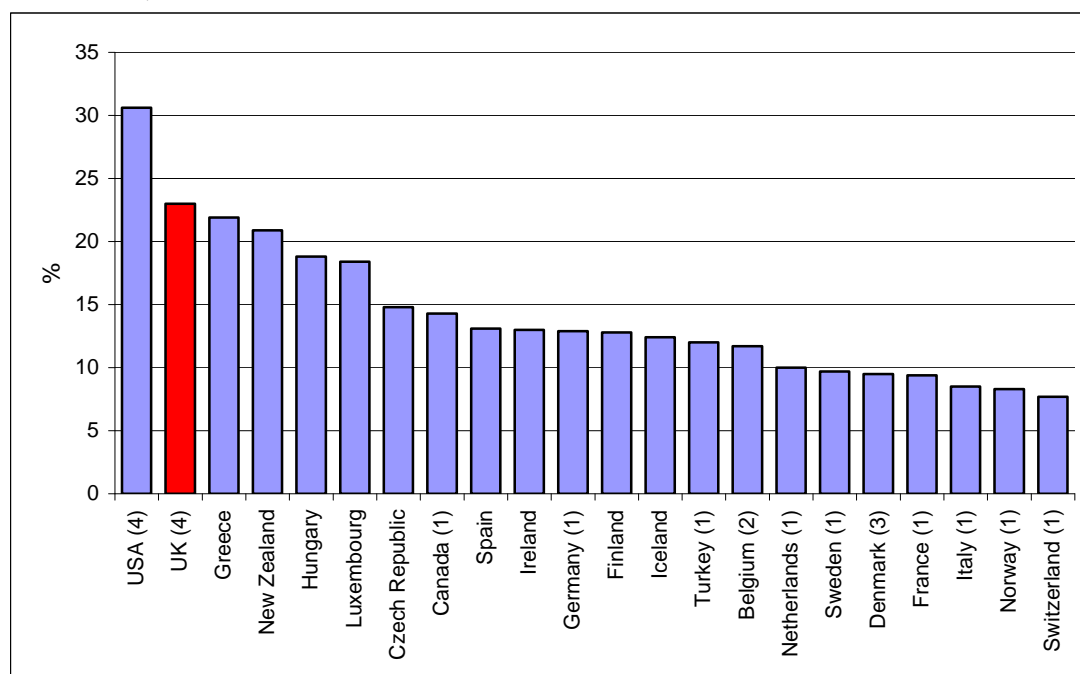


Source: HSE 2005

### International comparisons

The UK has the highest obesity rates in the European countries for which data are available. In 2003 23% of the adult population had a BMI of over 30kg/m<sup>2</sup>. This compares with a rate of 7.7% in Switzerland. The rate was 30.6% in the USA.

**Figure 20: Percentage of adult population with a BMI>30 kg/m<sup>2</sup>, selected countries, 2003**



NB: (1 2 or 3) shows that data refers to previous 1, 2 or 3 year(s); (4) indicates a difference in methodology.

Source: OECD Health data. 2005

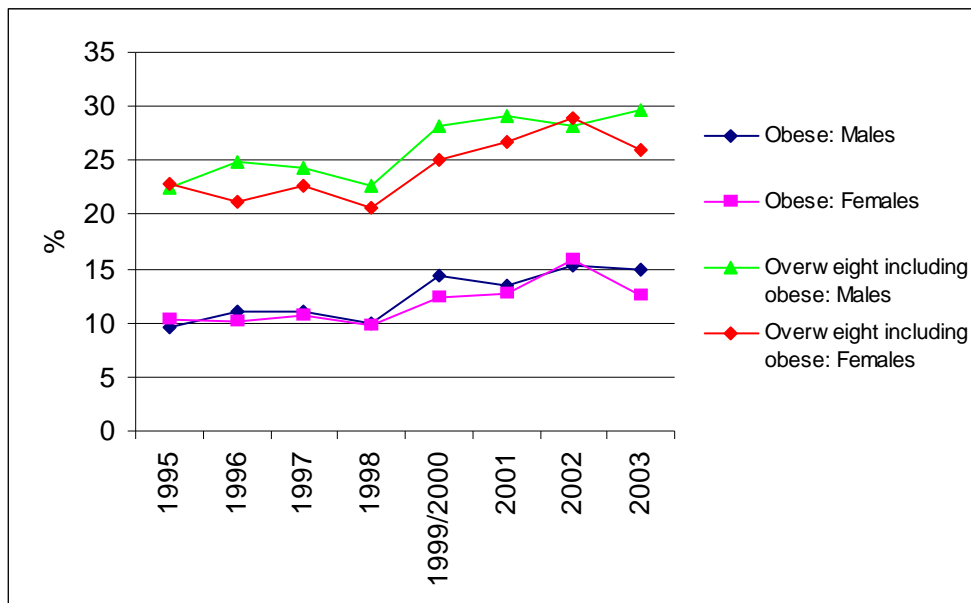
## Obesity rates in children

The public health White Paper *Choosing Health: Making Healthy Choices Easier* set out government commitments for action on obesity, including stemming the rise in obesity among children aged under 11 by 2010.

A recent report (Jotangia *et al* 2005) uses data from the Health Survey for England to examine obesity rates among young people aged 2 to 10 years old (in line with the PSA target above). Every year around 4,000 children, representative of the whole population, are interviewed.

Between 1995 and 1998 the proportion of children ages 2 to 10 who were overweight or obese was fairly stable after which time it started to rise. Obesity rates are generally similar amongst boys and girls of this age group but rather than looking at obesity alone, if we consider all *overweight* children age 2-10 then rates are higher amongst boys.

**Figure 21: Trends in overweight and obesity prevalence among children aged 2-10, by survey year, 1995 to 2003, England**

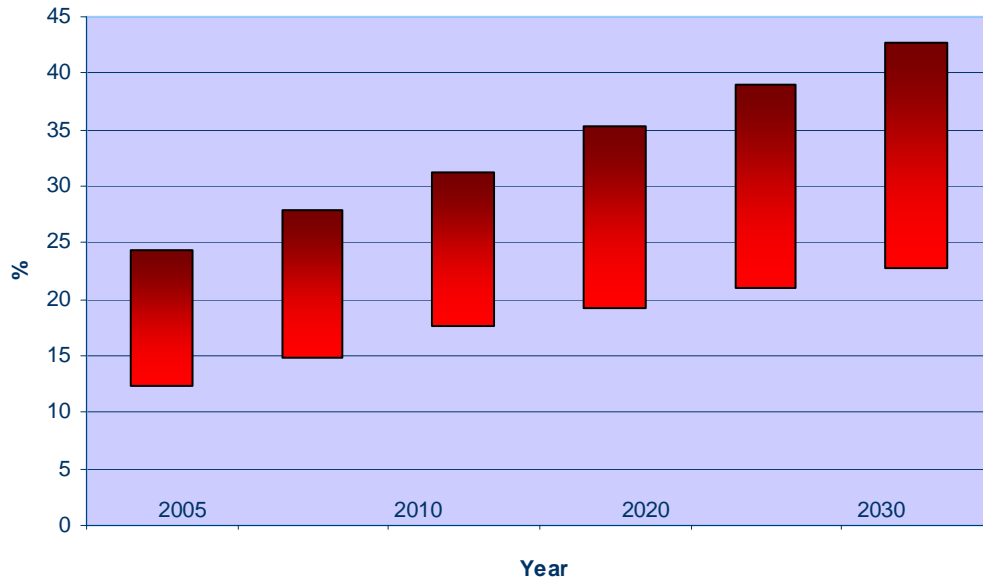


Source: Adapted from Jotangia *et al* DoH 2005

## Future projections

Estimated future rates of obesity are difficult to find. The International Association for the Study of Obesity are soon to produce some new projections for the UK. Data available for Europe however, do indicate that obesity rates across Europe are expected to rise significantly over the next 30 years.

**Figure 22: Projected adult obesity rates to 2030, Europe.**



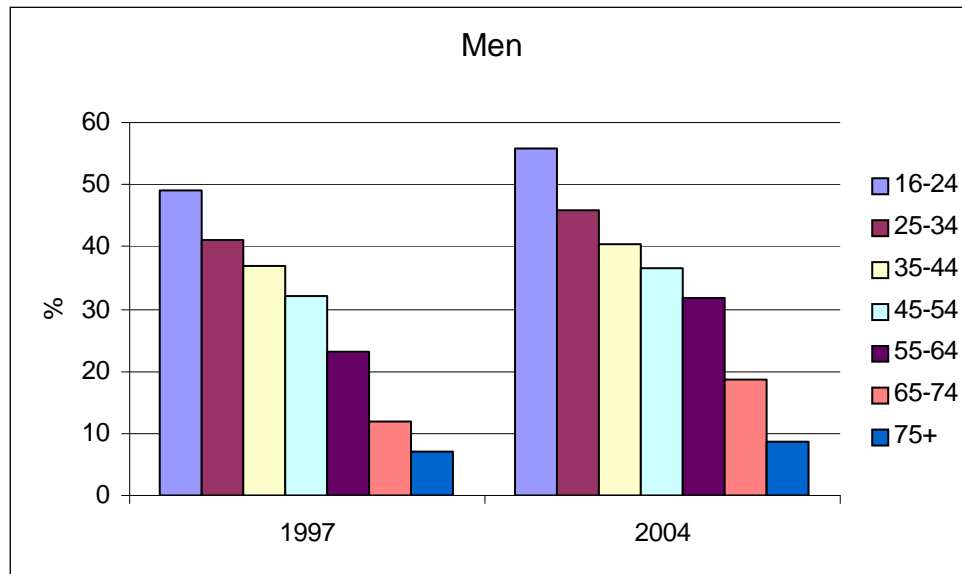
Source: IASO 2005

NB Lowest and highest estimates are shown

## Physical activity

### Physical activity rates amongst adults

**Figure 23: Proportion of adult population achieving the physical activity target<sup>26</sup>, 1997 and 2004, by age and sex, England: men**



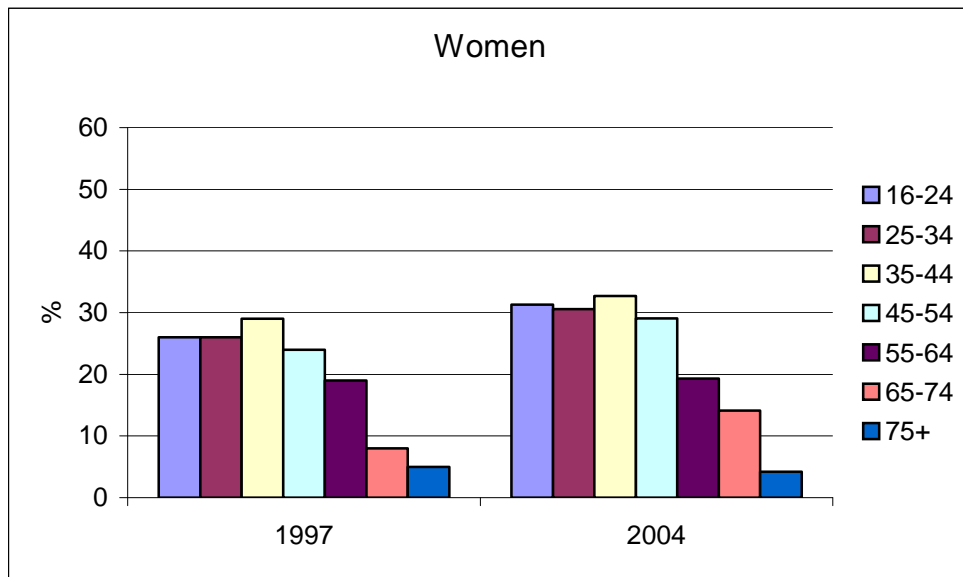
Source: HSE data 2005

Between 1997 and 2004, the proportion of men achieving the government's physical activity target of a minimum of 30 minutes of moderate activity, five days a week, has increased in all age groups. There is a defined gradient by age with higher proportions reaching the target in the younger groups. In 2004 a total of 35% of all men reached their target and this ranged from 56% in the 16-24 age group to 9% amongst those aged over 75.

Women appear to be less successful in reaching the government's target. Although rates have increased in all age groups between 1997 and 2004, they remain significantly lower than those for men. A less clear gradient is seen with age however, with proportions relatively similar across all age groups up to and including those aged 45-54. After this age thought levels of physical activity to start to decline.

<sup>26</sup> The government recommends a minimum of five days a week of 30 minutes or more moderate-intensity activity (DoH 2004).

**Figure 24: Proportion of adult population achieving the physical activity target, 1997 and 2004, by age and sex, England: women**



Source: HSE data 2005

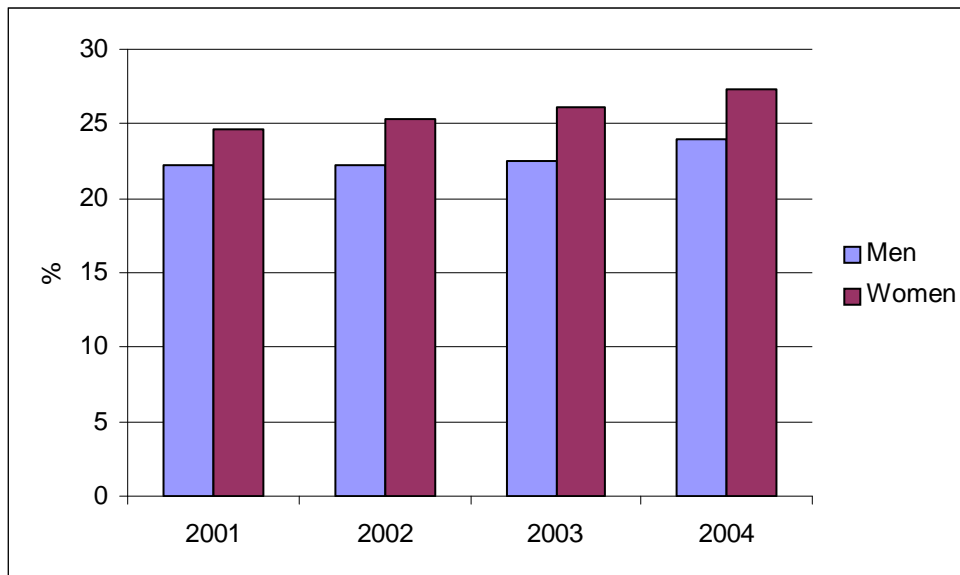


## Diet

### Fruit and vegetable consumption

The Government recommends an intake of at least five portions of fruit or vegetables per person per day to help reduce the risk of some cancers, heart disease and many other chronic conditions.

**Figure 25: Fruit and vegetable consumption, by survey year and sex**  
Proportion of adult population (aged 16 and over) eating 5 or more portions per day, England

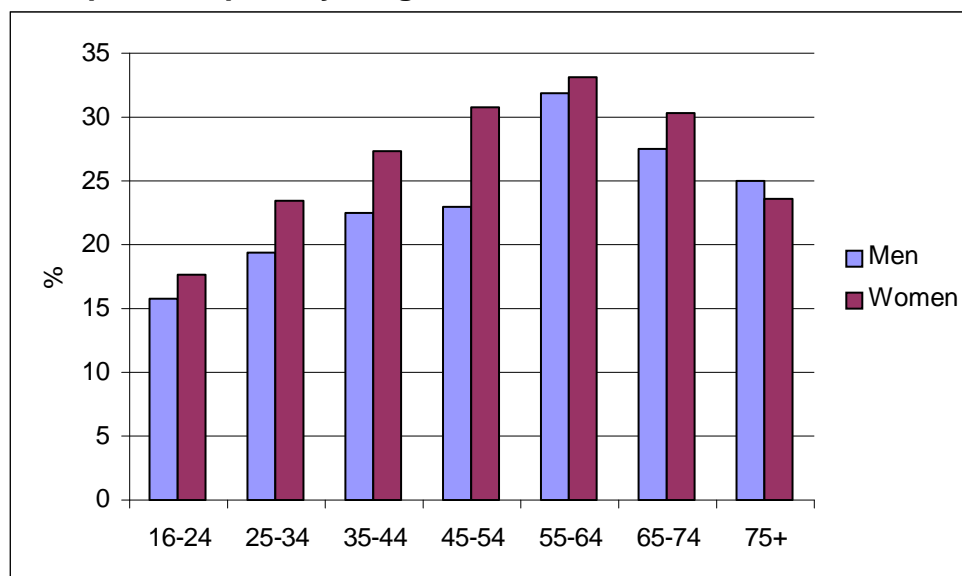


Source: HSE data 2005

The proportion of adults in England who eat 5 or more portions of fruit or vegetables per day has increased very slightly from 24% in 2001 to 26% in 2004. Rates are slightly higher amongst women and have been consistently so.

Significant differences in diet are seen by age. With the exception of the 75+ age group, women in all age groups are consistently more likely to eat the recommended daily amounts. Proportions eating 5 or more portions of fruit or vegetables daily, increase amongst both men and women with age until the age of 55-64 after which time they start to decline.

**Figure 26: Proportion of adult population (aged 16 and over) eating 5 or more portions per day, England 2004**



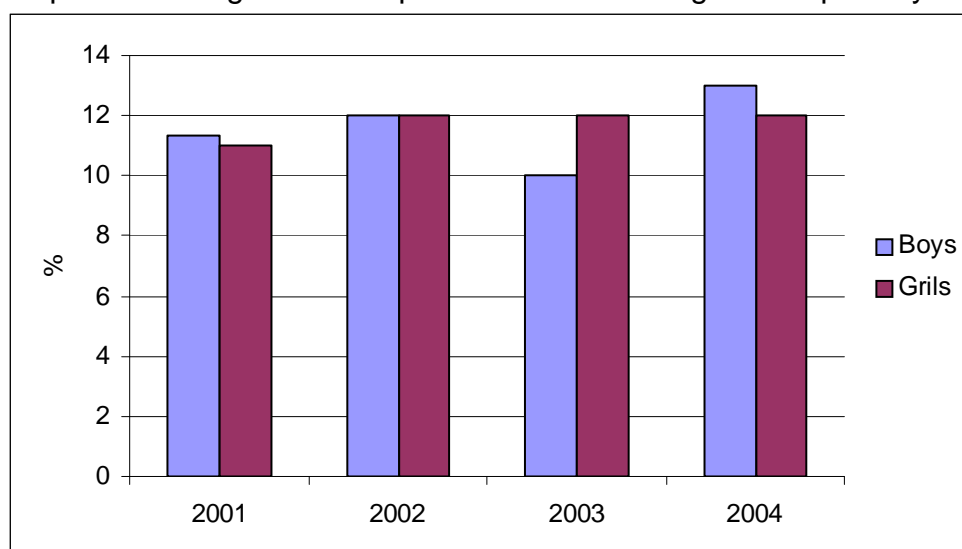
Source: HSE data 2005

### ***Diet in children***

The proportion of children achieving the government's target on fruit and vegetable consumption has remained fairly stable since 2001. In 2004, 13% of boys and 12% of girls aged 5-15 reported eating at least 5 portions daily (Figure 27). No firm differences are seen by age (HSE 2005).

**Figure 27: Children's fruit and vegetable consumption, by survey year, age and sex, England**

Proportion eating 5 or more portions of fruit or vegetables per day



Source: HSE data 2005

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Organisation for Economic Co-operation and Development OECD Health Data 2005. [http://www.oecd.org/document/16/0,2340,en\\_2649\\_34631\\_2085200\\_1\\_1\\_1\\_1,00.html](http://www.oecd.org/document/16/0,2340,en_2649_34631_2085200_1_1_1_1,00.html)



## Section 4: Improving Sexual Health

Building on the National Strategy for Sexual Health and HIV<sup>27</sup>, and the National Teenage Pregnancy Strategy<sup>28</sup>, Choosing Health and its Delivery plan, proposed a number of actions to improve sexual health. These included implementing a national chlamydia screening programme by March 2007, modernising sexual health services and reducing waiting times for referral to GUM clinics to 48 hours.

### PSA Targets

#### Department of Health/Department for Education and Skills PSA

- Reduce the under 18 conception rate by 50% by 2010 (from the 1998 baseline) as part of a broader strategy to improve sexual health<sup>29</sup>

#### NHS Local Delivery Plan data monitoring lines:

- Under18 conception rates
- Access to GUM clinics within 48 hours
- Decrease in rates of new diagnoses of gonorrhoea
- Percentage of people aged 15 to 24 accepting chlamydia screening

Teenage conception rates and rates of new cases of gonorrhoea are explored below.

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<sup>27</sup> DoH. The National Strategy for Sexual Health and HIV. 2001  
[www.dh.gov.uk/assetRoot/04/05/89/45/04058945.pdf](http://www.dh.gov.uk/assetRoot/04/05/89/45/04058945.pdf)

<sup>28</sup> DoH. National Teenage Pregnancy Strategy. 1999  
[www.dfes.gov.uk/teenagepregnancy/dsp\\_showDoc.cfm?FileName=teenpreg.pdf](http://www.dfes.gov.uk/teenagepregnancy/dsp_showDoc.cfm?FileName=teenpreg.pdf)

<sup>29</sup> See: [www.hm-treasury.gov.uk./media/4B9/FE/sr04\\_psa\\_ch3.pdf](http://www.hm-treasury.gov.uk./media/4B9/FE/sr04_psa_ch3.pdf)

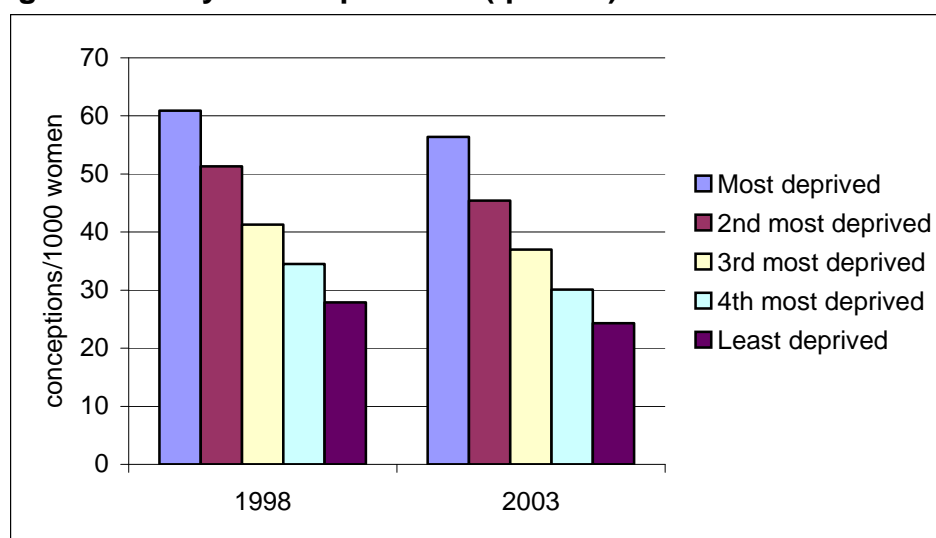
## Progress towards targets

### Teenage conception rates

There has been a 11.1% drop in the rate of under-18 conceptions between 1998 (the baseline year for the teenage pregnancy strategy) and 2004 from 46.1 per 1000 to 41.5 per 1000. This compares with a decline of 9.8% between 1998 and 2003 (ONS 2006). The decline has occurred across all quintiles of deprivation (DoH Status Report 2005).

Findings from a national evaluation of the teenage pregnancy strategy indicate that over a longer period (between 1994.98 and 1999.2002) teenage conceptions in the most deprived top tier of local authorities fell faster than in other areas.

**Figure 28: Rate of under-18 conceptions per 1,000 female population aged 15–17 by area deprivation (quintile)**



Source: Adapted from DoH Status Report 2005

### ***As summarized in the DoH Status report:***

There is a gradient in under-18 conception rates by area deprivation, with the most deprived areas having the highest conception rates and the least deprived the lowest.

In 2003 the under-18 conception rate in the most deprived areas was 32 per 1,000 higher than in the least deprived. In relative terms, the under-18 conception rate in the most deprived areas was 2.3 times the rate in the least deprived.

Between 1998 and 2003 the gap in under-18 conception rates between the most deprived areas and the England average has not changed significantly in absolute or relative terms. This also applies to the gap between the most deprived areas and the least deprived.

The national evaluation of the Teenage Pregnancy Strategy examined inequalities in teenage conception rates over a slightly longer time period (comparing 1994/98 with 1999/2002) and at a higher geographical level (top-tier local authorities rather than local authority districts).

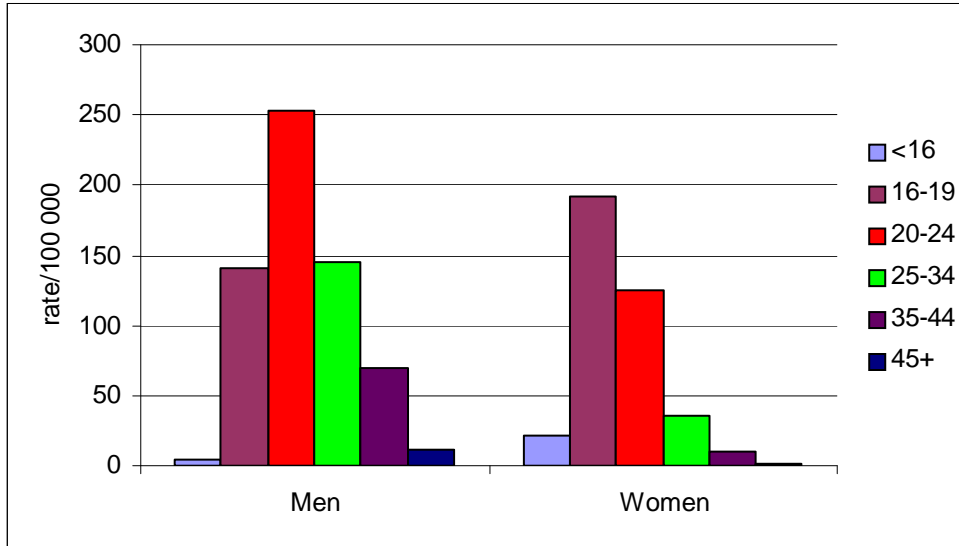
The evaluation found the greatest decline rates was in the most deprived quartile of authorities. This indicates that over a longer time period, progress has been made in reducing inequalities between the most deprived top-tier local authorities and other areas.

Adapted from: DoH Status report 2005

### Gonorrhoea rates

In 2004, gonorrhoea rates in England were highest in 20 to 24 year old men (229 per 100 000) and 16 to 19 year old females (168 per 100 000) (HPA 2006).

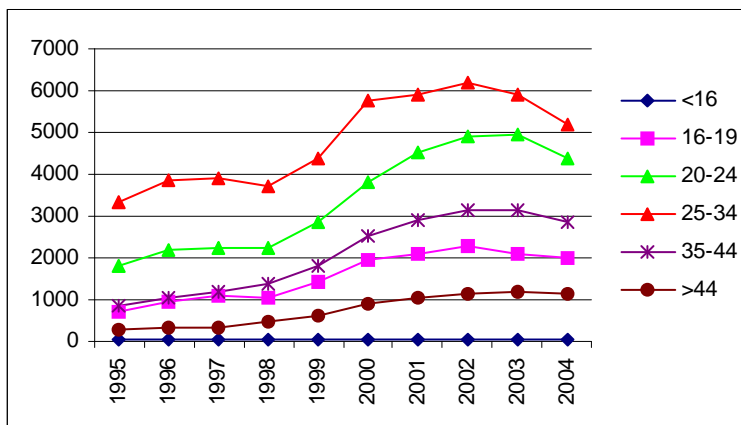
**Figure 29: Rates of new episodes of gonorrhoea England 2004**



Source: HPA 2005

Gonorrhoea rates rose steadily during the 1960s and 1970s and remained at high levels until 1985. Thereafter, numbers decreased sharply and during the early 1990s, the number of diagnoses fell to their lowest levels since recording began. However, since 1995, diagnoses of gonorrhoea have risen considerably in England. (HPA 2006).

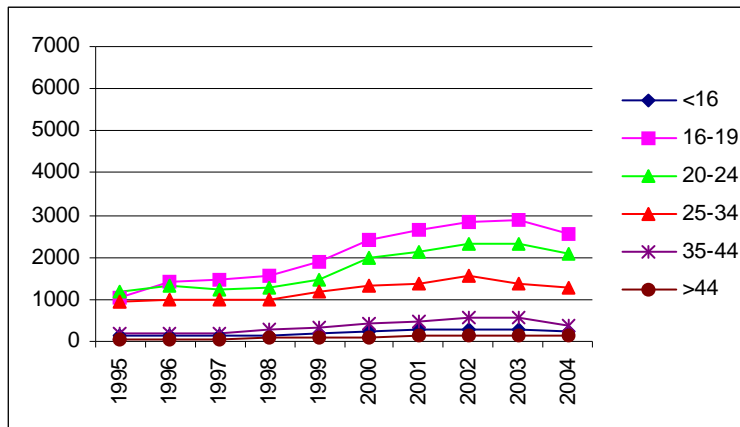
**Figure 30: New episodes of Gonorrhoea by sex: United Kingdom 1995 – 2002 (men)**



Rates have been consistently higher in men than in women but have increased in all age groups since 1995, with the sharpest increases seen in men aged 20 to 24 years and women aged 16 to 19 years.

Source: HPA 2006

**Figure 31:**  
**New episodes of Gonorrhoea by sex: United Kingdom 1995 – 2002**  
**(women)**



Source: HPA 2006

The decline in the incidence of gonorrhoea between 1985 and 1988 may reflect changes in sexual behaviour brought about in response to public awareness campaigns and the fear of a HIV epidemic. The subsequent rises after 1994 suggest that recently these behavioural modifications have not been sustained (HPA 2006).



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[www.dfes.gov.uk/teenagepregnancy/dsp\\_showDoc.cfm?FileName=teenpreg.pdf](http://www.dfes.gov.uk/teenagepregnancy/dsp_showDoc.cfm?FileName=teenpreg.pdf)

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## Section 5: Improving Mental Health and Well-being

Choosing Health aims to improve mental health by introducing the following initiatives<sup>30</sup>:

- Expanding help for people with mental illness
- Targeted action to improve the quality of patient experience
- Extended coverage of child and adolescent mental health services
- New services to improve mental and emotional well-being
- A healthy workplace programme
- The introduction of NHS Health Trainers

### PSA Targets

To reduce the death rate from suicide and undetermined injury by at least 20% by 2010

Improve life outcomes of adults and children with mental health problems by ensuring that all patients who need them have access to crisis services by 2005 and a comprehensive child and adolescent mental health service by 2006.

#### Supporting strategies:

- National Service Framework for Mental Health – Sept 1999  
[www.dh.gov.uk/assetRoot/04/01/45/02/04014502.pdf](http://www.dh.gov.uk/assetRoot/04/01/45/02/04014502.pdf)
- National Workforce Programme for Mental Health – NIMH(E)
- National Suicide Prevention Strategy – NIMH(E)
- Social Inclusion Programme – NIMH(E) [www.nimhe.org.uk](http://www.nimhe.org.uk)
- Delivering Race Equality in mental health care – Jan 2005 [www.dh.gov.uk](http://www.dh.gov.uk)
- Developing Choice, responsiveness and equity in health and social care – NIMH(E)
- Mental Health Promotion programme and Shift: the programme to reduce stigma – NIMH(E)

<sup>30</sup> DoH Choosing Health Delivery Plan 2005

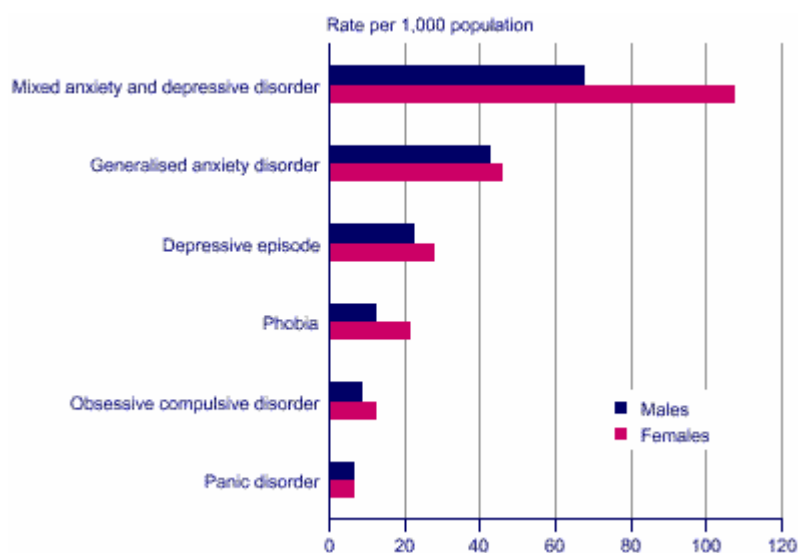
## Progress towards targets

### Morbidity data

In 2000 the Office for National Statistics (ONS) carried out a survey of psychiatric morbidity of people aged 16 to 74 in Great Britain. Results showed that one in six adults aged between 16 and 74 had a neurotic disorder, such as depression, anxiety or a phobia.

One in six adults in Great Britain had a neurotic disorder (such as anxiety and depression). The most common mental disorders were: mixed anxiety and depression (7 per cent for men, 11 per cent for women), anxiety (4 per cent for men, 5 per cent for women) and depression (2 per cent for men, 3 per cent for women)<sup>31</sup>.

**Figure 32: Prevalence of neurotic disorders, Great Britain 2002**



Source: ONS <http://www.nationalstatistics.gov.uk/cgi/nugget.asp?id=1333>

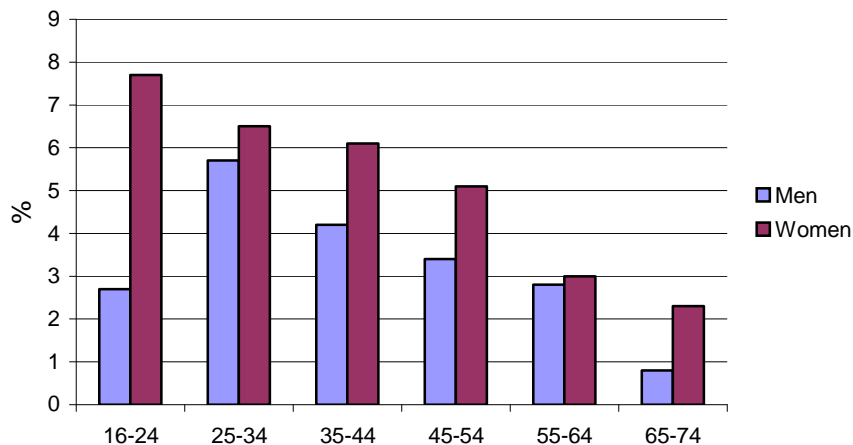
As shown in Figure 32 above, prevalence rates were higher among women for all disorders, apart for panic disorder which was equally common in both sexes. The magnitude of the difference was greatest for mixed anxiety and depressive disorder, which was reported in around 110 per 1000 women compared with around 70 per 1000 men.

<sup>31</sup> NIMHE. National Suicide Prevention Strategy for England. Annual Report on progress 2004: Psychiatric disorders and suicidal attempts were more likely to occur in people facing socio-economic disadvantage: that is people with unskilled occupations or who were unemployed, who lacked formal qualifications, who were renting accommodation from a local authority or housing association, who were living alone, or were separated or divorced.

## Suicide

In 2000 one in seven adults aged 16 to 74 in Great Britain had considered suicide at some point in their lives. 3.6% of men and 5.3% of women reported having actually attempted suicide. Differences were seen by age group, but in all age groups women were more likely than men to have attempted suicide<sup>32</sup>.

**Figure 33: Prevalence of ever attempting suicide: by age and sex, 2000**



Source: Survey of Psychiatric Morbidity among Adults in Great Britain, Office for National Statistics.

When we look at actual numbers of suicides, the majority occur in young men. In relation to women of the same age (see Figure 7, p10). The peak difference is the 25-34 age group in which 4 males commit suicide to each female<sup>33</sup>.

Suicide rates whilst fluctuating year on year, show a downward trend since the early 1980s. Latest available data (for the 3 years 2002/3/4) show a rate of 8.6 deaths per 100,000 population – a reduction of 6% from the 1995/6/7 baseline of 9.2<sup>34 35</sup>.

## International comparisons

The death rate to suicide and self-inflicted injury in the UK is significantly lower than the EU average. Rates both in the UK and across Europe are undergoing a steady and continuous decline.

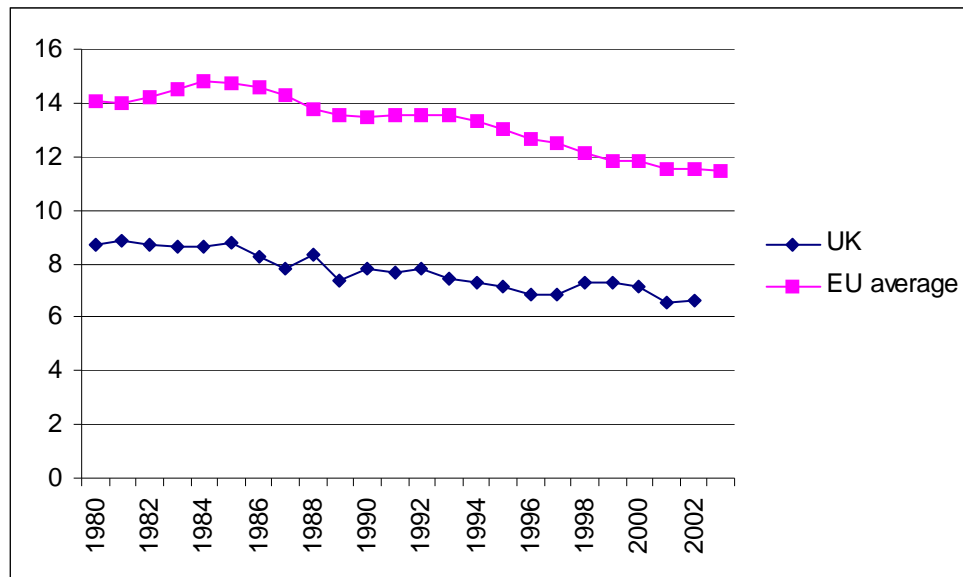
<sup>32</sup> Survey of Psychiatric Morbidity among Adults in Great Britain, Office for National Statistics

<sup>33</sup> National Suicide Prevention Strategy for England Annual Report on progress 2004

<sup>34</sup> National Suicide Prevention Strategy for England Annual Report on progress 2004

<sup>35</sup> E-Mental Health OHN Target. DoH 2004

**Figure 34: Standardised Death Rate (SDR), suicide and self-inflicted injury, all ages per 100 000. UK and EU average 1980-2003**

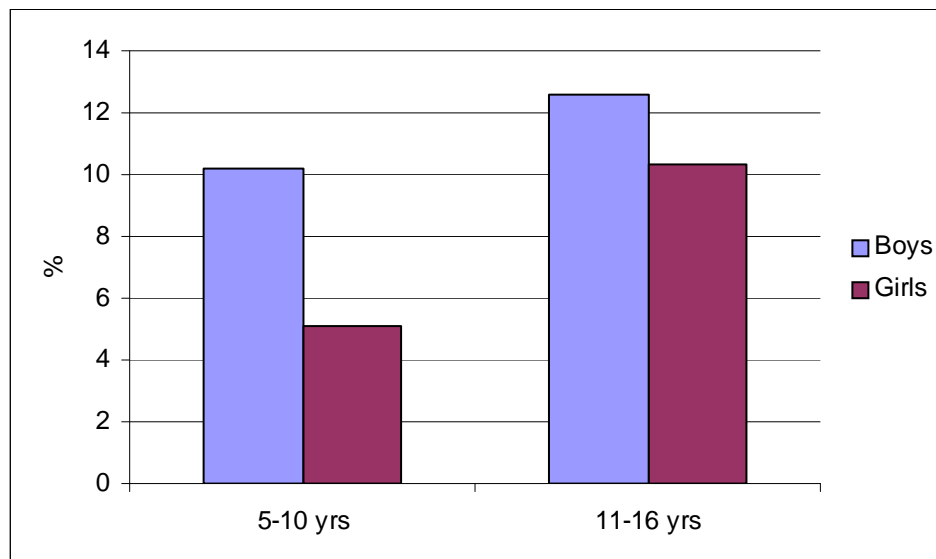


Source: WHO HFA database <http://data.euro.who.int/hfad/>. World Health Organisation Regional Office for Europe. Updated: June 2005

## Psychiatric morbidity in children

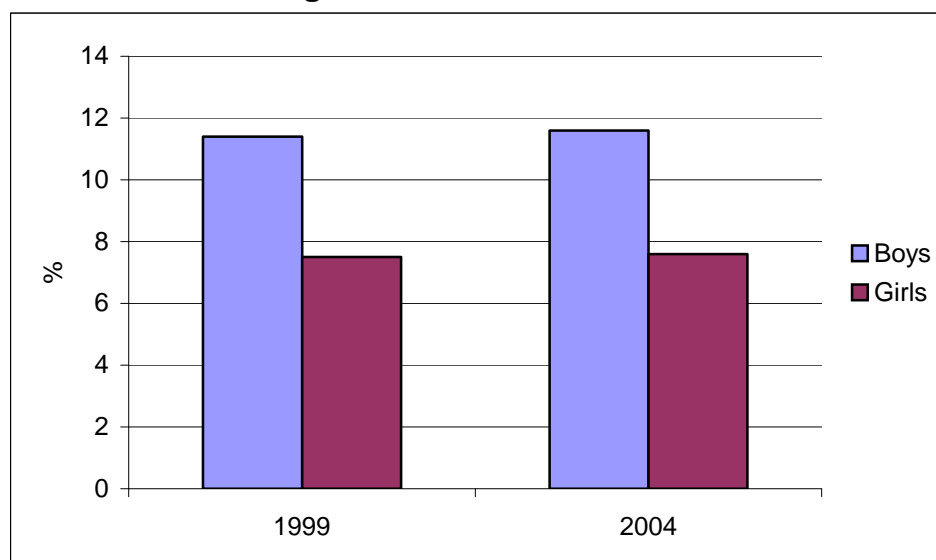
A survey conducted in 2004 among children in Great Britain<sup>36</sup> showed that 10% aged 5-16 had a clinically diagnosed mental disorder. 4% had an emotional disorder, 6% had a conduct disorder and 2% a hyperkinetic disorder.

**Figure 35: Prevalence of any mental disorder by age and sex, Great Britain, 2004**



Source: Green *et al.* ONS 2005: <http://www.dh.gov.uk/assetRoot/04/11/83/39/04118339.pdf>

**Figure 36: Prevalence of any mental disorder by sex, Great Britain, 1999 and 2004 Children aged 5-16**



Source: Green *et al.* ONS 2005: <http://www.dh.gov.uk/assetRoot/04/11/83/39/04118339.pdf>

There were no changes in the prevalence of mental disorders in children between 1999 and 2004. However the prevalence is significantly higher in boys than girls and this has remained the case over time.

<sup>36</sup> Source: Green *et al.* ONS 2005: <http://www.dh.gov.uk/assetRoot/04/11/83/39/04118339.pdf>

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World Health Organisation Regional Office for Europe. Updated: June 2005



## Section 6: Reducing harm and encouraging sensible drinking

### *Alcohol*

The *Alcohol Harm Reduction Strategy for England*, published in 2004 presents a cross government approach to tackling the harms and cost of alcohol misuse.

The NHS Plan<sup>37</sup> set out the Government's commitment to implementing an Alcohol Harm Reduction Strategy for England from 2004. The strategy sets out action for improvements in: communication, education, training for doctors and nurses, early identification or screening and brief interventions pilots, treatment audit/improvements in treatment services, tackling crime and disorder, and working with the drinks industry.

The NHS Improvement Plan<sup>38</sup> was published in June 2004 and sets out the priorities for the NHS up to 2008. It supports the Government's ongoing commitment to a 10-year process of reform first set in the NHS<sup>39</sup>.

Choosing Health and its delivery plan, build on the commitments in the Alcohol Harm Reduction Strategy and propose action to reduce alcohol related harm. This includes, developing a social responsibility scheme for alcohol, to protect young people by putting information on alcohol containers and in retail outlets, placing responsible drinking messages on alcohol advertisements and ensuring alcohol is not sold to under 18 year olds.

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<sup>37</sup> Department of Health. The NHS Plan: A plan for investment. A plan for reform. London: The Stationery Office, 2000. (Cm. 4818 – 1). Available on the internet at: <http://www.dh.gov.uk/assetRoot/04/05/57/83/04055783>.

<sup>38</sup> Department of Health. The NHS Improvement Plan: Putting people at the heart of public services. London: The Stationery Office, 2004. (Cm. 6268). Available on the internet at: <http://www.dh.gov.uk/assetRoot/04/08/45/22/04084522>.

<sup>39</sup> DoH. Statistics on Alcohol, England 2004

## PSA Targets

There are currently no targets in England, relating to a reduction in alcohol consumption<sup>40</sup>. However the Government has set out '*Government's Recommended Sensible Drinking Guidelines*<sup>41</sup>':

- a maximum intake of 2-3 units per day for women and 3-4 for men, with two alcohol-free days after heavy drinking; continued alcohol consumption at the upper level is not advised;
- that intake of up to two units a day can have a moderate protective effect against heart disease for men over 40 and post-menopausal women; and
- that some groups, such as pregnant women and those engaging in potentially dangerous activities (such as operating heavy machinery), should drink less or nothing at all.

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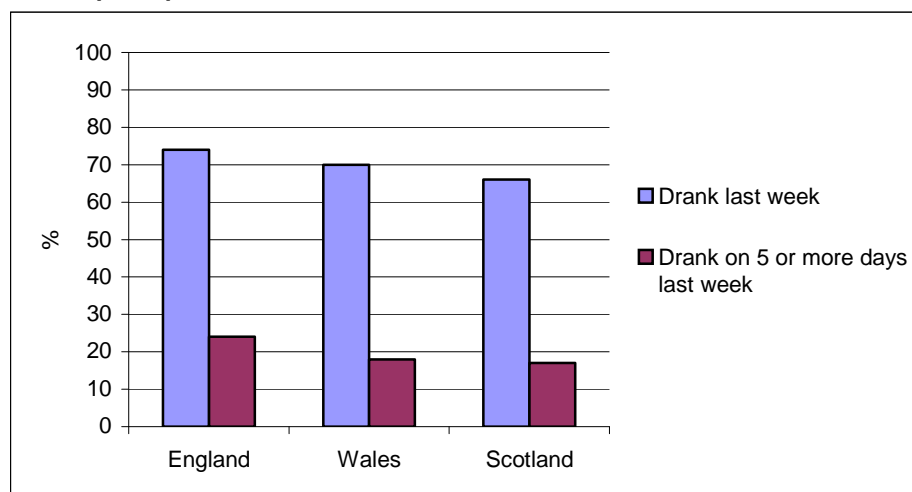
<sup>40</sup> Scotland has targets relating to a reduction in the proportion of the population exceeding the recommended weekly limits of alcohol for both men and women, as well as a target for a reduction in the frequency and level of drinking by 12-15 year olds.

<sup>41</sup> Further information is presented in the Alcohol Harm Reduction Strategy for England. Cabinet Office 2004

## Progress towards targets

### Drinking among adults aged 16 and over

**Figure 37: Adult (aged 16 or over) drinking in the last week, by country. 2004: (Men)**

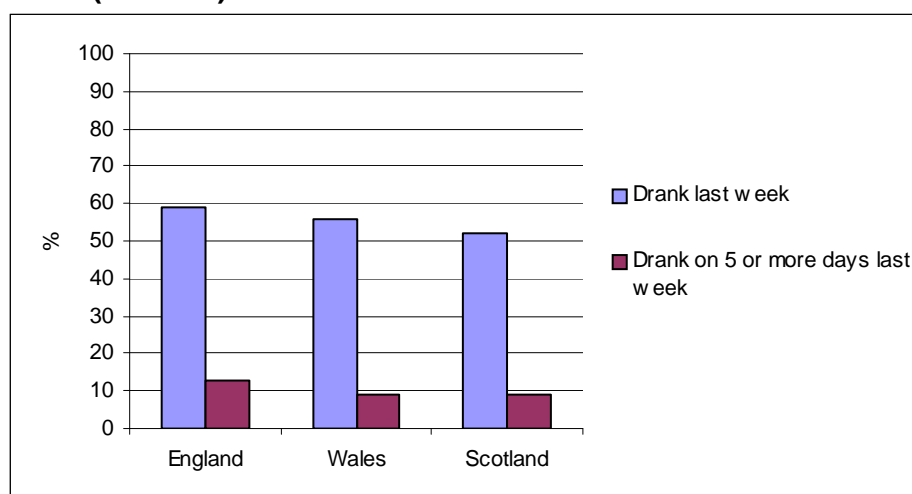


NB for base numbers refer to full data set

Source: GHS 2005

[http://www.statistics.gov.uk/downloads/theme\\_compendia/GHS04/GHS04contents.pdf](http://www.statistics.gov.uk/downloads/theme_compendia/GHS04/GHS04contents.pdf)

**Figure 38: Adult (aged 16 or over) drinking in the last week, by country. 2004: (Women)**



NB for base numbers refer to full data set

Source: GHS 2005

[http://www.statistics.gov.uk/downloads/theme\\_compendia/GHS04/GHS04contents.pdf](http://www.statistics.gov.uk/downloads/theme_compendia/GHS04/GHS04contents.pdf)

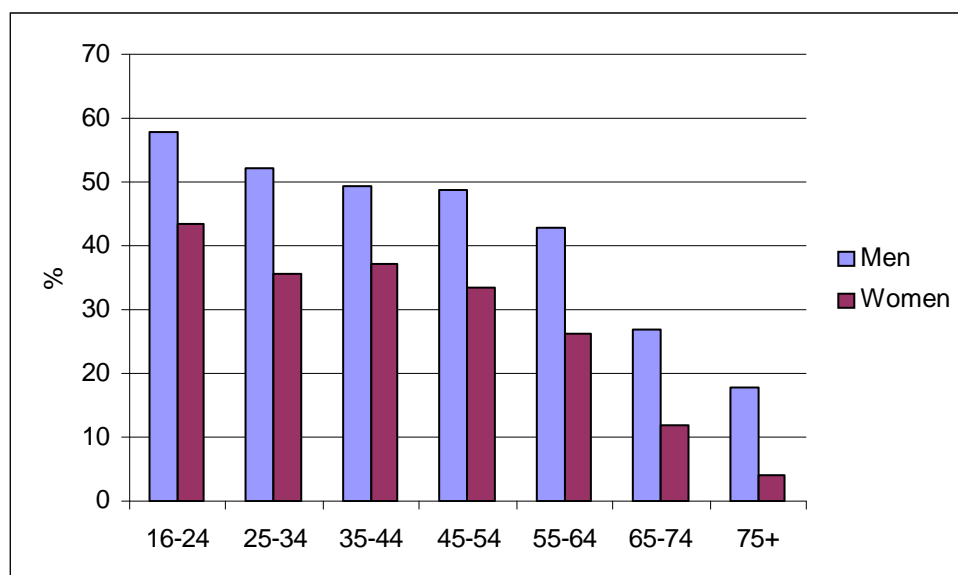
Information from the General Household Survey shows that in England in 2004, 74% of men and 59% of women had drunk an alcoholic drink on at least one day during the previous week. Men were not only more likely to drink than women, but to have drunk on more days of the week: 24% of men had drunk on five or more days during the previous week, compared with 13% of women. Data for Wales and Scotland are shown for comparison.

## Heavy Drinking

Looking at those exceeding recommended levels:

**Figure 39: Percentage of the adult population exceeding recommended maximum alcohol intake<sup>42</sup> on at least one day in the last week, by age and sex. England 2004**

Most recent data:



Source: HSE data 2005

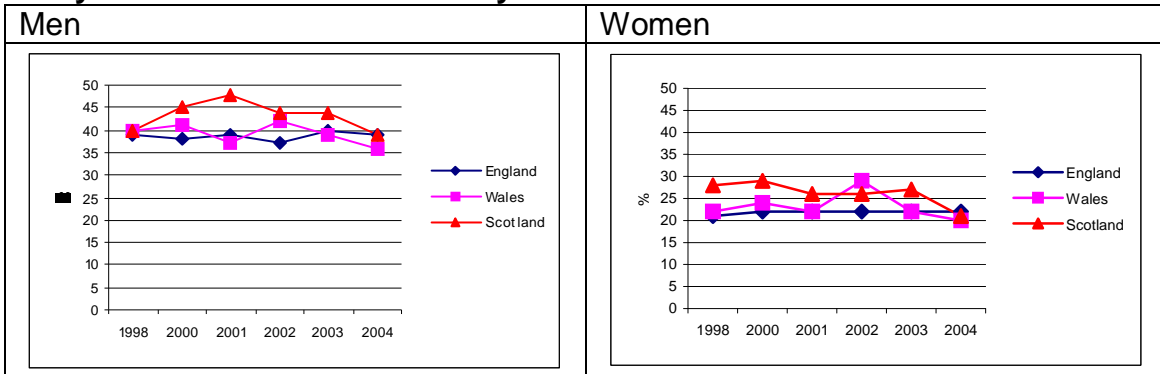
In 2004, 43% of men had drunk more than 4 units on at least one day in the previous week. The proportion who had done so varied with age, ranging from 58% of men aged 16-24, to 18% aged 75 and over.

Women were much less likely than men to have drunk above sensible levels: 28% had drunk more than 3 units of alcohol on at least one day in the previous week. Again, the likelihood of having done so was strongly related to age: 43% of women aged 16-24 had done so compared with 4% of those aged 75 and over.

<sup>42</sup> 4 units for men and 3 units for women

**Differences in drinking patterns over time.**

**Figure 40: Percentage who drank more than recommended maximum daily amount on at least one day in the last week**



NB for base numbers refer to full data set

Source: GHS 2005

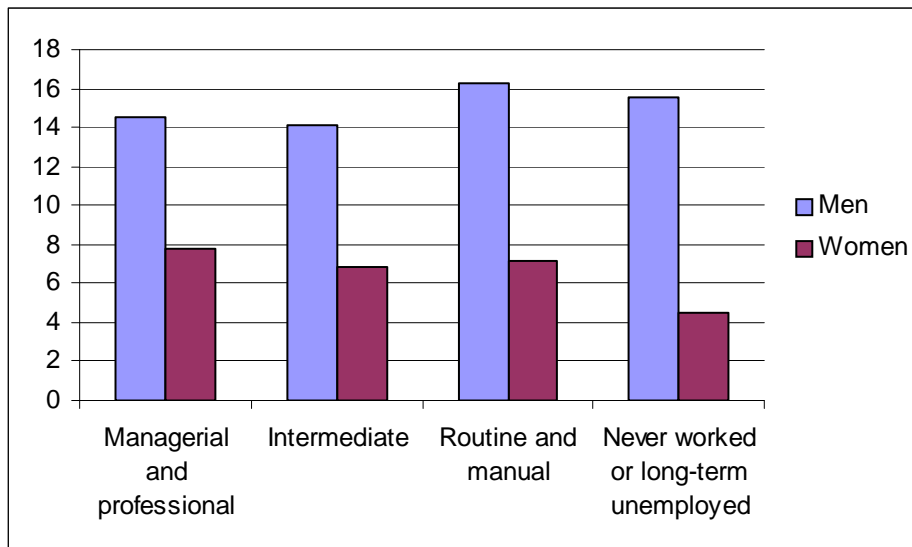
[http://www.statistics.gov.uk/downloads/theme\\_compendia/GHS04/GHS04contents.pdf](http://www.statistics.gov.uk/downloads/theme_compendia/GHS04/GHS04contents.pdf)

The percentage of adults drinking over the recommended daily amount has been quite stable in England since 1998 for both men and women, while the trend in both Wales and Scotland has fallen in recent years.

**Drinking patterns by social group**

**Figure 41: Average weekly alcohol consumption by sex and socio-economic group. Great Britain 2004**

Mean numbers of units per week



Note: The sample population consisted of 3,528 adults aged 16 or over

Source: ONS Omnibus survey 2004 (Lader D & Goddard E)

<http://www.dh.gov.uk/assetRoot/04/09/79/01/04097901.pdf>

Data from the ONS Omnibus survey show that average weekly alcohol consumption varies with social group for men, being higher amongst those from routine/manual occupations and unemployed groups than in those from managerial, professional and intermediate occupations. For women drinking patterns were more stable across socio-economic groups.

## Drinking patterns among young people

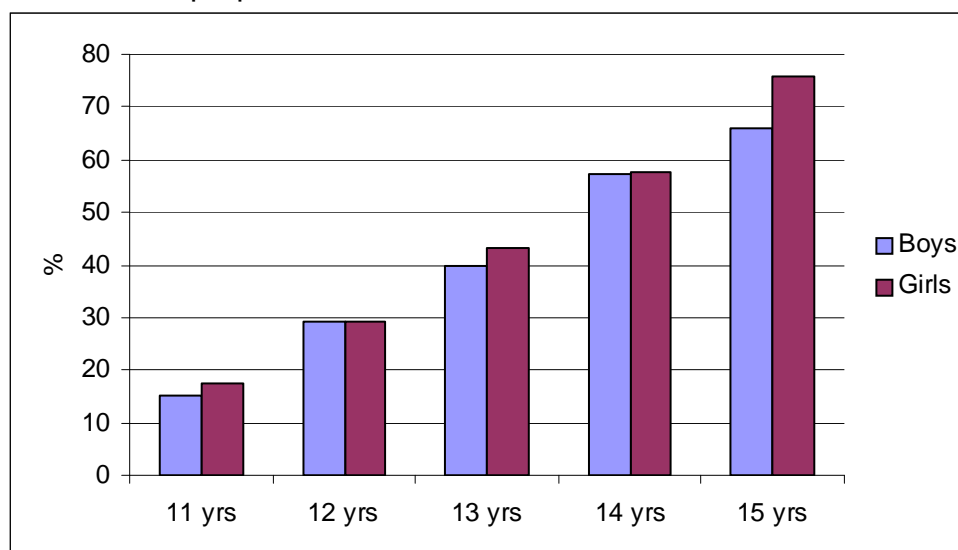
The proportion of young people (aged 8-15) in England, reporting experience of alcohol has remained relatively stable since 1998. Those reporting ever having drunk a proper alcoholic drink in 1998 was 39% for boys and 34% for girls. This figure remained relatively stable and was 31% and 32% respectively in 2004 (HSE 2005).

However the proportions drinking alcohol increase sharply with age: for example in England in 2004, only 15% of boys and 18% of girls aged 11 reported having ever had an alcoholic drink. Compared with 66% and 76% respectively of those aged 15 (HSE 2005).

If we look at all children for most recent year:

**Figure 42: Children's (aged 8-15) self-reported experience of alcohol, by sex. England 2004**

Ever drunk a proper alcoholic drink



Source: HSE 2005

## Alcohol-related ill-health

Alcohol consumption is a major public health problem, and the cause of about 4% of the global burden of disease (Leon & McCambridge 2006). It has doubled in Britain between 1960 and 2002 (AMS 2004).

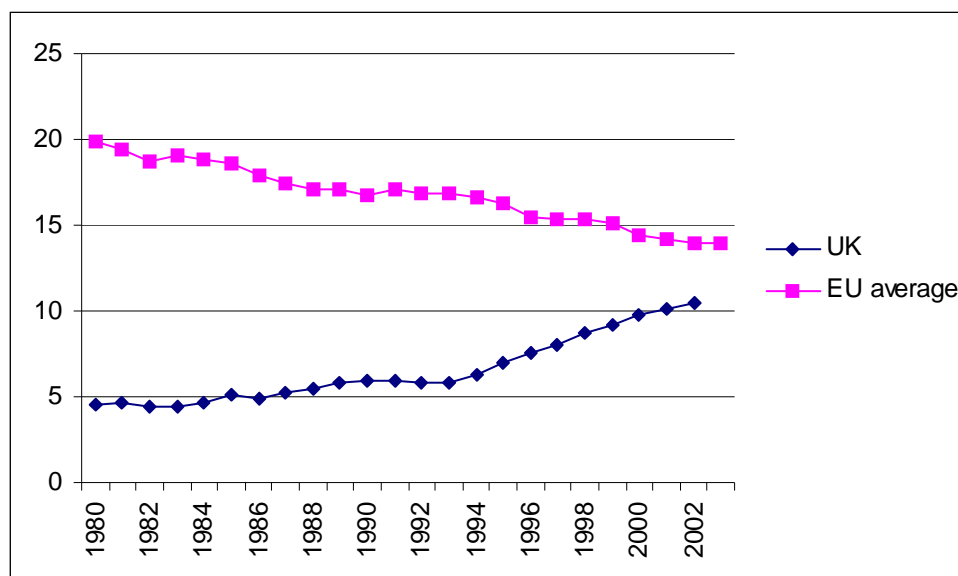
### Deaths from alcohol related diseases

Alcohol misuse can be directly linked to deaths from certain types of disease, such as liver cirrhosis, and in some cases it may also be associated with other causes of death, such as stroke.

The number of premature deaths associated in some way with alcohol misuse has been estimated at 22 000 per year (Cabinet Office Alcohol Harm Reduction Strategy for England 2004).

Detailed statistics on deaths from selected causes linked to alcohol presented elsewhere (DoH Statistics on alcohol: England, 2004). These data show alcohol related deaths in England and Wales to be on the increase among both men and women. Further evidence of this can be seen by comparing with other countries. The death rate from chronic liver disease and cirrhosis has been increasing in the UK since the late 1980s, whilst it has been falling in Europe as a whole. In Britain, the increases in mortality rates for both men and women, exist across all age-groups, and are accelerating (Leon & McCambridge 2006).

**Figure 43: Narrowing gap between the UK and European Union average death rates from chronic liver disease and cirrhosis. All ages per 100 000. 1980-2002**



Source: WHO HFA Database. 2005

<http://data.euro.who.int/hfad/>

## Drugs

1998 marked the beginning of the Government's Drug Strategy: *Tackling drugs to build a better Britain*<sup>43</sup>. It is a cross-government programme of policies and interventions which has the over-arching aim to 'reduce the harm caused by illegal drugs'. The four main elements of the strategy are young people, treatment of problem drug users, supply of drugs and drug-related crime.

In 2002 after a review conducted by the Home Affairs Select Committee, it was updated<sup>44</sup>. Then in 2004 the Government published *Tackling Drugs. Changing Lives*<sup>45</sup>, and its subsequent delivery plan<sup>46</sup>, which set out progress made in delivering the Drug Strategy and planned action for the period to 2008.

## PSA Targets

In 2004 a new Public Service Agreement (PSA) was set for the Government's Drug Strategy<sup>47</sup>. This includes three PSA targets to:

- Reduce the harm caused by illegal drugs including substantially increasing the number of drug misusing offenders entering treatment through the Criminal Justice System.
- Increase the participation of problem drug users in drug treatment programmes by 100% by 2008 and increase year on year the proportion of users successfully sustaining or completing treatment programmes.
- Reduce the use of Class A drugs and the frequent use of any illicit drug among all young people under the age of 25, especially by the most vulnerable young people.

The British Crime Survey (BCS)<sup>48</sup> is used to monitor the Public Service Agreement (PSA) target, shared between the Home Office and the Department for Education and Skills, to reduce drug use amongst young people. Data from the BCS are presented below:

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<sup>43</sup> Home Office *Tackling drugs to build a better Britain*. Cm 3945, HMSO 1998.

<sup>44</sup> Home Office *Updated drug strategy 2002*. Home Office. 2002

<sup>45</sup> Home Office *Tackling Drugs. Changing Lives*. Home Office 2004a

<sup>46</sup> Home Office. *Tackling Drugs. Changing Lives. Delivering the difference*. Home Office 2005

<sup>47</sup> For more information see: <http://www.drugs.gov.uk/drug-strategy/psa-targets/> and [http://www.hm-treasury.gov.uk/media//70320/sr04\\_psa\\_ch3.pdf](http://www.hm-treasury.gov.uk/media//70320/sr04_psa_ch3.pdf)

<sup>48</sup> The British Crime Survey (BCS) is a large nationally representative survey of over 28 000 adults living in private households in England and Wales. Since 1996 the BCS has included a comparable self-completion module of questions on illicit drug use (Roe 2005).

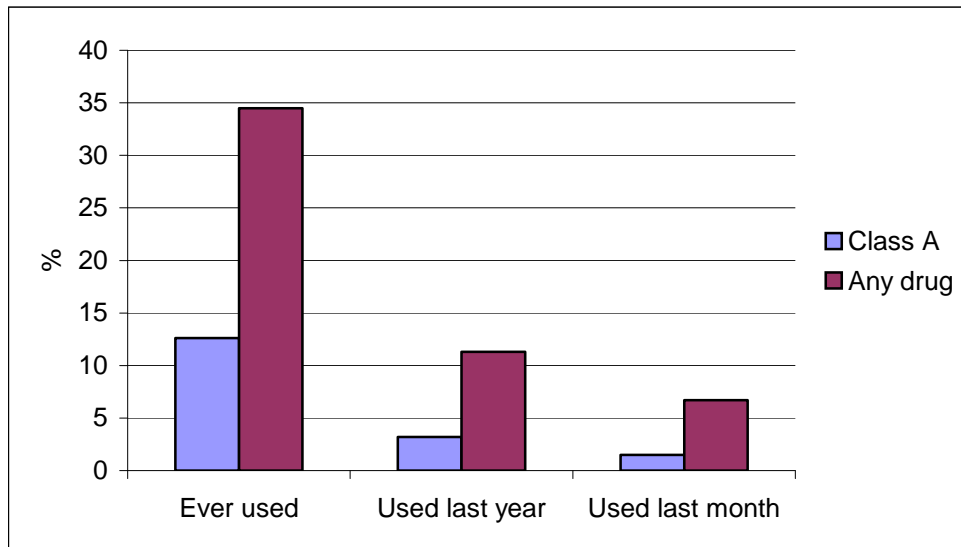


## Progress towards targets

### Current drug-taking patterns

The 2004/05 British Crime Survey estimated that 34.5% of 16-59 year olds had used one or more illicit drugs in their lifetime (Roe *et al* 2005). 11.3% had used one or more illicit drugs in the last year and 6.7% in the last month.

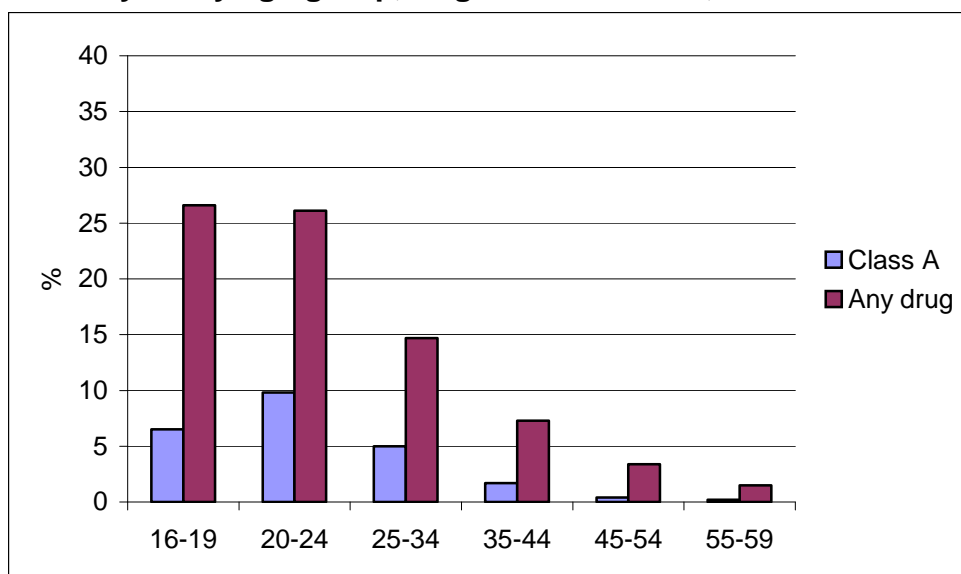
**Figure 44: Proportion of 16-59 year olds reporting having used drugs in England and Wales, 2004/05**



Source: Roe S (2005): Drug Misuse Declared: Findings from the 2004/05 British Crime Survey England and Wales.

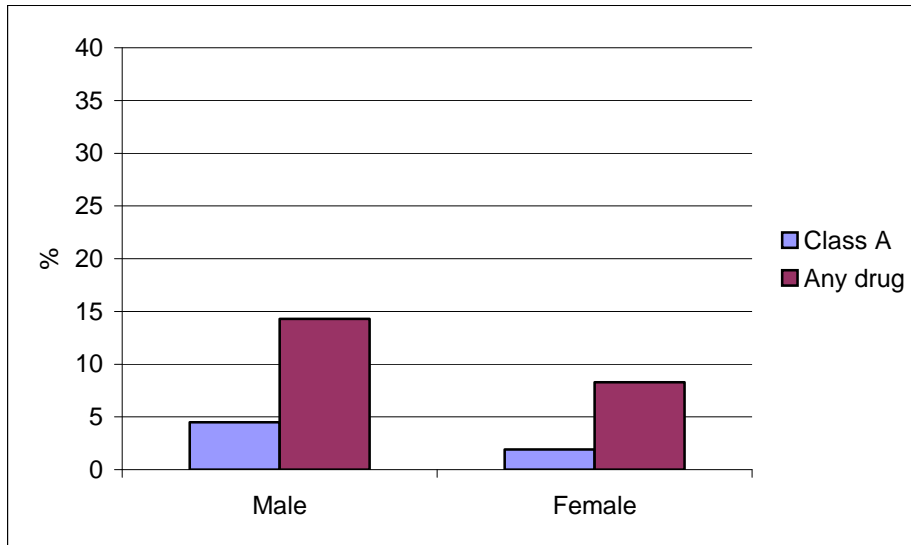
Drug use varies significantly by age group, being higher among the younger groups.

**Figure 45: Proportion of 16-59 year olds reporting having used drugs in the last year by age group, England and Wales, 2004/05**



Source: Roe S (2005): Drug Misuse Declared: Findings from the 2004/05 British Crime Survey England and Wales.

**Figure 46: Proportion of 16-59 year olds reporting having used drugs in the last year by gender, England and Wales, 2004/05**

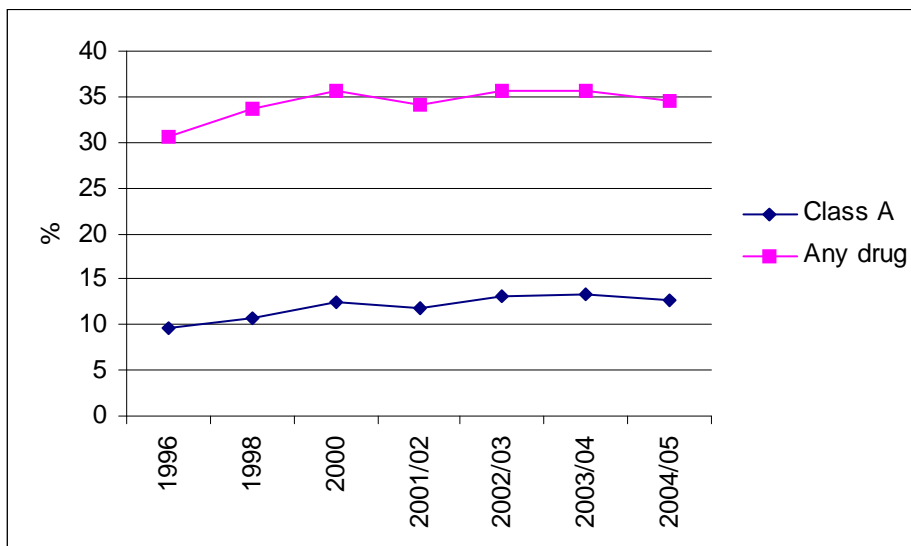


Source: Roe S (2005): Drug Misuse Declared: Findings from the 2004/05 British Crime Survey England and Wales.

Men report higher levels of any illicit drug use than women. In 2004/05 14.3% of men aged 16 to 59 reported use of any illicit drug in the last year compared to 8.3% of women.

### ***Differences in drug taking patterns over time.***

**Figure 47: Proportion of 16-59 year olds reporting ever having used drugs, England and Wales, 1996-2005**



Source: Roe S (2005): Drug Misuse Declared: Findings from the 2004/05 British Crime Survey England and Wales.

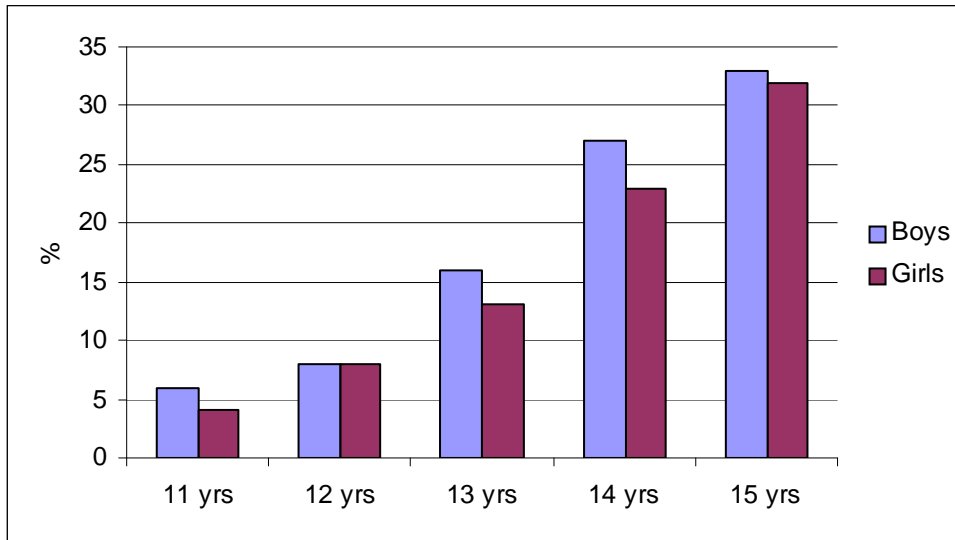
Between 1996 and 2000, patterns of illicit drug use among 16-59 year olds in England and Wales increased slightly, after which time they remained fairly stable.

### Drug taking patterns among young people

A recent report on the lifestyles of young people in England examined both the current rates of drug-taking and trend data back to 1998 (Fuller *et al* 2005).

Drug-taking is slightly higher among boys than girls and varies significantly with age. In 2004 6% of boys and 4% of girls reported having taken drugs in the last year, compared with 33% and 32% of 15 year olds respectively.

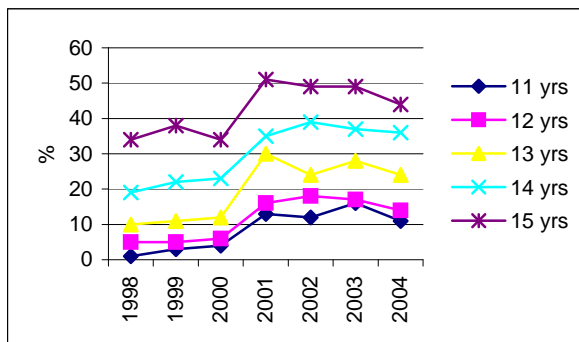
**Figure 48: Taken drugs in the last year, by age and sex. England 2004**



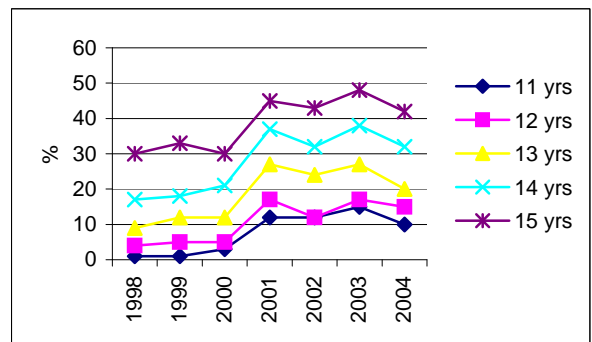
Source: Fuller *et al* 2005

**Figure 49: Ever taken drugs, by sex and age: 1998-2004**

Boys



Girls



NB: Estimates from 2001 onwards are not comparable with estimates from previous years because of the change in the way that drug taking was measured.

Source: Fuller *et al* 2005

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