LONDON
HEALTH COMMISSION

Health Equity Profile for London - Summary

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1. Summary

This report provides an overview of health inequalities in London. In doing so, it aims to help provide some understanding of the likely impact of the *Healthcare for London* proposed changes on those groups most at risk of being disadvantaged. The report aims to describe inequalities in health and in access to health services in London, using specific indicators of determinants of health and access to health care.

This profile describes both inequalities, such as variations in uptake of childhood immunisations and health inequities, such as poorer access to GP services by people in deprived areas. . Health inequalities describe differences of fact, which are not necessarily inequitable, as long as they are based on need, while health inequities are about lack of fairness.

The report focuses on those groups of people, who are most at risk of being disadvantaged, namely the equalities target groups: black, Asian and other minority ethnic groups (BAME); children and young people; people living with disabilities; people from faith groups; lesbian, gay and bisexual people; older people; women; and other vulnerable groups. It has not been possible to present information about each of these groups, since for some there is no routine data collection that would allow this. E.g. there are no data on mortality rates of different ethnic groups, faith groups or lesbian, gay and bisexual people.

London is populous and diverse, which presents a challenge when trying to develop a strategy for providing healthcare at the London level.

Inequalities in health are prevalent and widespread. Life expectancy in the capital ranges from over 80 years for men and women in Kensington and Chelsea, to around 78 years for women in Newham and only about 74 years for Islington men.

Wide variations exist between boroughs in terms of mortality, primary care provision and birth outcomes, with the most deprived boroughs usually featuring among those areas with the worst indicators. Variations also exist in uptake of preventive services, but these display a more complex pattern, not readily linked to area deprivation.

Overall, the distribution of inequalities is complex – it is not always the same geographical area that fares the worst, nor is it always the most deprived. Spearhead areas tend to fare worst in terms of health outcome, but they are not always the worst for each indicator.

In taking forward the *Healthcare for London* strategy it will be important to look at local community equity profiles, taking account of local intelligence, to ensure that health inequalities will be reduced and not increased.

Interpreting the indicators is not simple: it requires insight into the local culture and other local factors.

The key points and implications from this profile are summarised below and at the end of each section.

2. Background

- Inequalities in health exist between geographical areas and between socioeconomic groups.
- Health inequalities also exist between different age groups, gender groups and ethnic groups.
- The NHS has a significant role to play in reducing health inequalities, through understanding differing needs and equitable resource allocation.

3. London's Geography and Population

- London is a very populous and diverse city.
- London is a predominantly young city, with two thirds of residents being 40 years old or younger.
- London is also ethnically and religious diverse: one third of Londoners is of ethnic minority origin and a significant majority of residents of each borough belongs to a faith group.
- The capital is not uniform and individual boroughs are ethnically diverse to different degrees.

- Migration makes an important contribution to population change in London, but net migration cannot be measured.

Implications

- Targeted interventions will probably be required to ensure that the proposed changes result in services that provide services to meet the diverse needs of the diverse population of London.

4. Inequalities

- Inequalities in health mirror inequalities in general.
- There are both very affluent and very deprived areas and people in London.
- Levels of income deprivation and unemployment vary between boroughs, with unemployment ranging from 7% in Richmond, the most affluent area of London, to 24% in Hackney, one of the most deprived.
- London has 11 of the 70 areas in England that are in the most deprived fifth of areas and that are in the worst fifth of areas for life expectancy and mortality from cardiovascular disease and cancer.
- The equalities target groups, which have historically been disadvantaged or subject to discrimination, tend to have poorer access to health services and worse health outcomes than the general population.
- Life expectancy is highest and all-age, all cause mortality is lowest in affluent Kensington and Chelsea, while highest all-age, all cause mortality occurs in more deprived areas, such as Barking and Dagenham, Islington and Newham.

Implications

- Local factors, both area factors and individual factors, must be considered when implementing the *Healthcare for London* proposals in any given area.

5. Primary care and polyclinics

- There is marked variation in several aspects of access to primary care services across London boroughs.

- Some boroughs are currently under-doctored, i.e. there are fewer GPs per weighted population than the England average.
- There is variation in PCT performance on providing GP access within 48hours of requesting an appointment, ranging from less than 70% in Tower Hamlets to over 90% in Kingston.
- 7 PCTs appear to have a significant resident population (more than 10,000), who are not registered with a GP. This could represent a significant problem with access to primary care, but needs to be looked into further for full understanding.
- Primary care quality is even more variable than access, as measured by potentially avoidable emergency hospital admissions. These vary from just over 100 per 100,000population in Kensington and Chelsea to around 300 per 100,000 population in Ealing.

Implications

- Reorganisation of primary care services needs to take into account the potential difficulty of recruiting GPs into certain areas.
- Making it easier to register with a practice or making provision for unregistered populations to receive adequate services will also be important.

6. Preventive Health Care

- There is variation in access to and uptake of preventive services, which could be explained in part by different health seeking behaviours of different groups, but also in part by inability of services to reach certain groups.
- London shows variation in access to and effectiveness of smoking cessation services.
- Variation in access occurs by age and by borough. The worst access/poorest uptake of smoking cessation services is among those under 18 years, while 18 to 34 years old have the highest uptake.
- In Ealing nearly 80% of those smokers, who set a quit date with smoking cessation services remained quit at four weeks. Whereas, in Croydon only 40% were converted to four week quitters.

- There are variations in uptake of childhood immunisations at all ages and across boroughs. The picture is complex, with coverage differing between individual vaccines and no clear relationship to deprivation or affluence.
- Variations in uptake of flu vaccine by older people are less than for childhood immunisations.

Implications

- Understanding local factors and more precisely targeting preventive interventions could help improve their uptake and effectiveness.

7. Maternity

- High proportions of sole registered births, teen pregnancies and low birth weight occur in some of the most deprived London boroughs.
- Low birth weight shows marked variation across London with rates almost doubling from the lowest, in Richmond, to the highest, in Southwark.
- The infant mortality rate is 3-4 times higher in the areas with the highest rates than in the areas with the least infant deaths.
- Early booking is essential for good antenatal care. The proportion of women booking before 12 weeks of pregnancy varies markedly between boroughs. Late booking does not appear to be associated with deprivation – being far commoner in Tower Hamlets (over 60%0 than in Kingston upon Thames (less than 10%).

Implications

- To ensure the best outcomes, there might be more need for specialised obstetric units – or at least ready access to them – in the most deprived areas, with higher rates of risk factors for poor neonatal outcomes.

8. Stroke

- Stroke is a major cause of death and disability, contributing to the gap in CVD mortality between the spearhead areas and the country as a whole.
- There are ethnic variations in prevalence of hypertension and occurrence of strokes. The incidence of stroke is 60% higher in black people than in white.

- Stroke is primarily a disease of older people – 75% of strokes occur in those over 65 years.
- Despite its importance as a risk factor for CVD, hypertension is poorly managed, with only 15-18% of people being adequately treated.
- There is probably some under-recording of stroke in GP registers, meaning that opportunities for secondary prevention are being missed.
- Rates of both stroke and hypertension are lower across London than the England average, probably as a result of London's relatively young population.
- No routine dataset exists to enable us to determine what proportion of people who have had strokes were treated in specialist stroke units.

Implications

- Stroke prevention requires increased case finding for hypertension and better treatment.
- Recording of stroke in disease registers needs to improve, to enable more targeted secondary prevention.
- A single, national definition of a stroke unit and routine data collection are necessary to allow proper comparisons of treatment outcomes.

9. Conclusion

This report provides an overview of health inequalities in London. In doing so, it helps provide some understanding of the likely impact of the *Healthcare for London* proposed changes on those groups most at risk of being disadvantaged. The report describes inequalities in health and in access to health services in London, using specific indicators of determinants of health and access to health care.

Health inequalities exist across all the areas of health and health care considered here: primary care and preventive services, maternity care and stroke care. The pattern of inequalities is complex. To understand it fully we would need to take a more detailed look at inequalities in local areas and make use of local intelligence about the culture of the people and the services. In taking forward the *Healthcare for London* strategy, it will, therefore, also be important to use local community equity profiles to ensure the best outcome for equalities groups in local areas.