Unequal health - unequal life and death

Kate Gilchrist and Nicola Rosenberg

3.1 Infant mortality

Deaths in infancy have been recorded for centuries; so infant mortality has provided a good barometer of health as well as inequalities. Historically in the UK and across some parts of the globe today, infant mortality is a key marker of poverty. As Dr Duncan Forbes, Medical Officer for Brighton wrote in his 1924 Annual Report, “We know that general sanitation and standards of health and social conditions have improved greatly, and played a greater part in reducing infantile mortality than the intensive (health service) work.”

Infant mortality decreased from 160 infant deaths per 1,000 live births in 1901, to 4 per 1,000 in 2013 with 11 deaths in this year across the whole of the city. Happily, with such low figures, analysis of annual infant mortality in Brighton & Hove is no longer a very useful means of monitoring health inequalities, although collating data from several years can be helpful.

In 1913 Dr Forbes, published a comparison of infant mortality for the period 1901 – 1912 across different social groups. We updated these rates in our 2009 Public Health Annual Report and we do so again in this report. In the first decade of the 20th century, for every thousand births in 1901-1912 to 2.1 times higher in the least deprived areas have a lower rate. The most affluent areas have the highest birth rate, while those in the two most affluent quintiles, and highest deprivation, the numbers of births are lowest in the two most deprived areas.

We should celebrate this success, while understanding that every infant death is a personal family tragedy and recognising that inequalities persist for, if all groups had the lowest infant mortality rates in Brighton & Hove today, there would be on average three fewer infant deaths in the city each year.

Figure 3.1 Infant mortality group by family status 1901-1912 and by Index of Multiple Deprivation quintile for 2002-2007 and 2009-2013, Brighton & Hove (1901-1912 is Brighton only)

3.2 Fertility, births, and low birth-weight

Fertility and births

Birth rates in Brighton & Hove are falling. In 2013 in the city, there were 2,967 births to resident mothers – this was 200 fewer births than in 2012, and the lowest number seen in a decade. In 2013, in Brighton & Hove the general fertility rate (that is the number of live births for every one thousand females aged 15–44 years) was 45, much lower than both the South East (57) and England (62) (Figure 3.2). The city's general fertility rate has consistently been lower for decades, and this gap has increased in recent years. Most recently, Brighton & Hove has seen steady reductions since 2010, whereas across England the birth rate has been increasing since a low in 2001 (with the exception of 2012-13).

When we consider births and birth rates by quintile of deprivation, the numbers of births are lowest in the two most affluent quintiles, and highest in the middle group. However, when we adjust for the numbers of women aged 15–44 living in each area, and look at birth rates we see a different pattern. In Brighton & Hove, women living in the most affluent areas have the highest birth rate, while those in the most deprived areas have a lower rate.

Low birthweight

Babies born weighing less than 2,500 grams (5 lbs 8 oz) are defined as low birthweight. The main causes of a low birthweight are prematurity (being born before 36 weeks of gestation) or slow growth in the womb. Women who smoke during...
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Figure 3.2 General fertility rate: Number of live births per 1,000 females aged 15-44 years, Brighton & Hove, the South East and England, 2002-2013

Since the year 1999, in Brighton & Hove, 6 to 7% of babies have been born with a low birthweight. At the turn of the 21st century, (1999-2003) there was clear inequality with 8.5% babies born to mothers living in the 20% most deprived areas of the city. In relative terms the most deprived babies were 1.3 times more likely to be of low birthweight than the most affluent baby. By 2009-2013 this inequality had reduced and in relative terms the most deprived baby is now 1.5 times more likely to have a low birthweight compared to the least deprived baby. There is now an absolute difference of three babies in every hundred being born a low birthweight. As in the case of infant mortality, this is another example of reducing absolute and relative inequalities over time. Although examining low birthweight across deprivation quintiles (Figure 3.3), we see that only in the middle quintile has there been an actual reduction; so low birthweight is actually increasing, although the difference between different groups is falling.

This increase in low birthweight may reflect improved survival of babies born prematurely, higher incidence of multiple births and more births to mothers from BME groups. For example, low birthweight is more common in babies born to parents who are of Indian, Pakistani, Bangladeshi, African-Caribbean or Black African origin, than babies who are born to white European parents.

Tackling inequalities – Breastfeeding

Breastfeeding rates in Brighton & Hove are amongst the highest in the country. The overall rate was 13% highest for the year 2013/14 for the percentage of mothers initiating breastfeeding (89%) compared with the England average of 74%. There is variation across the city, although even in areas with the lowest rates, they are above the national average. The community breastfeeding team supports mothers to breastfeed and seeks to reduce breastfeeding inequalities. Rates are relatively low in North Portslade and the team works with peer support volunteers and midwifery colleagues to increase breastfeeding. The year breastfeeding increased by 5% over the previous year and the number of mums attending the breastfeeding drop-in almost doubled.

The peer support worker contacts mums during their pregnancy, inviting them to the breastfeeding drop-in, and then supports the family after birth by telephoning, visiting and attending the Children’s Centre. This pro-active service, rather than waiting for mothers to ask, is proving effective in increasing breastfeeding rates. Peer support is a key way to encourage families and communities to see breastfeeding as the ‘normal’ way to feed a baby.

“I just wanted to say how grateful I was for the help and support. Breastfeeding was the hardest thing I have ever done and on many occasions I was ready to quit...but luckily with the support I persevered and now nearly a year later I am still breastfeeding. I wouldn’t change it for the world. It was really nice to talk to other people at the Portslade support group and share stories and tips.”

Afi Hoodless, new mum in Portslade.
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3.3 Life expectancy, healthy life expectancy and premature mortality

Life expectancy, healthy life expectancy

Life expectancy continues to rise. For females in the city it is the same as England (83.1 years); for males it is seven months less (78.8 years in Brighton & Hove compared with 79.4 years in England, in 2011 to 2013) (Table 3.1). These increases in absolute life expectancy are seen at all ages. Even life expectancy for 85 year-olds, in both men and women, has increased by on average six weeks each year over the last decade (Figure 3.4).

Healthy life expectancy is higher for females in Brighton & Hove compared to nationally, while for men it has varied against national figures. It is worth noting that the healthy life expectancy in men and women is below retirement age. (Table 3.1).

Another way to look at this is the percentage of life spent in good health, for men this is 80% for the city and England, but for women it is lower at 78% in Brighton & Hove and 77% across England. Men have shorter lives, but a greater proportion is spent in good health.

More remarkable is the difference in life expectancy between the most and least deprived individuals in the city: 9.4 years for males and 6.1 years for females (2011-2013). This compares with a gap of 9.1 years for males and 6.9 years for females across England and is based upon the Slope Index of Inequality (Figure 3.5). In terms of progress against national equivalents there has been no significant change in the last 10 years.

In females, cancer is now the cause contributing most to the gap in life expectancy between the top and bottom deprivation quintiles, increasing from 21% to 25% between 2003-07 and 2010-2012. The contribution of circulatory diseases has more than halved, from 27% in 2003-07 and 2010-2012. As is the case for males, the contribution of respiratory diseases (14% to 19%), digestive diseases (10% to 15%) and external causes (12% to 16%) have all increased slightly.

For males, the greatest contributing cause in 2010-12 remains circulatory conditions (28% compared with 24% in 2003-2007) but the contribution of cancer to the gap in life expectancy has halved from 20% to 10%. Respiratory conditions (8% to 13.5%) and digestive diseases (10.5% to 14.5%) which include alcohol-related conditions such as chronic liver disease and cirrhosis and external causes of death (includes injury, poisoning and suicide) (from 14.5% to 17%) have all increased slightly.

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Table 3.1 Life expectancy and healthy life expectancy at birth (in years) for males and females in Brighton & Hove and England, 2009-2011 to 2011-2013

<table>
<thead>
<tr>
<th>Year</th>
<th>Brighton &amp; Hove</th>
<th>England</th>
<th>Brighton &amp; Hove</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>Females</td>
<td></td>
<td>Males</td>
<td>Females</td>
</tr>
<tr>
<td>2011-2013</td>
<td>78.8</td>
<td>79.4</td>
<td>83.1</td>
<td>83.1</td>
</tr>
<tr>
<td>2010-2012</td>
<td>78.7</td>
<td>79.2</td>
<td>83.0</td>
<td>83.0</td>
</tr>
<tr>
<td>2009-2011</td>
<td>78.3</td>
<td>78.9</td>
<td>82.6</td>
<td>82.9</td>
</tr>
</tbody>
</table>

Table 3.2 Life expectancy and healthy life expectancy at age 65, 75 and 85 years by gender in Brighton & Hove, 2000-2002 to 2011-2013

<table>
<thead>
<tr>
<th>Year</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011-2013</td>
<td>62.8</td>
<td>63.3</td>
</tr>
<tr>
<td>2010-2012</td>
<td>63.6</td>
<td>63.4</td>
</tr>
<tr>
<td>2009-2011</td>
<td>63.0</td>
<td>63.2</td>
</tr>
</tbody>
</table>


Note: Healthy life expectancy is the average years a person would live in good/fairly good health if s/he experiences the local age-specific mortality and health rates throughout life.

Figure 3.1 Life expectancy at age 65, 75 and 85 years by gender in Brighton & Hove, 2000-2002 to 2011-2013

Figure 3.2 Trend in healthy life expectancy at age 65, 75 and 85 years by gender in Brighton & Hove, 2000-2002 to 2011-2013

Figure 3.3 Trend in Slope Index of Inequality in life expectancy in Brighton & Hove, Males and Females 2002-04 to 2011-13

Figure 3.4 Life expectancy at age 65, 75 and 85 years by gender in Brighton & Hove, 2000-2002 to 2011-2013

Figure 3.5 Trend in Slope Index of Inequality in life expectancy in Brighton & Hove, Males and Females 2002-04 to 2011-13

Figure 3.6 Brighton & Hove Inequality gap, contribution of different diseases to inequalities in life expectancy

Causes of the gap in life expectancy

In the 2011 Public Health Annual Report we considered the contribution of different causes to the gap in life expectancy between the top and bottom quintiles in Brighton & Hove using data for 2003-2007. Public Health England have recently (January 2015) updated these analyses for each local authority in England for deaths in 2010-2012.

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Premature mortality

These differences in life expectancy reflect differing mortality rates. Although the progress in reducing inequalities in life expectancy in Brighton & Hove is uncertain, there has been progress in improving mortality differences.

Over a five year period (2009-2013) a total of 2,534 deaths in Brighton & Hove of people of all ages can be attributed to the impact of deprivation. This is equivalent to over 500 deaths annually. On a positive note, this is an improvement on previous years, the same analysis for the years 1988-1992 shows that there were 873 deaths a year in the city attributable to deprivation (Figure 3.7). The improvements are much more marked in the ‘all age’ group as opposed to the ‘under 75s’ age group (Figure 3.8). Nevertheless, if all areas had the mortality rates of the least deprived 20% in the city, among those aged less than 75 years (2009-13 data), there would be on average 87 fewer deaths per year. During 1988-1992, there were on average 153 extra deprivation related deaths in those aged under 75 years.

Therefore, between the periods 1988-1992 and 2009-2013 when death rates fell in all quintiles of deprivation, there was a reduction in both absolute and relative inequalities in Brighton & Hove for all deaths at all ages.

Irrespective of these improvements, there is still some way to go with over 500 ‘inequality’ or deprivation-related deaths in Brighton & Hove each year, 87 of people under the age of 75. The cartogram in Figure 3.9 shows the parts of the city affected most by this deprivation related premature mortality.

Tackling Inequalities – Preventing premature mortality audit

The Public Health Annual Report of 2011 first drew attention to these inequalities in premature mortality. Following its publication, the City Council and the Clinical Commissioning Group joined forces to undertake a Preventing Premature Mortality Audit in all GP practices led by the Public Health Team. Three important chronic diseases contribute to this premature mortality: diabetes, cardiovascular disease and respiratory disease (in particular chronic obstructive pulmonary disease, COPD). Smoking, alcohol use, obesity, isolation and mental ill health issues were identified as contributory factors. As a result, a comprehensive programme of better identification and recording, improved lifestyle advice and referral, and better links with secondary care has been initiated. Part of this programme involves recruitment to health trainer posts to work alongside practices to improve lifestyles and early presentation in the event of symptoms. These health trainers have focused their work on more deprived areas of the city (Figure 3.10), men and those with chronic conditions (three of the key groups identified in the audit).

Tackling Inequalities – George and alcohol

I found myself trapped in a cycle of binge drinking. I think it also fuelled an anxiety. I would call in sick at work, even days after a binge, as my body would still be recovering. My relationships suffered, I couldn’t remember what I said, who I offended... I put on weight and my relationship with my partner was on a downward spiral.

The health trainer helped me to reflect on my drinking, and figure out ways of addressing what were destructive behaviours. As someone who is actively involved in the LGBT community, I recognise now that the way I got involved was fueling my binges. I set out to “get wrecked” so as I could feel a sense of belonging, and the binges became a part of normal life.

I have figured out now that there is a lot more to the LGBT community. OK, binge drinking may be culturally ingrained in some sections, but not everywhere. Getting involved in doing other things means I still have a sense of inclusion. I won’t kid you, I did struggle at times with having to change relationships and friendships, but you have to if you want to cut out destructive behaviours. It’s painful and challenging, both emotionally and psychologically. But, I have now discovered a new network of LGBT friends, who don’t binge and who have really helped me put things into perspective and still feel very much part of the community.”
### 3.4 Disability and limiting long-term illness

*Disability* is an umbrella term used to describe impairments, activity limitations and participation restrictions. It is the interaction between individuals with a certain health condition (e.g. cerebral palsy, Down’s Syndrome and depression) and personal and environmental factors such as negative attitudes, inaccessible transportation and public buildings, and limited social supports. There are 11.6 million disabled people in Great Britain, of whom 5.7 million are adults of working age, 5.1 million are over state pension age and 0.8 million are children.

Rates of people living with a disability are increasing due to population ageing and increases in chronic health conditions. People with disabilities are particularly vulnerable to deficiencies in health care services and may be at greater risk of other health conditions associated with disability. They may experience age-related conditions prematurely and, associated with lower income, are more at risk of deprivation-related health risk behaviours such as smoking and poor diet.

In Brighton & Hove, there is a close relationship between disability and deprivation. People with a limiting long-term illness and disability (Figure 3.11) are significantly more likely to live in more deprived areas and this trend may be increasing. In 2001, 25% of people living with limiting long-term illnesses or disabilities lived in the 20% most deprived areas of the city; by 2011 this had increased slightly to 26%.

This difference is more evident in terms of people claiming Disability Living Allowance, although as the Index of Multiple Deprivation uses benefit claimant figures in its calculation this might be expected. In 2014, 38% of people claiming Disability Living Allowance live in the 20% most deprived areas in the city. Again, this figure had increased slightly in recent years.

These differences matter. If we were able to eliminate them, we would see a considerable reduction in poor mental and physical health (Figure 3.12). In Brighton & Hove, various dates (see chart labels)

#### Figure 3.12 Impact of removing inequalities between the most affluent and most deprived in Brighton & Hove (2012 data)

<table>
<thead>
<tr>
<th>Group</th>
<th>Percentage of People in 'poor' health</th>
</tr>
</thead>
<tbody>
<tr>
<td>All groups in the city had the lower rates seen in the most affluent, there would be:</td>
<td></td>
</tr>
<tr>
<td>16,000 fewer people at risk of major depression</td>
<td></td>
</tr>
<tr>
<td>11,200 fewer people who had ever self-harmed</td>
<td></td>
</tr>
<tr>
<td>10,600 fewer people with a limiting long-term illness</td>
<td></td>
</tr>
<tr>
<td>4,800 fewer people in ‘poor’ health</td>
<td></td>
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</tbody>
</table>

*Source* Census and Department for Work and Pensions

### 3.5 Mental health and wellbeing

Inequalities in mental health and wellbeing are stark, and it has long been established that mental ill health can result in deprivation (loss of employment, housing etc.) as well as from deprivation (stress is associated with mental illness). The strap-line of the 2014 national mental health strategy - ‘No health without mental health’ - is apt. Evidence shows that mental wellbeing underpins behaviour change and national guidance highlights the need to understand psychological concepts, including well-being, to motivate and support behavioural change.

There is reliable evidence for interventions across the life course for mental health and wellbeing and healthy behaviours. Improving the conditions of daily life from before birth, during early childhood, at school age, during family building and working ages, and at older ages provides opportunities both to improve mental health and to reduce the risk of mental health disorders. Comprehensive action across the life course is necessary, however there is considerable scientific consensus that giving every child the best possible start generates the greatest societal mental health benefits.

Findings from local Health Counts surveys of adults show that in Brighton & Hove between 2003 and 2012, the absolute inequality gap for risk of major depression fell, with the ranges falling from 22% risk for the most affluent and 51% for the most deprived in 2003, to 21% and 49% respectively in 2012. Relative inequality also fell slightly, from the most deprived person being 1.8 times more likely to be at risk of major depression than the most affluent in 2003, to 1.7 times in 2013. These are modest changes, but at least they do not show a widening picture.

Within the survey, and confirmed in the recent trans needs assessment, groups identified as being at increased risk of major depression include Trans, Lesbian, Gay, Bisexual, Unsure (LGBU) or other, Black or Minority Ethnic Groups, single, separated and divorced people, and those renting either privately or from a local authority or housing association.

**Tackling Inequalities – The Trans Community**

Trans is an umbrella term to describe people whose gender identity differs from their assigned sex at birth. National and international evidence describes how trans people are subject to inequality and discrimination across many spheres of life including health, housing, education, crime, social and family life.

In Brighton & Hove in 2012-13, a Trans Equality Scrutiny Panel considered the actions required to make life fairer for local trans people. The review was recognised with a national award for innovation, and an action plan to improve local services has followed. There has also been effective work in schools and with other young people, conducted in partnership with Allsorts.

Later in 2015, a needs assessment, jointly led with the trans community, will be published as part of the city’s Joint Strategic Needs Assessment programme. This has analysed local data, national evidence, service provider views, and has included local community research involving 150 people.

One of the key findings of this work is evidence of high rates of stress, anxiety and depression among trans people. One in three trans respondents report that they have self-harmed (more than three times the rate in the general population). Trans people also report difficulty in accessing health services and highlight the vital role played by community groups in providing mental health support. As part of the Brighton & Hove Happiness Strategy, peer support groups, provided by the Clare Project have been established for adults, and by Allsorts Youth for young people. These groups provide a safe space to discuss personal issues, and participants find out about other local sources of support.

Rian Gissell of Allsorts says: “We know that all of our trans young people have a tough time mentally and some of them even think about suicide. This ‘safe space’ which is for the under 26s, gives people somewhere to go where they can express their gender identity in a supportive environment. The number of trans children and young people accessing Allsorts doubled last year. So it’s vital we carry on this work for young people, and the people who look after them.”
3.6 Health-related behaviours

Health-related behaviour is influenced by environmental, social, economic and cultural factors, as well as by chronic diseases. Adverse health behaviours like smoking are more prevalent in socially and economically disadvantaged people. To mitigate the impact of social disadvantage, we need to address wider factors as well as to provide support to individuals to change health behaviours. There is good evidence that efforts solely focused on the behaviour change of individuals are ineffective. Population approaches are required although action needs to be targeted at those who need support the most.

Smoking

The key national priority areas for evidence based actions on reducing the prevalence of smoking are:

- stopping the promotion of tobacco;
- making tobacco less affordable;
- effective regulation of tobacco products;
- helping tobacco users to quit;
- reducing exposure to second-hand smoke;
- effective communication on tobacco control.

School based smoking prevention programmes are cost effective with longer-term savings of £15 for every £1 spent. Programmes to develop children’s life skills such as problem-solving, building self-esteem and improving resilience to peer and media pressure, can reduce smoking initiation by 12%. Tobacco control at a population level has most. Action needs to be targeted at approaches are required although smoking are:

- reducing the prevalence of smoking;
- increasing or high risk levels of secondhand smoke;
- reducing exposure to second-hand smoke;
- making tobacco less affordable;
- introducing a minimum unit price of alcohol of £0.45 would have the greatest effects for harmful drinkers on low incomes who buy more alcohol at less than the minimum unit price threshold compared with other groups. Much alcohol attributable harm occurs in middle or older age groups as a result of years of drinking above the lower risk guidelines, therefore even a relatively small reduction of around 2% in the total annual consumption can have a significant impact upon long-term and chronic illnesses. At the individual level there is good evidence that risk assessment/ screening, interventions and treatment programmes commissioned by local authorities and the NHS, and school based interventions can all reduce alcohol-related harm.

Diet, physical activity and obesity

Obesity is associated with deprivation, while being overweight is not. There is evidence that some interventions that aim to prevent, reduce or manage obesity reduce the social gradient in obesity. For children, interventions delivered at school and in the community, as well as those interventions that use community empowering mechanisms can be effective in reducing obesity in more deprived areas. For adults, tailored weight loss programmes in primary care and community based weight loss interventions are most effective, although only in the short term, and the effect is greatest for low-income women.

Sexual health

Every £1 spent on contraception to prevent teen pregnancy saves £11 in fewer terminations and reduced antenatal and maternity care. Schools are the most commonly reported source of information about sexual health and are where efforts are needed to inform people about healthy sexual activity. In 2013 in Brighton & Hove, the chlamydia diagnosis rate in 15-24 year olds was 3,133 per 100,000 population. This is equivalent to 51% of 15-24 year olds tested. The positivity rate was 6.2%. Brighton & Hove ranks 22/326 Local Authorities (LAs) in England for chlamydia diagnosis rates (1st rank = highest rates). Screening is carried out in a range of settings across the city, however, irrespective of relatively high screening rates, in order to address the inequalities in chlamydia prevalence, it is important to assess who is being screened where.

Health behaviours in Brighton & Hove

The information on health behaviours in Brighton & Hove, including associated inequalities, comes largely from local Health Counts surveys, conducted on three occasions over the last 20 years with data on lifestyles comparable between 2003 and 2012. The results show a mixed picture. Compared to the most affluent person, the most deprived individual in the city is:

- 1.7 times more likely to be obese, - an increase from 1.2 in 2003 - with an absolute gap increase from 2 to 7 percentage points, equivalent to a rise from 2,000 to 5,000 people affected;
- 2.3 times more likely to smoke – a reduction from 2.5 times in 2003 – with an absolute reduction in the gap from 25 to 18 percentage points, equivalent to a fall from 23,800 extra smokers in 2003 to 16,900 extra smokers in 2012;
- 1.1 times more likely NOT to eat five a day of fruit and vegetables - a reduction from 1.2 in 2003 - with a reduction in the absolute gap from 11 to 5 percentage points, equivalent to a fall from 7,300 extra smokers in 2003 to just 300 extra in 2012;
- more physically active – in both 2003 and 2012 there was an inverse relationship between deprivation and physical activity – the most affluent person was 2.3 times more likely to be physically active at recommended levels than the most deprived in 2003, and 6% less likely in 2012. There is no inequality in higher risk drinking nor was there any inequality in the prevalence of overweight (unlike obesity). The differences in health behaviours attributable to inequalities

Figure 3.13 Impact of removing inequalities between the most affluent and most deprived in Brighton & Hove (2012 data)

If all groups in the city had the lower rates seen in the most affluent there would be:

- 16,900 fewer smokers
- 3,000 fewer people drinking at increasing or high risk levels
- 9,300 fewer people who have ever been diagnosed with a sexually transmitted infection
- 5,000 fewer people who are obese

Source: Health Counts Surveys, Brighton & Hove Public Health Team

Figure 3.14 Adults engaging in three or four health risk behaviours, by gender and deprivation quintile, Brighton & Hove 2003 and 2012

<table>
<thead>
<tr>
<th>Deprivation Quintile</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Least deprived</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most deprived</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Least deprived</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most deprived</td>
<td></td>
<td></td>
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</tbody>
</table>
are shown in Figure 3.13.

### Multiple health risk behaviours

Lifestyle behaviours rarely occur in isolation although there is evidence that the local population is becoming more health conscious. The Health Counts surveys show that the proportion of the population engaged in three or four of designated health risk behaviours (smoking, drinking above recommended levels, not keeping physically active and not eating five a day) declined from 26.6% in 2003 to 16.6% in 2012.

In terms of inequalities, there has been some improvement, with rates falling across all deprivation quintiles. In males, the relative inequality widened whereas in females both the absolute and relative inequalities narrowed (Figure 3.14).

Because adverse health behaviours tend to cluster, in particular in more deprived groups, local authorities and the NHS need to adopt an integrated holistic approach that is able to encompass multiple unhealthy behaviours and make “every contact count”. This is the approach in Brighton & Hove, for example through the Health Trainers and Public Health Community Nurses.

#### 3.7 What can we conclude?

There has been some progress in reducing health inequalities in Brighton & Hove over recent years although the picture is mixed, and as has been illustrated in Chapter 1 of this report, it may depend on your point of view and whether you consider relative or absolute inequalities to be more important.

The data on infant mortality stretches back over a century and there have been huge reductions in the absolute inequality and even some improvement in relative inequality. Birth rates are declining in Brighton & Hove and women living in the most affluent areas have the highest fertility rates. Low birthweight rates are increasing but inequalities, both absolute and relative are falling. The increase in low birthweight overall may reflect improved survival of premature babies as well as an increasing proportion of births coming from certain ethnic minority groups, known to give birth to smaller babies. Breastfeeding rates, already high in the city, continue to improve and there are increasing efforts to address the relatively lower breastfeeding rates in more deprived areas.

Life expectancy is increasing and the gap between male and female life expectancy has fallen in recent years. Compared to national rates however, there has been no significant change in males or females. Progress with regard to inequalities in mortality rates has been better, with a falling all cause mortality rate, and reductions in the gap between the most affluent and most deprived. There is still some way to go however, as each year in Brighton & Hove 500 more people die, simply as a result of deprivation, with an extra 87 dying prematurely. Queen's Park, Westbourne and Withdean are the wards most affected by this premature mortality.

There is a clear relationship between deprivation and disability and this relationship appears to be strengthening. The impact of the welfare reforms with changes to the Disability Living Allowance discussed in Chapter 6 may make this relationship more acute yet. Similarly, there is a strong relationship between mental ill health and deprivation, however, locally there is some evidence that mental wellbeing inequalities may be falling.

The relationship between lifestyles and inequalities has changed over the years. There is currently no association between being overweight, nor drinking above recommended levels and deprivation. There is however a strong relationship between smoking, obesity, unhealthy diet and deprivation. Inequalities are widening regarding obesity but are improving in smoking and in consumption of a healthy diet.

There are opportunities to look at screening programmes, including the chlamydia screening programme and monitor if these are tackling inequalities.

In order to tackle health inequalities, we need to take action across the life course, and especially early in life. We need to take population measures AND target individuals at risk. Making every contact with a health professional count, and recruiting local people with local knowledge, such as health trainers, can go a long way to addressing these health inequalities which continue to blight the city.

### Tackling Inequalities - NHS Health Checks

The NHS Health Checks programme aims to help prevent heart disease, stroke, diabetes, kidney disease and even certain types of dementia. Everyone between the ages of 40 and 74 years, who has not already been diagnosed with one of these conditions or has certain risk factors, is eligible for an NHS Health Check. To address the health inequalities better, the local programme has been redesigned, building on the success of the city’s programme last year that delivered the highest numbers of checks (5,871) in one year since the programme began in 2009.

The new programme priorities and supports GP surgeries to give a check to people living in the most deprived parts of the city. The check now includes an assessment of mental wellbeing. Participants are reporting that they find the new service friendly, efficient and very educational. The programme includes information on preventing cancer as well, and actively promotes referrals for people to improve their health such as stopping smoking or losing weight. A voluntary organisation, the Trust for Developing Communities, is supporting the programme by working with community development workers and volunteers to encourage more men who live in deprived areas of the city to go for their NHS Health Checks.

To make sure the programme is addressing inequalities in health, we are collecting more information about who is attending the checks and a health equity audit will be carried out at the end of the year.

**Figure 3.15 Summary of change in health inequalities over time in Brighton & Hove**

**Table 3.15**

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Wider absolute inequality</th>
<th>Narrower absolute and relative inequality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant mortality</td>
<td>Low birthweight</td>
<td>Smoking</td>
</tr>
<tr>
<td>Multiple unhealthy behaviours</td>
<td>Not eating</td>
<td>Risk of major depression</td>
</tr>
<tr>
<td>Multiple unhealthy behaviours</td>
<td>High risk drinking</td>
<td>Obesity</td>
</tr>
<tr>
<td>Fallen in last 6 months</td>
<td>Poor health</td>
<td>Limiting long-term illness/disability</td>
</tr>
<tr>
<td>Increasing or higher risk drinking</td>
<td>Vascular conditions/diabetes</td>
<td>Weight/obesity</td>
</tr>
</tbody>
</table>
Child poverty and poverty in older people

Ann Alexander, Sarah Colombo and Peter Wilkinson

4.1 What do we know?

Child poverty

Inequalities affect children not only in early life, but also with adverse outcomes much later. Babies with a low birthweight are 5 times more likely to die in infancy than those of normal birth weight. The annual cost of caring for these babies, from birth to 18 years is around £13 billion for England and Wales. A Child’s early development score at 22 months is an accurate predictor of educational outcomes at age 26, which in turn is related to long-term health outcomes. The UK performs poorly in comparison to similar countries on mortality in the under 5 years: a recent PHE 2015 cartogram of percentage of dependent children living in poverty, Brighton & Hove, 7,235 (82%) children living in poverty were in families where children or adults have disabilities, are at greater risk of living in poverty. However, there is currently no data on this at local level.

The Government measures child poverty as ‘the proportion of children living in families in receipt of out of work (means-tested) benefits or in receipt of tax credits where their reported income has remained static over the past 30 years.’

4.2 A city divided?

Child poverty

Every sixth child in Brighton & Hove is living in poverty although these rates are lower than the national rates (Figure 4.1). Although high, child poverty rates are falling as they are in many other places. In 2012 in Brighton & Hove, 17.5% of the total population of dependent children and young people under the age of twenty in the city were in families living on less than 60% of median national income: that is a 2.1% improvement on 2011. The proportion of children in poverty in Brighton & Hove is lower than the England average (18.6%). Child poverty is also higher in local comparator cities: between 2011 and 2012, in Portsmouth it fell from 24.4% to 22.3%, and in Southampton from 25.3% to 22.7%. However, child poverty is significantly lower in the South East regional average, which reduced from 14.6% in 2011 to 13.6% in 2012.

It is important to appreciate that child poverty is a relative indicator measured by reference to the median income, therefore it is affected by falls and increases in average income. The median income threshold for child poverty for a couple with two children aged 5 and 14 yrs dropped from £334 per week in 2011, to £312 per week in 2012. The threshold is fixed on a low but stable income close to the threshold will be recorded as no longer living in poverty if the threshold reduces to just below their household income in actual terms. Hence, a reduction in relative child poverty does not necessarily mean that families are any better off than they were when recorded as in poverty. National (HMRC) commentary on the national fall in child poverty between 2011 and 2012 equates the fall primarily to this change in the income threshold. Child poverty is much more prevalent in single parent households. In 2012, of those children living in poverty in receipt of Income Support or Job Seekers Allowance, 5,540 were living in lone parent families compared with 1,695 in ‘couple families’.

Whilst children in poverty live in all areas across the city, there are concentrations of families coping with poverty in the most financially deprived neighbourhoods, such as East Brighton (36%) and Mouleecomb and Lewes wards (37%). The wards with the lowest rates of child poverty are Hove Park and Withdean, both with 6% (Figure 4.2).

As well as lone parent families, larger families are also recognised as being more vulnerable to child poverty. In Brighton & Hove in 2012, there were 3,070 children living in poverty from families with three or four children compared with 7,450 from families with three or fewer children. National research also shows that black and minority ethnic families, Gypsy and Traveller families and families where children or adults have disabilities, are at greater risk of living in poverty. However, there is currently no data on this at local level.

The contributing factors to child poverty in Brighton & Hove include the high cost of housing, the lower than average wage levels and the highly competitive jobs market with degree level applicants competing well below their skill levels. These issues are discussed further in Chapter 6 on Welfare Reform.

Tackling child poverty

In August 2012 in Brighton & Hove, 7,235 (82%) children living in poverty were in families in receipt of out of work benefits and 1,550 (18%) were in families in receipt of child tax credit and/or working tax credit. The government’s Child Poverty Strategy 2014-17 identifies the five key family characteristics, which make it harder for some families to find their way out of poverty.

1. Long-term worklessness;
2. Low qualifications;
3. Raising children alone;
4. Having three or more children; and
5. Experiencing ill health.

The strategy plans to reduce child poverty through actions in three main areas:

1. Supporting families into work and increasing their earnings;
2. Improving living standards; and
3. Raising educational attainment.

There are several initiatives that aim to tackle child poverty in Brighton & Hove. The Stronger Families, Stronger Communities programme; a multi-agency programme, which supports families in the city with complex problems is successful locally in supporting families to reduce anti-social behaviour, increase school attendance and gain employment. The Council’s Early Help Hub is a new Children’s Services provision that coordinates and targets help to families before problems deteriorate thereby improving family resilience. The Monekyworks programme, delivered by a consortium of advice, adult
4 Child poverty and poverty in older people

Tackling Inequalities

Troubled families? Vicky and Leanne (names have been changed).

Following the riots of August 2011 the Government introduced new legislation including a programme for local authorities to work in a more proactive and coordinated way with what was termed ‘Troubled Families’. This led to the creation of a ‘Stronger Families, Stronger Communities’ team in Brighton & Hove. This team is seen as a key part of the city’s efforts to intensively support families with multiple disadvantage. The case of Leanne illustrates well the extent of support required to tackle what may seem to be an intractable situation.

Teenage Leanne lives with her mother Vicky. Her father lives separately from Leanne and her siblings. Their relationship broke down after Leanne’s father was shot, the family moved and Vicky was left to raise the children single-handedly.

Teenage, Leanne went on to have an unplanned pregnancy and was supported by Young Parents’ Services to stay in school while raising her daughter. She completed her GCSEs and became a student nurse. Leanne’s grandmother provided emotional support and helped set up a household for her daughter.

Vicky received support from the Young Parents’ Service and the Teenage Pregnancy Prevention Service. Her primary school was also supportive. The school suggested she seek support from a peer mentor, who provided advice and assistance with homework.

Dealing with difficulties

Vicky also spoke to the Police about her daughter’s drug use and the Youth Offending Team assisted with tackling Leanne’s use of drugs. Teenage Leanne lives with her mother Vicky. Her father lives separately from Leanne and her siblings. Their relationship broke down after Leanne’s father was shot, the family moved and Vicky was left to raise the children single-handedly.

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Vicky received support from the Young Parents’ Service and the Teenage Pregnancy Prevention Service. Her primary school was also supportive. The school suggested she seek support from a peer mentor, who provided advice and assistance with homework.

As a result of these intensive interventions, Leanne’s attendance has increased to 100% on a full time timetable. She has not been arrested since work began, and her mother now calls the Police if she stays out after her bail curfew. There has been no reports of her associating with her former peer group and no reports of criminal activity from the Community Safety Team, the Police or Business Crime Reduction Partnership.

4.3 What can we conclude?

Child poverty

Child poverty is an important marker for reduced life chances. It affects substantial numbers of children in the city - 1 in 6, and although rates are lower than nationally and in comparator cities, recent reductions may owe more to changes in the threshold for defining child poverty rather than any real improvement. In Brighton & Hove the highest rates of child poverty are in East Brighton, and in Moulsecoomb and Bevendean wards where 1 in 3 children live in poverty.

Child poverty is more common in ethnic minority groups, in Gypsies and Travellers and in families where there are disabilities. Strategies to reduce child poverty, including in Brighton & Hove aim to raise educational attainment, improve children’s living conditions and support families into work.

Poverty in older people

For many people retirement brings financial and social freedom, as well as increased choice - over 55 year olds control 80 per cent of the nation’s wealth and account for 40% of the UK’s annual consumer spending.11 However for those living in poverty, this may not be the case.

4.4 What do we know?

Poverty in older people

In Brighton & Hove older people (aged 65 years and over) comprise over 13% of all residents. The number of older people has declined by nearly 12% since 2001 and the city has a lower proportion of older people compared to regionally and nationally. Older people (65 years and over) live across all areas of the city, although the largest communities are in Rottingdean (22%) and Woodingdean (14%). In six of the city’s 21 wards, fewer than one in ten people is aged 65 years and over with the lowest percentage in St Peters and North Laine (6%).

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average of 20.5% in England. Older people in poverty are spread across the city although more concentrated in the city's more deprived areas, such as Hangleton and Knoll, Hollingbury, East Brighton and Queen's Park. The lowest concentrations of older people in poverty are in Withdean, Hove Park and Patcham and Rottingdean Coastal.

The changes in income of older people in recent decades, contrasts with the situation in younger and working age people. Over the last 20 years, there has been a large reduction in the proportion of pensioners living in poverty. This contrasts with a much slower decline in child poverty and working-age poverty. Nationally, in 2012/13, 13% of pensioners were living in a low-income household (defined as a household with net income after housing costs of less than 60% of the median national household income for that year). For adults aged 60 years and over, this represents a reduction from 2002/03, with the most substantial falls amongst the eldest: a fall of 15% for 75-79 year olds and 14% for those aged 80 years and over.

The number of people aged 60 years and over in receipt of means tested rent or council tax reduction has decreased from 13,243 (26%) in 2009 to 10,690 (21%) in 2015; and the number in receipt of pension credit has fallen from 12,510 (24%) in 2009 to 7,490 (15.9%) in 2015. Older people aged 65 years and over, 5% provide some form of unpaid care, and half of these carers provide 50 hours or more of care.11

Tackling poverty in older people

There are a number of initiatives in place in the city to tackle poverty in older people some of which are described more fully in Chapter 6 on Welfare Reform.

Within the city are commissioned just to help older people get out. There are over 1,000 free and low cost social activities for older people in Brighton & Hove. The council and the CCG have jointly commissioned the city wide Connect programme to coordinate activities, (see ‘It’s Local Actually’ website). Age UK, Impact initiatives with Barclays and the council Library Service are working together to enhance older people's digital skills. Some of these projects are inter-generational (eg Age UK and Impact) and there is potential for this work to improve financial inclusion via libraries and other ‘access points’.

The council funds Citizens’ Advice Bureau (CAB) welfare benefits advice in six GP surgeries in Brighton & Hove, four of which are in the city’s most deprived quartile. Nearly one fifth of those accessing the service are aged 60 years and over and on average they receive an additional £2,445 in benefits. The city council in collaboration with Age UK and in particular the number and proportion of 85 year olds and over will increase.

Just under 24% of older people in Brighton & Hove experience income deprivation and the distribution of older people’s poverty differs from child poverty. The area with the highest proportion of older people (Rottingdean) actually has the lowest concentration of older people in poverty.

Key programmes that are being developed include: the development of a digital inclusion strategy; and carer support.

4.6 What can we conclude?

Levels of poverty among older people in Brighton & Hove are lower than levels of child poverty and reductions have been greater than the reductions in child poverty. Older people’s benefits have, until now at least, been relatively protected, compared to many other benefits. The population of older people in Brighton & Hove in recent years has been falling, especially in central wards. This is set to change and in particular the number and proportion of 85 year olds and over will increase.

Strategies to address poverty in older people need to include initiatives to tackle isolation and confidence, as well as practical issues such as transport, financial inclusion, and carer support.

Tony Mernagh (Happiness Champion)
Executive Director of the Economic Partnership
Interviewed by Tom Scanlon

Past

I grew up in the 1960s in the north east of England; we weren’t dirt poor but we were certainly poor. Having failed the 11+ exam I went to a secondary school where I really flourished. They had just started to ‘allow’ secondary school students to take ‘O’ Levels and I did well - inspired by some good teachers. I’m still in touch with one of them. 45 years later I went to university to study Botany and Zoology and I became a teacher myself. After university, my wife and I both taught just outside London before going off to work at a British School in El Salvador. It was, to say the least, very exciting, a civil war broke out shortly after we arrived, most of the other UK ex-pats left and we rose rapidly to senior positions. The 5 years there were probably the most formative years of my life, and we still keep in touch with several former pupils.

Present

Back in the UK, I taught in East Brighton for a short while and then we were invited into a family business partnership publishing greetings cards. We opened a retail outlet in Brighton and our classroom administrative skills transferred easily to the shop floor. It was 1980s boom time and we thrived. We had to steer our way through the 1991 crash but by the mid 1990s we had well and truly looked for a new challenge. I became the voluntary Chair of the North Lane Traders’ Association, then, with the development of Churchill Square, I was appointed the Town Centre Manager. Through that position, I got involved in the Economic Partnership and took up the position of Executive Director in early the 2000s. We developed a Business Improvement District and the largest Business Crime Reduction Partnership (BCRP) in the UK. That has been so successful that we now administer other BCRPs including several in London. When I give up the Economic Partnership – I’m retiring this year – I’ll carry on with some part-time BCRP outsourcing work.

Future

To tackle inequalities we need to focus on a number of things. Education was my way out of poverty and it is a sad indictment that so many young people do so poorly at our schools. We have two good universities and we end up importing highly qualified residents. Our universities have a responsibility to reach out to local disadvantaged pupils; we may be on the cusp of that but so far we haven’t done nearly enough. We also have to start early and opportunity initiatives like Sure Start are crucial. Housing is a severe limiting factor in Brighton & Hove. We simply need to build up and build more as a matter of urgency; on the urban fringe, on brownfield sites, and on some green spaces - we have 660,000 hectares just the other side of the A27. We also need to develop more business opportunities. I know from my own retail experience that graduates are too often in jobs for which they are overqualified and so they deny opportunities for school leavers. We are developing our digital sector and it could be a real leader and major employer in Brighton & Hove. However, sadly, I am not too optimistic for the city of the future. Brighton & Hove’s city is brimming with ideal ideas but the sector is simply undeliverable. Local authorities, the police and the NHS are all buckling at the knees and the poorest will inevitably suffer most. As a society, I believe you measure progress by how you treat the old and the sick, and the opportunities you provide for the young; making progress on that will require the reversal of a lot of inequality.