



***Tackling Health Inequalities: Status
Report on the Programme for Action –
2006 Update of Headline Indicators***

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2006 Update to Tackling Health Inequalities: Status Report on the Programme for Action

Introduction

This document updates by a further year (to 1 August 2006) the health inequalities Public Service Agreement target and headline indicators that appeared in the *Status Report on the Programme for Action* published by the Department of Health in August 2005. It follows the style and format of the 2005 report. As expected, the report largely confirms the position set out in the earlier report with only minor changes.

In terms of the changes reported on the 2002 target for life expectancy (baseline 1997–99), the update shows

- a slight reduction in the gap for male life expectancy for 2002–04 compared to 2001–03 – it is now back at the baseline level
- a slight increase in the gap for female life expectancy for 2002–04 compared to 2001–03.

The update also reports on developments against the revised 2004 target on life expectancy.

For the infant mortality aspect of the target (1997–99 baseline), the update shows

- no change between 2001–03 and 2002–04

In terms of the cross government headline indicators, slight improvements in the trends in inequalities were recorded in

- road accident casualties for children
- educational attainment
- housing quality.

There were some signs of a widening of inequalities in smoking in pregnancy between the routine and manual group and all mothers between 2000 and 2005.

The trends in the other indicators are the same as reported in 2005.

This 2006 update was developed with colleagues from the government departments signed up to *Tackling Health Inequalities: A Programme for Action*, and overseen by the Scientific Reference Group on Health Inequalities.

Further updates of progress against the target will be published on the Department of Health website (www.dh.gov.uk/healthinequalities/) as the data becomes available.

The national health inequalities target – assessment of progress

1. The health inequalities Public Service Agreement (PSA) target is to reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth.
2. This target was originally included as a national PSA target as part of the 2002 Spending Review (SR2002). It was underpinned by two more detailed objectives:
 - Starting with local authorities, by 2010 to reduce by at least 10% the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole.
 - Starting with children under one year, by 2010 to reduce by at least 10% the gap between the 'routine and manual' socio-economic group and the population as a whole.
3. The target was reaffirmed as a national PSA target during the 2004 Spending Review (SR2004). The detailed objective for infant mortality remained unchanged, but the detailed objective for life expectancy was amended as follows:
 - 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 and the population as a whole.
4. The objective for life expectancy is now focused on narrowing the gap between the England average and the areas with the worst health and deprivation indicators, a fixed set of areas known as the Spearhead Group. The Spearhead Group is made up of 70 local authority districts (LADs), defined as those that are in the bottom fifth of districts nationally for three or more of the following five indicators:
 - male life expectancy at birth;
 - female life expectancy at birth;
 - cancer mortality rate in under-75s;
 - cardiovascular disease mortality rate in under-75s; and
 - Index of Multiple Deprivation 2004 (local authority summary) average score.

Life expectancy component

SR2002 version of the target

5. Data for 2002–04 indicate that the relative gap in life expectancy between England and the fifth of local authority districts (LADs) with the lowest life expectancy is about the same as at the baseline for the SR2002 version of the target (1997–99) for males, having increased above the baseline gap in the intervening years. For females, the relative gap in life expectancy between England and the fifth of LADs with the lowest life expectancy has increased since 1997–99 and is now 6% wider than at the baseline.
6. This target has been superseded by the SR2004 version of the target.

Table 1: Life expectancy at birth for England and the fifth of LADs with the lowest life expectancy

		Baseline 1997–99**	1998–00	1999–01	2000–02	2001–03	Latest 2002–04	Target 2010	% change 1997–99 to 2002–04
England	M	75.13	75.38	75.71	76.01	76.24	76.55		
	F	80.02	80.19	80.42	80.66	80.72	80.91		
Lowest fifth of LAs*	M	73.12	73.35	73.67	73.98	74.17	74.51		
	F	78.49	78.61	78.84	79.05	79.09	79.26		
Absolute gap (difference)	M	2.00	2.03	2.04	2.03	2.07	2.04		
	F	1.54	1.58	1.58	1.61	1.63	1.65		
Relative gap (% difference)	M	2.67%	2.69%	2.69%	2.67%	2.72%	2.66%	2.40%	0%
	F	1.92%	1.97%	1.96%	2.00%	2.02%	2.04%	1.73%	+6%

* The fifth of LADs in England with the lowest life expectancy.
 ** The baseline figures for the target are fitted data for 1997–99 (from a fitted trend line based on data for 1995–97 to 1999–01).
 Life expectancy data source: Office for National Statistics (ONS).

SR2004 version of the target

7. The target is a 10% reduction in the relative gap (ie percentage difference) in life expectancy at birth between the fifth of areas with the worst health and deprivation indicators (the Spearhead Group) and England as a whole.
8. Data for 2002–04 indicate that the relative gap in life expectancy between England and the Spearhead Group is wider than at the baseline (1995–97) for both males and females. For males, the relative gap is 1% wider than at the baseline, for females 8% wider.
9. Life expectancy at birth has improved for England as a whole and for the Spearhead Group of LADs. However, life expectancy has improved more slowly in the Spearhead Group than for England as a whole. This is a long-term trend, driven by a complex and wide-ranging network of factors.
10. Many policies and programmes that will have an impact on the life expectancy gap are in place, as set out in *Tackling Health Inequalities: A Programme for Action*, and the programme is being developed further.

Table 2: Life expectancy at birth for England and the Spearhead Group of LADs

		Baseline							Latest	% change	
		1995–97	1996–98	1997–99	1998–00	1999–01	2000–02	2001–03	2002–04	Target 2010	1995–97 to 2002–04
England	M	74.61	74.84	75.09	75.38	75.71	76.01	76.24	76.55		
	F	79.69	79.84	79.97	80.19	80.42	80.66	80.72	80.91		
Spearhead Group	M	72.69	72.90	73.09	73.40	73.73	74.06	74.25	74.56		
	F	78.28	78.38	78.49	78.69	78.93	79.16	79.21	79.37		
Absolute gap (difference)	M	1.92	1.94	2.00	1.98	1.98	1.95	1.99	1.99		
	F	1.41	1.46	1.48	1.50	1.49	1.50	1.51	1.54		
Relative gap (% difference)	M	2.57%	2.59%	2.66%	2.63%	2.62%	2.57%	2.61%	2.60%	2.32%	+1%
	F	1.77%	1.83%	1.85%	1.87%	1.85%	1.86%	1.87%	1.90%	1.59%	+8%

Life expectancy data source: ONS.

Additional analysis on the inequalities in life expectancy is provided in annex 2.

Infant mortality component

11. The target is a 10% reduction in the relative gap (ie percentage difference) in infant mortality rates between the 'routine and manual' socio-economic group and England as a whole from the baseline year of 1998 (the average of 1997–99) to the target year 2010 (the average of 2009–11).
12. Infant mortality 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 in the total population between the target baseline (1997–99) and the latest period (2002–04). This is a long-term trend, driven by a complex and wide-ranging network of factors.
13. The infant mortality rate in the routine and manual group was 19% higher than in the total population in 2002–04, the same as in 2001–03. This compares with 13% higher in the baseline period of 1997–99.
14. Many policies and programmes that will have an impact on the infant mortality gap are already in place, as set out in *Tackling Health Inequalities: A Programme for Action*, and the programme is being developed further.

Table 3: Infant mortality rates by National Statistics Socio-Economic Classification (NS SEC), defined by father's occupation

Three-year average infant mortality rates by NS SEC 90 for 1994–2000, and by NS SEC for 2001 onwards, by selected NS SEC analytical classes

England and Wales		Infant deaths per 1,000 live births (a)								
		NS SEC 90				NS SEC*				
				Baseline				Latest		
		1994–96	1995–97	1996–98	1997–99	1998–00	1999–01	2000–02	2001–03	2002–04
All within marriage and joint registrations (b)		5.9	5.8	5.7	5.6	5.4	5.3	5.2	5.0	4.9
NS SEC three-class version – routine and manual group (c)		6.7	6.6	6.4	6.3	6.2	6.2	6.0	6.0	5.9
Relative gap (% difference) **		15%	14%	12%	13%	14%	17%	16%	19%	19%

Source: ONS.
 (a) Figures for live births are a 10% sample coded for the father's occupation.
 (b) 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.
 (c) The routine and manual group includes lower supervisory and technical, semi-routine and routine occupations.
 * Using NS SEC 90 for data up to 2000 and NS SEC for 2001 and subsequent years' data.
 ** The percentage difference between the routine and manual rate and the overall rate (taken as a percentage of the overall rate) represents the relative gap, which is the target measure.

15. There are some important groups that are not identified in this table. Sole registrations account for around 10% of all infant deaths and are associated with above average rates of mortality (6.3 deaths per 1,000 live births in 2004). And the NS SEC 'other' category – including the long-term unemployed and those who have never worked – accounts for almost a further 10% of all infant deaths and is associated with particularly high death rates in infancy (8.4 deaths per 1,000 live births in 2004). This is set out in table 4 below on an annual basis (single year figures are presented here because the figures for 'other' social groups are not comparable pre- and post-2001).

Table 4: Infant mortality rate (per 1,000 live births) – sole registrations and social class/NS SEC 'other' category

England and Wales		Registrar General's social class						NS SEC		
		1996	1997	1998	1999	2000	2001	2002	2003	2004
Sole registration		7.1	7.6	7.6	7.6	7.7	7.6	6.6	7.3	6.3
'Other' social class/NS SEC										
Inside marriage		8.3	9.0	8.5	7.3	7.7	7.1	9.1	8.4	7.2
Outside marriage/ joint registration		13.8	13.3	14.7	15.4	16.8	12.5	13.4	9.5	9.6
All		10.2	10.6	10.7	10.3	11.2	9.3	11.1	8.9	8.4

Source: ONS.

16. Ethnicity is a factor in higher infant mortality rates in some groups. Routine data on infant mortality by ethnic group are not currently available. Data are available on infant mortality by mother's country of birth. This is not the same as measuring infant mortality by ethnic group, as it includes only first-generation migrants and about half the minority ethnic population is UK-born. Among babies born in England and Wales to mothers who were born in Pakistan, the infant mortality rate was 8.9 per 1,000 births in 2004 – almost double the national average.

The national headline indicators – summary tables

17. For most of the indicators, we have presented the same analysis as in *Tackling Health Inequalities: Status Report on the Programme for Action* (2005), but have updated this to include data available at 1 August 2006.
18. The main inequalities analysis for indicator 9 (proportion of households living in non-decent housing) has been revised. We now present the gap between non-vulnerable private households and both vulnerable private households and social sector tenants. This brings the analysis in line with that presented by the Department for Communities and Local Government (DCLG) in the *English House Condition Survey 2004 Headline Report*, which incorporates a more statistically robust assessment of progress in narrowing the gap.

Indicator 1a: Age-standardised death rates per 100,000 population for the major killer diseases (cancer, circulatory diseases), ages under 75 (for the 20% of areas with the highest rates compared with the national average) – CANCER

Overall summary: 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.

Figure 1: Age-standardised death rates per 100,000 population for cancer, ages under 75, by area deprivation

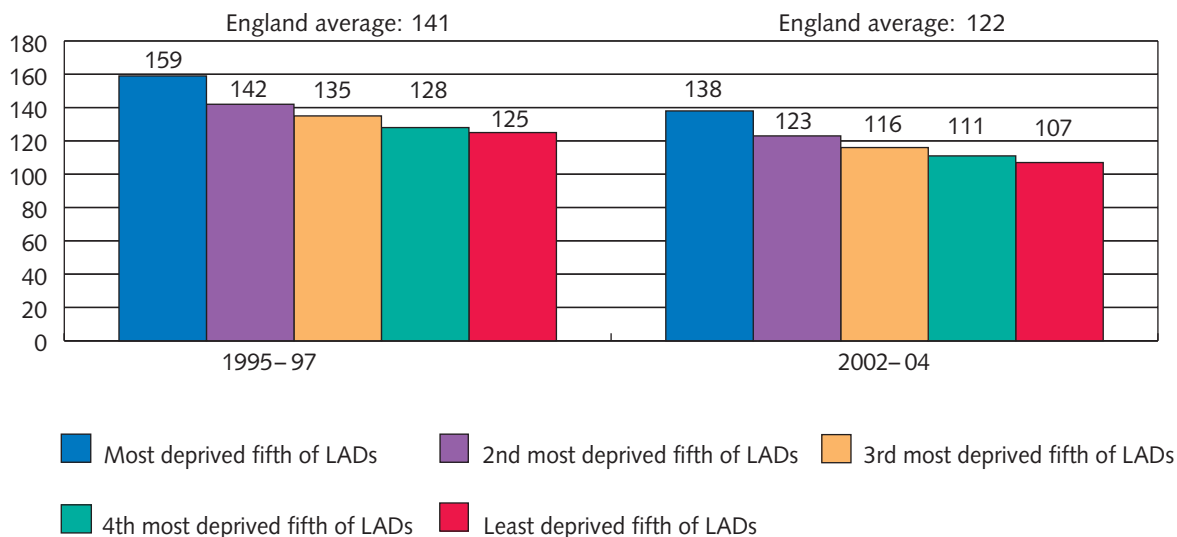
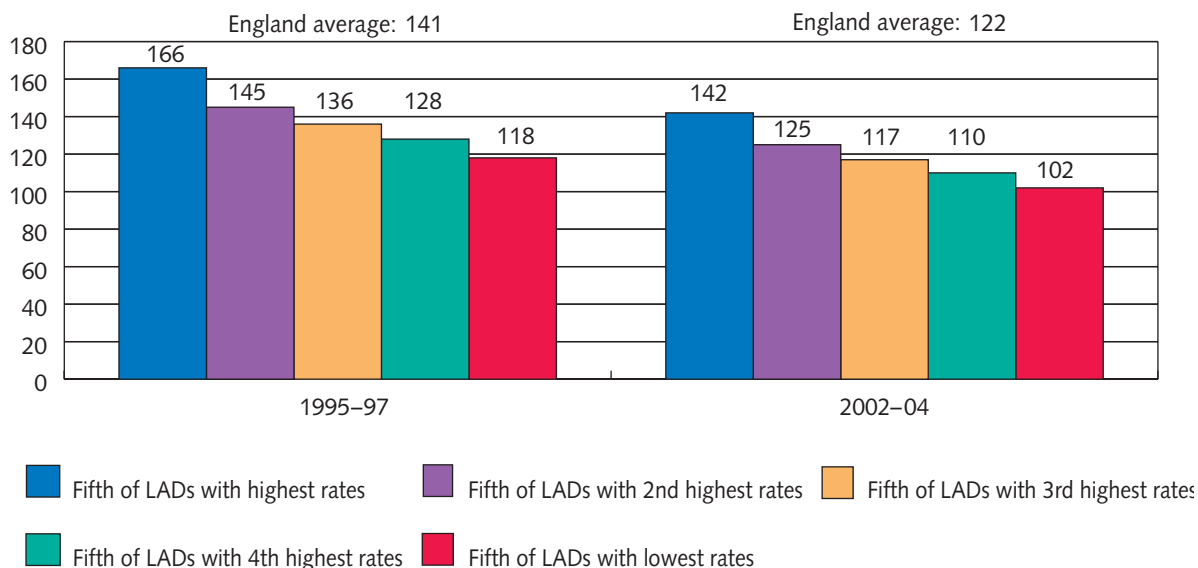


Figure 2: Age-standardised death rates per 100,000 population for cancer, ages under 75, by area



COMPARISON	ABSOLUTE GAP (DIFFERENCE)			RELATIVE GAP (RATIO)		
	BASELINE 1995–97	LATEST 2002–04	TREND	BASELINE 1995–97	LATEST 2002–04	TREND
Area deprivation						
Most deprived fifth of LADs vs England	18.0 (17.1, 19.0)	16.8 (15.9, 17.7)	●	1.13 (1.12, 1.14)	1.14 (1.13, 1.15)	●
Most deprived fifth of LADs vs least deprived fifth	34.7 (32.8, 36.6)	31.6 (29.9, 33.3)	●	1.28 (1.26, 1.30)	1.30 (1.28, 1.31)	●
Area						
Fifth of LADs with highest death rates vs England	24.9 (23.8, 26.1)	20.1 (19.1, 21.0)	✓	1.18 (1.17, 1.19)	1.17 (1.15, 1.18)	●
Fifth of LADs with highest death rates vs fifth with lowest rates	48.2 (46.3, 50.2)	39.6 (37.9, 41.3)	✓	1.41 (1.39, 1.43)	1.39 (1.37, 1.41)	●
COMMENTARY						
<ul style="list-style-type: none"> • There is a gradient in cancer death rates (ages under 75) by area deprivation, with the most deprived fifth of LADs having the highest death rates and the least deprived fifth the lowest death rates. • For example, in 2002–04 the cancer death rate (ages under 75) in the most deprived fifth of LADs was 32 deaths per 100,000 higher than in the least deprived fifth. In relative terms, the cancer death rate (ages under 75) in the most deprived fifth of LADs was 1.30 times the rate in the least deprived fifth, ie 30% higher. • Since 1995–97, the gap in cancer death rates between the most deprived fifth of LADs and the England average has not changed significantly in absolute or relative terms. This also applies to the gap between the most deprived fifth of LADs and the least deprived fifth. • The gap between the fifth of LADs with the highest death rates and the England average has decreased in absolute terms since 1995–97, but with no significant change in relative terms. This also applies to the gap between the fifth of LADs with the highest death rates and the fifth with the lowest rates. • The Department of Health has set a PSA target to reduce the absolute gap in cancer death rates (ages under 75) between the fifth of areas with the worst health and deprivation indicators (known as the Spearhead Group) and the population as a whole. Between 1995–97 and 2002–04, the absolute gap between the Spearhead Group and the England average cancer death rate narrowed by 9% (but with no narrowing of the relative gap). 						
Data notes:						
Source: ONS (death registrations and mid-year population estimates).						
Death rates are directly age-standardised rates, standardised to the European Standard Population, for International Classification of Diseases, 10th revision (ICD10) C00–C97 (for 1995–97, ICD9 140–208 adjusted for comparability with ICD10).						
Area deprivation is measured by the Index of Multiple Deprivation 2004, local authority summary (average score) (DCLG).						

KEY: ✓ = decreasing inequality ✗ = increasing inequality
 ● = no significant change — = insufficient data

Indicator 1b: Age-standardised death rates per 100,000 population for the major killer diseases (cancer, circulatory diseases), ages under 75 (for the 20% of areas with the highest rates compared with the national average) – CIRCULATORY DISEASES

Overall summary: 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.

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

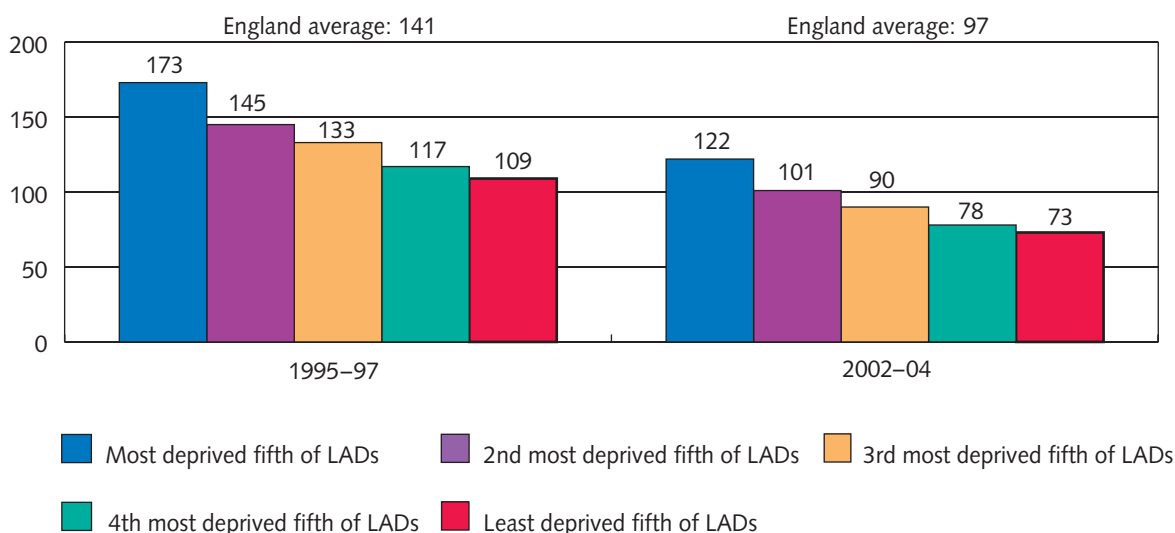
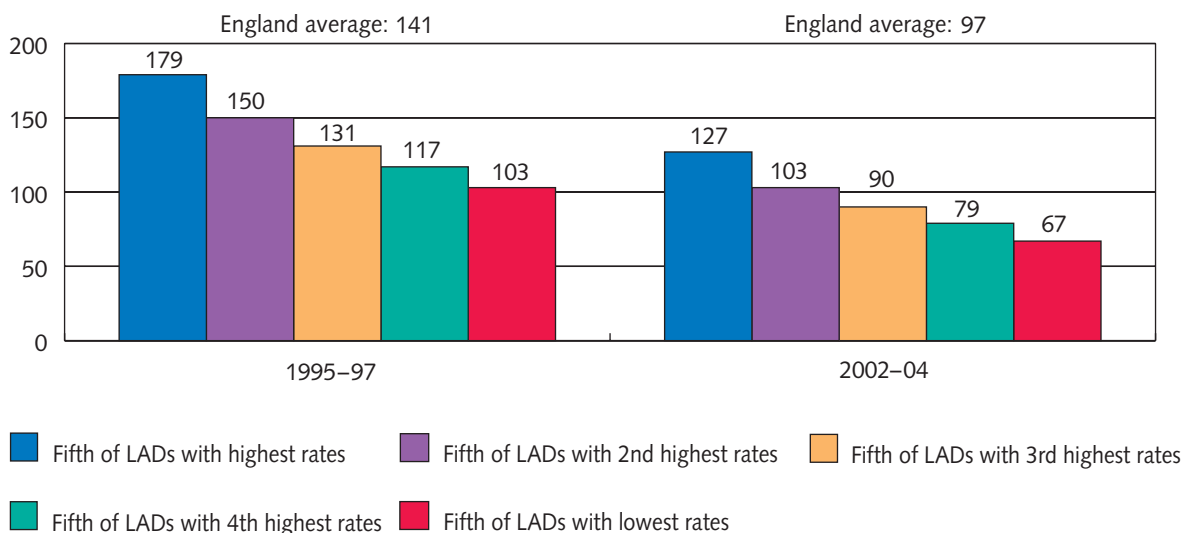


Figure 4: Age-standardised death rates per 100,000 population for circulatory diseases, ages under 75, by area



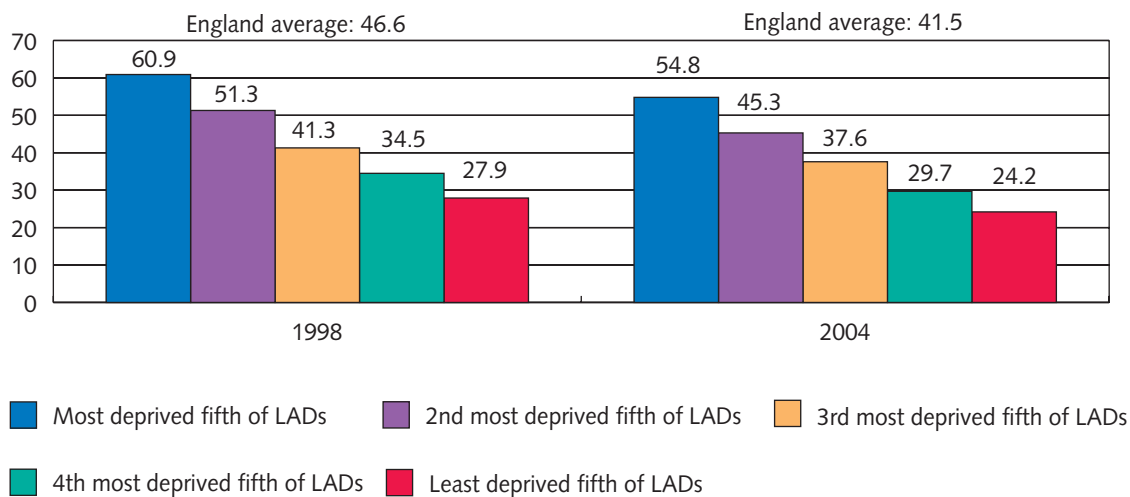
COMPARISON	ABSOLUTE GAP (DIFFERENCE)			RELATIVE GAP (RATIO)		
	BASELINE 1995–97	LATEST 2002–04	TREND	BASELINE 1995–97	LATEST 2002–04	TREND
Area deprivation						
Most deprived fifth of LADs vs England	31.3 (30.3, 32.3)	24.8 (24.0, 25.7)	✓	1.22 (1.21, 1.23)	1.26 (1.24, 1.27)	✗
Most deprived fifth of LADs vs least deprived fifth	63.8 (62.0, 65.6)	49.0 (47.6, 50.5)	✓	1.59 (1.56, 1.61)	1.68 (1.65, 1.70)	✗
Area						
Fifth of LADs with highest death rates vs England	37.9 (36.8, 38.9)	30.1 (29.2, 31.0)	✓	1.27 (1.26, 1.28)	1.31 (1.30, 1.32)	✗
Fifth of LADs with highest death rates vs fifth with lowest rates	76.0 (74.1, 77.8)	59.4 (57.9, 60.9)	✓	1.74 (1.71, 1.76)	1.88 (1.85, 1.92)	✗
COMMENTARY						
<ul style="list-style-type: none"> • There is a gradient in circulatory disease (also known as cardiovascular disease) death rates (ages under 75) by area deprivation, with the most deprived fifth of LADs having the highest death rates and the least deprived fifth the lowest death rates. • For example, in 2002–04 the circulatory disease death rate (ages under 75) in the most deprived fifth of LADs was 49 deaths per 100,000 higher than in the least deprived fifth. In relative terms, the circulatory disease death rate (ages under 75) in the most deprived fifth of LADs was 1.68 times the rate in the least deprived fifth, ie 68% higher. • Since 1995–97, the gap in circulatory disease death rates between the most deprived fifth of LADs and the England average has decreased in absolute terms but increased in relative terms. This also applies to the gap between the most deprived fifth of LADs and the least deprived fifth. • Since 1995–97, the gap in circulatory disease death rates between the fifth of LADs with the 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 fifth of LADs with the highest death rates and the fifth with the lowest rates. • The Department of Health has set a PSA target to reduce the absolute gap in circulatory disease death rates (ages under 75) between the fifth of areas with the worst health and deprivation indicators (known as the Spearhead Group) and the population as a whole. Between 1995–97 and 2002–04, the absolute gap between the Spearhead Group and the England average circulatory disease death rate narrowed by 25% (but with no narrowing of the relative gap). 						
Data notes:						
Source: ONS (death registrations and mid-year population estimates).						
Death rates are directly age-standardised rates, standardised to the European Standard Population, for ICD10 I00–I99 (for 1995–97, ICD9 390–459 adjusted for comparability with ICD10).						
Area deprivation is measured by the Index of Multiple Deprivation 2004, local authority summary (average score) (DCLG).						

KEY: ✓ = decreasing inequality ✗ = increasing inequality
 ● = no significant change — = insufficient data

Indicator 2: Rate of under-18 conceptions

Overall Summary: There has been an 11.1% drop in the rate of under-18 conceptions between 1998 and 2004 (with the average rate for the most disadvantaged areas also falling), but no significant narrowing of inequalities.

Figure 5: Rate of under-18 conceptions per 1,000 female population aged 15–17 by area deprivation



COMPARISON	ABSOLUTE GAP (DIFFERENCE)			RELATIVE GAP (RATIO)		
	BASELINE 1998	LATEST 2004	TREND	BASELINE 1998	LATEST 2004	TREND
Area deprivation						
Most deprived fifth of LADs vs England	14.3 (13.6, 15.0)	13.3 (12.7, 14.0)	●	1.31 (1.29, 1.32)	1.32 (1.31, 1.34)	●
Most deprived fifth of LADs vs least deprived fifth	33.0 (31.7, 34.2)	30.6 (29.5, 31.8)	●	2.18 (2.11, 2.26)	2.26 (2.18, 2.35)	●
COMMENTARY						
<ul style="list-style-type: none"> • There is a gradient in under-18 conception rates by area deprivation, with the most deprived fifth of LADs having the highest conception rates and the least deprived fifth the lowest conception rates. • For example, in 2004 the under-18 conception rate in the most deprived fifth of LADs was 31 conceptions per 1,000 women aged 15–17 higher than in the least deprived fifth. In relative terms, the under-18 conception rate in the most deprived fifth of LADs was 2.26 times the rate in the least deprived fifth. • Between 1998 and 2004, the gap in under-18 conception rates between the most deprived fifth of LADs and the England average has not changed significantly in absolute or relative terms. This also applies to the gap between the most deprived fifth of LADs and the least deprived fifth. • The Teenage Pregnancy Strategy has agreed local conception reduction targets of between 40% and 60% by 2010 for each top-tier local authority in England, with the greatest reductions sought in areas with the highest rates. Achieving these targets will underpin delivery of national targets while reducing inequality between areas with the highest rates and the average by at least 25%. Around four in five local authorities have experienced an overall decline in their under-18 conception rate from 1998 to 2004, the remaining local authorities having rates that are static or have increased since 1998. The range of progress between top-tier local authorities is wide – from a 42% decline to a 43% increase from 1998 to 2004. 						
Data notes:						
Source: ONS (conception statistics and mid-year population estimates).						
Area deprivation is measured by the Index of Multiple Deprivation 2004, local authority summary (average score) (DCLG).						

KEY: ✓ = decreasing inequality ✗ = increasing inequality
 ● = no significant change — = insufficient data

Indicator 3: Road accident casualties

Overall summary: There have been improvements in child road accident casualty rates since 1998 (including for the most disadvantaged areas). There has been a narrowing of inequalities in absolute terms, but no significant change in relative terms.

Figure 6: Road accident casualties per 100,000 resident population, children (ages 0–15), by area deprivation

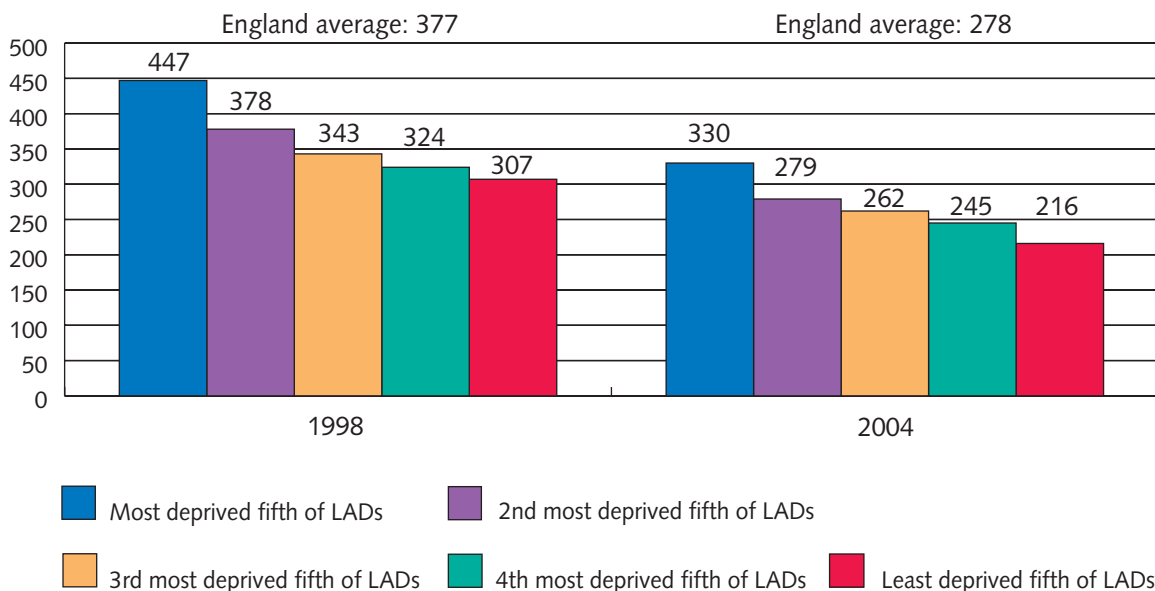
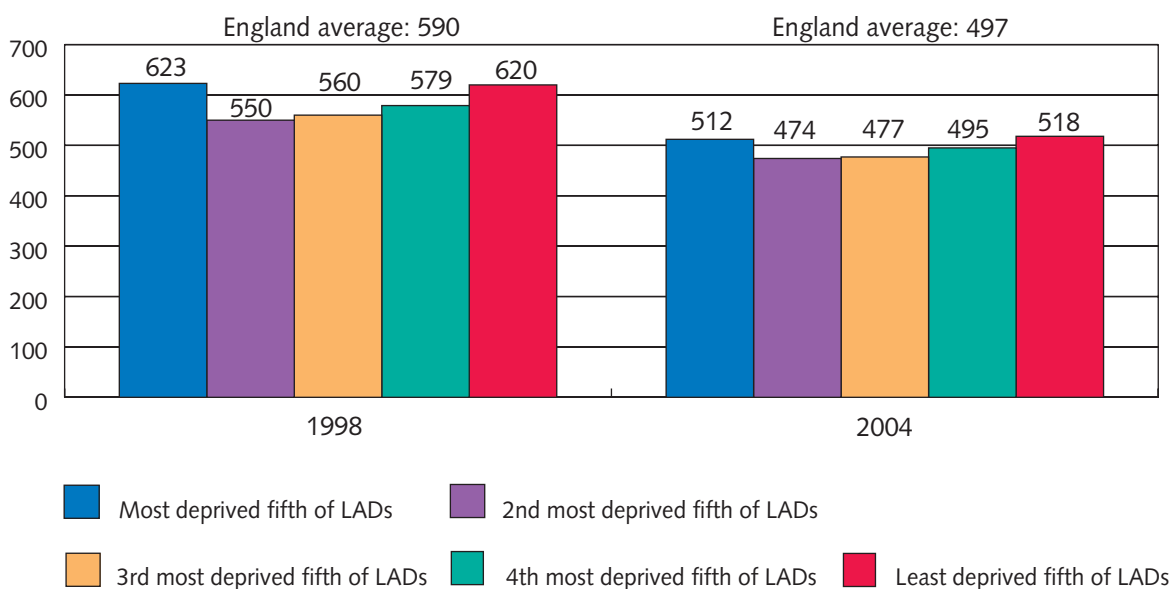


Figure 7: Road accident casualties per 100,000 resident population, all ages, by area deprivation



COMPARISON	ABSOLUTE GAP (DIFFERENCE)			RELATIVE GAP (RATIO)		
	BASELINE 1998	LATEST 2004	TREND	BASELINE 1998	LATEST 2004	TREND
Children – area deprivation						
Most deprived fifth of LADs vs England	70 (65, 76)	52 (47, 57)	✓	1.19 (1.17, 1.20)	1.19 (1.17, 1.21)	●
Most deprived fifth of LADs vs least deprived fifth	140 (129, 151)	114 (104, 123)	✓	1.46 (1.41, 1.50)	1.53 (1.47, 1.59)	●
All ages – area deprivation						
Most deprived fifth of LADs vs England	32 (29, 36)	16 (13, 19)	✓	1.05 (1.05, 1.06)	1.03 (1.03, 1.04)	✓
Most deprived fifth of LADs vs least deprived fifth	2 (-4, 9)	-6 (-12, 1)	●	1.00 (0.99, 1.02)	0.99 (0.98, 1.00)	●
COMMENTARY						
<ul style="list-style-type: none"> Note that for the casualty rates used in the analysis presented, the numerator is the number of casualties based on place of accident rather than place of residence, and the denominator is the resident population. There is a gradient in road accident casualty rates for children by area deprivation, with the most deprived fifth of LADs having the highest casualty rates and the least deprived fifth the lowest casualty rates. For example, in 2004 the child road accident casualty rate in the most deprived fifth of LADs was 114 casualties per 100,000 higher than in the least deprived fifth. In relative terms, the child road accident casualty rate in the most deprived fifth of LADs was 1.53 times the rate in the least deprived fifth, ie 53% higher. The gap in child road accident casualty rates between the most deprived fifth of LADs and the England average was lower in 2004 than in 1998 in absolute terms. In relative terms, the gap was not significantly different in 2004 from 1998 (having increased above the 1998 level in intervening years). This also applies to the gap between the most deprived fifth of LADs and the least deprived fifth. The gap in child road accident casualty rates improved in 2004 over recent years because there was little change or a slight increase in rates in the least deprived fifths of LADs between 2003 and 2004, whereas rates in the most deprived fifth continued to fall. Data for future years will confirm whether this improvement in the gap is the start of a continuing trend. The gradient in road accident casualty rates for all ages by area deprivation is less clear, with both the most and least deprived fifths of LADs having higher casualty rates than other areas. To help tackle the higher incidence of road casualties among people from disadvantaged communities, the Department for Transport (DfT) has set a target to reduce casualty numbers in disadvantaged areas (identified as Neighbourhood Renewal Fund areas) by more than the percentage decline across England as a whole. Latest data for 2004 show there has been a greater reduction since the baseline year (1999–2001) in the number of road accident casualties in disadvantaged districts than in England as a whole (15.8% compared with 12.3% – figures are for all ages). 						
Data notes:						
Source: DfT (STATS19 road casualty data), ONS (mid-year resident population estimates).						
Area deprivation is measured by the Index of Multiple Deprivation 2004, local authority summary (average score) (DCLG)						

KEY: ✓ = decreasing inequality ✗ = increasing inequality
 ● = no significant change — = insufficient data

Indicator 4: Number of primary care professionals per 100,000 population

Overall summary: There have been improvements in the number of full-time equivalent GPs per 100,000 weighted population since September 2002 (including for the most disadvantaged areas), but there has not been a significant narrowing of inequalities. The number of deprived primary care trusts (PCTs) more than 10% below the England average number of full-time equivalent GPs per 100,000 weighted population has increased since September 2002.

Figure 8: Number of full-time equivalent GPs per 100,000 weighted population by area deprivation

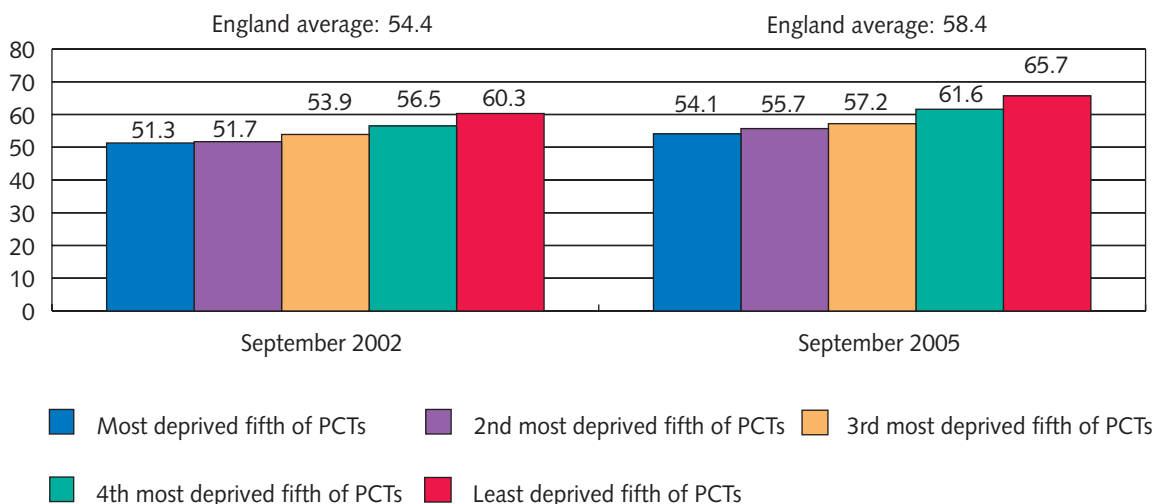
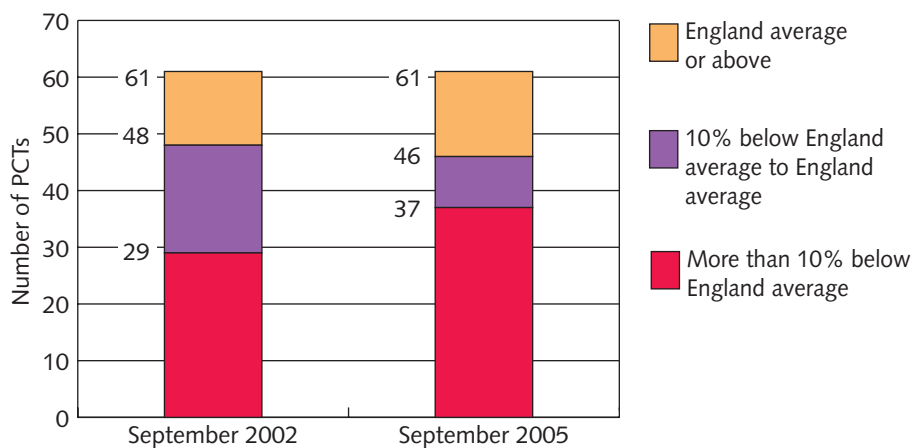


Figure 9: PCTs in the most deprived fifth by full-time equivalent GPs per 100,000 weighted population band



COMPARISON	ABSOLUTE GAP (DIFFERENCE)			RELATIVE GAP (RATIO)		
	BASELINE Sep 2002	LATEST Sep 2005p	TREND	BASELINE Sep 2002	LATEST Sep 2005p	TREND
Area deprivation						
Most deprived fifth of PCTs vs England	-3.1 (-4.3, -2.0)	-4.4 (-5.6, -3.2)	●	0.94 (0.92, 0.96)	0.93 (0.90, 0.95)	●
Most deprived fifth of PCTs vs least deprived fifth	-9.0 (-11.2, -6.9)	-11.6 (-13.8, -9.4)	●	0.85 (0.82, 0.88)	0.82 (0.79, 0.85)	●
COMMENTARY						
<ul style="list-style-type: none"> Figures are based on the number of full-time equivalent GPs per 100,000 population weighted for age and need, for PCTs prior to the reorganisation of October 2006. (The term full-time equivalent (fte) replaces whole-time equivalent (wte) used previously). September 2005 figures are provisional. The method for weighting the populations used for September 2002 has been revised to ensure comparability with the September 2005 figures. There is a gradient in the number of full-time equivalent GPs per 100,000 weighted population by area deprivation, with the most deprived fifth of PCTs having the fewest full-time equivalent GPs per 100,000 and the least deprived fifth of PCTs the most full-time equivalent GPs per 100,000. Between September 2002 and September 2005, there was no significant change in the gap in the number of full-time equivalent GPs per 100,000 weighted population between the most deprived fifth of PCTs and both the England average and the least deprived fifth of PCTs. Although some deprived PCTs have a relatively high number of full-time equivalent GPs per 100,000 weighted population, at September 2005 a high proportion of PCTs in the most deprived fifth (46 out of 61) were below the England average level. Nearly two-thirds of PCTs in the most deprived fifth (37 out of 61) were more than 10% below the England average level (an increase from September 2002, when 29 out of 61 PCTs were more than 10% below the England average level). 						
Data notes:						
<p>Source: Census of General and Personal Medical Services, The Information Centre for health and social care. GP retainers and registrars are excluded. The population is the GP-relevant population constrained to ONS population estimates, weighted for age and to reflect need for GP consultations. For the September 2002 figures, the population is based on GP lists in the ADS2003 reconciled to mid-2002 ONS population estimates; for the September 2005 figures, the population is based on GP lists in the ADS2004 reconciled to 2003-based ONS population projections for 2005. The September 2005 figures are provisional as population projections are used. Age and need weightings for both September 2002 and September 2005 are based on the method used for the 2006/07 PCT revenue allocations for primary medical services.</p> <p>Area deprivation is measured by the Index of Multiple Deprivation 2004, PCT summary (average score) (produced by the Healthcare Commission, based on DCLG data).</p>						

KEY: ✓ = decreasing inequality ✗ = increasing inequality
 ● = no significant change — = insufficient data

Indicator 5: Percentage uptake of flu vaccinations by older people (aged 65+)

Overall summary: Between 2002 and 2005, the percentage uptake of flu vaccinations by older people increased (including for the most disadvantaged areas), accompanied by a slight narrowing of inequalities in absolute and relative terms. This does not mean that all of the most deprived PCTs are improving relative to the least deprived PCTs. However, more deprived PCTs achieved the 70% uptake target in 2005 than in 2002.

Figure 10: Percentage uptake of flu vaccinations among over-65s by area deprivation

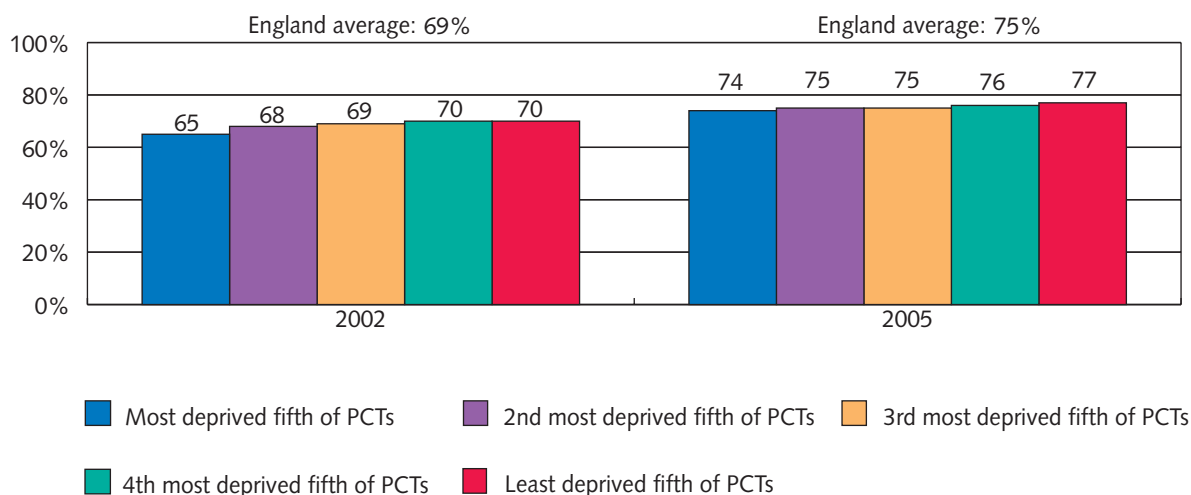
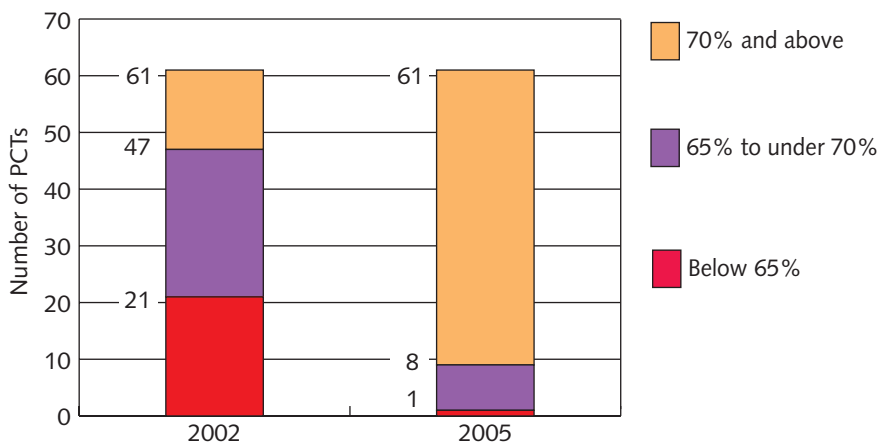


Figure 11: Number of PCTs in the most deprived fifth by percentage uptake band for flu vaccinations among over-65s



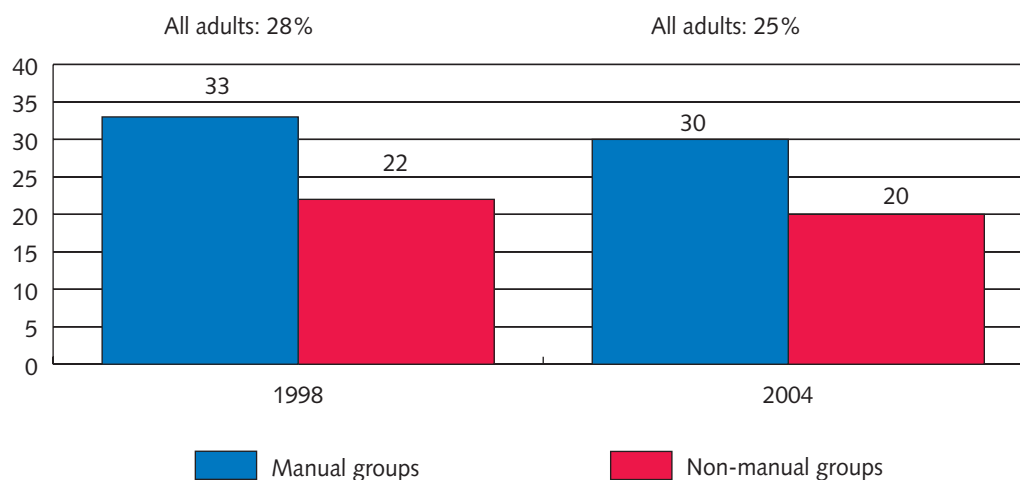
COMPARISON	ABSOLUTE GAP (DIFFERENCE)			RELATIVE GAP (RATIO)		
	BASELINE	LATEST	TREND	BASELINE	LATEST	TREND
	2002	2005		2002	2005	
Area deprivation						
Most deprived fifth of PCTs vs England	-3.6 (-3.7, -3.5)	-1.7 (-1.8, -1.7)	✓	0.95 (0.95, 0.95)	0.98 (0.98, 0.98)	✓
Most deprived fifth of PCTs vs least deprived fifth	-5.4 (-5.5, -5.3)	-3.3 (-3.3, -3.2)	✓	0.92 (0.92, 0.92)	0.96 (0.96, 0.96)	✓
COMMENTARY						
<ul style="list-style-type: none"> • There is a slight gradient in the uptake of flu vaccinations among over-65s by area deprivation, with the most deprived fifth of PCTs having the lowest uptake and the least deprived fifth having the highest uptake. • Between 2002 and 2005, the gap in flu vaccination uptake between the most deprived fifth of PCTs and both the England average and the least deprived fifth of PCTs narrowed in absolute and relative terms (the 2005 position continuing the narrowing trend shown up to 2004). • Although some deprived PCTs achieved the target uptake of flu vaccinations by older people of at least 70%, in 2002 the uptake in a high proportion of PCTs in the most deprived fifth (47 out of 61) was below 70%. Uptake in around a third of PCTs in the most deprived fifth (21 out of 61) was below 65%. In 2005, more PCTs in the most deprived fifth achieved 70% uptake. Only 8 out of the 61 PCTs in the most deprived fifth had uptakes below 70%, with only 1 PCT in the most deprived fifth having an uptake below 65%. • All PCTs in the most deprived fifth with below 70% uptake in 2005 also had below 70% uptake in previous years (2002–04), ie none of these PCTs had previously achieved over 70% uptake but slipped back in 2005. 						
Data notes:						
Source: Data collection from GPs, managed by the Centre for Infection – part of the Health Protection Agency – on behalf of the Department of Health.						
Area deprivation is measured by the Index of Multiple Deprivation 2004, PCT summary (average score) (produced by the Healthcare Commission, based on DCLG data).						

KEY: ✓ = decreasing inequality ✗ = increasing inequality
 ● = no significant change — = insufficient data

Indicator 6a: Prevalence of smoking among people in manual social groups (Part 1 of Prevalence of smoking among people in manual social groups and among pregnant women)

Overall summary: Since 1998, smoking prevalence among all adults has fallen (including among manual groups), but there has been no significant change in inequalities for manual groups compared with non-manual groups or all adults.

Figure 12: Smoking prevalence (aged 16 and over) by socio-economic group, England (weighted data)



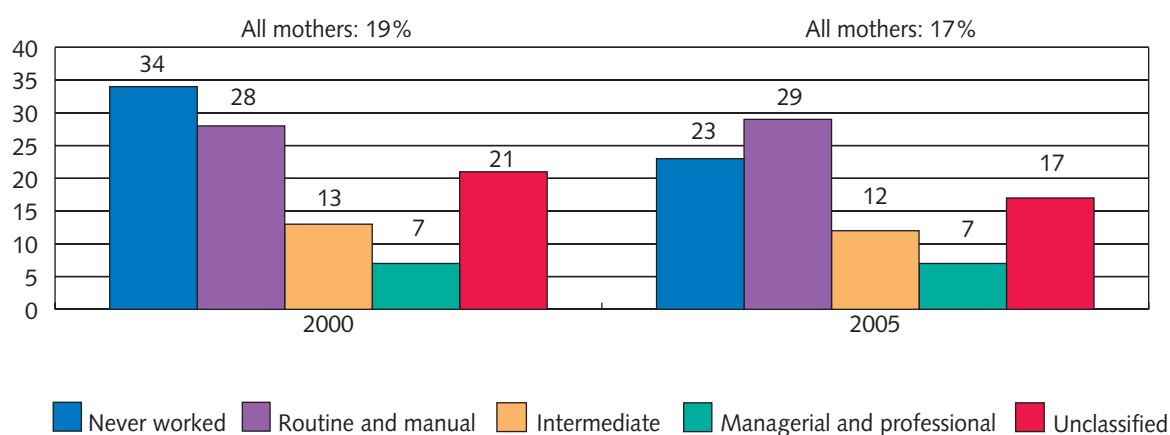
COMPARISON	ABSOLUTE GAP (DIFFERENCE)			RELATIVE GAP (RATIO)		
	BASELINE 1998	LATEST 2004	TREND	BASELINE 1998	LATEST 2004	TREND
Socio-economic group						
Manual groups vs all adults	5 (4, 6)	5 (4, 6)	●	1.19 (1.16, 1.22)	1.20 (1.16, 1.23)	●
Manual groups vs non-manual groups	11 (9, 12)	9 (8, 11)	●	1.49 (1.40, 1.58)	1.45 (1.36, 1.55)	●
COMMENTARY						
<ul style="list-style-type: none"> Smoking prevalence among manual groups is consistently higher than in non-manual groups and in the adult population as a whole. For example, in 2004 smoking prevalence in manual groups was 9 percentage points higher than in non-manual groups. In relative terms, smoking prevalence in manual groups was 1.45 times the prevalence in non-manual groups, ie 45% 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 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. 						
Data notes:						
Source: General Household Survey(GHS) (ONS).						
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. (For 1998, both weighted and unweighted data were calculated, to give an indication of the effect of weighting – it increased smoking prevalence for all adults and for manual and non-manual groups by 1 percentage point.)						
From 2001 onwards, figures are based on the new NS SEC classification recoded to produce previous socio-economic group categories (ie manual/non-manual groups).						
Approximate 95% confidence intervals for the gap measures have been calculated assuming a simple random sample. As the GHS does not use a simple random sample, this may slightly underestimate the size of the confidence intervals.						

KEY: ✓ = decreasing inequality ✗ = increasing inequality
 ● = no significant change — = insufficient data

Indicator 6b: Prevalence of smoking among pregnant women (Part 2 of Prevalence of smoking among people in manual social groups and among pregnant women)

Overall summary: Between 2000 and 2005, the overall prevalence of smoking throughout pregnancy decreased slightly, including a large fall in prevalence among women in the ‘never worked’ category but a slight increase among the routine and manual group. There were some signs of a widening of inequalities for the routine and manual group.

Figure 13: Percentage of women who smoked throughout pregnancy by socio-economic group (NS SEC), England



COMPARISON	ABSOLUTE GAP (DIFFERENCE)			RELATIVE GAP (RATIO)		
	BASELINE 2000	LATEST 2005	TREND	BASELINE 2000	LATEST 2005	TREND
Socio-economic group (NS SEC) (England data)						
Routine and manual group vs all mothers	9 (7, 11)	12 (10, 14)	•	1.48 (1.35, 1.60)	1.73 (1.64, 1.82)	✗
Routine and manual group vs managerial and professional group	21 (18, 24)	22 (19, 24)	•	3.77 (3.06, 4.63)	4.05 (3.42, 4.79)	•
COMMENTARY						
<ul style="list-style-type: none"> As in 2000, data from the 2005 Infant Feeding Survey show a clear variation by socio-economic group in the prevalence of smoking throughout pregnancy in England, with prevalence decreasing from the routine and manual group to the intermediate group, and from the intermediate group to the managerial and professional group. In 2005, the ratio of prevalence of smoking throughout pregnancy in the routine and manual group to the managerial and professional group was 4.05. Between 2000 and 2005, the prevalence of smoking throughout pregnancy in the routine and manual group increased by 1 percentage point. There was no significant change in the gap in prevalence between the routine and manual group and the managerial and professional group, in absolute or relative terms. For the gap between the routine and manual group and all mothers, there was no significant change in the absolute gap, but a widening of the relative gap. (Although both relative gap measures indicate a widening of inequalities, this is within the bounds of expected sampling error for the gap between the routine and manual group and the managerial and professional group. Confidence intervals are wide for the inequality measures as data are based on a sample survey.) There was a large improvement in the prevalence of smoking throughout pregnancy in the ‘never worked’ group between 2000 and 2005, with a larger fall in prevalence than for any other socio-economic group. In 2000, the ‘never worked’ socio-economic group had the highest prevalence of smoking throughout pregnancy (34%); by 2005 this had fallen to 23%, lower than the routine and manual group. 						
Data notes:						
Source: Infant Feeding Survey (carried out by BMRB Social Research on behalf of the UK Health Departments, published by The Information Centre for health and social care).						

KEY: ✓ = decreasing inequality ✗ = increasing inequality
 • = no significant change — = insufficient data

Indicator 7: Proportion of those aged 16 who get qualifications equivalent to five GCSEs at grades A* to C

Overall summary: Between 2002 and 2005, the proportion of pupils achieving five or more A*–C grades at GCSE increased (including among pupils eligible for free school meals (FSM)), with signs of a slight narrowing of the attainment gap between pupils eligible for FSM and all pupils.

Figure 14: Percentage of pupils aged 16 achieving five or more GCSEs at grades A*–C (or equivalent) by FSM eligibility, England

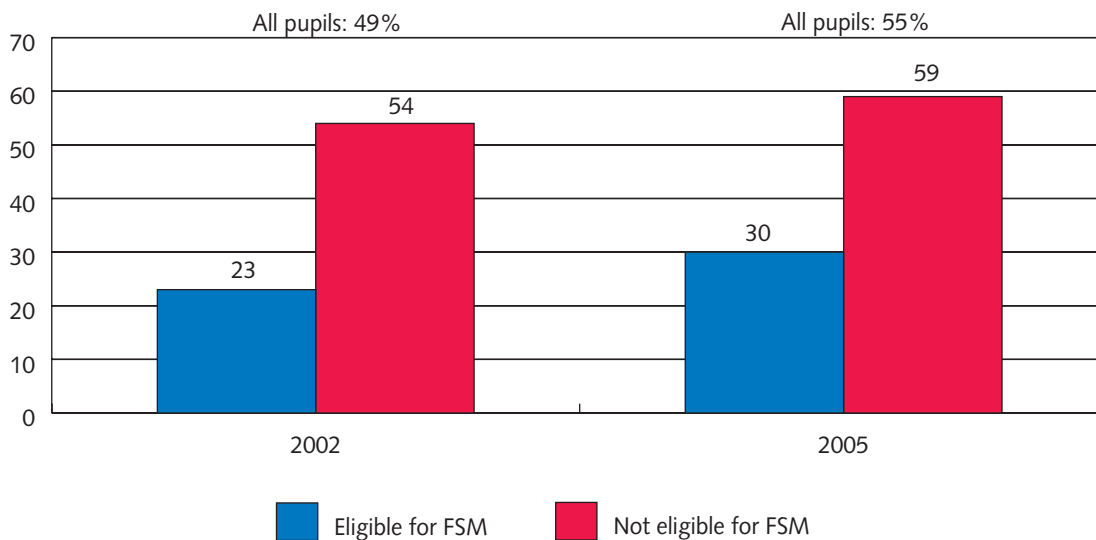
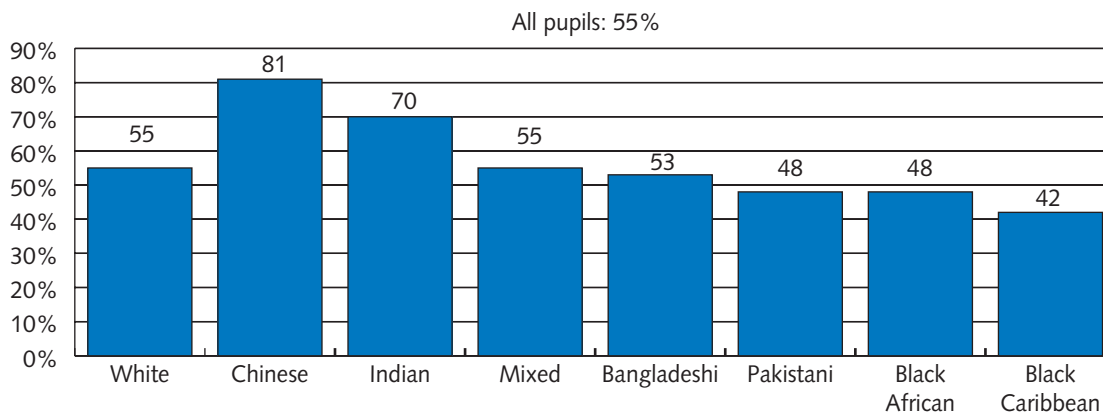


Figure 15: Percentage of pupils at Key Stage 4 achieving five or more GCSEs at grades A*–C (or equivalent) by selected ethnic groups, England, 2005



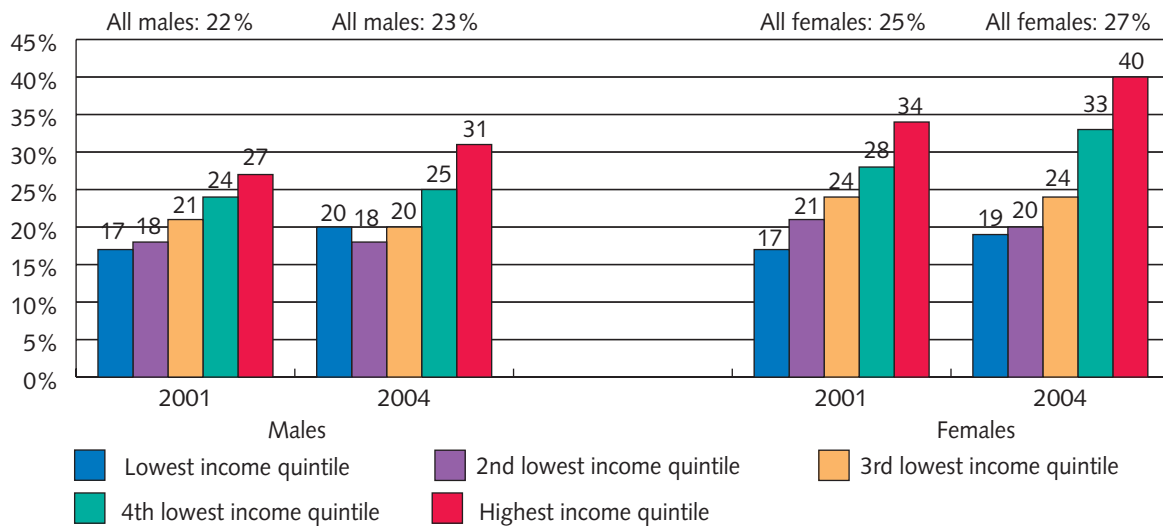
COMPARISON	ABSOLUTE GAP (DIFFERENCE)			RELATIVE GAP (RATIO)		
	BASELINE 2002	LATEST 2005	TREND	BASELINE 2002	LATEST 2005	TREND
Eligibility for FSM						
Eligible for FSM vs all pupils	-26 (-26, -26)	-25 (-25, -25)	✓	0.47 (0.46, 0.47)	0.54 (0.54, 0.55)	✓
Eligible for FSM vs not eligible for FSM	-31 (-31, -30)	-29 (-29, -29)	✓	0.43 (0.42, 0.43)	0.51 (0.50, 0.51)	✓
COMMENTARY						
<ul style="list-style-type: none"> • The proportion of pupils achieving five or more A*–C grades at GCSE is lower among pupils who are eligible for FSM than among pupils who are not eligible for FSM. • For example, in 2005 the proportion of pupils aged 16 achieving five or more A*–C grades at GCSE among pupils eligible for FSM was 29 percentage points lower than the proportion among pupils not eligible for FSM. In relative terms, the proportion among pupils eligible for FSM was 0.51 times the proportion among pupils not eligible for FSM, ie 49% lower. • Between 2002 and 2005, the proportion of pupils aged 16 achieving five or more A*–C grades at GCSE among pupils eligible for FSM increased. In addition, the attainment gap between pupils eligible for FSM and all pupils overall narrowed slightly in both absolute and relative terms. This also applies to the gap between pupils eligible for FSM and pupils not eligible for FSM. • GCSE attainment varies between minority ethnic groups. For example, for pupils at Key Stage 4, Chinese and Indian pupils perform above the England average attainment of five or more A*–C grades at GCSE, whereas Black African, Black Caribbean, Pakistani and Bangladeshi pupils perform below the England average. However, analysis presented in the Department for Education and Skills (DfES) Statistical Bulletin <i>Statistics of Education: Trends in Attainment Gaps: 2005</i> (June 2006) suggests that between 2003 and 2005 attainment of five or more A*–C grades at GCSE improved faster among Black African, Black Caribbean, Pakistani and Bangladeshi pupils than the England average. 						
Data notes:						
Source: Matched data in the National Pupil Database (DfES).						
Data are for pupils in maintained schools only. 'Pupils aged 16' means pupils aged 16 at the end of the academic year. 'Pupils at Key Stage 4' means pupils who have reached the end of Key Stage 4 (ie who have completed Year 11 – most pupils at the end of Year 11 are aged 16, but some may be slightly older or younger).						

KEY: ✓ = decreasing inequality ✗ = increasing inequality
 ● = no significant change — = insufficient data

Indicator 8: Proportion of people consuming five or more portions of fruit and vegetables per day in the lowest quintile of household income distribution

Overall summary: Between 2001 and 2004, inequalities in consumption of five or more portions of fruit and vegetables per day did not change significantly in absolute or relative terms.

Figure 16: Percentage of adults (aged 16 and over) consuming five or more portions of fruit and vegetables per day, England, by household income quintile



COMPARISON	ABSOLUTE GAP (DIFFERENCE)			RELATIVE GAP (RATIO)		
	BASELINE 2001	LATEST 2004	TREND	BASELINE 2001	LATEST 2004	TREND
Household income						
Adults, male – lowest income quintile vs England	–6 (–8, –3)	–4 (–7, 0)	●	0.75 (0.65, 0.86)	0.85 (0.70, 1.03)	●
Adults, female – lowest income quintile vs England	–8 (–10, –6)	–7 (–10, –5)	●	0.69 (0.62, 0.77)	0.72 (0.63, 0.83)	●
Adults, male – lowest income quintile vs highest income quintile	–11 (–14, –7)	–11 (–17, –5)	●	0.61 (0.51, 0.72)	0.64 (0.50, 0.82)	●
Adults, female – lowest income quintile vs highest income quintile	–17 (–20, –13)	–20 (–26, –15)	●	0.51 (0.44, 0.58)	0.49 (0.40, 0.59)	●
COMMENTARY						
<ul style="list-style-type: none"> • There is a gradient in the proportion of adults consuming five or more portions of fruit and vegetables per day by household income quintile, with the lowest income quintile having the lowest proportion consuming ‘five a day’ and the highest income quintile the highest proportion (except for adult males in 2004, where the lowest income quintile has a slightly higher proportion consuming ‘five a day’ than the second lowest income quintile). • For example, in 2004 the proportion of adult females consuming five or more portions of fruit and vegetables per day in the lowest household income quintile was 20 percentage points lower than the proportion in the highest household income quintile. In relative terms, the proportion of adult females consuming five or more portions of fruit and vegetables per day in the lowest household income quintile was 0.49 times the proportion in the highest household income quintile, ie about 50% lower. • Between 2001 and 2004, inequalities in consumption of five or more portions of fruit and vegetables per day did not change significantly in absolute or relative terms. (Confidence intervals are wide for the inequality measures as data are based on a sample survey, so it is difficult to make a robust assessment of change over time.) 						
Data notes:						
Source: Health Survey for England (carried out by the Joint Health Surveys Unit of the National Centre for Social Research (NatCen) and the Department of Epidemiology and Public Health at the Royal Free and University College Medical School, on behalf of The Information Centre for health and social care).						

KEY: ✓ = decreasing inequality ✗ = increasing inequality
 ● = no significant change — = insufficient data

Indicator 9: Proportion of households living in non-decent housing

Overall summary: Between 1996 and 2004, the proportions of vulnerable private sector households and of social sector tenants living in non-decent housing decreased, with a narrowing of inequalities between these groups and non-vulnerable private sector households in both absolute and relative terms.

Figure 17: Percentage of households living in non-decent housing by sector/vulnerable household status

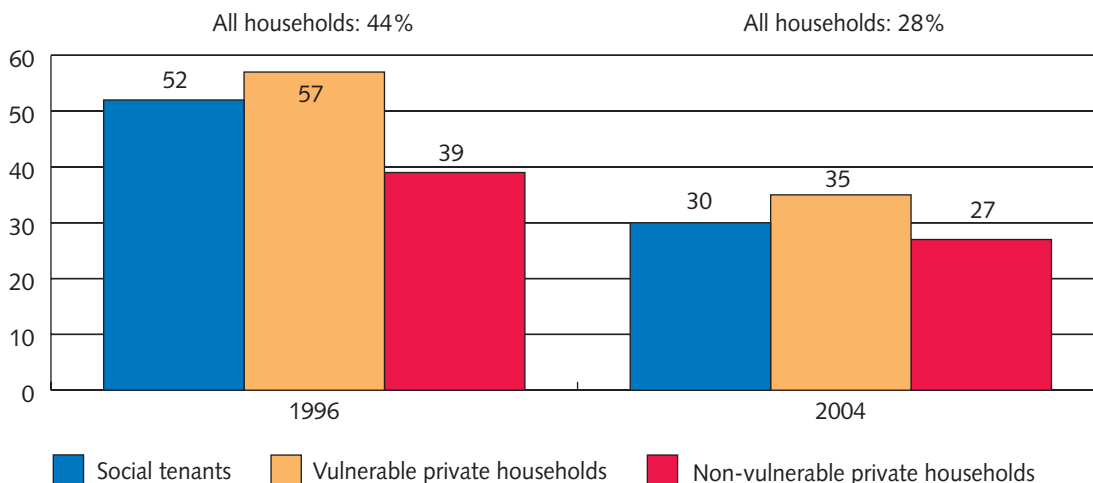
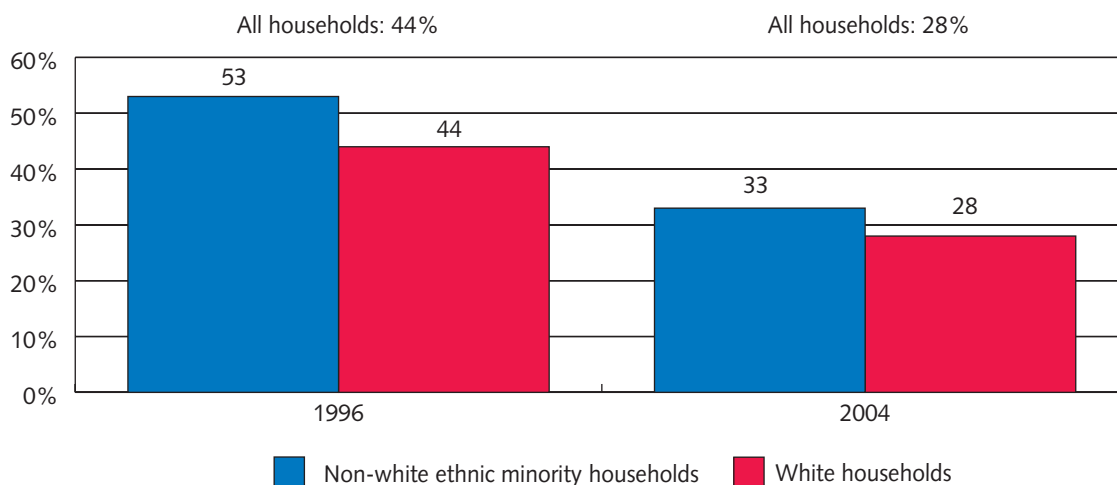


Figure 18: Percentage of households living in non-decent housing by ethnic identity, England



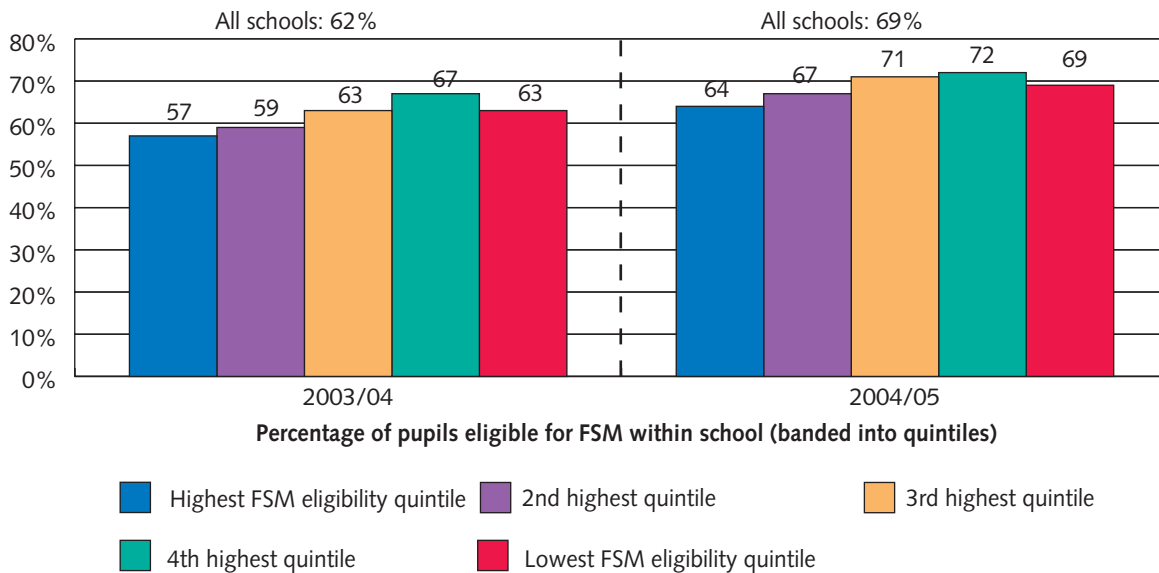
COMPARISON	ABSOLUTE GAP (DIFFERENCE)			RELATIVE GAP (RATIO)		
	BASELINE 1996	LATEST 2004	TREND	BASELINE 1996	LATEST 2004	TREND
Sector/vulnerable household status						
Vulnerable private sector households vs non-vulnerable private sector households	19	9	✓	1.49	1.34	✓
Social tenants vs non-vulnerable private sector households	14	5	✓	1.36	1.20	✓
COMMENTARY						
<ul style="list-style-type: none"> • Definition of a decent home – for a dwelling to be considered 'decent' it must: meet the statutory minimum standard for housing; be in a reasonable state of repair; have reasonably modern facilities and services, and, provide a reasonable degree of thermal comfort. • Vulnerable households are those in receipt of income- or disability-related benefits. Both vulnerable private sector households and social sector tenants are more likely to live in non-decent housing than non-vulnerable private sector households. In 2004, the proportion of vulnerable private sector households living in non-decent housing was 1.34 times the proportion of non-vulnerable private sector households, ie 34% higher. The proportion of social sector tenants living in non-decent housing was 1.20 times the proportion of non-vulnerable private sector households, ie 20% higher. • The proportion of households living in non-decent housing fell substantially for all groups between 1996 and 2004. • Between 1996 and 2004, the gap between the proportion of vulnerable private sector households and non-vulnerable private sector households living in non-decent homes narrowed in both absolute and relative terms. The gap between the proportion of social tenants and non-vulnerable private sector households living in non-decent homes also narrowed in absolute and relative terms. • Although the majority of households living in non-decent homes are white, ethnic minority households are more likely to live in non-decent homes. In 2004, 33% of non-white ethnic minority households lived in non-decent homes, compared with 28% of white households. This compares with 53% of non-white minority ethnic households and 44% of white households living in non-decent homes in 1996. While this suggests that there has been greater improvement since 1996 for ethnic minority households than for white households, this is not yet statistically significant. 						
Data notes:						
Source: English House Condition Survey (EHCS) (DCLG).						
The EHCS was carried out every five years until 2001, when the survey was reorganised with the introduction of continuous fieldwork from April 2002 to provide annual results from 2003.						
The absolute and relative gap measures are calculated using modelled estimates based on fitting a linear model to survey data from across the whole time period, rather than using direct survey estimates based on data from each particular year only. Confidence intervals have not been calculated for the absolute and relative gap measures, but the significance of the change in the gaps (at the 95% confidence level) was assessed using a statistical test applied to the linear model.						

KEY: ✓ = decreasing inequality ✗ = increasing inequality
 ● = no significant change — = insufficient data

Indicator 10: Percentage of schoolchildren who spend a minimum of two hours each week on high-quality PE and school sport within and beyond the curriculum

Overall summary: Participation in PE and school sport is lower on average in School Sport Partnership schools with a high proportion of pupils eligible for free school meals (FSM). Latest data for 2004/05 are not directly comparable with previously available data for 2003/04.

Figure 19: Percentage of school children who spend a minimum of two hours in a typical week on high-quality PE and school sport by level of eligibility for FSM within school



COMPARISON	ABSOLUTE GAP (DIFFERENCE)			RELATIVE GAP (RATIO)		
	BASELINE 2003/04	LATEST 2004/05	TREND	BASELINE 2003/04	LATEST 2004/05	TREND
Eligibility for FSM (schools banded into quintiles by percentage of pupils eligible for FSM)						
Highest FSM eligibility quintile vs all schools	-5	-5	—	0.92	0.93	—
Highest FSM eligibility quintile vs lowest FSM eligibility quintile	-6	-5	—	0.90	0.92	—
COMMENTARY						
<ul style="list-style-type: none"> As in 2003/04, in 2004/05 participation in PE and school sport was lower on average in School Sport Partnership schools with a high proportion of pupils eligible for FSM. The fifth of Partnership schools with the highest proportion of pupils eligible for FSM had 64% of pupils participating in at least two hours of PE and school sport in a typical week. This compares with 69% of pupils in the fifth of Partnership schools with the lowest proportion of pupils eligible for FSM and 72% of pupils in the fifth of Partnership schools with the second lowest proportion of pupils eligible for FSM. Data for 2004/05 are not directly comparable with data for 2003/04, as the number of schools covered by School Sport Partnerships increased between the two years. However, the data for 2004/05 show higher participation in PE and school sport both for all schools and in each FSM eligibility quintile of schools. There was little difference in the absolute or relative gap measures between the two years. The DfES and the Department for Culture, Media and Sport have a PSA target to enhance the take-up of sporting opportunities 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 within and beyond the curriculum increases to 75% by 2006 and to 85% by 2008, and to at least 75% in each School Sport Partnership by 2008. 						
Data notes:						
Source: Annual survey of School Sport Partnerships (DfES). The survey only covers School Sport Partnerships. The number of schools covered by School Sport Partnerships increased between 2003/04 and 2004/05 – full coverage of schools will not be achieved until September 2006.						

KEY: ✓ = decreasing inequality ✗ = increasing inequality
 ● = no significant change — = insufficient data

Indicator 11: Proportion of children living in low-income households

Overall summary: The proportion of children in England living in low-income households has fallen since the baseline of 1998/99. This fall is shown for both relative and absolute low-income measures and across all low-income thresholds, and on both before and after housing cost measures.

Figure 20: Percentage of children in England living in low-income households (below 60% of Great Britain median income)



MEASURE	BASELINE 1998/99	LATEST 2004/05	TREND
Relative low income (before housing costs)	24%	19%	✓
Absolute low income (before housing costs)	22%	11%	✓
Relative low income (after housing costs)	33%	28%	✓
Absolute low income (after housing costs)	31%	15%	✓

COMMENTARY

- The data shown are for the percentage of children in England living in low-income households (the low income threshold being 60% of GB median household income). For relative low income, the threshold moves each year. For absolute low income, the threshold is fixed at 1996/97 levels in real terms.
- The proportion of children in England living in low-income households has fallen since the baseline of 1998/99 (for both relative and absolute low-income measures, on both before and after housing cost measures).
- In addition to the improvement on the relative and absolute low-income measures, the proportion of children in England living in households with persistent low incomes (below 60% of the GB median) has fallen from 20% in the period 1991–94 to 13% in the period 2001–04. (Persistent low income is defined as low income – before housing costs – in three out of the four years in each period.)

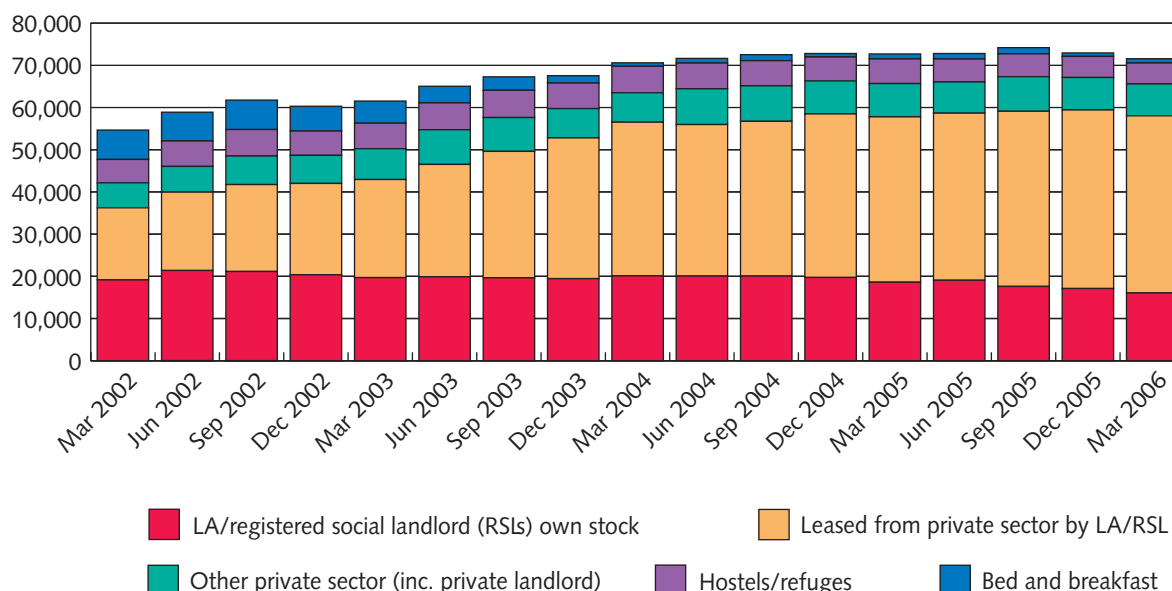
Data notes:
Source: Households Below Average Income (Department for Work and Pensions).

KEY: ✓ = decreasing inequality ✗ = increasing inequality
 • = no significant change — = insufficient data

Indicator 12: Number of homeless families with children in temporary accommodation

Overall summary: Since March 2002, there has been a reduction in the number of homeless families with children in bed and breakfast accommodation, but an increase in the number of homeless families with children living in temporary accommodation overall (although this number has fallen in recent quarters).

Figure 21: Homeless families in temporary accommodation arranged by local authorities (LAs) by type of accommodation, England



MEASURE	BASELINE Mar 2002	LATEST Mar 2006	TREND
Number in temporary accommodation (including bed and breakfast)	54,660	71,560	✗
Number in bed and breakfast accommodation	6,960	1,020	✓

COMMENTARY

- The number of homeless families with children in bed and breakfast accommodation fell from 6,960 at the end of March 2002 to 1,020 at the end of March 2006 (ie reduced by 85%).
- The number of homeless families with children in all forms of temporary accommodation (including bed and breakfast) increased between March 2002 and March 2006, from 54,660 to 71,560. However, the number in temporary accommodation levelled off from September 2004 and has fallen in the most recent quarters (and is at its lowest level since March 2004).
- People from black and minority ethnic groups continue to be over-represented among those accepted as homeless. Of the 93,980 households accepted as homeless during 2005/06, 21% were from a black or minority ethnic background (the same as in 2004/05). (There were a further 5% where the ethnic origin was not known.)
- Although the number of homeless families with children in all forms of temporary accommodation has increased since March 2002, the proportion in shared accommodation such as bed and breakfast hotels, hostels or women's refuges has fallen. At the end of March 2006, around 90% of families with children in temporary accommodation were in self-contained homes, compared with around 75% at the end of March 2002.

Data notes:

Source: Data collected by DCLG's Housing and Communities Analysis and Housing Strategy and Support teams from P1E forms returned by local authorities.

'Homeless families with children' means homeless households with dependent children and/or an expectant mother.

Figures are grossed (imputed) national totals based on local authority returns.

KEY: ✓ = decreasing inequality ✗ = increasing inequality
• = no significant change — = insufficient data

Annex 1

The national headline indicators – some data issues

1. The use of indicators for quantitative monitoring is limited by the availability of data. Data may not be available for all areas relevant to tackling health inequalities. Even where data are available, there will be limitations due to the time it takes for the figures to become available after the period to which they relate. Qualitative monitoring of action taken is also required, to supplement quantitative monitoring of indicators.
2. The national headline indicators provide a broad summary of the areas to be monitored and represent available and already collected data sets. The areas covered are those where interventions are expected to make a significant impact on inequalities.
3. Data are presented for the national headline indicators, focusing on measures of inequality in relation to the indicators. An assessment of progress in reducing inequalities since the baseline period is presented.
4. Some further background information on measuring inequalities (including the use of absolute and relative gap measures) can be found in Annexes 1, 4 and 5 of *Tackling Health Inequalities: Status Report on the Programme for Action* (2005).

Measures of inequality

5. For most of the indicators, the inequality measures presented are the absolute and relative gaps between the most disadvantaged group and a reference group (the least disadvantaged group and/or the whole population). That is, the position of the most disadvantaged group is compared with the least disadvantaged group and/or the national average.
6. The most and least disadvantaged groups are identified using socio-economic measures (area deprivation, social class, income) or suitable proxy measures (vulnerable households, eligibility for free school meals (FSM)). Limitations of data availability mean it is not possible to identify the comparison groups in the same way for all the indicators.
7. The absolute gap is measured by the difference between indicator values in the groups compared. Differences closer to 0 indicate lower inequality. The relative gap is measured by the ratio between indicator values in the groups compared. Ratios closer to 1 indicate lower inequality.
8. The gap between comparison groups measures the inequality between the average levels of the indicator in each group, based on aggregate data for each group as a whole. There are likely to be inequalities within each group as well as between groups. (Where groups are defined by geographical areas, there will be inequalities within the areas – ie at a smaller area level – as well as between the areas.) Within-group inequalities are not measured by the gap between groups, but could be revealed by data at a lower level of aggregation.

9. A narrowing of the gap between comparison groups indicates a reduction in inequality between the average levels of the indicator in each group. However, the picture at a lower level of aggregation may be more complex. For the gap to narrow, some parts of the disadvantaged group must improve relative to the reference group. But this does not mean that all parts of the disadvantaged group will improve relative to the reference group, and the gap between groups can narrow while inequalities within the disadvantaged group widen. For example, the average death rate for the most deprived fifth of LADs may improve faster than the England average, while the gap in death rates between particular LADs within the most deprived fifth widens and some LADs improve more slowly than the England average (so improvements in service delivery designed to narrow inequalities between areas may leave within-area inequalities unchanged or even widen them).
10. Analysis of the gap between groups is presented in this report as a high-level summary measure of inequalities between groups at aggregate level.
11. For two indicators, data are not analysed using the gap between comparison groups. For indicator 11, the extent of child poverty is monitored (as measured by the proportion of children living in low-income households). For indicator 12, the extent of homelessness is monitored (as measured by the number of homeless families with children living in temporary accommodation). For both indicators, a reduction in extent indicates a reduction in inequality.

Baselines

12. For each of the indicators, baseline periods have been selected against which progress is measured. While it is desirable to have a consistent baseline period across the indicators, this is not possible because of data availability. Where possible, baselines have been set at or close to 1997. However, for many of the indicators data are not available prior to more recent years, or comparable data are available only for more recent years due to changes in data collection.

Assessment of change

13. Data are presented for the latest year and for the baseline period. An assessment is made of whether inequalities are narrower in the latest year compared with the baseline on each of the inequality measures presented. For some indicators, data are available only for the baseline period, so no assessment of change can be made.
14. The statistical significance of any change in the inequality measures is taken into account in assessing progress. Approximate 95% confidence intervals have been calculated for many of the inequality measures, to give an indication of the extent of possible sampling error (for those indicators based on sample surveys) or of expected random variation over time (for those indicators not based on sample surveys). Assessment of significant change is based on whether the confidence intervals for the differences and ratios between the baseline and latest year overlap. Confidence intervals for some of the measures based on sample surveys are quite wide, so it is difficult to make a robust assessment of progress.

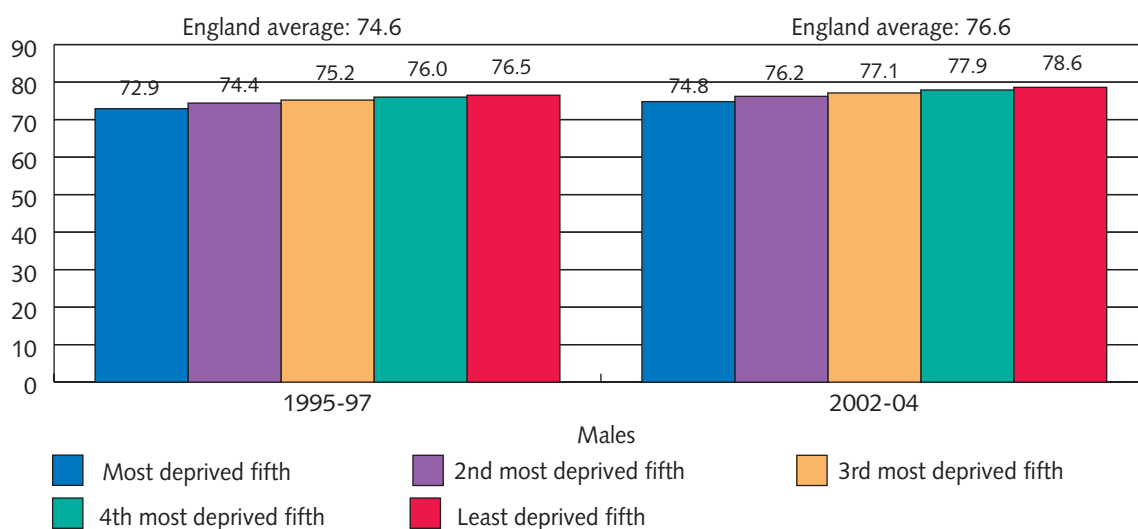
Annex 2

Further information on inequalities in life expectancy at birth

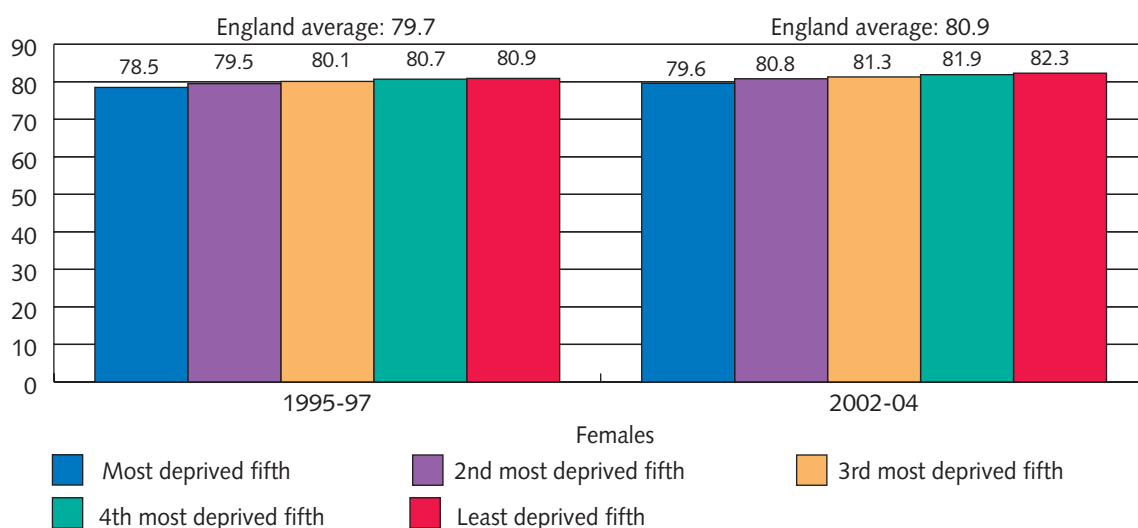
The health inequalities 2004 PSA target aims to reduce area-based inequalities in life expectancy at birth, as measured by the gap between the Spearhead Group of local authority districts and the England average. The Spearhead Group is identified as the most disadvantaged areas based on five indicators, including area deprivation but also male and female life expectancy, and premature mortality from cancer and cardiovascular disease. It is also useful to monitor inequalities in life expectancy between the most and least deprived areas consistent with the approach taken for the headline indicators, particularly cancer and circulatory disease mortality, and this analysis is presented below.

Overall summary: There have been improvements in life expectancy at birth since 1995-97 (including for the most disadvantaged areas), but with signs of a slight widening of inequalities.

Male life expectancy at birth (years), by area deprivation



Female life expectancy at birth (years), by area deprivation



COMPARISON	ABSOLUTE GAP (DIFFERENCE)			RELATIVE GAP (RATIO)		
	BASELINE 1995-97	LATEST 2002-04	TREND	BASELINE 1995-97	LATEST 2002-04	TREND
Area deprivation						
Males – most deprived fifth of LADs vs England	-1.7	-1.8	●	0.977	0.977	●
Males – most deprived fifth of LADs vs least deprived fifth	-3.7	-3.8	✗	0.952	0.951	●
Females – most deprived fifth of LADs vs England	-1.2	-1.3	✗	0.985	0.984	✗
Females – most deprived fifth of LADs vs least deprived fifth	-2.4	-2.7	✗	0.971	0.967	✗
COMMENTARY						
<ul style="list-style-type: none"> • There is a gradient in life expectancy at birth by area deprivation for both males and females, with the most deprived fifth of LADs having the lowest life expectancy and the least deprived fifth the highest life expectancy. • For example, in 2002-04 life expectancy at birth in the most deprived fifth of LADs was 3.8 years lower than in the least deprived fifth for males, and 2.7 years lower than in the least deprived fifth for females. • In 2002-04, the gap in female life expectancy between the most deprived fifth of LADs and the England average was slightly wider than in 1995-97 in both absolute and relative terms. For males, the 2002-04 gap between the most deprived fifth of LADs and the England average was not significantly different from in 1995-97. • In 2002-04, the gap in female life expectancy between the most deprived fifth of LADs and the least deprived fifth was slightly wider than in 1995-97 in both absolute and relative terms. For males, the 2002-04 gap between the most deprived fifth of LADs and the least deprived fifth was slightly wider than in 1995-97 in absolute terms, but not significantly different in relative terms. 						
Data notes:						
Source: ONS with further analysis by DH (England figures published by ONS, figures by area deprivation calculated by DH from death registrations and mid-year population estimates supplied by ONS)						
Area deprivation is measured by the Index of Multiple Deprivation 2004, LA summary (average score) (DCLG)						
Confidence intervals are not presented for the gap measures, but the significance of the change in the gaps was tested at the 95% confidence level.						

KEY: ✓ = decreasing inequality ✗ = increasing inequality
 ● = no significant change — = insufficient data



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<http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthInequalities/HealthInequalitiesGeneralInformation/fs/en>

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